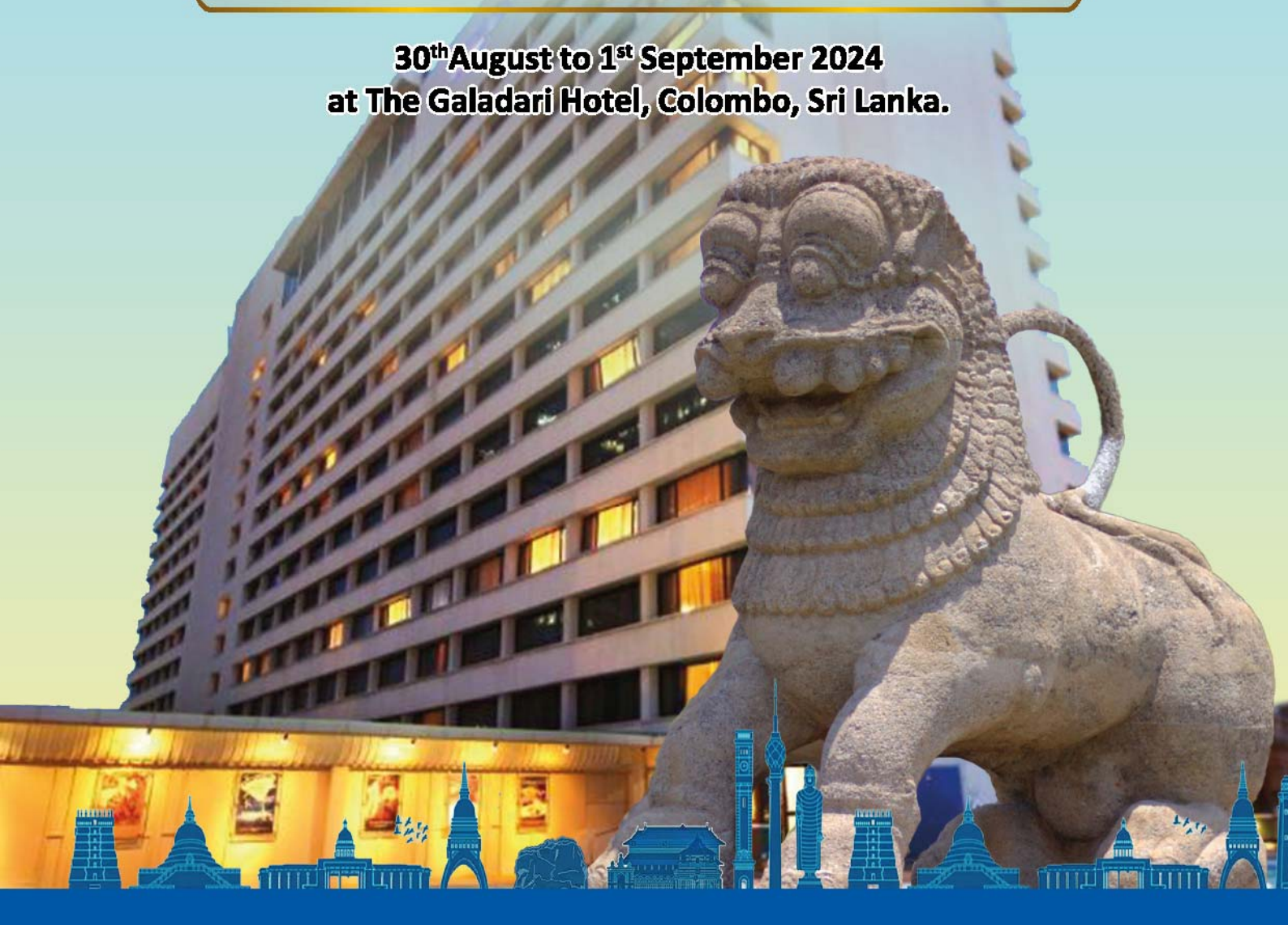
SRI LANKA COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

57 TH ANNUAL ACADEMIC CONGRESS

"Quality health care through standards in training and service delivery" - A right of all women

PROGRAMME BOOK

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



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

Edited by
Dr. Darshana Abeygunawardana
Dr. Achintha Dissanayake

Contents

MESSAGE FROM THE CHIEF GUEST

The SLCOG has been at the forefront of providing training and development of skills in Obstetrics and Gynaecology since 1972. This "mission" of the SLCOG has contributed greatly to the enviable perinatal and maternal morbidity and mortality indices that Sri Lanka enjoys in the region.

The SLCOG has also contributed significantly to the development and success of regional and international Obstetrics and Gynaecology organisations such as SAFOG, AOFOG, and FIGO. Many of its members and fellows have held and continue to hold illustrious positions in these organisations, and the SLCOG should rightly be proud of all these achievements.

Regular scientific discourse of high quality is a sine qua non of any eminent professional organisation, and the SLCOG Congress is no exception. Now in its 57th edition, this Congress promises updates, cutting-edge technology, and insightful opinions delivered by an impressive range of speakers.

This excellent scientific program, combined with the traditionally warm hospitality and incomparable cuisine, is the perfect setting for you to renew friendships and establish new ones.

Come and be part of this great event. You will not leave disappointed!

Dr. Ravi Chandran
Hon. Secretary, FIGO
Past President, AOFOG

MESSAGE FROM THE GUEST OF HONOUR

It gives me immense pride to be invited as a Guest of Honour at the Sri Lanka College Sessions in Colombo in August 2024.

I have always looked forward to my trips here, and one not only ensured excellent scientific content, but the warmth, affection, and friendship of the members of the college is overwhelming.

I have been attending the sessions for several years now and have developed close friendships with most of you, which I treasure immensely.

As President of the SAFOG, I am honoured to head an organisation that had a start in 1996 and has grown steadily under the able leadership of stalwarts from our region.

Sri Lankan obstetricians and gynaecologists have contributed immensely to the progress of the Federation.

This term, I intend to spread the message of Respectful Maternity Care, which has been neglected as we have tried to achieve excellence in areas like Assisted Reproductive Technology (ART), minimally invasive surgery, and improved maternal and neonatal indices.

We must realise that looking after our patients compassionately and humanely and giving them emotional support during labour is equally important. The scientific program this year is excellent, and I am sure the delegates will benefit from the discussions.
I look forward to interacting with each of you in the two days that we will be spending together.

Looking forward to meeting again in the years to come.

Prof. Shyam Desai
President, SAFOG

MESSAGE FROM THE SPECIAL GUEST

Hello, and welcome to the 57th Annual Academic Congress SLCOG 2024.

Obstetricians and Gynaecologists the world over focus on assisting women and their families to have their best lives by delivering health care at the highest standards possible.

This is the guiding principle of Congress 2024: “Quality health care through standards in training and service delivery—a right of all women.”

As one of several international speakers, it is an honour to return to your shores and be able to contribute to this festival of education and insight. Meetings like this, with such a full spectrum of important topics presented by respected experts in their fields, reinforce the strong relationships and bonds between our colleges and countries. Getting together, sharing knowledge and skills, established and evolving, clearly demonstrates SLCOG’s overwhelming commitment to improving the health of Sri Lankan women.

Enjoy, and at Congress’s end, may we all walk away just that little bit smarter and with some new friends.

Kind regards.

Prof. Gregory Joseph Duncombe
Director, Obstetrics and Gynaecology, Logan and Beaudesert Hospitals, Brisbane
Associate Professor, Faculty of Medicine, University of Queensland, Australia.

MESSAGE FROM THE PATRON SLCOG

On the occasion of the 57th Annual Scientific Congress of the Sri Lanka College of Obstetricians & Gynaecologists, it is a great pleasure for me as Patron to warmly welcome all the delegates to this congress.

A very warm welcome to delegates who have travelled from other parts of the world, the Asian region, the Asean and Oceania region, as well as other parts of the world, UK, Australia, USA, and Europe, to participate at our congress in order to exchange and discuss various issues that are common to all of us with respect to improving maternal and newborn health as well as other problems associated with the health of women and adolescent girls.

The Sri Lanka College of Obstetricians & Gynaecologists has had contact with the Royal College of Obstetricians & Gynaecologists for the past several years. We also have established solid relations with the Asean Oceania Federation of Obstetrics and Gynaecology (AOFOG), the International Federation of Obstetrics and Gynaecology (FIGO), and the American College of Obstetrics and Gynaecology. We have recently established relations with the Royal Australian College of Obstetrics and Gynaecology as well.

We are proud to say that the maternal mortality rate in Sri Lanka currently is the lowest in the South Asian region. Our goal is to further reduce it to reach world standard in Sri Lanka. The South Asian Federation of Obstetrics and Gynaecology (SAFOG) was formed by the college in the year 2000 for the purpose of establishing discussions with similar colleges in this region.

The Perinatal Society was formed in 2001 to assist in the management of newborn babies. The Menopause Society of Sri Lanka was also formed in the year 2000 in order to focus on women in the post-reproductive period of their lives. The President and the Council of SLCOG have worked extremely hard to organise a very interesting Congress this year as well as pre-congress workshops and post-congress programs focusing on Quality Health Care through Standards in Training and Service Delivery, a right of all women. The congress promises to be extremely interesting and illuminating, focusing on excellence in management and treatment.

We warmly welcome our honoured Chief Guest, Prof. Shyam Desai from India, who is a dear friend of ours, and Guest of Honour, Dr. Ravi Chandran, as well as Dr. Gregory Duncombe from Australia. Thank you for your presence with us. We also welcome all our other foreign guests and local participants. We hope that all of you will enjoy the conference and that our foreign guests will enjoy your stay in Sri Lanka with its scenic beauty and warm hospitality, and that the topics and the discussions that ensue will enable us to enhance our knowledge on optimum care for our women and babies.

Dr Marlene Abeyewardane
Patron
Sri Lanka College of Obstetricians & Gynaecologists

MESSAGE FROM THE PRESIDENT OF SLCOG

It is a great pleasure to send this message on the occasion of the 57th Annual Academic Congress of the Sri Lanka College of Obstetricians and Gynaecologists.

This year's congress theme, "Quality health care through standards in training and service delivery"—a right of all women—resonates deeply with our mission to uphold the highest standards of care for women across Sri Lanka. This congress not only promotes learning and innovation but also encourages collaboration across borders and specialties. It's a platform where diverse expertise comes together to advance women's health care.

Our program features a comprehensive line-up of pre- and post-congress workshops, plenary sessions, symposia, 'Young Gynaecologist Award' session, and presentations of research papers.

Notably, we are honoured to feature the distinguished Prof. D. A. Ranasinghe Oration, Dr. Rohana Haththotuwa Oration, Dr. P. Dissanayake Endowment Lecture, and sessions by esteemed international bodies like RANZCOG, AOFOG, RCOG, FOGSI, OGSB, and SAFOG.

I would like to extend my heartfelt appreciation to our renowned speakers for their invaluable contributions and to the authors of the free papers. Special thanks go to the scientific and abstract committees, as well as the SLCOG office staff, whose dedication ensures the seamless execution of this congress.

We are also grateful to our sponsors, whose unwavering support has been crucial in succeeding our goals.

To all participants and speakers, I wish you a productive and enriching congress experience. May your discussions spark new insights and your contributions lead to positive changes in women's healthcare across our nation.

Dr. Mangala Dissanayake
President
Sri Lanka College of Obstetricians and Gynaecologists

MESSAGE FROM THE SECRETARY SLCOG

It is with great pleasure and honour that I welcome you all for the 57th Annual Academic Congress of the Sri Lanka College of Obstetricians and Gynaecologists held from 30th August to 01st of September 2024 at the Galadari Hotel Colombo.

The theme for this year's congress, "Quality health care through standards in training and service delivery a right for all women," provides an excellent overture to the tailor-made academic line-up aimed at uplifting the care given to women through our healthcare system. There are several symposia in collaboration with international organisations such as FIGO, RCOG, RANZCOG, and SAFOG, with several prestigious international and national faculty providing their valuable insights into advances in the field of obstetrics and gynaecology. The variety of topics covered by the pre-congress and post-congress workshops further supplements the scientific congress. Key highlights in the academic program include the Professor D. A. Ranasinghe oration, Dr Rohana Haththotuwa oration, Dr P. Dissanayake endowment lecture, and the Young Gynaecologist Award (YGA). I am sure this rich academic program will aid in enhancing the knowledge and broadening the horizons of all delegates.

I am grateful for the leadership and guidance provided by Dr Mangala Dissanayaka, President of SLCOG and the dedication of all council members in organising the congress. My heartfelt gratitude goes out to the organising committee members and administrative staff of the SLCOG for their hard work in making this event a success.

Lastly, looking forward to a promising academic session filled with an enjoyable social interaction in the heart of Colombo. I sincerely hope all international delegates find time, amidst the busy academic schedule, to enjoy the beauty of Sri Lanka and the warm hospitality. Wishing you all an enjoyable stay and all the best!

Dr Achintha Dissanayake
Hon. Secretary
Sri Lanka College of Obstetricians & Gynaecologists

MESSAGE FROM THE CHAIRMAN SCIENTIFIC ACTIVITIES AND RESEARCH

It is with great pleasure and honour that I, as the Chairman of Scientific Activities and Research at the Sri Lanka College of Obstetricians and Gynaecologists, extend a warm welcome to you for the Annual Scientific Congress 2024.

This year's theme, "Quality Health Care through Standards in Training and Service Delivery: A Right for All Women" emphasises the vital role of quality health care in enhancing women's health and improving clinical outcomes for both women and their offspring.

Access to quality health care is not only a fundamental right but also a cornerstone for the well-being and productivity of our society. This congress is designed to serve as a platform for sharing cutting-edge knowledge among key stakeholders in obstetrics and gynaecology.

From informative pre-congress workshops to symposia and free paper presentations, we aim to foster discussions that lead to advancements in our field. Through these collaborative efforts and shared knowledge, we can work towards a future where every woman receives the quality health care she deserves.

I extend my heartfelt gratitude to all our esteemed speakers, chairpersons, moderators, and organising committee members, whose dedication and expertise have been instrumental in making this event possible. Your tireless efforts ensure that the SLCOG continues to serve as a beacon of excellence in obstetrics and gynaecology. I believe this congress will play a vital role in advancing management strategies that will significantly enhance women's health care across our nation. Together, let us pave the way for a healthier future for women in Sri Lanka and beyond.

Dr. Darshana Abeygunawardana
Chairman, Scientific Activities and Research,
Sri Lanka College of Obstetricians and Gynaecologists.

SRI LANKA COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS COUNCIL - 2024

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Course Coordinator – MD part II	Dr. Chinthaka Banagala

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Dr. Madura Jayawardene	Dr. Rishard Mohamed	Dr. S. N. K. Rodrigo
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Prof. Rukshan Fernandopulle	Dr. Madhava Karunaratne	Dr. Maithri Chandraratne
Prof. Cyril Randeniya		

Co-opted Members

Dr. Chandana Jayasundara	Dr. U. D. P. Ratnasiri	Dr. Kanishka Karunaratne
Dr. Gamini Perera		

Sri Lanka College of Obstetricians & Gynaecologists Council 2024

Seated Left to Right - Dr Gamini Perera - *Coopted Member,* Dr Ruwan Silva - *Treasurer*, Dr Sudath Senaratne - *Social Activities Secretary*, Dr Kanishka Karunaratne - *Coopted Member*, Dr U.D.P.Ratnasiri - *Coopted Member*, Prof.C.Randeniya - *Council Member*, Dr A.Sritharan - *Chairman Ethics*, Dr S.P.Akmcemana - *President Elect*, Dr Mangala Dissanayake - *President*, Dr Darshana Abeygunawardana - *Chairman, Scientific Activities & Research*, Dr Shemoon Marleen - *Chairman Continuing Professional Development*, Dr Harsha Atapattu - *Chairman-Education And Setting Standards*, Prof. Rukshan Fernandopulle - *Council Member*, Dr Achintha Dissanayake - *Hony Secretary.*

Standing-Left to Righ - Dr U.G. Kariyawasam - *Council Member*, Dr Sakunthala Senewiratne - *Council Member*, Prof.Jagath Herath - *Chairman Regional Activities And Developments*, Prof. Nishendra Karunaratne - *Chairman Global Relationships*, Dr Madura Jayawardana - *Council Member*, Dr R.M.C.B.Hunukumbura - *Council Member*, Dr Chaminda Mathota - *Council Member*. Dr Nilan Rodrigo - *Council Member*, Dr Prabath Randombage - *Asst. Secretary*, Prof. Krishan Silva - *Council Member*, Dr Udara Jayawardana - *Asst. Secretary*, Dr Sumith Warnasuriya - *Council Member*, Dr B.P.G.N.Silva - *Council Member*, Dr Chandana Jayasundara - *Secretary 2023-Co-opted Member.*

ORGANIZING COMMITTEE

Congress Chairman	Dr Mangala Dissanayaka	
Advisory Committee	Dr Marlene Abeyewardane	Dr Gamini Perera
	Dr Rohana Haththotuwa	Dr Kanishka Karunarathne
Scientific Committee Chairman	Dr Darshana Abeygunawardana	
Scientific Committee	Prof Rukshan Fernandopulle	Dr U D P Ratnasiri
	Dr Prabhodana Ranaweera	Dr S P Akmeemana
	Dr Madura Jayawardena	Dr Udara Jayawardena
	Dr Prabath Randombage	Dr Chandana Jayasundara
Abstract Committee	Dr Shemoon Marleen	Dr Harsha Atapattu
	Dr Janaki Karunasinghe	Dr Achintha Dissanayaka
	Dr Nilan Rodrigo	Prof C Randeniya
	Dr M R M Rishard	Prof Lanka Dasanayaka
	Dr M A G Iresha	Dr U D P Ratnasiri
	Prof Chanil Ekanayaka	Dr Gamini Perera

SUB COMMITTEE

Inauguration	Dr Diluk Senadheera	Dr Chaminda Hunukumbura
	Dr Rajeev Vithanage	
Registration	Dr Ruwan Silva	Dr U G Kariyawasam
Publications	Dr Achintha Dissanayaka	Prof Chanil Ekanayake
Souvenirs	Dr Jagath Herath	
Accommodation & Transport	Prof Nishendra Karunaratne	
Banquet	Dr Sudath Senarathne	Dr Janaki Karunasinghe
	O & G Ladies Forum	
Website/Audio Visuals	Dr Chaminda Mathota	
Trade and Exhibition	Prof Sanath Lanerolle	Dr Ruwan Silva

SRI LANKA COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS

57 TH ANNUAL ACADEMIC CONGRESS

"Quality health care through standards in training and service delivery" - A right of all women

PRE-CONGRESS WORKSHOPS

Pre Congress Workshop - 01

57TH ANNUAL ACADEMIC CONGRESS

SRI LANKA COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

"Quality health care through standards in training and service delivery" - A right of all women

Insight in to ART

19th August 2024 | 8.30 AM – 1.30 PM | Auditorium, SLCOG House

8.30 A.M. – 9.00 A.M.	Registration
9.00 A.M. – 9.05 A.M.	Welcome speech – Dr Mangala Dissanayake
9.05 A.M. – 9.15 A.M.	ART in Sri Lanka; where do we stand ? – Dr Milhan Batcha
9.15 A.M. – 9.45 A.M.	Patient selection & preparation for IVF – Dr Chaminda Hunukumbura
9.45 A.M. – 10.15 A.M.	IVF Protocols – Dr Inoshi Bambaranda
10.15 A.M. – 10.45 A.M.	Oocyte retrieval – Prof Ajith Fernando
10.45 A.M. – 11.15 A.M.	Role of the Embryologist in ART – Prof Sumedha Wijeratne
	TEA BREAK
11.30 A.M. – 12.00 P.M.	Embryo transfer – Dr Udara Jayawardena
12.00 P.M. – 12.30 P.M.	IVF add-ons – Dr Gayani Thissera
12.30 P.M. – 1.00 P.M.	ESHRE Guidelines on ART – Ms. Magdalena Depa-Martynow The Head of Cook Medical's Global Clinical Specialists Team
1.00 P.M. – 1.30 P.M.	Ethical and Legal considerations in ART– Prof Athula Kaluarachchi
	LUNCH

Led by


Dr Mangala Dissanayake
President, SLCOG


Dr Darshana Abeygunawardane
Chairman Scientific Activities & Research, SLCOG

Coordinate by


Dr Chaminda Hunukumbura


Dr Udara Jayawardena

Faculty


Dr Chaminda Hunukumbura


Dr Udara Jayawardena


Dr Milhan Batcha


Prof Ajith Fernando


Prof Sumedha Wijeratne


Dr Inoshi Bambaranda


Prof Athula Kaluarachchi


Dr Gayani Thissera


Ms Magdalena Depa-Martynow

REGISTRATION FEES

CONSULTANTS - RS 2000/=

PG TRAINEES - RS 1000/=

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Pre Congress Workshop - 02

57TH ANNUAL ACADEMIC CONGRESS

SRI LANKA COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

"Quality health care through standards in training and service delivery" - A right of all women

UPDATES IN LABOUR CARE & PHYSIOLOGICAL CTG INTERPRETATION

23rd August 2024 | **8.45 AM – 3.30PM** | **Auditorium, SLCOG House**

8.45 A.M. – 8.50 A.M.	Opening Remarks	Dr Mangala Dissanayake, President SLCOG
8.50 A.M. – 9.00 A.M.	Welcome & Introduction of Overseas Faculty	Dr Darshana Abeygunawardana, Chairman, Scientific activities & research, SLCOG
9.00 A.M. – 9.40 A.M.	WHO Labour Care Updates	Dr Chandana Jayasundara, Senior Lecturer, Faculty of Medicine, University of Colombo
9.40 A.M. – 10.10 A.M.	PPH Care Bundle	Dr U D P Ratnasiri Consultant Obstetrician & Gynaecologist
10.10 A.M. – 10.30 A.M.	TEA BREAK	
10.30 A.M. – 12.00 P.M.	Fetal monitoring in practice Healthy fetus & fetal reserve Fetal physiology – CTG features The fetal response to stress Types of Hypoxia Managing Hypoxia	Dr S Raajkumar Consultant Obstetrician & Gynaecologist, Clinical lead for Obstetrics & Gynaecology Southern University Hospital, NHS Trust, UK
12.00 P.M. – 12.30 P.M.	Labour companion role, preparation & outcome	Dr M R M Rishard, Senior lecturer, Faculty of Medicine, University of Colombo
12.30 P.M. – 1.00 P.M.	LUNCH	
1.00 P.M. – 2.00 P.M.	Infecctions / Chorioamnionitis Meconium stained liquor	Dr Priyantha Kandanearachchi Consultant Obstetrician & Gynaecologist, Trainer of Intrapartum fetal surveillance (IFS) Wales, UK
2.00 P.M. – 3.30 P.M.	Case Discussion + Q & A Abnormal patterns (sinusoidal, pseudo sinusoidal, zig-zag variability)	Dr S Raajkumar / Dr Priyantha Kandanearachchi / Dr M R M Rishard / Dr Damith Siriwardena/ Dr Buddhika Asela
3.30 P.M. – 4.00 P.M.	Competency assessment – Pass mark 85%	
4.00 P.M. onwards	Certification & Vote of Thanks	Dr Chandana Jayasundara, Senior Lecturer, Faculty of Medicine, University of Colombo

LED BY

DR MANGALA DISSANAYAKE , PRESIDENT, SLCOG

MODERATOR

DR DARSHANA ABEYGUNAWARDANA, CHAIRMEN, SCIENTIFIC ACTIVITIES & RESEARCH, SLCOG

CO - ORDINATED BY

DR CHANDANA JAYASUNDARA,

DR BUDDHIKA ASELA

DR DAMITH SIRIWARDENA

FACULTY

DR S RAAJKUMAR

DR P KANDANEARACHCHI

DR U D P RATNASIRI

DR M R M RISHARD

DR DAMITH SIRIWARDENA

DR C JAYASUNDARA

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**free registration*

Pre Congress Workshop - 03

57TH ANNUAL ACADEMIC CONGRESS

SRI LANKA COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

"Quality health care through standards in training and service delivery" - A right of all women

COMPREHENSIVE COLPOSCOPY

with Hands - on Session

26th August 2024 | **7.30 AM – 4.00 PM** | **Apeksha Hospital, Maharagama**

7.30 A.M. – 8.00 A.M.	Registration	
8.00 A.M. – 8.15 A.M.	Welcome address	Dr Mangala Dissanayake, President SLCOG
8.15 A.M. Onwards	Lecture presentations & Discussions	
	Pathophysiology of Cervix and Cervical Screening	Dr Priyantha Kandanearachchi
	Treatment options, Diathermy safety, Risks & Follow up care	
11.00 A.M. – 11.30 A.M.	TEA BREAK	
	Case Discussion	Dr Priyantha Kandanearachchi
1.00 P.M. – 1.30 P.M.	LUNCH	
1.30 P.M. – 4.00 P.M.	Hands – on Session	
4.00 P.M. onwards	Thanking Speech & Certificates	

Faculty


Dr Priyantha Kandanearachchi


Dr Chinthana Hapuachchige


Dr Rajitha Wijesinghe


Dr Kelum Jayasinghe


Dr Thanuya Mahendran

Co-ordinated by


Dr Ruwan Silva

Registration Fees

Consultants – RS 2000/=

PG Trainees – RS 1000/=

(30 Participants Only)

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Pre Congress Workshop - 04

57TH ANNUAL ACADEMIC CONGRESS

SRI LANKA COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

"Quality health care through standards in training and service delivery" - A right of all women

LIVE LAPAROSCOPIC SURGERY *workshop*

28th August 2024 | **7.30 AM – 4.00 PM** | **University Hospital, KDU**

7.30 A.M. – 7.50 A.M	Introduction to Gynaecological Laparoscopy Workshop	Dr Kumara Dissanayake
7.50 A.M. – 8.00 A.M	Welcome address	Dr Mangala Dissanayake, President SLCOG
8.00 A.M. – 9.30 A.M	SURGERY No 1 Laparoscopic Adenomyomectomy	Dr Rajesh Modi
9.30 A.M. – 9.50 A.M	Adenomyosis and surgical approach	Dr Sampath Gnanarathne
9.30 A.M. – 11.00 A.M	SURGERY No 2 Burch colposuspension	Dr Nagendra Sardeshpande
11.00 A.M. – 11.30 A.M	TEA BREAK	
11.30 A.M. – 12.30 P.M	SURGERY No 3 Laparoscopic tubal anastomosis	Dr Rajesh Modi
12.30 P.M. – 1.00 P.M	Application of Laparoscopy in complex & rare cases	Dr Kumara Dissanayake
1.00 P.M. – 3.00 P.M	SURGERY No 4 Laparoscopic excision of deep endometriosis	Dr Nagendra Sardeshpande
3.00 P.M. – 4.00 P.M	Discussion & sharing experiences Q & A / Panel Discussion	Dr Rajesh Modi, Dr Sardeshpande, Dr Chaminda Mathota, Prof Rasika Herath, Dr Pubudu Pathiraja, Prof Nishendra Karunarathne
4.00 P.M. onwards	Thanking Speech & Certificates	

Faculty


Dr Rajesh Modi


Dr Nagendra Sardeshpande


Dr Chaminda Mathota


Prof Rasika Herath


Dr Kumara Dissanayake


Prof Nishendra Karunarathne


Dr Pubudu Pathiraja

Co – ordinated by


Dr Kumara Dissanayake


Dr Prabath Randombage

Registration Fees

Consultants – RS 2000/=

PG Trainees – RS 1000/=

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Pre Congress Workshop - 05 A

SRI LANKA COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

57TH ANNUAL ACADEMIC CONGRESS

PRE CONGRESS WORKSHOP ON

FETAL MEDICINE

29th August 2024

SLCOG House, No 112, Model Farm Road, Colombo 08

In collaboration with the SAFOG Imaging Science Committee.

Prof. Basky Thilaganathan
Obstetrician & Gynaecologist, UK

Miss Luxmi Velauthar
Obstetrician & Gynaecologist, UK

Prof. Tiran Dias
Professor in Fetal Medicine Sri Lanka

Dr. Shemoon Marleen
Chair CPD, SLCOG
Chair Imaging Science Committee, SAFOG

Dr. Archana Baser
SAFOG, India

Dr. Mangala Dissanayake
President SLCOG

Dr. Darshana Abeygunawardana
Chairman Scientific Activities and Research SLCOG

"Quality health care through standards in training and service delivery" - A right of all women

Pre Congress Workshop - 05 B

8.30 am – 8.55 am	Registration
8.55 am – 9.00 am	Welcome address by the President, **Dr. Mangala Dissanayake**
9.00 am – 9.30 am	Update on Fetal Therapy **Prof. Basky Thilaganathan**
9.30 am – 10.00 am	Prediction and prevention of preeclampsia **Dr. Laxmi Velauthar**
10.00 am – 11.00 am	Live demo- Fetal anomaly/ trans-abdominal cervical length/ uterine artery Doppler and placenta **Prof. Basky Thilaganathan**
11.00 am – 11.15 am	Tea Break
11.15 am – 11.45 am	Optimum management of threatened pre- term labour **Dr. Shemoon Marleen**
11.45 am – 12.15 pm	Screening and diagnosis of placenta accreta spectrum disorder **Prof. Basky Thilaganathan**
12.15 pm – 12.45 pm	Digital technology to improve pregnancy outcomes **Prof. Basky Thilaganathan**
12.45 pm – 1.30 pm	Live Demo
1.30 pm – 2.00 pm	Case-based discussion of common fetal anomalies **Dr. Archana Baser**
2.00 pm	Lunch

REGISTRATION FEES

Consultants	2000 LKR
PG Trainees	1000 LKR

Technology Partner

GE HealthCare

For Registrations

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slcogoffice@gmail.com

Pre Congress Workshop - 06

Pre Congress Workshop - 06 B

8.30 A.M. - 9.06 A.M.	Welcome	Dr Achintha Dissanayake and team from Sri Lanka
	Inauguration	
	Address by President SLCOG	Dr Mangala Dissanayake
	Address by President SAFOG	Prof Shyam Desai (India)
	Address by Secretary General SAFOG	Prof Farhana Dewan (Bangladesh)
	Address by Chief Guest	Prof Rohana Haththotuwa (Sri Lanka)
	Aim of the Workshop	Dr Hema Divakar / Dr Priti Kumar (India)
SESSION 1 - Preconceptional Care ; Chairperson		
9.06 A.M. - 9.21 A.M.	Preconception nutrition and use of FIGO checklist	Dr Hema Divakar (India)
9.21 A.M. - 9.41 A.M.	Breastfeeding – current issues and challenges to protect, promote and support breastfeeding	Zivai Murira, Regional Advisor Nutrition, UNICEF ROSA
9.41 A.M. - 9.56 A.M.	Mental well being - paying attention to prevention and early detection	Dr Anupama Rao (Jhpiego)
9.56 A.M. - 10.06 A.M.	Roleplay by Participants for Mental Screening (GAD 2 and PHQ2 Scale for initial screening)	Judges - Dr Mridula Sharma, Dr Gayan Niranga
10.06 A.M. - 10.11 A.M.	Interaction	
SESSION 2 - Special Care in Pregnancy		
10.11 A.M. - 10.21 A.M.	GDM Screening	Dr Achintha Dissanayake
10.21 A.M. - 10.31 A.M.	MNT	Vidya Thobbi
10.31 A.M. - 10.41 A.M.	Management of GDM	Prof Farhana Dewan
10.41 A.M. - 10.56 A.M.	Breastfeeding - and contraception in GDM	Dr Priti Kumar
10.56 A.M. - 11.06 A.M.	Care of New Born in GDM mothers	Dr Mridula Sharma
11.06 A.M. - 11.11 A.M.	Case Presentation on GDM	Dr Archana Pathak
11.11A.M. - 11.21 A.M.	Interactions with Participants	Dr Priti Kumar & Dr Malith Perera
11.21 A.M. - 11.31 A.M.	Quiz on GDM	Dr Preeti Priyadarshani / Dr Shobha Shavi
11.31 A.M. - 11.46 A.M.	**TEA**	
SESSION 3 - Labour Room Scenarios		
11.46 A.M. - 11.56 A.M.	Scene - 1 : Active Management of 3rd Stage of Labour	Dr Preeti Priyadarshani
11.56 A.M. - 12.06 P.M.	Demonstration	Dr Sonia Mandappa & Dr Uma Jaiswal
12.06 P.M. - 12.11 P.M.	Red Alert - Case presentation on PPH	Dr Parul Kotdawala
12.11 P.M. - 12.31 P.M.	Interaction with Participants	Dr Parul Kotdawala / Dr Indunil Piyadigama
12.31 P.M. - 12.41 P.M.	Summery	Dr Parul Kotdawala
12.41 P.M. - 12.56 P.M.	Scene - 2 : Hypertensive emergency	Dr Lila Vyas
12.56 P.M. - 1.01 P.M.	Eclampsia - Case Presentation	Dr Sonia Mandappa
1.01 P.M. - 1.16 P.M.	Interaction with Participants for Management	Dr Suchitra Pandit & Dr Dinusha Liyanapatabendi
1.16 P.M. - 1.26 P.M.	Role play	Dr Suchitra Pandit
1.26 P.M. - 1.36 P.M.	Quiz on HDP & PPH	Dr Anupam Singh / Dr Amrita Agrahari
1.33 P.M. - 1.43 P.M.	Scene - 3: Alternate Birthing Positions	Dr Nivedita Datta
1.33 P.M. - 2.00 P.M.	**LUNCH BREAK**	
SESSION 4 - Hands On		
2.00 P.M. - 2.10 P.M.	Correct method of Measuring BP	Dr Kaveri Shaw/ Dr Indunil Piyadigama
2.10 P.M. - 2.20 P.M.	Magnesium Sulphate in Eclampsia	Dr Vidya Thobbi / Dr Shobha Shavi / Dr J K M K Rasika
2.20 P.M. - 2.30 P.M.	Estimation of Blood Loss	Dr Babita Shukla / Dr Dinusha Liyanapatabendi
2.30 P.M. - 2.40 P.M.	Aortic Compression	Dr Nivedita Datta / Dr Gayan Niranga
2.40 P.M. - 2.50 P.M.	NASG (2 tables)	Dr Preeti Priyadarshani / Dr Uma Jaiswal / Dr Malith Perera
2.50 P.M. - 3.00 P.M.	Vote of Thanks	Dr Priti Kumar

Pre Congress Workshop - 07

57TH ANNUAL ACADEMIC CONGRESS

SRI LANKA COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

"Quality health care through standards in training and service delivery" - A right of all women

Obstetric Anal Sphincter Injury repair

Hands-on Workshop

30th August 2024 | 8.00 AM - 12.30 PM | Castle Street Hospital for Women

8.00 AM – 8.15 AM	Registration	
8.15 AM – 8.20 AM	Welcome Address	Dr. Mangala Dissanayake, President SLCOG
8.20 AM – 8.45 AM	Introduction	Dr. Janaki Karunasinghe
8.45 AM – 9.15 AM	Background & Management of OASIs	Dr. Ruwan Fernando
9.15 AM – 10.15 AM	Video demonstration- Identification of Anal sphincter injury & Repair	
10.15 AM – 10.30 AM	Tea Break	
10.30 AM – 12.30 PM	Hands-on repair on Pig sphincter	
12.30 PM 1.00 PM	Discussion	
1.00 PM	Vote of Thanks	

Led by:

Dr Mangala Dissanayake

Co-ordinated by:

Dr Ruwan Silva

Dr Darshana Abeygunawardena

Faculty

Dr Janaki Karunasinghe

Dr Ruwan Fernando

Registration Fees

Consultants – RS 2000/=

PG Trainees – RS 1000/=

(30 Participants Only)

Account Name: Sri Lanka College of Obstetricians & Gynaecologists
Account No: 0820 00623484 001
Bank: Seylan Bank, Borella Branch.

Supported by:

GlobalMed LIFELINE TO HEALTH

Pre Congress Workshop - 08

57TH ANNUAL ACADEMIC CONGRESS

SRI LANKA COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

"Quality health care through standards in training and service delivery" - A right of all women

Master the tips of LAPAROSCOPIC SUTURING

4th September 2024

Laparoscopy Skills Centre, Department of Surgery, UOC

8.00 AM to 1.45 PM

8.00AM – 8.25AM	Registration	
8.25AM – 8.30AM	Welcome address and opening remarks	Dr Mangala Dissanayake President, SLCOG
8.30AM – 8.45AM	Introduction to the workshop	Prof Rasika Herath
8.45AM – 9.30AM	**Basics of laparoscopic suturing**	
	Needle into peritoneal cavity	
	Intra-abdominal needle handling	
	Tissue handling at laparoscopic suturing	Dr Sumudu Kumarage Prof Rasika Herath
	Laparoscopic knotting techniques	
	Needle out from peritoneal cavity	
9.30AM – 10.15AM	**Other tips for better handling**	
	30-degree camera navigation	
	Finer grasping for better control – self practice methods	Dr Prabath Randombage Dr Chaminda Mathota
	Extracorporeal knotting	
10.15AM – 10.30AM	**Tea break**	
10.30AM – 1.00PM	**Hands on 1** Laparoscopic suturing	Facilitators: Prof Rasika Herath Dr Sampath Gnanarathna Dr Chaminda Mathota Dr Kumara Dissanayake Dr Prabath Randombage Prof Madura Jayawardena Dr Indunil Piyadigama
1.00PM – 1.45PM	**Hands on 2** Laparoscopic tissue handling	
1.45PM	**Closing remarks & Lunch**	Dr Achintha Dissanayake

Led by

Dr Mangala Dissanayake
President, SLCOG

Dr Darshana Abeygunawardane
Chairman Scientific Activities & Research, SLCOG

Co-ordinated by

Prof Rasika Herath
Professor in Obstetrics & Gynaecology, FOM, UOK

Dr Prabath Randombage
Senior Lecturer, FOM, UOK

Faculty

Dr Sumudu Kumarage

Dr Chaminda Mathota

Prof Madura Jayawardena

Dr Sampath Gnanarathna

Dr Indunil Piyadigama

Dr Kumara Dissanayake

Registration Fees

Consultants – RS 2000/=

PG Trainees – RS 1000/=

Register via +94 11 2 689 036 / +94 77 9 678 787 / slcogoffice@gmail.com

Account Name: Sri Lanka College of Obstetricians & Gynaecologists
Account No: 0820 00623484 001
Bank: Seylan Bank, Borella Branch.

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Pre Congress Workshop - 09

57TH ANNUAL ACADEMIC CONGRESS

SRI LANKA COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

"Quality health care through standards in training and service delivery" - A right of all women

SCIENCE OF ENERGY

Safe and effective use of monopolar, bipolar, advanced bipolar and harmonic

04th October 2024 | **8.00 AM - 12.30 PM** | **Main Auditorium, SLCOG House**

8.00AM – 8.25AM	REGISTRATION	
8.25AM – 8.30AM	WELCOME ADDRESS AND OPENING REMARKS	
8.30AM – 9.30AM	Introduction to SoE	• Principles of sealing and the physics of electricity • Tissue changes with heat • Introduction to radiofrequency (monopolar, bipolar) energy • Pitfalls of not knowing enough about energy devices
9.30AM – 10.00AM	Monopolar technologies	• How electricity interacts with metal in the body (implants, staple lines) • Direct coupling, capacitive coupling • Differences between Cut & Coag modes
10.00AM –10.15AM	PRACTICAL & VIDEO DEMONSTRATION 1	
10.15AM – 10.30AM	TEA BREAK	
10.30AM – 11.00AM	Bipolar and advanced bipolar technologies	• Introduction to bipolar • Advanced bipolar • What gives a good seal? Heat, compression and time • How does bipolar work? Tips for safe use.
11.00AM – 11.30AM	Ultrasonic and advanced ultrasonic technologies	• Shortcomings of RF energy • Introduction to harmonic • How harmonic generates heat • Difference between MIN and MAX mode, functions of harmonic • Tips to manage device heat and minimize lateral thermal spread
11.30AM – 12.30PM	PRACTICAL & VIDEO DEMONSTRATION 2	
12.30 PM	CLOSING REMARKS & LUNCH	

Led by

Dr Mangala Dissanayake
President, SLCOG

Dr Darshana Abeygunawardane
Chairman Scientific Activities & Research, SLCOG

Co-ordinated by

Dr Madava Karunarathne
Consultant Obstetrician & Gynaecologist SJGH

Dr Prabath Randombage
Senior Lecturer FOM, UOK

Faculty

Prof Madura Jayawardena

Dr Indunil Piyadigama

Registration Fees

Consultants – RS 2000/=

PG Trainees – RS 1000/=

Register via +94 11 2 689 036 / +94 77 9 678 787
slcogoffice@gmail.com

Account Name: Sri Lanka College of Obstetricians & Gynaecologists
Account No: 0820 00623484 001
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SRI LANKA COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS

57 TH ANNUAL ACADEMIC CONGRESS

"Quality health care through standards in training and service delivery" - A right of all women

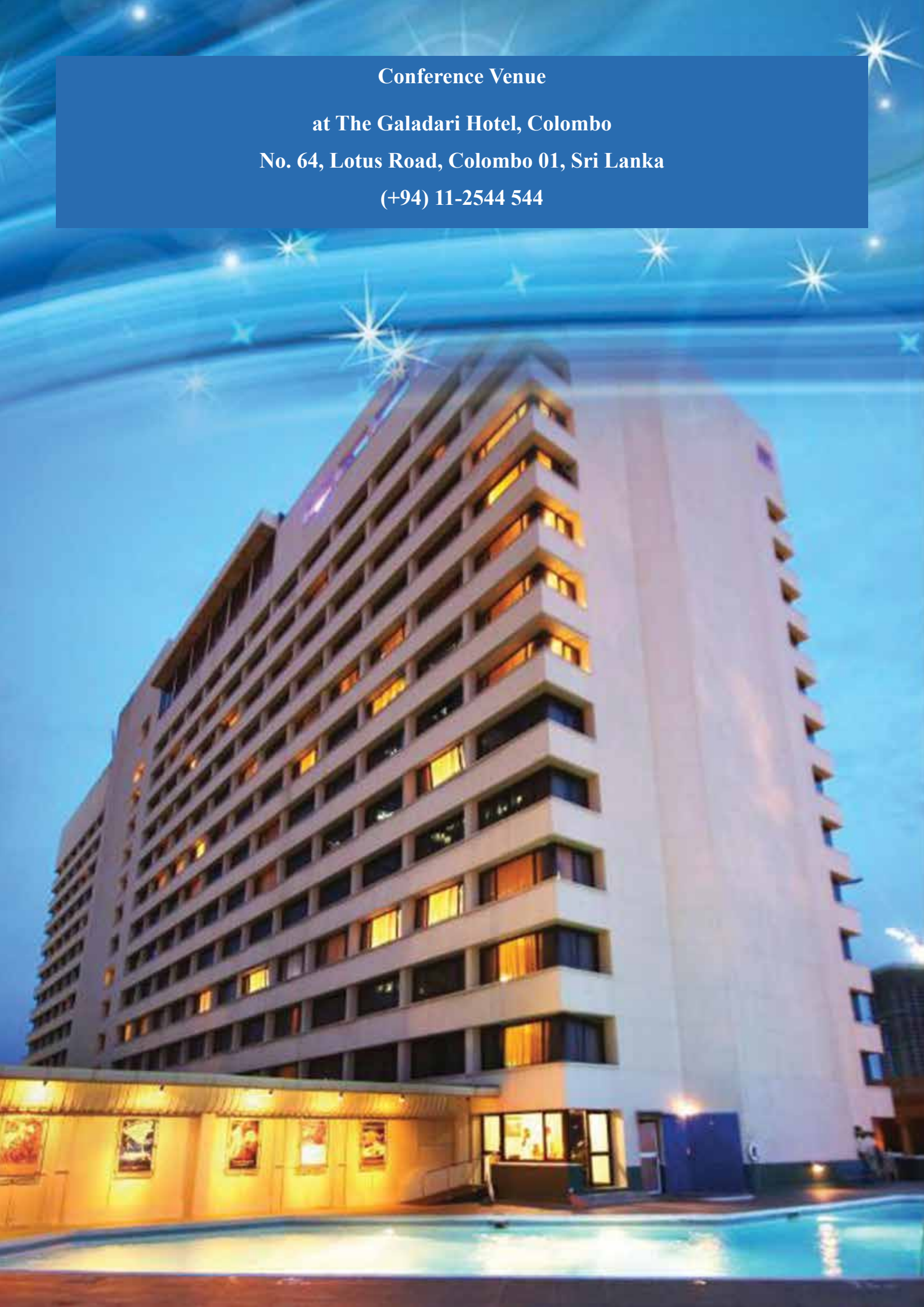
SCIENTIFIC CONGRESS

Conference Venue

at The Galadari Hotel, Colombo

No. 64, Lotus Road, Colombo 01, Sri Lanka

(+94) 11-2544 544



57 TH ANNUAL ACADEMIC CONGRESS

30th August to 1st September 2024

at Galadari Hotel, Colombo, Sri Lanka.

INAUGURATION

30th August 2024

5.30 pm	Guests take their seats.
5.45 pm	Arrival of the Chief Guest, Guest of Honour and Special Guest
6.00 pm	Ceremonial Procession
6.10 pm	Lighting of the Traditional oil lamp and National Anthem
6.20 pm	Welcome Address by the President, SLCOG - ***Dr. Mangala Dissanayake***
6.30 p.m.	Address by the Special Guest ***- Prof. Gregory Joseph Duncombe***
6.40 pm	Address by the Guest of Honour - ***Dr. Shyam Desai***
6.50 p.m.	Address by the Chief Guest - ***Dr. Ravi Chandran***
7.05 pm	Fellowship Ceremony
7.30 pm	Prof. D.A. Ranasinghe Memorial Oration by ***Professor Hemantha Senanayake***
8.15 pm	Vote of Thanks - ***Dr. Achintha Dissanayake*** Hony. Secretary, SLCOG
	Cultural show and the Reception

DAY 01 | SCIENTIFIC PROGRAMME | 31ST AUGUST 2024

TIME	HALL – A	HALL – B	HALL – C
8.00 AM – 9.00 AM	**FREE PAPERS (1 - 6) - SESSION 1** *Chairpersons; Dr Harsha Atapattu , Dr Sampath Gnanaratne*	**FREE PAPERS (7 - 12) - SESSION 2** *Chairpersons; Prof Lanka Dasanayaka, Dr Ruwan Silva*	**FREE PAPERS (13 - 18) - SESSION 3** *Chairpersons; Dr Shemoon Marleen, Dr Chaminda Hunukumbura*
9.00 AM - 9.30 AM	**KEYNOTE SPEECH** **Cesarean Section on demand - Dr Ravi Chandran (FIGO)** *Chairpersons; Dr Rohana Haththotuwa, Dr Mangala Dissanayake*		
9.30 AM - 10.00 AM	**PLENARY LECTURE 1** **The relative importance of fetal size versus Doppler indices in preventing stillbirth at term - Prof Basky Thilaganathan** *Chairpersons; Dr Rohana Haththotuwa, Dr Mangala Dissanayake*		
10.00 AM - 10.45AM	**DR P. DISSANAYAKE ENDOWMENT LECTURE** **The placenta and its effects on Obstetricians and Gynaecologists - Prof Greg Duncomb (RANZCOG)** *Chairpersons; Dr Marlene Abeyewardana, Dr Mangala Dissanayake, Dr Darshana Abeygunawardana*		
10.45 AM - 11.00 AM	**Tea break & Poster Viewing**		
11.00 AM - 11.40 AM	**RANZCOG SESSION** **Clinical Governance Framework: Patient safety and quality improvement systems** **Dr Hasthika Ellepola** **Can we reduce preventable stillbirths Australia - Introduction to the safer baby bundle** **Dr Dulanthi Tudawe** *Chairpersons; Dr S P Akmeemana, Dr S Raajkumar*	**GUEST LECTURE 1,2** **Global Health 2024 - Dr Gillian Gibson (Pre-recorded)** **Challenges faced by cervical screening and how to address this in our own setting** **Dr P P Kandanaerachchi** *Chairpersons; Prof Rukshan Fernandopulle, Prof Gregory Duncombe*	**SYMPOSIUM 1** **FOGSI** **What's new in male infertility management** **Dr Hrishikesh Pai** **Reaching every girl every women Role of FEMTECH** **Dr Hema Divakar** **Management of Preeclampsia** **Dr Suchitra Pandit** *Chairpersons; Dr Gamini Perera , Dr Chaminda Hunukumbura*
11.40 AM - 12.00 PM	**GUEST LECTURE 3** **Reduction in maternal mortality and vision for the future** **Dr Shyam Desai (President SAFOG)** *Chairpersons; Dr U D P Ratnasiri , Prof Farhana Dewan*	**GUEST LECTURE 4** **Abnormal uterine bleeding in perimenopausal women** **Prof Deepal Weerasekara** *Chairpersons; Dr Ananda Ranathunga, Dr Hema Divakar*	

12.00 PM – 1.00 PM	**SYMPOSIUM 2** **"Medical Disorders in Pregnancy"** Hyperglycaemia in Pregnancy - Dr Uditha Bulugahapitiya Overcoming challenges of renal disorders during pregnancy Dr Chanaka Abeyrathna Evaluation of Liver Diseases in Pregnancy - Dr Eranda Luxman *Chairpersons; Prof Athula Kaluarachchi, Dr Shemoon Marleen*	**SYMPOSIUM 3** **"Urogynaecology"** Management of recurrent prolapse - Dr Ruwan Fernando Open vs Laparoscopic BURCH: an overview Dr Sampath Gnanarathna Newer advances in managing OAB Dr Prabath Randombage *Chairpersons; Dr Madhava Karunarathna, Dr B A K G Mahendra*	**Prof Sir Sabaratnam Arulkumaran YGA Session SLCOG** Judges; Dr Gamini Perara, Dr U D P Ratnasiri *Chairpersons; Prof Hemantha Senanayake , Dr Jaydeep Tank*
1.00 PM – 2.00 PM	**Lunch & Poster Viewing** *"Challenges in Obstetric care & information delivery. How digital platforms help" - Dr Binu Joy (Mega Life Sciences)*		**RANZCOG session for PG Trainees**
2.00 PM – 3.00 PM	**RCOG SESSION** Pregnancy of Unknown Location Dr Sundararajah Raajkumar Update and controversies of gynaecology oncology surgery Dr Pubudu Pathiraja Robotics assisted surgery in complex gynaecology Dr B A K G Mahendra *Chairpersons; Dr U D P Ratnasiri, Dr Samanthi Premarathna*	**SYMPOSIUM 4** **"Miscellaneous"** Pregnancy and skin - Dr Premanie Raajendran Emergency and elective uterine artery embolization - Dr Praneeth Athukorala (Interventional Radiologist) Common Bowel Diseases in Pregnancy Dr Nilesh Fernandopulle *Chairpersons; Dr Chandana Jayasundara , Dr Hema Divakar , Dr Kapila Withanachchi*	**SYMPOSIUM 5** **OGSB** Moderator - Dr. Shahi Farzana Tasmin Chronic Pelvic Pain - Prof. Salma Rouf Prediction and Prevention of Pre-eclampsia Prof. Laila Arjumand Banu Rising trends of Endometrial Cancer. How to Prevent? - Prof. Sabera Khatun Postpartum Haemorrhage-An Update Prof. Ferdousi Begum *Chairpersons ; Prof. Farhana Dewan , Prof. Begum Nasrin, Prof. Gulshan Ara*
3.00 PM – 4.00 PM	**SAFOG SESSION** "Perinatal Mental health issues– Addressing the Silent Burden" - Panel Discussion Keynote Address by President SAFOG Dr Shyam Desai – on "Respectful Maternity care" Dr Hema Divakar, Dr Farhana Dewan, Dr Kamrun Nessa Runa , Dr U D P Ratnasiri , Dr Dasanthi Akmeemana, Dr Rashid Latif Moderator: Dr Anupama Rao (Advisor, Maternal, Newborn and child Health Jhpiego, India) *Chairpersons; Dr Rohana Haththotuwa , Prof. AB Bhuiyan, Prof. Ferdousi Begum*	**SYMPOSIUM 6** **"Current principles and advances in Gynae Oncology"** Concepts in Gynaecological Oncosurgery - Staging, Radical resection and Debulking Dr Rajitha Wijesinghe Fertility sparing in Gynaecological Oncology Dr Thanuya Mahendran Personalisation of Adjuvant treatment with molecular bio markers in gynaecological Cancers Dr Sachintha Wijesiriwardana *Chairpersons; Dr Kanishka Karunaratne, Dr Pubudu Pathiraja, Dr Ruwan Silva*	**FREE PAPERS (19-24) - SESSION 4** *Chairpersons; Dr M R M Rishard , Dr Chinthaka Banagala*
3.00 PM – 4.00 PM	**GUEST LECTURE 5** The unpredictable unforgiving thin line (A Clinical Governance Analysis between near miss and Catastropic Adverse Events) - Dr Sumith Warnasuriya *Chairpersons; Dr M D P Gooneratne, Dr Sanjay Kalra*	**GUEST LECTURE 6** To induce labour or nor? A dilemma to many Dr Romanie Fernando *Chairpersons; Dr Madhava Karunarathne, Dr Jaydeep Tank*	**GUEST LECTURE 7** Diagnosing adenomyosis ; How much do we miss - Dr Chandana Jayasundara *Chairpersons; Prof Farrukh Zaman, Dr Sampath Gnanarathna*
4.20 PM - 4.35 PM	**Tea break & Poster Viewing**		

DAY 02 | SCIENTIFIC PROGRAMME | 1ST SEPTEMBER 2024

TIME	HALL – A	HALL – B	HALL – C
7.30 AM – 9.00 AM	**FREE PAPERS (25-32) - SESSION 5** *Chairpersons; Prof Rukshan Fernandopulle, Dr Iresha Mapitigama*	**FREE PAPERS (33-40) - SESSION 6** *Chairpersons; Dr Harsha Atapattu , Dr Prabodhana Ranaweera*	**FREE PAPERS (41-48) - SESSION 7** *Chairpersons; Prof Rasika Herath, Dr Darshana Abeygunawardana*
9.00 AM - 9.35 AM	**DR ROHANA HATHTHOTUWA ORATION** **Endometriosis Best Practice and Recent Advances** **Dr Jaydeep Tank** *Chairpersons; Dr Marlene Abeyewardena, Dr Mangala Dissanayake , Dr Achintha Dissanayake, Dr Darshana Abeygunawardana*		
9.35 AM - 10.00 AM	**GUEST LECTURE 8** **Confidential Enquiry in to Maternal Deaths: gaining insight towards a national response by** **Dr Lakshmen Senanayake** *Chairpersons; Dr Mangala Dissanayake, Prof Mahesh Choolani*	**GUEST LECTURE 9** **Why mother's die due to sepsis: an evolving challenge** **Dr Ananda Ranathunga** *Chairpersons; Dr Ajita Wijesundara , Dr Chinthaka Banagala*	**GUEST LECTURE 10** **Knowing the boundaries during surgery for endometriosis - Prof Rasika Herath** *Chairpersons; Dr Sumith Warnasuriya , Dr Indu Asanka Jayawardane*
10.00 AM - 11.00 AM	**AOFOG SESSION** **Introduction to the AOFOG - Dr Rohana Haththotuwa** **Artificial Intelligence in Obstetrics and Gynaecology** **Prof Mahesh Choolani** **Reducing the Prenatal exposure to toxic environmental agents: The Obstetrician's role - Dr U D P Ratnasiri** **Antenatal Screening for Pre-Eclampsia -** **Dr Ho Miaw Ping** **Q&A** *Chairpersons; Dr Rohana Haththotuwa , Dr Janaki Karunasinghe*	**GUEST LECTURE 11,12,13** **Critical Issues for Sustaining Progress in Maternal and Newborn Health in South Asia** **Dr Sudha Sharma (Pre-recorded)** **Vitamin D supplimentation in Pregnancy; What's latest evidence - Dr Sanjay Kalra** **Understanding genetics for obstetricians** **Dr Narendra Malhotra** *Chairpersons; Prof W I Amarasinghe, Prof Chanil Ekanayake*	**FREE PAPERS (49-54) - SESSION 8** *Chairpersons; Prof Madura Jayawardane, Dr Buddhika Asela Amarasena*
11.00 AM - 11.15 AM		**Tea break & Poster Viewing**	
11.15 AM - 12.15 AM	**SYMPOSIUM 7** **by Menopause Society** **Impact of Estrogen Decline on Female Heart - Dr. M.D.P Gooneratne** **Sexuality after menopause - Dr. Harsha Atapattu** **Genitourinary Syndrome of Menopause: diagnosis revisited - Dr. C.D Ekanayake** *Chairperson; Dr S P Akmeemana, Dr Achintha Dissanayake*	**SYMPOSIUM 8** **"Updates of Obstetrics & Gynaecology"** **Updates of Managing Superficial Thrombophlebitis in Pregnancy - Dr M C Gihan** **Exclusion of ACUMS, at evaluating severe dysmenorrhea - Dr Buddhika Asela Amarasena** **Therapeutic Effects of Micronutrient Supplementation on Sperm Parameters** **Dr Sowmya N.S.** *Chairpersons; Dr Ananda Ranathunga , Dr Prabodhana Ranaweera*	**FREE PAPERS (55-60) - SESSION 9** *Chairpersons; Dr S Sritharan, Dr Ruwan Silva*

12.15 PM – 1.15 PM	**UNICEF SESSION** **"Maternal Nutrition & Obesity in Pregnancy"** **Maternal Obesity; longterm implications on mother and baby** **Dr Sanjay kalra** **Current trends in approach to Obesity in - Dr Farhana Dewan** **Programatic priorities for maternal nutrition interventions across the life course - Dr Zivai Murira** *Chairpersons; Prof Madura Jayawardane, Dr Damith Siriwardhana*	**SYMPOSIUM 9** **"PPH/Blood Tranfusion"** **Pregnant women; where a transfusion is not an option** **Dr Kumuduni Gonsalkorale** **PPH; places of Prostagladin and Intrauterine haemorrhage control devices - Dr Girija Wagh** **Transfusion in pregnancy: effect on haematological parameters and pregnancy outcome** **Dr Wasanthi Wickremasinghe** *Chairpersons; Dr Lakshmen Senanayake , Dr Indunil Piyadigama*	**FREE PAPERS (61-66) - SESSION 10** *Chairpersons; Dr R Prathapan, Dr Diluk Senadheera*
1.15 PM – 2.15 PM	**Lunch & Poster Viewing**		**RANZCOG session for PG Trainees**
2.15 PM – 3.15 PM	**UNFPA SESSION** **"Innovation and Digitalization to Advance Sexual and Reproductive Health and Rights of Women and Girls"** **Importance of fostering digitalization and gender transformative innovation and technology to advance SRHR of women and girls - Dr Kaushalya Mendis** **Inclusive innovation ecosystems and digital transformation experiences from South Asia - UNFPA** **Mr Sunil Jacob** **Bridging the digital divide and how this can advance SRHR of women and girls in hard to reachareas** **Dr Asanthi Fernando HPB** **Q&A** *Chairpersons; Mr. Kunle Adeniyi, Dr Janaki Karunasinghe*	**SYMPOSIUM 10** **by Perinatal Society** **Panel discussion on "Responsibility of the community and the government in managing the burden of prematurity"** **Dr Surantha Perera (Moderater)** **Dr U D P Ratnasiri** **Dr Susie Perera** **Dr Himali Herath** *Chairpersons; Dr Sudath Senaratne, Dr Diluk Senadheera*	**SYMPOSIUM 11** **"Miscellaneous"** **Navigating the complexities of large fibroids in pregnancy : key strategies** **Dr Amila Rubasinghe** **Screening for fetal cardiac abnormalities** **Dr Achintha Dissanayake** **Cosmetic Gynaecology: Not a taboo and FGM anymore - Dr Prabath Randombage** *Chairpersons; Dr. Ruwan Silva, Dr Shemoon Marleen*
3.15 PM – 4.15 PM	**SYMPOSIUM 12** **"Infertility"** **Right time Right choice for infertility treatments** **Dr Jaideep Malhotra** **PCOS; from infertility to pregnancy - Dr Bharti Kalra** **Recurrent Implantation Failures** **Dr Chaminda Hunukumbura** *Chairpersons; Dr Milhan Batcha, Dr Udara Jayawardana*	**SYMPOSIUM 13** **"Paediatric and Adolescent Gynaecology"** **Navigating premature Menarche: Causes, Health Implications, and Management Strategies** **Dr. Sumudu Seneviratne** **Primary Amenorrhoea: Unveiling the Mystery in clinical practice and Charting the Path to Treatment** **Dr. Probodhana Ranaweera** **Congenital Gynecological Problems of the Lower Genital Tract: Expert Insights from a Pelvic Surgeon** **Prof. Hemantha Senanayake** *Chairpersons; Prof Rasika Herath, Dr U G Kariyawasam*	
4.15 PM – 4.30 PM	**Tea break**		
4.30 PM - 5.00 PM	**Valedictory & Conclusion**		

FACULTY

SRI LANKA

Prof. Hemantha Senanayake

Dr Lakshmen Senanayake

Dr Rohana Haththotuwa

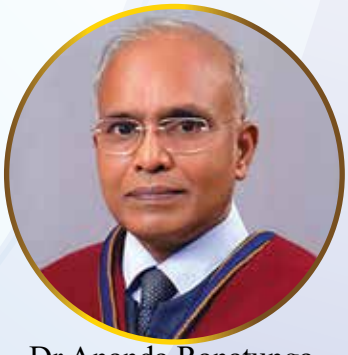
Dr M. D. P. Gooneratne

Dr. U.D.P. Ratnasiri

Prof. Deepal Weerasekara

Dr M C Gihan

Dr. Sumith Warnasuriya



Dr Ananda Ranatunga

Dr. Chaminda Hunukumbare

Prof. Rasika Herath

Dr Achintha Dissanayake


Dr. Probodhana Ranaweera


Dr. Romanie Fernando


Dr. Harsha Atapattu


Dr. Wasanthi Wickremasinghe


Dr. Amila Rubasinghe


Dr. Sampath Gnanarathna


Dr. Eranda Luxman


Dr. Premanie Raajendran


Dr. Sachintha Wijesiriwardana


Dr. Praneeth Athukorala


Dr. Chanaka Abeyrathna


Dr. Rajitha Wijesighe


Dr. Sumudu Seneviratne


Dr. Thanuya Mahendran


Dr. Kumuduni Gonsalkorale

Dr Kaushalya Mendis

Dr Asanthi Fernando Balapitiya

Dr Buddhika Asela Amarasena

Dr. Susie Perera

Dr Nilesh Fernandopulle

Dr Chandana Jayasundara

Dr. Himali Herath

Dr. Surantha Perera

Dr Uditha Bulugahapitiya

Dr Dasanthi Akmeemana

Dr. Prabath Randombage

INDIA

Prof. Shyam Desai

Dr. Narendra Malhothra

Dr. Sanjay Kalra

Dr. Jaideep Malhothra

Dr. Bharti Kalra

Dr. Girija Wagh

Dr. Hema Divakar

Mr. Sunil Thomas Jacob

Dr. Suchitra Pandit

Dr. N.S. Sowmya

Dr. Hrishikesh Pai

UNITED KINGDOM

Dr. Pubudu Pathiraja

Dr. Ruwan Fernando

Prof. Basky Thilaganathan

Dr Priyantha Kandanearachchi

Dr. S. Raajkumar

Dr B. A. K. G. Mahendra

MALAYSIA

Dr. Ravi Chandran

Dr. Ho Miaw Ping

AUSTRALIA

Dr. Dulanthi Tudawe

Dr. Gillian Gibson

Dr. Hasthika Ellepola

Prof. Gregory Duncombe

BANAGALADESH

Prof. Laila Arjumand Banu

Prof. Ferdousi Begum

Prof. Sabera Khatun

Prof. Farhana Dewan

Prof. Salma Rouf

NEPAL

Dr. Sudha Sharma

Dr. Zivai Murira

SINGAPORE

Prof. Mahesh Choolani

CONFERENCE PROCEEDINGS

KEYNOTE SPEECH

Caesarean Section on demand

Dr Ravi Chandran - Honorary Secretary, FIGO
Past President, AOFOG
Consultant Obstetrician and Gynaecologist, Gleneagles Hospital, Kuala Lumpur, Malaysia

CDMR is Caesarean Delivery on Maternal Request in the absence of any maternal or fetal indication. Despite its steady rise over the last decade or so, its true incidence remains unknown, and present data is likely the tip of the iceberg. This increasing CDMR rate not only reflects changing medical practice, but also the shift in attitudes of both patients and healthcare providers. This in turn has given rise to debate and discussion among medical researchers on the most appropriate ways in which to address the challenging clinical and ethical issues brought on by CDMR.

DR P. DISSANAYAKE ENDOWMENT LECTURE

The Placenta and its Effects on Obstetricians and Gynaecologists

Prof Greg Duncomb – Director, Obstetrics and Gynaecology, Logan and Beaudesert Hospitals, Brisbane, Queensland
Associate Professor, Centre for Clinical Research and Department of Obstetrics and Gynaecology, Faculty of Medicine, University of Queensland

From creation, formation, division, implantation, communication, control, expansion, extension, remodelling, invasion, separation, and accretion, the placenta continuously insinuates itself in our day-to-day activity.

My professional life has been mostly as a day-to-day "patient-facing" clinician. However, many of the friends and colleagues I have met along the way have sustained my passion for all aspects of science. Intellectual academic exploration of the placenta's formation, its communication, and programming of the maternal anatomy and physiology is still not understood beyond (some very convincing) theory. In 2015, I was inducted as the primary clinician of the University of Queensland Exosome Research Laboratory. The studies in Exosome functionality and association in pregnancy and now cancer are expanding at a rapid rate. I will share some of the best of this cutting-edge research from this now-world-renowned facility.

The placenta plays a central role in the pathogenesis of multiple pregnancies and significantly influences our management and associated outcomes. This is the bread and butter for Maternal Fetal Medicine specialists. Being part of many collaborative efforts in the investigation of this condition, many colleagues to thank and much to share.

Sometimes the placenta has an irregular structure, both in itself and in its relationship with the maternal connections. This can produce life-affecting events for the mother and her baby. This is one area where we can still lose one of our patients if an error is made before delivery or we fall short in skill or support at the crucial time. We need to maintain diagnostic alertness and coalface surgical skills—a great deal to think about in this space.

The placenta is probably the least understood organ that is essential for human existence while also having the biggest impact. There is much to discuss.

ABSTRACTS OF PLENARIES

PLENARY LECTURE 01
THE RELATIVE IMPORTANCE OF FETAL SIZE VERSUS DOPPLER INDICES IN PREVENTING STILL-BIRTH AT TERM

Prof Basky Thilaganathan - Professor and Director, Fetal Medicine Unit and Clinical Director, The SAFE National cf DNA screening laboratory, St George's University Hospitals NHS Foundation
Trust Clinical Director, Tommy's National Centre for Maternity Improvement, Royal College of Obstetrics and Gynaecology

Stillbirth is a devastating pregnancy complication that still affects many women, particularly from low and middle-income countries. It is often labelled as 'unexplained' and therefore unpreventable, despite the knowledge that placental dysfunction has been identified as a leading cause of antepartum stillbirth. Currently, screening for pregnancies at high-risk for placental dysfunction relies on checklists of maternal risk factors and serial measurement of symphyseal-fundal height to identify small for gestational age fetuses. More recently, the first-trimester combined screening algorithm developed by the Fetal Medicine Foundation has emerged as a better tool to predict and prevent early-onset placental dysfunction and its main outcomes of preterm pre-eclampsia and fetal growth restriction by the appropriate use of Aspirin therapy for women identified at high-risk by such screening. There is currently no equivalent to predict and prevent late-onset placental dysfunction, although algorithms combining an ultrasound-based estimation of fetal weight, assessment of maternal and fetal Doppler indices, and maternal serum biomarkers show promise as emerging new screening tools to optimize pregnancy monitoring and timing of delivery to prevent still birth.

ABSTRACTS OF SESSIONS

RANZCOG SESSION
Clinical Governance Framework: Patient Safety and Quality Improvement Systems

Dr Hasthika Ellepola - Senior Staff Specialist, Obstetrics & Gynaecology Department, Logan Hospital, Queensland
Senior Lecturer, Griffith University, School of Medicine, Gold Coast, Queensland

The Clinical Governance Standard aims to ensure that a clinical governance framework is implemented to ensure that patients and consumers receive safe and high-quality health care.

This standard aims to ensure that there are systems in place within health service organizations to maintain and improve the reliability, safety, and quality of health care. This standard, together with the Partnering with Consumers Standard, sets the overarching requirements for the effective implementation of all other standards. The Clinical Governance Standard recognises the importance of governance, leadership, culture, patient safety systems, clinical performance, and the patient care environment in delivering high-quality care.

The concept and model of clinical governance in healthcare settings and organizations improve quality of care, service users and staff satisfaction, and team performance. Successful interprofessional working practices in healthcare settings contribute to improving the quality of health service delivery. Improved quality of care, better staff satisfaction, improved team performance, and better communication and interaction are the benefits of implementing the clinical governance framework in healthcare organizations and settings.

Key elements are:

- Partnering with consumers
- Safe environment for the delivery care
- Governance, leadership, and culture
- Patient safety and quality improvement systems
- Clinical performance and effectiveness.

National plan for endometriosis: Medical management of DIE with colorectal extension is based on suppressing the symptoms, is not curative, and is often associated with significant adverse effects. It is unclear whether medical management prevents disease progression; however, discontinuing medical treatment commonly results in the recurrence of symptoms.

Women with endometriosis should be referred to a gynaecologist with a special interest in endometriosis, and women with DIE should be referred to accredited centres where gynaecologists work in appropriate clinical teams, audit their outcomes, and have sufficient workload to maintain their surgical skills. Decisions for laparoscopy should be made with the intention of performing treatment at the primary operation, as repeat laparoscopies are associated with increased risks for the patient and increased related costs. 'Diagnostic laparoscopy' should be an outmoded concept because symptoms suggestive of endometriosis should be assessed by a surgeon with the appropriate experience to treat any endometriosis found. Indications for repeat or second laparoscopies should be limited to cases of severe disease, where there is an increased risk of surgery that will require further discussion with the patient. Long-term treatment of women with chronic pelvic pain associated with endometriosis involves repeated courses of medical therapy, surgical therapy, or both. In such circumstances, a multidisciplinary approach involving a pain clinic and counselling should be considered early in the treatment plan.

Woman-centred care: Strategic directions for Australian maternity services: Australia is regarded as a safe country in which to have a baby and compares well on a number of accepted measures of safety and quality of care. However, as for all systems of health care and service delivery, there are areas for continued improvement. Across states and territories, there are differences in women's access to services, their choice of care and/or carers, and the provision of culturally safe care that ensures women are always treated with respect and dignity.

Woman-centred care: Strategic directions for Australian maternity services (the Strategy) provides overarching national strategic directions to support Australia's high-quality maternity care system and enable improvements in line with contemporary practice, evidence, and international developments.

Can We Reduce Preventable Stillbirths Australia: Introduction to the Safer Baby Bundle

Dr Dulanthi Tudawe - Staff Specialist, Obstetrics & Gynaecology Department, Logan Hospital, Queensland

Stillbirth is a personal tragedy for the families involved and a serious public health problem involving psychosocial, emotional, and financial burden on everyone that is involved. Globally, there are 2.6 billion late gestation stillbirths each year. The rate of stillbirth in Australia is almost 35% higher than other top-performing countries. In Australia, the current still birth rate is 6.8 per 1000 births. In many cases stillbirth is preventable, and research shows 20–30% of late gestation stillbirths could be avoided with improved care.

The Safer Baby Bundle (SBB) is a national initiative that was implemented in Australia, with five evidence-based elements to address key areas where improved practice can reduce the number of stillborn babies in Australia after 28 weeks, which is the primary outcome measure in this study.

Currently, the states of Victoria, Queensland, and NSW in Australia have rolled out this initiative since 2019. To ensure that these resources are shared among all, newer culturally appropriate pregnancy resources have been made available for First Nations women and migrant refugee women in our communities that are impacted by stillbirth. At Logan Hospital, we care for women from these communities. This has been a very useful tool for us in implementing women-centred respectful care for our women. We have models of care from women from these communities where obstetricians, midwives, and allied health teams provide the best care possible for these women.

Implementation of the SBB is supported by a comprehensive package of evidence base and collaboratively developed resources by the Stillbirth Centre of Research and Excellence in Australia. In brief, these include best practice recommendations, implementation toll including clinical check lists, management algorithms, Key performance indicator and audits, an educational program for health care providers, and information and educational resources for women and their families.

The overall goal of this initiative is to reduce stillbirths by 20% by 2023. The hope is to reduce maternal morbidity and neonatal morbidity and mortality.

RCOG SESSION
Pregnancy of Unknown Location

Dr Sundararajah Raajkumar – Consultant Obstetrician and Gynaecologist
Clinical Lead for Obstetrics and Gynaecology, Lead for Early Pregnancy Assessment Unit (EPAU), South end University Hospital NHS Foundation Trust, United Kingdom
Chairman, RCOG - Sri Lanka Liaison Group

Pregnancy of unknown location (PUL) is a condition when pregnancy is not detected in spite of a positive pregnancy test. This is encountered when managing patients in EPAU. This lecture discusses the management strategies of PUL.

Update and Controversies of Gynaecology Oncology Surgery

Dr Pubudu Pathiraja - Consultant in Gynaecology Oncology, Cambridge University Hospital foundation Trust, United Kingdom

This presentation, "Controversies and Updates in Gynaecology Oncology," aims to explore the latest developments and ongoing debates within the field of gynaecological oncology. The discussion will encompass recent advancements in diagnostic techniques, treatment modalities, and patient management strategies.

Key topics include the evolving role of minimally invasive surgery, the impact of genetic and molecular profiling on personalised treatment plans, and emerging therapeutic options for advanced-stage cancers. The presentation will also address the controversies surrounding screening guidelines, the integration of novel biomarkers in clinical practice, and the ethical considerations in treatment decision-making.

I am keen to focus on insights into current challenges and future directions in gynaecological oncology, with an emphasis on improving patient outcomes through evidence-based practices and innovative approaches.

Robotics Assisted Surgery in Complex Gynaecology

Dr B.A.K.G. Mahendra - Consultant Obstetrician and Gynaecologist, Queens and King George Hospitals NHS Trust, Romford, United Kingdom.

Robotic surgery has emerged as a transformative innovation in obstetrics and gynecology, particularly for managing complex surgically challenging gynaecological cases. Central to this advancement is the integrated precision of robotics with the skill of surgeons, providing unparalleled visualization and dexterity. This technology enables minimally invasive procedures, significantly reducing patient trauma, recovery time, and the risk of complications. It has made a difference to surgeons' physical health and extended their service longer than before. Key applications include delicate myomectomy, hysterectomy for a larger uterus, extensive endometriosis resection, pelvic organ prolapse repair, and gynecologic oncology surgeries. Despite its advantages, challenges such as high costs and the need for specialized training persist. As robotic surgery continues to evolve, its role in enhancing women’s health is expected to grow, necessitating careful consideration by healthcare providers and patients.

SAFOG SESSION: PERINATAL MENTAL HEALTH
Keynote Address: Respectful Maternity Care

Prof Shyam Desai – President, SAFOG

Respectful maternity care is a human right of every woman and her baby to be treated with care, respect, and dignity, free from harm, and to maintain absolute liberty and autonomy. Any disrespectful maternity care is an infringement on women's fundamental human rights. Maternity today stands with women and their babies – strongly advocating for the right to respectful maternity care worldwide.

Women have the right to receive respectful maternity care in all healthcare systems around the world. Women's experiences with maternity caregivers can either be empowering and comforting or inflict lasting damage and deep emotional trauma. Either way, memories of childbearing experiences can stay with women throughout their lifetimes.

In a report for the US Agency for International Development, Diana Bowser and Kathleen Hill published their discoveries of the overwhelming presence of poor maternal care in facility-based childbirth. The report revealed evidence of disrespect and abuse, as well as childbearing women's fear of physical and emotional trauma inflicted by maternal care professionals. Bowser and Hill established that the fear of receiving abuse acts as a deterrent for women seeking proper maternal care.

In 2019's "Accountability for Respectful Maternity Care", authors Afulani and Moyer claim governments, facilities, and private healthcare providers acknowledge mistreatment at an increasing rate, and some are committed to reducing such treatment, yet the authors question the lack of accountability. According to Afulani and Moyer, a #whatdowomenwant campaign by the White Ribbon Alliance found the top demand worldwide was more dignified and respectful healthcare. There have been successful advancements in the field of OBS/GYN over the past few decades: infertility, minimally invasive surgery, and a reduction in maternal mortality. In the sap organ region there has been no worthy effect. The overall maternal mortality has dropped by 34.3% over 20 years, from 339 maternal deaths per hundred thousand births in 2000 to 223 maternal deaths in 2020. This is according to a report by the WHO and other UN agencies, memories of childbirth save with the women throughout their lives. This calls for better understanding, better care, and compassion during pregnancy and childbirth. We can improve upon the experience of a woman, as during the pregnancy, emotional, physical, and medical aspects would have to be covered at the end of the experience. She should look back and save her. The experience or otherwise the entire sequence would seem a nightmare. Yes, they can make Chapati or something respectful maternity care well described, rational approach for improving person-centred and equitable intrapartum and postpartum care, but unfortunately, in spite of being identified. It still lacks a standard definition, a clear measurement method, or evidence of effectiveness. When the concept of respectful maternity care came about, the plan began in 1948. The Declaration of Human Rights 1990, was a declaration of elimination of violence against women, and thereafter there's been gathering evidence of disrespect and abuse of women giving birth, 2011. The RMC charter is based on international human rights, declarations, and conventions that constitute the universal rights of childbearing women and there is an updating on the charter in 2019, this charter, the various rights that woman has, the freedom from harm and ill-treatment, the right to information and informed consent the right to a companion of the choice in preference during maternity care, right to privacy and confidentiality The women are ever right to be treated with this dignity and respect. Equality, Freedom from discrimination, and equitable care should be given the highest attainable level of healthcare, The right to liberty, autonomy, self-determination freedom from arbitrary detention, and rights of women and newborns for timely and effective grievance redressal has to be, honoured, and there is an international report for US agencies and the international development, Kathleen Hill and Diana browser, so there is an overwhelming presence of poor maternal care facility based trial. Birth is evidence of disrespect, abuse, and women, fear of physical and emotional trauma, infected by healthcare professionals, being in developing countries are keen that women come from having home deliveries to the institution where they are better looked after medically. It will prevent maternal death and internal mobility and therefore we must improve the situation in the institutions so the women feel that it is safe and respectful care will be given to these women when they come to the institutions

Indian women experience at least one instance of mistreatment during their confinement, a pulled prevalence of disrespect and abuse was found in 72% of cases when we think of abuse will also involve privacy and confidentiality for communication. No consent for healthcare procedures, such as an AR MR administration of intravenous glucose, most importantly, lack of courtesy and poor interpersonal skills, which may be physical and verbal abuse and lack of professional ethics and integrity. Environment may be a little wonderful. Sometimes there may be physical abuse of the mother, notably by junior midwives. The Indian government has implemented several programs to reduce metal mortality and infant metal rates with Janani Shishu Suraksha Yojana, promotes institutional deliveries and over the last two decades now, 86% of all deliveries take place in institutions. However, the quality of care requires much to be desired principles of compassionate and respectful care. Lacking it has been found low maternal socioeconomic status like an education and empowerment of women, caste, and ethnicity, a key determines of social hierarchy and access to care, lack of support by community in adequate service providers and poor standards of services that are rendered prejudices and mids, surround treatment and care of women, lack of leadership provided from community and the government and lack of national policies, besides enforcement and redressal mechanisms in South Asia, similarly, disrespect and abuse during labour and child, birth is well documented in studies from seven S. Asian countries which most of the research conducted in Nepal in India while the experience of abuse and neglect common, then critical themes emerged related to neglected choices and compromise quality of care in the context of institutional care experiences and the imperative need for improved investment and training and significant policy and legislative change to enforce equitable and respectful maternity care and practice women with vulnerable background, socially disadvantaged and economically, poor or more likely to experience higher level of abuse and receive poor quality of care is an urgent need for well resource. Sustain commitment to mandate in support the provision of respectful and equitable maternity care. How does one rectify the situation? Conducting workshops for paramedics and medical doctors seems a useful approach to revealing disrespect and abuse, deep, rooted and practice and provides an opportunity to rectify the problem, more extensive interventional study will be crucial to address the white predictions of disrespect and abuse

Well, what is V that responsible for respectful maternity care can we do? What can we do? So we are the healthcare providers, professional organizations, training institutions, women advocates, pregnant women, and families and communities are all responsible for this. The other organizations that have similar objectives are the Initial International Childhood Initiative, 2019 WHO Positive Childbirth, 2018 from medical ethics and Guidelines and the National Health Mission India Laksha guidelines 2017 Sudhi Laksha, which was Set up by the Ministry of Health and Family Welfare, the government of India launched a program on 11 December 2017 to reduce maternal and newborn mobility and mortality. Improve the quality of care during delivery and immediate postpartum period enhance the satisfaction of beneficiaries, and positive birthing experience, and provide respectful maternity care to all pregnant women attending public health facilities, sustained efforts to achieve sustainable development. Goal targets and goals are related to maternal newborn health. Maintain an accelerate and progress and in all preventable, maternal, newborn, and child deaths proximately, 46% of maternal deaths over 40% of birds and 25% of under-five death stick base on the day of the delivery itself, which just tells us how important that part of the entire processes where there in the institution and going, jail and we are responsible for their good outcome quality of care. If it can be improved can provide much better statistics. Subsequently quality of care is increasingly recognised as a critical aspect of the unfinished material and newborn health agenda. Mainly concerning care around labour and delivery, and the immediate postnatal period. Sri Laxmi program consists of ensuring a comforting position, and companionship avoiding stress, proper triaging at admission, avoiding unnecessary induction and augmentation maintenance of privacy and cleanliness, and sensing healthcare providers or positive interactions. So the mother should get a positive experience of care now. Sometimes you wonder what are the reasons why this particular care is inadequate, the mistreatment is not only exclusively caused by incompetent health workers but is related to the systemic health system and social changes in green from patriarchal dominance and communities. They feel that this disrespect is internalised and normalised by women. The women themselves do not have high expectations of how they should be treated by health workers. We have to break this particular line of thought and we as health professionals should realise that a high level of respectful care during labour is the need of the hour. Global communities have taken cognizance of the problem, but there are no definite policies that have been adopted or defined and no action has been taken Sorgen these next two years intense to make it a point to take up this challenge, respectful and quality-driven healthcare is what we propose.

AOFOG SESSION
Artificial Intelligence in Obstetrics and Gynaecology

Prof Mahesh Choolani - Head, Department of Obstetrics & Gynaecology, Yong Loo Lin School of Medicine, National University of Singapore, Singapore
Co-Director, National University Centre for Women and Children (NUWoC), National University Hospital, Singapore
Chief and Senior Consultant, Department of Obstetrics & Gynaecology, National University Hospital, Singapore
Group Chief, Obstetrics & Gynaecology, National University Health System, Singapore

Artificial intelligence (AI) presents a transformative approach to addressing critical challenges in Obstetrics & Gynaecology (OB/GYN) care. Contrary to concerns about replacing physicians, AI augments medical expertise, offering collaborative solutions to improve efficiency, safety, and healthcare accessibility, achieving quality-driven care. AI and Large Language Models (such as ChatGPT, Bing, Gemini, and Bard) could potentially expedite the learning process for all healthcare professionals and students while enhancing the capabilities of doctors, nurses, and allied health professionals to provide high-quality patient care.

The American Medical Association uses the term Augmented Intelligence (AI) to highlight how artificial intelligence could assist doctors in diagnostic and therapeutic activities, emphasising its role in enhancing human capabilities rather than replacing them. Augmented AI systems use machine learning to detect OB/GYN abnormalities early, improving patient safety. AI integration in healthcare demonstrates the potential to improve patient outcomes by enhancing diagnostic accuracy and personalised treatment strategies. Reduced medical errors and complications result from optimised interventions, minimising unnecessary hospitalisations and resource burdens. These systems streamline routine tasks, enabling physicians to focus on complex patient needs. Thus, AI not only addresses labour shortages but also reduces healthcare costs while elevating the quality of patient care.

Despite its promises, responsible AI implementation is crucial. Concerns about information bias, data privacy, and mind-set manipulation necessitate ethical guidelines. It is imperative to establish frameworks ensuring patient safety, data privacy, and ethical practice. Overall, AI's role in OB/GYN care extends beyond replacement fears to offer collaborative solutions. Open dialogue and collaboration are key to upholding patient safety and ethical practice in the AI-enabled healthcare era.

Reducing the Prenatal exposure to toxic environmental agents: The Obstetrician's role

Dr U.D.P. Ratnasiri - Consultant Obstetrician and Gynaecologist, Vice President, SAFOG
Past President SLCOG
Past President, Perinatal society of Sri Lanka

Toxic exposures related to reproductive and developmental health primarily have been associated with infertility and miscarriage, obstetric outcomes such as preterm birth and low birth weight, neurodevelopmental delay such as autism and attention deficit hyperactivity disorder, and adult and childhood cancer.

Although there is substantial overlap in the type of exposure and the associated health outcomes. Exposures generally can be grouped into the following categories: toxic chemicals, air pollution, and climate change-related exposures. Obstetric care clinicians do not need to be experts in environmental health science to provide useful information to patients and refer patients to appropriate specialists, if needed, when a hazardous exposure is identified. It is important for obstetrician-gynaecologists and other obstetric care clinicians to become knowledgeable about toxic environmental exposures that are endemic to their specific geographic areas, such as local water safety advisories (e.g., lead-contaminated water), local air quality levels, and patients' proximity to power plants and fracking sites.

Clinical encounters offer an opportunity to screen and counsel patients during the pre-pregnancy and prenatal periods—particularly individuals most disproportionately affected—about opportunities to reduce toxic environmental health exposures.

Given that intrauterine gestation is a critical and particularly susceptible window of human development, obstetrician-gynaecologists and other obstetric health care clinicians can be effective in reducing prenatal exposure to environmental health threats because they are uniquely positioned to educate patients about the effects of environmental exposure before and during pregnancy.

Antenatal Screening for Pre-Eclampsia

Dr Ho Miaw Ping - Consultant Obstetrician and Gynaecologist, Maternal-Fetal-Medicine Specialist, Sunway Medical Centre, Kuala Lumpur, Malaysia

Pre-eclampsia remains one of the leading causes of maternal mortality and severe morbidity worldwide. It causes not only short-term but also longer-term implication to the pregnancy and the pregnant mother. It occurs in 2–8% of the pregnant population, and the incidence varies between different nations, strongly related to socio-economic and demographic factors. However, certain factors such as maternal age, BMI, underlying medical comorbidities, and past history of pre-eclampsia continue to play a significant role in the occurrence of this condition. Given the significant burden associated with preterm pre-eclampsia and the availability of preventive measures using low-dose Aspirin, the ability to screen and predict preterm pre-eclampsia emerges as an important game changer. The FMF Bayes-theorem-based screening method has been validated in large-scale studies, both in European and Asian countries, and is now widely applied in major obstetric health care settings worldwide. However, many developing countries, including those of AOFOG members, face challenges in performing pre-eclampsia screening due to limited resources, especially in rural areas. Hence, a novel yet cost-effective screening algorithm is needed in the effort to improve screening and reduce preterm pre-eclampsia among AOFOG countries.

UNICEF SESSION: MATERNAL NUTRITION & OBESITY IN PREGNANCY
Maternal Obesity; Long-term Implications on Mother and Baby

Dr Sanjay Kalra - Consultant Endocrinologist, Bharti Hospital, Karnal, India

Obesity is becoming more and more common across the world, including Sri Lanka. South Asians, in fact, have higher adiposity and adverse cardio-vascular outcomes at lower levels of body mass index (BMI). Hence, lower thresholds are suggested for the diagnosis of overweight (≥23 kg/m2) and obesity (≥25 kg/m2). Normal weight obesity, characterized by a normal body weight, but high body fat percentage, is also associated with adverse metabolic health. This is diagnosed by bio impedance (body fat ≥30% in women) and may be suspected by a waist circumference ≥80 cm in women. Adding to the complexity is sarcopenic obesity, in which increased body weight and low muscle mass coexist together. Maternal obesity is diagnosed based on pre-pregnancy anthropometry. Diseases like type 2 diabetes, hypertension, and polycystic ovary syndrome (PCOS) may coexist with obesity in women. Obesity is associated with impaired sexual function, subfertility, and increased early pregnancy loss. In pregnancies that continue, the risk of gestational diabetes mellitus (GDM) and pregnancy-induced hypertension (PIH) is higher.

Preterm rupture of membranes (PROM), preterm labour, and requirement for operative delivery are higher in women living with obesity. The fetus faces a greater risk of intrauterine growth retardation (IUGR), macrosomia, neonatal jaundice, and need for intensive care after delivery.

We highlight the concept of **trans-generational vipaka (karma)**, or trans-generational metabolic memory. The offspring of an obese mother have a greater chance of developing obesity and metabolic syndrome in later life. However, this can be modulated by weight control prior to conception, appropriate nutritional and metabolic care during pregnancy, and breastfeeding after delivery.

Current Trends in Approach to Obesity in Pregnancy

Prof Farhana Dewan - Professor, Department of Obstetrics & Gynaecology, IBN SINA Medical College, Bangladesh
President, OGSB
Secretary General, SAFOG

Achieving and maintaining a woman's optimal nutritional status, fitness, and weight before, during, and between pregnancies (including while breastfeeding) has immediate and long-term benefits for the health of the woman and her child/children. Women who are above a healthy weight in pregnancy have a higher risk of complications.

Adults have been classified according to BMI, i.e., underweight <18.50 kg/m2, normal range- 18.50–24.99 kg/m2; overweight ≥25.00 kg/m2; Pre-obese- 25.00–29.99 kg/m2; Obese class I- 30.00–34.99 kg/m2; class II ≥40.00 kg/m2 and class III ≥45.00 kg/m2 Obesity is defined as a Body Mass Index (BMI) of 30 kg/m2. BMI is calculated by dividing the woman's weight in kilograms by the square of her height in metres (kg/m2).

Obesity has risk for the mother & the fetus Spontaneous Miscarriage, Recurrent Miscarriage, Pre-eclampsia/Gestational HTN, Cardiac disease (MI/Stroke), Gestational Diabetes, Higher rates of caesarean section, Thromboembolism, Wound infection, Post-Partum Haemorrhage (PPH), Low breast feeding rates, Anaesthetic complications, Death/severe morbidity, are to the complications, which may arise.

The risks on fetus may be Congenital anomalies, Prematurity, Macrosomia, Shoulder Dystocia, Difficulty in intra-partum monitoring, Stillbirth, Neonatal death, Risk of childhood and adult obesity & metabolic disorder. Regarding the management, pregnancy care is an important area where we need to council these women on the importance of Obesity in Pregnancy and the impact and consequences of it.

There should be added facilities for delivery of these women in midwife-led care (MLC) and a free option to refer to a consultation-led unit (CLU) where complications arise in women of BMI >38 or BMI >40 kg/m2. During pregnancy, folic acid should be given 400 µg/day and nutritional advice, including diet and exercise, should be given. The fetus should be screened for congenital anomalies.

There may be difficulties in USG evaluation of the pregnancy due to obesity. While planning mode of delivery, the risks involved during induction of labour and the problems during labour monitoring should be explained to the woman. An anaesthesiologist should check the woman beforehand. If elective Caesarean Section is decided, special precautions should be taken accordingly.

Programatic priorities for maternal nutrition interventions across the life course

Dr Zivai Murira - Regional Advisor - Nutrition, UNICEF, South Asia

All countries in South Asia region have committed to the 2030 Sustainable Development Goals to end hunger and all forms of malnutrition (SDG-2). The nutritional status of women in South Asia has been steadily improving, but further progress is needed to address all forms of malnutrition among women of reproductive age. Too many women in the region continue to enter pregnancy with one form of malnutrition or another - thinness (22 per cent), anaemia (49 per cent) and obesity (20 percent).

Securing access to nutritious foods, along with essential nutrition services, positive nutrition practices and care is fundamental to girls and women's nutrition, wellbeing, and survival. A lifecycle approach to maternal nutrition, encompassing the critical life stages of preconception, pregnancy and postpartum up to a child's second birthday (i.e., the 1,000-day window of opportunity) is critical to ensure a continuum of care and that women fully benefit from high impact evidence-based nutrition interventions. The presentation will share the status, trends, and inequities in the nutritional status of adolescent girls and women of reproductive age (15–49 years), and the barriers they face in accessing nutritious diets, utilizing essential nutrition services and benefiting from positive nutrition and care practices. It will discuss the programmatic priorities for maternal nutrition interventions across the life course. The presentation will conclude with a discussion on key priorities and actions needed to accelerate improvements in women's nutrition across South Asia region.

UNFPA SESSION: INNOVATION AND DIGITALIZATION TO ADVANCE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF WOMEN AND GIRLS

Importance of Fostering Digitalization and Gender Transformative Innovation and Technology to Advance SRHR of Women and Girls

Dr Kaushalya Mendis - Senior Registrar, Health Informatics attached to the Health Information Unit, Ministry of Health, Sri Lanka

Inclusive Innovation Ecosystems and Digital Transformation: Experiences from South Asia

Mr Sunil Jacob - State Head, UNFPA Madhya Pradesh State office, India

Bridging the Digital Divide and How This Can Advance SRHR of Women and Girls in Hard to Reach Areas

Dr Asanthi Fernando - Consultant Community Physician
Deputy Director and Head of the Health Communication and Life Skills Unit and the Media and Publicity Unit, Health Promotion Bureau, Ministry of Health, Sri Lanka

UNFPA Concept note

Background
Innovation and digitalization opens avenues to improve access to quality healthcare services as it can reach most vulnerable and underserved communities including women and girls. With more and more people using digital technologies, it is important to harness the opportunity to disseminate accurate information available online.

UNFPA's Strategic Plan 2022-25 also identifies 'Innovation and Digitalization' as one of the six accelerators to achieve the plan's outputs. The Innovation Ideathon creates the opportunity to find solutions for our goals by thinking and acting differently, we can meet the challenges of our time and achieve our goals. Sri Lanka records 12.34 million internet users, with an internet penetration of 56.3 percent and 34.2 percent social media users. A total of 32.49 million cellular mobile connections were active in Sri Lanka in early 2024, with this figure equivalent to 148.2 percent of the total population. 1 However, it is important to note the digital divide that exists in the country, with male computer literacy being 36.1%, compared to 32.6% for females and digital literacy rates being 54.5% for females and 60.3% for males during the same year. Therefore, while digital transformation opens doors to advance service delivery, it is essential to look into the rural areas and marginalized communities, and ensure that they have access to and are equipped with the necessary literacy, skills and resources. Designing and developing these innovative solutions keeping women, girls and other marginalized groups in mind is essential to ensure that the most vulnerable are reached.

In Sri Lanka, digitalization and innovation are critical for addressing sexual and reproductive health (SRH) issues, particularly to ensure the health and well-being of women and youth. Youth often lack access to comprehensive sexual education (CSE) due to limited resources and the social stigma surrounding SRH topics. A significant proportion of Sri Lankan youth remain inadequately informed about their SRHR andavailable services. Digital tools, such as mobile apps and online platforms, can bridge this gap by providing easily accessible, reliable information and educational resources to young people, regardless of their location. Further, women and youth in rural or underserved areas face challenges in accessing health services especially around SRH due to limited healthcare infrastructure.Digital health solutions, such as mobile clinics, telemedicine and remote consultations, can support in addressing these issues. This approach not only enhances access to essential services but also empowers women to take control of their reproductive health.

The Sri Lanka College of Obstetricians and Gynaecologists (SLCOG) will be holding its 57th Annual Academic Congress from 30th August to 1st September 2024 at Hotel Galadari in Colombo, Sri Lanka, with the theme "Quality health care through standards in training and service delivery – A right of all women". This creates a good opportunity to bring together experts from the country and region to discuss global best practices and strategize the way forward to advocate

together to harness Innovation and Digitalization to advance the sexual and reproductive health and rights of women and girls while bridging the digital divide. Proposed Activity As part of UNFPA's support for the congress, a panel discussion will be organized on 1st September 2024 under the topic "Innovation and Digitalization to advance the sexual and reproductive health and rights of women and girls"

Objectives

- Highlight the importance of fostering gender-transformative innovation and technology to advance the sexual and reproductive health and rights (SRHR) of women and girls.
- Share experiences from South Asia on creating inclusive innovation ecosystems and digital transformations.
- Discuss strategies to bridge the digital divide and how this can advance the SRHR of women and girls in hard-to-reach areas. Expected outputs
- Enhanced understanding among stakeholders of the importance of digitalization and gender- transformative innovation in advancing SRHR.
- Improved awareness of best practices and strategies from South Asia that can be applied to create inclusive innovation ecosystems.
- Joint advocacy to bridge the digital divide, focusing on reaching women and girls in marginalized and rural communities to improve access to life-saving services and information
- Formulation of paper with recommendations to support innovation and digitalization in advancing SRHR for women and girls.

ABSTRACTS OF SYMPOSIA

DAY 01
SYMPOSIUM 1: FOGSI

What's New in Male Infertility Management?

Dr Hrishikesh Pai - President, Federation of Obstetrics and Gynaecological Societies of India
Professor, Reproductive Medicine, D.Y. Patil International University, India
Medical Director, Bloom IVF Group, India

Reaching every girl every women- Role of FEMTECH

Dr Hema Divakar - Division Director, FIGO Well Women Healthcare

Introduction

FEMTECH, short for Female Technology, represents a burgeoning field dedicated to leveraging technology to address women's health issues. Over recent years, FEMTECH has evolved from a niche area into a significant component of healthcare innovation.

Understanding FEMTECH

FEMTECH encompasses a range of technological solutions designed specifically for women's health needs. These technologies include apps, wearables, and digital platforms focusing on various aspects such as menstrual health, fertility, pregnancy, menopause, and general well-being. By addressing unique health challenges faced by women, FEMTECH seeks to improve quality of life and enhance healthcare accessibility.

Impact on Women's Health

1. Menstrual Health: One of the earliest applications of FEMTECH, menstrual tracking apps, has transformed how women manage their menstrual cycles. These apps offer insights into cycle patterns, predict ovulation, and provide symptom tracking. For many, this means better management of menstrual health, reducing the impact of disorders like PCOS or endometriosis through informed tracking and timely intervention.

2. Fertility: Fertility apps and wearable devices have empowered women to take charge of their reproductive health. By tracking physiological indicators such as basal body temperature and hormone levels, these technologies facilitate more accurate ovulation prediction, aiding those trying to conceive. They also provide valuable data for fertility specialists, enhancing treatment plans.

3. Pregnancy: Pregnancy-related FEMTECH innovations include remote monitoring tools and telemedicine platforms. These tools allow expectant mothers to track fetal development, monitor health metrics, and communicate with healthcare providers from home. This not only improves accessibility to prenatal care but also ensures timely intervention in case of complications.

4. Menopause: Managing menopause symptoms has been significantly improved by FEMTECH. Wearable devices that monitor physiological changes and apps that offer symptom tracking and management strategies help women navigate this life stage with greater ease. These technologies provide personalized insights and support, which can be crucial for managing symptoms effectively.

5. General Well-being: Beyond reproductive health, FEMTECH also addresses general wellness. Apps focused on mental health, fitness, and nutrition cater specifically to women's needs, promoting overall well-being and encouraging healthier lifestyles.

Overcoming Barriers

FEMTECH plays a crucial role in overcoming several barriers in women's healthcare:

1. Accessibility: FEMTECH solutions are making high-quality health information and monitoring tools more accessible, particularly in underserved areas. Mobile technology enables remote access to healthcare services, bridging gaps in regions with limited medical infrastructure.

2. Affordability: As FEMTECH evolves, the cost of technology is decreasing. This trend makes health management tools more affordable, contributing to broader access for women across different socio-economic backgrounds.

3. Education: FEMTECH platforms often include educational components, helping users understand their health better. This is particularly valuable in areas where health education is limited, empowering women with knowledge and tools to manage their health proactively.

Conclusion:

The ongoing evolution of technology promises new advancements in FEMTECH. From AI-driven diagnostic tools to advanced wearable sensors, future innovations will likely offer even greater insights and management capabilities.

FEMTECH is profoundly transforming women's health by providing innovative, accessible, and personalized solutions. Its role today is pivotal in addressing specific health challenges faced by women and overcoming barriers to healthcare access. As technology continues to advance, FEMTECH will play an increasingly vital role in improving health outcomes and empowering women to take control of their well-being. The continued development and integration of FEMTECH hold the promise of a healthier, more informed future for women worldwide.

Management of Pre-eclampsia

Dr Suchitra Pandit - Consultant Obstetrician and Gynaecologist, Surya Group of Hospitals, Mumbai, India
FOGSI representative to SAFOG

Hypertensive disorders in pregnancy

Introduction: Hypertensive disorders in pregnancy (HDP) are the spectrum of disorders ranging from already existing chronic hypertension in the index pregnancy to complex multisystem disorder like pre-eclampsia leading to the com-

plications like eclampsia, HELLP syndrome, acute renal failure, pulmonary oedema, stroke, and left ventricular failure. They mainly contribute to a high maternal and perinatal morbidity and mortality; hence, early diagnosis is helpful.

Prediction of HDP:

Universal screening is recommended, but there is no single effective screening test.
No single test proposed till date to predict HDP qualifies to be recommended for screening.
Assessment of clinical risk factors helps us to be more vigilant to prevent HDP and its complications. The best and most simplified way to do it is by using the HDP-Gestosis Score.

Prevention of HDP:
In 'at-risk' women for HDP, Aspirin 75 mg along with Calcium 1-1.5 gram daily is recommended.

Diagnosis:
When the blood pressure reading of a pregnant woman is =/>140/90 mmHg, following investigations are advisable to assess the severity of the disease.

Urine albumin: urine dipstick method or urine protein: creatinine ratio
Complete blood count: platelet count and anaemia assessment
Liver and kidney function tests.
Additional laboratory investigations:
Coagulation profile (when the platelet count is <100,000/mm3)
Serum electrolytes (in severe disease)

Management: Early diagnosis and assessment of severity is important to minimize complications.

Anti-hypertensive medicines in proper dosages will reduce the risk of complications.

Magnesium sulfate (MgSO4) to prevent eclampsia in severe cases of HDP is the mainstay, along with corticosteroids for fetal lung maturity. Prompt but steady reduction of blood pressure in hypertensive emergencies and timely referral to a well-equipped tertiary care in cases of severe pre-eclampsia, HELLP/Eclampsia with all the supportive medication and documentation is necessary. Timely delivery also reduces maternal and perinatal mortality and morbidity.

Medical management: The World Gestosis Organization recommends that a systolic blood pressure of =/>140 mmHg and/or a diastolic blood pressure of =/>90 mmHg warrant anti-hypertensive therapy.[14]
Target range of blood pressure to be kept:

Systolic </=140 mmHg
Diastolic </=90 mmHg: Avoid hypotension.

Anti-hypertensives (non-severe HDP):

1. Labetalol: 200-1200 mg/day in 2 divided doses It is accepted as the first-line and effective medication during pregnancy. Preferred medication when baseline pulse is >100/min It is contraindicated in asthma, CCF, diabetes mellitus, and cases of bradycardia.
2. Nifedipine: 20-120 mg/day of slow-releasing preparations in 2-3 divided doses Preferred medication when baseline pulse is <100/minMaternal adverse effects include tachycardia, palpitations, headaches, and facial flushing. Never administer Nifedipine sublingually.

3. Methyldopa: 500-2000 mg per day orally in 2-3 divided doses. Methyldopa is the most time-tested and safe anti-hypertensive. Currently, availability of the drug is a challenge. The drug is to be discontinued in the postpartum period to avoid postpartum depression.

Drugs contraindicated in pregnancy: ACE inhibitors, ARBs, ß-blockers, and diuretics.

Anti-hypertensives for rapid control (severe HDP):
Target: <140/90 mmHg
Lower the blood pressure promptly but slowly:

Drug	Dosage	Points to remember
Nifedipine	10-30 mg orally (not sublingually) If BP is not controlled, it can be repeated within 30 to 45 minutes. The maximum total dose of 120 mg is not to be exceeded. On control, slow release preparations are started.	Contraindicated in CCF and AV or SA nodal abnormalities
Labetolol	Slow IV injections: 10 to 20 mg IV, then 20 to 80 mg every 20 to 30 minutes The maximum total dose of 300 mg is not to be exceeded. Alternate IV infusion regimen: After initial loading dose, an infusion can be started at 1–2 mg/min and is titrated until desired effect. Oral tablets can be used in a conscious patient in the dose of 200 mg.	Contraindicated in CCF, DM, asthma, and bradycardia.
Hydralazine	5 mg, IV or IM, then 5 to 10 mg every 20 to 40 minutes; once BP controlled, repeat every 3 hours; for infusion: 0.5 to 10.0 mg/h; if no success with 20 mg IV or 30 mg IM, consider another drug.	It is associated with maternal hypotension, more of caesarean sections, placental abruptions, and oliguria.
Nicardipine	The average starting dose is 1.5 mg/h. It can be increased up to 6 mg/h for the desired effect according to the 0.5 µg/kg/min equation.	It is 100 times more water-soluble than Nifedipine, so it can be administered IV, making it an easily titratable IV calcium channel blocker.

Seizure prevention:

In all cases of severe pre-eclampsia, a loading dose of Magnesium sulfate (MgSO4) is recommended to prevent eclampsia. As per Magpie Trial (2004)18, a full dose of MgSO4 should be given to prevent eclampsia and reduce morbidity and mortality. Magnesium sulfate can be given as per Pritchard's regime or Zuspan's regime.

Pritchard's regime (1995): Magnesium sulfate loading dose of 4 gm intravenous (IV) as 10 ml of 50% solution over 5 minutes. This is followed by a maintenance dose of MgSO4, 10 gm of 50% solution, and 5 gm in each buttock as deep

IM injection (can add 1 ml of lignocaine in the same syringe). This is continued for 24 hours. Zuspan (1978): loading dose IV 4 gm prepared in the same way as the intramuscular dose and later followed by an infusion of 1 gm/hr.

The magnesium level should be kept between 4-7 meq/litre. For this, monitoring is done by checking the patient's Patellar (deep tendon) reflex, respiratory rate, and urine output. Patellar reflexes should be present, as these are the first to go if there is toxicity. The respiratory rate should be >16/min, and urine output should be >30 ml/hour.

Decision to deliver:

It should be carefully taken after assessing maternal and fetal risks.
Gestational Hypertension: Pregnancy can be continued till the term.
Mild Pre-eclampsia: Can be delivered after 37 completed weeks.
Severe pre-eclampsia: Can be delivered after 34 completed weeks.
Eclampsia: Should be delivered once mother is stabilized after Magnesium sulfate (MgSO4)

Labour induction with an appropriate method can be carried out safely. A Caesarean section is done for obstetric indications only. Preventing postpartum haemorrhage is important.

Postpartum Care:
Every patient with pre-eclampsia should be monitored closely for postpartum complications. Follow for blood pressure for 3 months with advice regarding antihypertensive medicines and regular visits. They should be counselled for contraception at least for a period of 2–3 years. The preferred method would be an IUCD or Progestogen only pills. They should be counselled regarding the importance of pre-conceptional counselling in subsequent pregnancy. Long-term surveillance is needed as pre-eclampsia increases the long-term risk of chronic hypertension, IHD, cerebrovascular disease, kidney disease, DM, thromboembolism, hypothyroidism, and impaired memory.

SYMPOSIUM 2: MEDICAL DISORDERS IN PREGNANCY

Hyperglycaemia in Pregnancy

Dr Uditha Bulugahapitiya - Consultant Endocrinologist, National Hospital of Sri Lanka
Chairperson of the Specialty Board in Endocrinology, Postgraduate Institute of Medicine, University of Colombo

The prevalence of obesity is rising worldwide and an increasing number of women of reproductive age group are either obese or overweight. Obesity is strongly associated with diabetes mellitus in pregnancy, which affects nearly 2-18% of all pregnancies globally. The incidence of gestational diabetes mellitus (GDM) is increasing on par with obesity rates. Hyperglycemia in pregnancy contributes to the risk of developing metabolic disorders and type 2 diabetes in mothers as well as offspring.

Diabetes mellitus in pregnancy results from an interaction between genetic and environmental risk factors. It is characterised by insulin resistance and impaired beta cell function of the pancreas, thus sharing some similarities with Type 2 DM.

Diabetes in pregnancy and obesity are independently associated with adverse maternal and neonatal outcomes in both the short term and long term. In general, specific risks of diabetes in pregnancy include spontaneous abortion, fetal anomalies, preeclampsia, fetal demise, macrosomia, neonatal hypoglycemia, hyperbilirubinemia, and neonatal respiratory distress syndrome, among others. Both conditions increase the offspring's predisposition to obesity, impaired glucose tolerance, and GDM creating a vicious cycle of accumulating risk in subsequent generations. Thus, safe and effective interventions in preventing diabetes in pregnancy are of paramount importance.

Studies in lifestyle modification on preventing type 2 DM, which shares a similar pathophysiology to GDM have shown promising results with significant risk reduction. Adherence to a healthy lifestyle pre-pregnancy is associated with reduced risk of GDM. Studies on lifestyle interventions of combined moderate physical activity and diet in high-risk

women of GDM show promising results, making it a way forward to overcome this vicious cycle. Further, introducing digital material for self-management and monitoring blood glucose during pregnancy is recommended to minimise future risk.

Overcoming Challenges of Renal Disorders During Pregnancy

Dr Chanaka Abeyrathna - Consultant Nephrologist
MSc in Transplant Medicine, UK
Fellowships in Renal pathology, Pancreas and kidney transplant, and Glomerulonephritis

Renal disorders during pregnancy can pose unique challenges. As obstetricians, you may have often encountered mothers with pre-existing renal conditions such as chronic kidney disease, glomerulonephritis, congenital renal disease, transplanted kidneys, or patients with pregnancy-induced renal impairments. Such conditions are often shown to be cumulatively detrimental to both fetal and maternal outcomes that may potentially occur as a result of reciprocal influence between renal diseases and pregnancy. If not properly taken care of, renal disorders in pregnancy may often lead to severe feto-maternal morbidity or even mortality.

The anatomical adaptations and physiological alterations occurring with pregnancy may often favour the flare-up of pre-existing renal disorders. Consequently, patients are at increased risk of developing other gestational complications such as pre-eclampsia, preterm delivery, IUGR, etc. Moreover, due to the risk of teratogenicity, the choices of medications that can be used are also limited. Therefore, the liberal management of renal conditions is often truncated. Further, the alterations that may occur in biochemical markers during pregnancy often give rise to diagnostic pitfalls and may even complicate disease monitoring processes. In addition, the outcome of pregnancy directly correlates with the degree of severity of renal impairment as well as the presence of other comorbid conditions.

Nevertheless, impressive improvements in perinatal outcomes can be accomplished by timely expert intervention.

The cornerstone of management of renal disease includes careful attention throughout while taking many clinical aspects into consideration. Ideally, care must be initiated with preconception counselling, which must then be followed by proper antenatal and postpartum management. This can be best achieved by a combined expertise of specialists in Obstetrics, Nephrology, Neonatology, and Urology etc. The key priority here should encompass working collaboratively in a multidisciplinary team to ensure early diagnosis, judicious application of therapeutic interventions, and sustained optimizations of renal care management. As nephrologists, our main purpose is to provide our fair share to ensure that renal diseases are not an obstacle to healthy reproduction.

Evaluation of Liver Diseases in Pregnancy

Dr Eranda Luxman - Senior Clinical Fellow in Hepatology, King's College Hospital NHS Trust, London

Liver disease in pregnancy poses significant risks to both maternal and fetal health, requiring careful evaluation and management. The primary liver conditions of concern include Intrahepatic Cholestasis of Pregnancy (ICP), Acute Fatty Liver of Pregnancy (AFLP), and HELLP syndrome. Evaluation begins with a thorough clinical history with special consideration in to the gestational age and assessment of symptoms such as jaundice, itching, and abdominal pain. Laboratory tests, including liver function tests, hepatitis serologies, and coagulation profiles, are essential for diagnosing and distinguishing between different liver disorders. Imaging, primarily through ultrasound, aids in assessing liver structure and identifying complications. Specific conditions like ICP and AFLP demand prompt diagnosis and targeted treatment strategies to mitigate risks. Ongoing fetal monitoring through ultrasound and non-stress tests ensures fetal well-being, especially in cases of severe liver disease. A multidisciplinary approach involving obstetricians, hepatologists, and neonatologists is crucial for optimal outcomes. Early detection and management of liver disease in pregnancy are vital to improving maternal and fetal health outcomes.

SYMPOSIUM 3: UROGYNAECOLOGY

Management of Recurrent Prolapse

Dr Ruwan Fernando - Consultant Obstetrician and Urogynaecology Subspecialist, Imperial College Healthcare, NHS Trust, St Mary's Hospital, London
Co-director, Urogynaecology Subspecialty Training Programme, St Mary's Hospital, London

Pelvic organ prolapse affects almost half of all women over 50 years, with a lifetime prevalence of 30–50%. Women with a normal life expectancy of 79 years have a 12% chance of at least one surgery for prolapse or incontinence, with a re-operation rate of 29% after five years.

Risk factors for recurrent prolapse after primary surgery include high BMI, pregnancy and vaginal birth after surgery, and co-existing medical conditions such as chronic cough, diabetes, and connective tissue disorders.

Recurrence of prolapse after previous surgery is classified as anterior compartment (recurrent cystocele), middle compartment (vaginal vault), posterior compartment (recurrent rectocele), or a combination of more than one compartment.

Use of support pessaries such as gellhorn or shelf pessaries is indicated in women who are not suitable for surgical treatment or who wish non-surgical treatment.

Prior to surgical treatment for recurrent prolapse, detailed investigations into lower urinary tract and bowel function are essential.

Surgery for isolated recurrent cystocele or rectocele needs some degree of augmentation as there is limited native tissue available during the second repair. Use of biological mesh, such as porcine derivatives, is recommended compared to synthetic mesh because of the major adverse effects associated with the latter. Use of synthetic mesh kits is not recommended for any type of prolapse repair due to the high rate of complications such as bladder, bowel, and vaginal extrusion of mesh, dyspareunia, and pelvic pain.

The approach to vaginal vault surgery should be based on the patient's age, fitness for surgery, and the need to preserve sexual function. Abdominal sacrocolpopexy is recognised as the gold standard treatment for vaginal vault prolapse. The success rate of open versus laparoscopic scarocolpopexy is comparable.

Vaginal repair of vault prolapse includes sacrospinous fixation, transvaginal utero-sacral ligament suspension, and colpocleisis.
Recurrent prolapse is a complex condition requiring individualised patient care. The gynaecologist needs to be skilled in a number of different prolapse surgical techniques in order to provide the best care. Patient characteristics, expectations, and treatment goals need to be considered when deciding on the route of surgery and individualise accordingly.

Open vs. Laparoscopic BURCH: An Overview

Dr Sampath Gnanarathna - Senior lecturer in Obstetrics and Gynaecology, Department of Obstetrics and Gynaecology, Faculty of Medicine, University of Peradeniya, Sri Lanka
Consultant Obstetrician and Gynaecologist, University Professorial Unit, Teaching Hospital, Peradeniya, Sri Lanka

Stress urinary incontinence (SUI) is a common condition that significantly interferes with the quality of life. SUI affects an estimated 17–45% of adult women in industrialized countries. Burch colposuspension is a widely accepted surgical technique for managing SUI, particularly when it is associated with urethral hypermobility. In 1949, Marshall and Marchetti developed the MMK procedure, a surgical technique to treat SUI through surgery. It involved fixing the endopelvic fascia to the pubic periosteum and raising the bladder neck. This technique was modified by Hirsch and Cowan, followed by Burch.

]The open Burch colposuspension was long considered the "gold standard" for SUI treatment. However, the laparoscopic approach to colposuspension has several advantages over open surgery, including reduced scarring, a shorter duration of hospital stay, faster recovery, and a return to normal activities. Both laparoscopic and open Burch colposuspension have similar outcomes in terms of cure rates, as observed in both short-term and long-term follow-up studies (85% vs. 88% at 18-month follow-up).

The procedure has undergone numerous modifications, such as the use of stitches versus mesh and staplers for the suspension, single-bite versus double-bite techniques, transperitoneal versus extraperitoneal approaches, and the use of absorbable versus non-absorbable suture materials. Further evaluation and follow-up studies are encouraged to establish strong evidence for these different techniques. Finally, burch colposuspension in the laparoscopic approach is as effective as the open approach in treating SUI, while also providing patients with the benefits of minimally invasive surgery.

Newer advances in managing OAB

Dr Prabath Randombage - Senior Lecturer in Obstetrics and Gynaecology, Faculty of Medicine, University of Kelaniya, Sri Lanka
Consultant Obstetrician and Gynaecologist, Colombo North Teaching Hospital, Ragama, Sri Lanka

Overactive bladder syndrome (OAB) is defined as urinary urgency, frequency, and nocturia, with or without urge incontinence (UI), in the absence of urinary tract infection. While antimuscarinics remain a mainstay for OAB management, they are associated with a significant side effect profile. Hence, the failure rate or discontinuation at one year exceeds more than 50%. Current advances include the use of newer medications, such as beta-3 adrenergic agonists and novel formulations of anticholinergics, which offer improved efficacy and reduced side effects.

Pelvic floor muscle training with or without biofeedback has proven effective in managing stress and also the urge incontinence. Treatment of genitourinary syndrome of the menopause with local oestrogens has also shown promise. Botulinum toxin, which is licensed and being used in many other fields in Sri Lanka, is shown to be effective in managing UI, where gynaecologists can be trained in cystoscopic delivery of the medication. Another means of minimally invasive procedures for OAB includes cystoscopy-guided radiofrequency and more popularising LASER treatment modalities.

At present, third-line treatment options like neuromudulation and bladder surgeries are unpopular in Sri Lanka. Hence, while moving away from a strict stepwise approach, clinicians can offer a menu of available treatment options, including non-invasive and minimally invasive procedures. Furthermore, the role of digital health solutions, including mobile applications and tele-health services, is expanding in patient education and self-management.

Key words: Overactive bladder, OAB, Urge incontinence

SYMPOSIUM 4: MISCELLANEOUS

Pregnancy and Skin

Dr Premanie Raajendran - Consultant Dermatologist, National Hospital of Sri Lanka, Colombo

The skin undergoes significant changes during pregnancy due to marked changes in the levels of sex hormones, particularly oestrogen and progesterone.

Skin conditions during pregnancy generally can be divided into three categories: hormone-related (physiological changes), pregnancy-specific, and pre-existing dermatoses.

Any cutaneous change is rarely ignored as the mother is concerned about her own and her fetus' well-being, and it is essential to clearly distinguish these different dermatoses, as some of them, such as pemphigoid gestationis, impetigo herpetiformis, and intrahepatic cholestasis of pregnancy, can have fetal consequences.

This talk will present on the physiological changes of pregnancy and on pregnancy-specific dermatoses to increase awareness and help clinicians to recognize, diagnose, and manage these unique conditions.

Emergency and Elective Uterine Artery Embolization

Dr Praneeth Athukorala - Consultant Interventional Radiologist, Neuro-trauma Centre, National Hospital of Sri Lanka, Colombo

Pelvic embolization in women is conventionally indicated in uncontrolled vaginal bleeding in postpartum uterine atony, pelvic vascular malformation, of symptomatic fibroid, and cessation of postsurgical active arterial oozes. Demand for such intervention is ever-increasing.
Thorough knowledge about pelvic arterial anatomy is a prerequisite, and selection of the appropriate embolization techniques is essential to prevent unwanted side effects caused by non-target embolization.

Conventionally, uterine artery embolization is an alternative approach to management of symptomatic fibroids that are not responding to conservative therapy, which results in selective infarction of the tumour. Radiation exposure is a concern, especially among young patients.

An emergency selective uterine arterial embolization in PPH is a lifesaving and effective alternative to hysterectomy in terms of future preservation of the uterus but can be technically challenging due to oxytocin-induced vasospasm.

Uterine arterial embolization in ectopic cervical pregnancy is rarely performed but is an adjunctive in the management of such a condition. Some centres may perform pre-curettage bilateral selective embolization considering the risk of intractable bleeding that can occur after conventional curettage.

Common Bowel Diseases in Pregnancy

Dr Nilesh Fernandopulle - Consultant Gastroenterologist and Senior Lecturer, University Surgical Unit, National Hospital Sri Lanka

Gastrointestinal symptoms during pregnancy occur commonly. Nausea, vomiting, and heart burn may be particularly distressing during the first trimester but can present at any time during pregnancy and appear to be caused by gestationally induced anatomic and hormonal factors. Constipation is very common, and its causes are many, including alterations in dietary habits, lack of exercise, and physical compression of the sigmoid colon by an expanding uterus, and a decreased transit time. Diarrhoea is less common, usually is not serious, and resolves spontaneously. When diarrhoea presents with blood, pus, and mucus, however, it is generally indicative of an underlying infectious or idiopathic inflammatory bowel disorder. Abdominal pain may be a difficult problem to assess during pregnancy. The acute abdomen is managed as in the non-pregnant patient. In evaluating the less urgent causes of abdominal pain, however, the physician needs to weigh the potential risks of diagnostic procedures to the pregnant woman and the fetus.

SYMPOSIUM 5: OGSB

Chronic Pelvic Pain

Prof Salma Rouf - Professor in Obstetrics & Gynaecology
Secretary General, Obstetrical & Gynaecological Society of Bangladesh (OGSB)

Chronic Pelvic Pain (CPP) can be defined as intermittent or constant pain in the lower abdomen or pelvis of at least 6 months in duration, not occurring exclusively with menstruation or sexual exposure and not associated with pregnancy. It is a symptom, not a diagnosis; though not a life-threatening condition, it has a significant impact on quality of life and functional capability. CPP is the most common and difficult problem encountered by health care providers, with an estimated prevalence ranging from 5.7% to 26.6%. Pelvic pain is associated with a wide range of conditions involv-

ing reproductive, gastrointestinal, genitourinary, musculoskeletal, or psychological systems. The aim of management should be to focus on accurate diagnosis and effective treatment to reduce disruption of women's lives, avoid endless investigations and referrals, and remove the women's perception that it is not curable.

Obtaining a complete and detailed history is the most important key to formulating a diagnosis. Use of the review of systems to obtain a focused, detailed history of the organ systems involved is helpful for having a correct diagnosis. A physical examination of CPP is very different from a routine gynaecological examination. Two approaches for treatment of CPP are practiced: treat the pain as a diagnosis or treat the disorders that cause or contribute to the pain. Effective therapeutic trials could be achieved by using both approaches. Along with the medical therapeutic trials pelvic floor physical therapy, cognitive behavioural therapy, sex therapy, multidisciplinary chronic pain management, and complementary and alternative medicine (CAM) are emerging. CPP is disappointing for the physicians to treat and frustrating for the patients to get a cure. Physicians must be concerned not to dismiss organic causes as psychological. Treatment options are also multi-dimensional, with the involvement of a multidisciplinary gynaecological and non-gynaecological approach and a rehabilitation model. Women should not leave with the feeling that they have to live with pain.

Prediction and Prevention of Pre-Eclampsia

Prof Laila Arjumand Banu - Chief Consultant & Head of the Department of Obstetrics and Gynaecology, Lab Aid Specialized Hospital, Dhaka, Bangladesh
Past President, Obstetrical & Gynaecological Society of Bangladesh (OGSB)

Screening of all pregnant women is recommended to identify those at higher risk for PE so that they can receive preventive measures and greater maternal-fetal surveillance during pregnancy. The best strategies for screening PE involve several parameters in combinations from a risk calculation algorithm. PE is an important cause of maternal and perinatal mortality worldwide; it accounts for 10-15% of direct maternal deaths, and 99% of these deaths are in low-income countries.

Pre-eclampsia is defined as systolic blood pressure of at or more than 140 mmHg and/or diastolic blood pressure of at or more than 90 mmHg on at least 2 occasions measured 4 hours apart in previously normotensive women and is accompanied by one or more of the following new onset conditions after 20 weeks gestation. Proteinuria is evidence of PE. Preventive measures against PE have been heavily studied. Because the pathogenesis of PE is not completely understood, prevention remains a complex issue. Some currently accepted recommendations are:

1. Diet—supplementation with a balanced protein and energy diet does not appear to reduce the risk of PE. Further, there is no evidence that changing salt intake has an effect.
2. Calcium supplementation of at least 1 g/day is recommended during pregnancy as it prevents, where dietary calcium is low.
3. Aspirin—Taking aspirin is associated with a 1 to 5% reduction in premature birth in women at high risk.
4. The WHO recommends low-dose Aspirin for the prevention of PE.
5. Women with a history of previous pre-eclampsia are at increased risk of PE and other adverse pregnancy outcomes in subsequent pregnancies.
6. The magnitude of this risk is dependent on gestational age at time of disease onset, severity of the disease, and presence or absence of pre-existing medical disorders.
7. So far, no recommended tests exist that can predict the future onset of PE early in pregnancy. Liquid biopsy's that measure circulating cfRNA offer an opportunity to study the development of pregnancy-related complications in a non-invasive manner and to bridge gaps in clinical care.

Rising Trends of Endometrial Cancer. How to Prevent?

Prof Sabera Khatun - Founder Chairman, Department of Gynaecological Oncology, Bangabandhu Sheikh Mujib Medical University (BSMMU), Bangladesh
Senior Consultant Obstetrician and Gynaecologist, Lab-Aid Cancer Hospital Superspecialty Centre, Dhaka

Endometrial cancer incidence is increasing in countries undergoing transition from low to high-income countries. This increase in incidence is mostly due to the increase in prevalence of diabetes, hypertension, obesity, late age in marriage, infertility, anovulation, PCOS, nulliparity, employment in sedentary work, and overall early menarche and late menopause. Granulosa cell tumours in menopausal women also produce excessive oestrogen. All these factors are related to high unopposed oestrogen activity on endometrium.

High and unopposed oestrogen in blood leads to excessive proliferation of endometrium, which is unopposed by the anti-proliferative action of progesterone, because most of these conditions hamper ovulation, leading to a low progesterone level in the blood. This excessive proliferation leads to endometrial hyperplasia, and when it is associated with atypia, leads to endometrial cancer.

Endometrial cancer is of two types:

1. Types I or Endometrioid type of adenocarcinoma
2. Type II or Non-endometrioid type of adenocarcinoma.

Differences in two types are cited below:

Type I (90%)	Type II (10%)
1. Oestrogen dependent	1. Atrophic endometritis related
2. Arise from endometrial hyperplasia preceded by EIN	2. Oestrogen or endometrial hyperplasia independent.
3. Slowly growing	3. Rapidly growing
4. Well differentiated, good prognosis	4. Poorly differentiated, poor prognosis
5. 70% confined to corpus at diagnosis	5. 50% spread beyond corpus at diagnosis
6. Overall survival: 83%	6. Overall survival: 52%

How to prevent?

Eighty percent of endometrial carcinomas are type I and oestrogen dependent. So, if hyperestrogenetic conditions can be prevented, 80% endometrial cancer can be prevented. Among all the conditions, obesity and diabetes can easily be prevented by diet control and physical exercise. Even endometrial hyperplasia can be treated conservatively by high-potency progesterone in women less than 40 years of age or who want pregnancy, by which endometrial cancer can be prevented. The role of prophylactic total abdominal hysterectomy is well recommended in women with atypical endometrial hyperplasia and age more than 40 years.

Postpartum Haemorrhage- An Update

Prof Ferdousi Begum - Professor, Department of Obstetrics & Gynaecology, Ibrahim Medical College and Institute of Women & Child Health, Dhaka
Past President, South Asian Federation of Obstetrics & Gynaecology (SAFOG)

Postpartum haemorrhage (PPH), commonly defined as a blood loss of 500 ml or more within 24 hours after birth, is the leading cause of maternal mortality worldwide. It affects millions of women every year and accounts for over 20% of all maternal deaths reported globally. Death from PPH is largely preventable and has been nearly eliminated in high-income countries (HICs). Yet women in low- and middle-income countries (LMICs) continue to be disproportionately affected.

Most maternal deaths from PPH occur in sub-Saharan Africa and south Asia. WHO has updated the recommendations on the assessment of postpartum blood loss and use of a treatment bundle for postpartum haemorrhage 2023.

Recommendation 1: For all women giving birth, routine objective measurement of postpartum blood loss is recommended to improve the detection and prompt treatment of postpartum haemorrhage. Methods to objectively quantify blood loss, such as calibrated drapes for women having vaginal birth, can achieve this.

Recommendation 2: A standardized and timely approach to the management of postpartum haemorrhage (PPH), comprising an objective assessment of blood loss and use of a treatment bundle supported by an implementation strategy, is recommended for all women having a vaginal birth. The care bundle for first-line treatment of PPH should include rapid institution of uterine massage, administration of an oxytocic agent and Tranexamic acid, intravenous fluids, examination of the genital tract, and escalation of care.

In recognition of the growing need for global action to improve PPH prevention and care, the World Health Organization (WHO) worked together with key stakeholders to develop a Roadmap to combat postpartum haemorrhage. The Roadmap outlines goals, activities and milestones for global-level research, normative work (i.e., relating to norms and standards), implementation, and advocacy between 2023 and 2030 to address key PPH priorities and fast-track progress towards SDG target 3.1. This Roadmap establishes an innovative, solution-driven, and customised strategic framework that is centred on the maternal health goals and priorities of countries with a high burden of PPH and which calls for investments into critical areas of health systems, with special emphasis on LMICs. The Roadmap aims to align efforts and foster cooperation among all partners working on PPH to combat postpartum haemorrhage between 2023 and 2030 by pursuing the required technical, investment, and policy objectives that will deliver on the core priorities of ongoing global initiatives for maternal and newborn health. A Global PPH Day will be established, and a suitable date will be identified with the aim of holding the first Global PPH Day in 2025, which will also serve as a launch pad for the PPH branding strategy.

FIGO recommendations on the management (prevention and treatment) of postpartum haemorrhage, 2022, are one of the important guidelines.

SYMPOSIUM 6: CURRENT PRINCIPLES AND ADVANCES IN GYNAECOLOGICAL ONCOLOGY

Concepts in Gynaecological Oncosurgery - Staging, Radical Resection and Debulking

Dr Rajitha Wijesinghe - Consultant Gynaecological Oncologist, Department of Gynaecological Oncology, National Hospital, Kandy, Sri Lanka

Management of any cancer should be based on adherence to basic scientific concepts. This includes the concepts of the intention of treatment, the intention of surgery, and proper staging.

Intention treatment refers to the intended outcome of the principal treatment modality. This would include primary treatment, adjuvant treatment, and palliative treatment. The goal of primary treatment is to completely remove/kill the cancer cells while adjuvant treatment aims to kill any cancer cells that are left behind after primary treatment. Palliative treatment helps to relieve signs and symptoms of the cancer or side effects of its treatment.

Surgical treatment for gynaecological cancer would either be excision, resection, or debulking. In an excision surgery, only a portion of a body part is removed while resection involves the removal of an entire body part (ICD 10 PCS). In radical resection, the entire involved intra-compartment and extra compartmental uninvolved tissue is removed. Debulking (Cytoreduction) is a surgery performed to decrease the amount of cancer in advanced malignancies.

Staging is an assessment of how far a cancer has spread within the body at the time of diagnosis. This would follow the TNM classification. Staging would be performed after a combined clinical, radiological, surgical, and pathological assessment of the cancer spread. Staging would be a prognostic indicator as well as the most important determinant of primary and adjuvant treatment.

Fertility Sparing in Gynaecological Oncology

Dr Thanuya Mahendran - Consultant Gynaecological Oncologist, Teaching Hospital, Jaffna, Sri Lanka

The effect of cancer treatments on fertility and pregnancy outcomes is a distressing concern among the increasing population of reproductive-age women with gynaecologic cancer. Fertility preservation techniques have improved over the last two decades, and observational studies have led to careful implementation of a variety of fertility-sparing treatment options for selected reproductive-age women with early-stage gynaecologic cancer.

Women with early-stage cervical cancer may be candidates for fertility-sparing cervical conization, simple trachelectomy, or radical trachelectomy. In women with stage I epithelial ovarian cancer, fertility-sparing surgery appears safe overall, although controversy remains in patients with high-risk features. In women with low-grade, early-stage endometrial cancer, hormonal therapy has emerged as a viable option. The rapid growth of assisted reproductive technologies (ART) has increased the options for cancer patients wanting to preserve fertility prior to commencing cancer therapy.

Criteria for patient selection for fertility-sparing therapy are not well defined; thus, patients and providers must carefully discuss potential risks and benefits. Determining which women with gynaecologic cancer are appropriate candidates for fertility-sparing treatments, assessing fertility potential, and helping women conceive after cancer treatment is best accomplished through multidisciplinary collaboration between gynaecologic oncologists and fertility specialists. Early involvement of fertility specialists during treatment planning is imperative in optimizing opportunities for counselling and outcomes.

Personalisation of Adjuvant Treatment with Molecular Bio Markers in Gynaecological Cancers

Dr Sachintha Wijesiriwardana – Consultant Clinical Oncologist, District General Hospital, Avissawella, Sri Lanka

Personalizing adjuvant treatment for gynaecological cancers using molecular biomarkers is an advanced approach aimed at improving treatment efficacy and minimizing unnecessary side effects. Adjuvant treatment refers to additional cancer therapy given after the primary treatment (surgery, chemotherapy, or radiation) to reduce the risk of cancer recurrence. In gynaecological cancers (like ovarian, cervical, and endometrial cancers), adjuvant therapies often include chemotherapy, radiation, or hormone therapy and are now revolutionized with Immunotherapy and targeted treatment.

Role of Molecular Biomarkers

Molecular biomarkers are specific molecules found in blood, tissue, or other bodily fluids that can provide information about the cancer's characteristics. In the context of gynaecological cancers, biomarkers can help in:

- Predicting Recurrence: Some biomarkers can help predict the likelihood of cancer returning, which guides the decision on whether adjuvant therapy is necessary.
- Selecting Therapy: Biomarkers can indicate which therapies are likely to be most effective based on the molecular profile of the cancer.
- Assessing Risk: They can help in assessing the risk of adverse effects from certain treatments, allowing for a more tailored approach.

Key Biomarkers in Gynaecological Cancers

- Ovarian Cancer:
    - o BRCA1/2: Mutations in these genes are associated with a higher risk of ovarian cancer and influence the choice of therapy, such as PARP inhibitors.
    - o Homologous Recombination Deficiency (HRD): Assessed through genomic tests, this can indicate susceptibility to certain therapies like PARP inhibitors.

- Endometrial Cancer:
    - Molecular Subtype Classification: Endometrial cancers can be classified into different subtypes (e.g., POLE ultra-mutated, MMR-deficient, p53 mutated), which influences the choice of adjuvant therapy.
    - MSI (Microsatellite Instability): High MSI can predict responsiveness to immune checkpoint inhibitors.
- Cervical Cancer:
    - PD-L1 Expression: This can be important for immunotherapy decisions, as high PD-L1 expression may predict a better response to checkpoint inhibitors.

Implementing Personalised Treatment

- Testing and Analysis: Patients are typically tested for relevant biomarkers through biopsies, blood tests, or other diagnostic procedures. The results help determine the most effective treatment strategy.
- Multidisciplinary Approach: Personalization often involves a team of specialists, including oncologists, pathologists, and genetic counsellors, to interpret biomarker data and decide on the best treatment plan.
- Ongoing Monitoring: Personalised treatment is dynamic, requiring regular monitoring and adjustments based on the patient's response and any new biomarker information.

Overall, the advantages of targeted treatments in cancer therapy lie in their ability to offer more precise, effective, and personalised approaches to combating cancer, with the potential for improved outcomes and a better quality of life for patients. Personalizing adjuvant treatment with molecular biomarkers holds promise for improving outcomes in gynaecological cancers by tailoring therapies to individual patients' needs. This approach aims to enhance efficacy, reduce toxicity, and ultimately improve survival and quality of life.

DAY 02

SYMPOSIUM 7: BY MENOPAUSE SOCIETY

Impact of Oestrogen Decline on Female Heart

Dr M.D.P. Gooneratne - Senior Consultant Obstetrician and Gynaecologist
Founder President, Menopause Society of Sri Lanka

Menopause is characterized by a marked decline in oestrogen, among other hormonal changes. Oestrogen is cardio-protective through a number of mechanisms. Oestrogen binds to Oestrogen receptor alpha and beta (ERα, ERβ) and G protein-coupled Oestrogen receptor (GPER), which are present in cardiomyocytes, fibroblasts, mitochondria, and vascular smooth muscle cells. Oestrogen enhances vasodilatation by stimulating Nitrous Oxide Synthase (NOS) production and inhibiting the angiotensin pathway. Oestrogen by inhibiting fibroblast migration and proliferation, protects the female heart against cardiac fibrosis and Extra Cellular Matrix (ECM) remodelling. By enhancing Vascular Endothelial Growth Factor, oestrogen stimulates angiogenesis, playing a major role in preventing ventricular failure. Oestrogen improves mitochondrial function, reduces reactive oxygen species (ROS), and improves cell survival.

With the cardio-protective effect of oestrogen, women experience their first myocardial infarction ten years later than men. The incidence of Coronary Heart Disease (CHD) and mortality from it in women markedly increase after menopause. Risk factors for CHD, like diabetes, dyslipidaemia, and metabolic syndrome, also increase after menopause. Women have a higher prevalence of ischemia with non-obstructive Coronary Artery disease and lower atherosclerotic plaque burden, and they have atypical symptoms with microvascular dysfunction. With oestrogen deficiency, menopausal women have ventricular dysfunction, and they have predominantly heart Failure with preserved Ejection Fraction. Oestrogen decline at menopause can cause cardiovascular calcification, which leads to coronary calcification and aortic stenosis. Early menopause is associated with increased risk of CHD and atrial fibrillation.

Sexuality after Menopause

Dr Harsha Atapattu – Consultant Obstetrician and Gynaecologist, De Soysa Maternity Hospital for Women, Colombo, Sri Lanka

Sexual function and response show an individual variation.

Sexual response has 4 phases. Desire, arousal, orgasm, and resolution. The main hormones involved in female sexuality are oestrogen, progesterone and androgens. With menopause the production of ovarian oestrogen, progesterone and inhibin is stopped; production of androstenedione and testosterone continues.

Women live nearly one-third of their life span in the post-menopausal age group. The changes in sexual well-being that occur are caused by both menopause and aging. Midlife stress and demands add to this. These changes can sometimes cause havoc on a woman's sexual life.

Vaginal dryness, body changes, concerns on body image, feeling non-attractive any more, changes in weight and fat distribution, urinary incontinence, arthritis, and back pain contribute to post-menopausal sexual dysfunction after menopause.

Main treatment modalities include conversation with the healthcare provider, weight loss, exercise, and lifestyle modification. Regular stimulation of the vagina is very important. Sex therapy some time may not be directed towards having intercourse and orgasm.

Lubricants, menopausal hormone therapy, sexual devices, Kegel exercises, and pelvic floor physical therapy all play a role. Partner counselling and keeping the sex fresh and special are of utmost importance.
Problems of oestrogen deficiency can be diverse. Menopause may be a blessing for a significant proportion of women with regard to their sexual life.

Menopause and aging are not the end of a woman's sexual life.

Brain is the most powerful sexual organ. With the right attitude about sexuality and some responsible choices about health, the body can give pleasure for years and years. Take care of it and enjoy the life.

Genitourinary Syndrome of Menopause: Diagnosis Revisited

Dr Chanil Ekanayake - Senior Lecturer in Obstetrics & Gynaecology, Faculty of Medicine, Sabaragamuwa University of Sri Lanka
Honorary Consultant Obstetrician & Gynaecologist, Professorial Unit, Teaching Hospital, Ratnapura

The genitourinary syndrome of menopause (GSM) includes vaginal symptoms, sexual symptoms, and urinary symptoms. It is more comprehensive and replaces the previous terms; vulvovaginal atrophy and atrophic vaginitis which did not consider urinary symptoms.

Oestrogen has a role in the function of the lower urinary tract during the reproductive period, and its deficiency after menopause causes lower urinary tract symptoms. Lack of awareness of the association between recurrent urinary symptoms and GSM may result in unnecessary investigations or therapy. Although these symptoms are not life-threatening, they are progressive and have a negative impact on the quality of life of these postmenopausal women.

Despite not adding to mortality in old age, GSM is an important disease entity because it affects approximately half of postmenopausal women. It also increases in severity with age, unlike vasomotor symptoms which resolve with time. Furthermore, it is a heterogeneous entity with vaginal, sexual, and urinary symptoms, and as such, diagnosis may some-

times prove to be challenging because these symptoms are common among women. Thus, there is a need to refine the diagnostic criteria of GSM so that symptom severity is also considered rather than just a blanket inclusion of all symptoms irrespective of severity.

Low-dose vaginal oestrogens are the preferred choice of treatment which responds in almost 85% of cases. Systemic hormone replacement therapy (HRT) is indicated for these non-responders and women with systemic symptoms. There is also evidence for the use of new SERMs which show positive results against GSM.

SYMPOSIUM 8: UPDATES OF OBSTETRICS & GYNAECOLOGY

Updates of Managing Superficial Thrombophlebitis in Pregnancy

Dr M.C. Gihan - Senior Lecturer in Obstetrics and Gynaecology, Department of Obstetrics and Gynaecology, Faculty of Medicine, University of Peradeniya, Sri Lanka
Consultant Obstetrician and Gynaecologist, University Professorial Unit, Teaching Hospital, Peradeniya, Sri Lanka

Thrombosis is a process of blood clot formation within the blood vessels involving arteries, veins, or capillaries. It is predisposed by factors leading to vascular endothelial injury, stasis of blood flow, and hypercoagulability.

Pregnancy is a hypercoagulable state due to an increase in clotting factors, reduction in endogenous anticoagulants, pelvic venous congestion, vasodilation, and venous stasis. It commonly manifests as thrombosis in lower limb veins, cerebral vessels, retinal, and coronary arteries. Ultimately, it leads to devastating complications depending on the site of thrombus formation. Postpartum period carries about 5 folds higher risk of thrombosis than antenatal period, which is predisposed by haemoconcentration, immobility, caesarean sections, operative vaginal deliveries, sepsis, inadequate hydration, and analgesics.

Thrombophilia is a condition that carries an increased risk of thrombus formation. Antithrombin deficiency, factor V Leiden deficiency, prothrombin gene mutation, and protein C and S deficiency are known as heritable thrombophilia. antiphospholipid syndrome, systemic lupus erythematosus, heart failure, malignancies, and nephrotic syndrome are the classic examples of acquired thrombophilia.

Deep vein thrombosis in the lower limbs is the most common manifestation of thrombosis during pregnancy, which may end up in pulmonary embolism, respiratory distress, and maternal mortality. Thus, the risk assessment and prophylaxis of DVT is the key step in managing the obstetric population.

Pulmonary embolism is a leading cause of direct maternal mortality worldwide, which is significantly reduced due to antenatal risk assessment and thromboprophylaxis with mechanical and pharmacological agents.

Cerebral venous thrombosis is a rare complication secondary to thrombotic tendency during pregnancy. It carries high morbidity and mortality due to diagnostic dilemma, vague presentation, and rapid deterioration. Thrombosis in coronary arteries is a major cause of acute coronary syndrome during pregnancy and postpartum. It may be predisposed by pregnancy-associated physiological changes, background comorbidities, and hypercoagulable state.
Thrombosis in retinal, mesenteric, renal, and splenic vessels are extremely rare entities associated with thrombotic tendency in pregnancy.

The clinical picture, ultrasonography, contrast-enhanced imaging, and magnetic resonance imaging play a major role in the diagnosis of thrombosis associated with pregnancy. Multidisciplinary specialty involvement, anticoagulation, hydration, symptomatic relief, and psychological support are the important aspects in managing thrombotic complications in pregnancy. Early diagnosis and interventions enhance the pregnancy outcome and reduce maternal morbidity and mortality.

Exclusion of ACUMS, At Evaluating Severe Dysmenorrhea

Dr Buddhika Asela Amarasena – Consultant Obstetrician and Gynaecologist, District General hospital, Ampara, Sri Lanka

Introduction: Accessory cavitated uterine malformation is an uncommon developmental anomaly where additional uterine cavities are present due to incomplete fusion of the Müllerian ducts during fetal development. This condition can lead to a variety of reproductive issues, especially severe dysmenorrhea, menstrual irregularities, difficulties with conception, and an elevated risk of pregnancy complications.

Diagnosis is typically achieved through imaging modalities like ultrasound scans, hysterosalpingography, or MRI, which can reveal the extent and nature of the malformation. Treatment strategies are tailored to the individual's symptoms and may involve surgical intervention or other therapeutic approaches. Even though the surgical excision is curative, there is a paucity of data regarding fertility outcomes after excision.

Conclusion: ACUMs are an underdiagnosed Müllerian anomaly in women with refractory dysmenorrhoea. Further work is required to establish the true prevalence of ACUMs within the population.

Therapeutic Effects of Micronutrient Supplementation on Sperm Parameters

Dr Sowmya N.S. – Co-founder & Chief Operating Officer, StudyMEDIC Academy Private Limited, India
Senior Consultant Obstetrician and Gynaecologist, Nyle Hospital, Kaiparambu, Thrissur, India
Chairperson of International Coordination Committee of EBCOG

Introduction: Infertility affects a significant proportion of couples worldwide, with male factors contributing to about 30–50% of cases. Recent research highlights the role of micronutrients in maintaining and improving sperm health.

Objective: This presentation explores the impact of micronutrient supplementation on sperm parameters, including count, motility, morphology, and overall fertility potential.

Methods: We review current evidence from clinical trials and observational studies on the effects of key micronutrients and antioxidants such as zinc, selenium, vitamin C, vitamin E, lycopene, and CoQ10. These nutrients are essential for various physiological processes, including sperm production, DNA synthesis, and oxidative stress reduction.

Results: Our analysis elucidates how deficiencies or imbalances in these micronutrients impair sperm quality and how targeted supplementation can mitigate these effects. Key findings suggest that micronutrient supplementation can significantly improve sperm parameters, enhancing both quantity and quality.

Discussion: This presentation will discuss the mechanisms by which micronutrients influence sperm health, summarize recent study results, and emphasize the need to integrate micronutrient supplementation into clinical practice for addressing male infertility.

Conclusion: By synthesizing current research, we aim to provide a comprehensive overview of how optimizing micronutrient levels can serve as a viable therapeutic strategy for improving reproductive outcomes in men.

SYMPOSIUM 9: POSTPARTUM HAEMORRHAGE/ BLOOD TRANSFUSION

Pregnant Women; Where a Transfusion is Not an Option

Dr Kumuduni Gonsalkorale - Consultant Transfusion Physician, Blood Bank, Colombo South Teaching Hospital, Sri Lanka

Pregnant women who have had severe, life-threatening anaphylaxis from previous transfusions and Jehovah's Witnesses who refuse blood transfusions require special management during pregnancy, delivery, and the postnatal period. For Jehovah's Witnesses, whose religious beliefs prohibit transfusions, additional care is needed for the baby's well-being. Deliveries should take place in a tertiary care hospital.

Patient Blood Management (PBM) protocols are essential for these cases, which aim to avoid or minimize blood transfusion, thereby reducing hospital stay and related complications. PBM, therefore, is ideal for every patient undergoing routine surgery. PBM is built on three pillars: optimizing red cell mass, minimizing blood loss, and optimizing the physiological reserve of anaemia. These pillars are applied across the antenatal, delivery, and postnatal periods.

At the booking visit, a full blood count, blood grouping, and screening must be done. It is critical to optimize the haematocrit at 40% in early pregnancy to cope with a major blood loss. Daily iron and vitamin C are given for iron deficiency and erythropoietin for refractory anaemia with a haematocrit less than 30% or less than 35% in high risk of obstetric haemorrhage.

Postpartum haemorrhage (PPH) can occur in up to 5% of deliveries; hence, patients must be well-informed about the risks of refusing blood. A formal informed consent with a documented delivery plan, including acceptable emergency measures, is required.

Management of these patients requires a personalised plan formulated with the cooperation of a multidisciplinary team. Early recognition of PPH and active management of labour with early use of tranexamic acid are crucial. If the patient agrees, cell salvage techniques and normovolemic haemodilution (removing and preserving blood preoperatively) can be used to avoid allogenic transfusion. Recombinant factor VIIa (rFVIIa) is another option accepted by many Jehovah's Witnesses for the acute management of major haemorrhage. The expertise of the surgical and anaesthetic teams in a tertiary care setting, along with these transfusion alternatives, will help in ensuring a safe pregnancy and delivery.

PPH; Places of Prostaglandin and Intrauterine Haemorrhage Control Devices

Dr Girija Wagh - Professor in Obstetrics and Gynaecology, Bharati Vidyapeeth University Medical College, Pune, India
Head, High Risk Obstetric Unit, Bharati Vidyapeeth University Medical College & Hospital (BVDUMCH)

Postpartum haemorrhage (PPH) remains a critical concern in obstetrics. During this talk, we will focus on two essential aspects;

- Prostaglandins:
  Prostaglandins play a pivotal role in uterine contraction and haemostasis.
  Common medications include oxytocin, ergometrine, and PG analogues like misoprostol.
  Oral or sublingual misoprostol effectively reduces severe haemorrhage after childbirth.

- Intrauterine Haemorrhage Control Devices:
  When medical therapies alone are insufficient, these devices are crucial.
  Approaches include uterine balloon tamponade (vaginal balloons), uterine suction tamponade, and compression sutures (e.g., Esike's method).
  Technological advances, such as cell salvage and ultrasound, also contribute to improved outcomes

Transfusion in Pregnancy: Effect on Haematological Parameters and Pregnancy Outcome

Dr Wasanthi Wickremasinghe - Lecturer and Consultant Clinical Haematologist, Department of Pathology, Faculty of Medicine, University of Moratuwa, Sri Lanka

Blood and blood product transfusion is an essential component in obstetric care and could be lifesaving at times. However, it could be a challenge to transfuse in pregnancy due to physiological changes that occur in the mother during pregnancy, allo-immunization risk, and potential risk of transmission of infections to the fetus. It is important to identify patients with appropriate indications for transfusions, provide safe blood without delay when indicated, and avoid unnecessary transfusions.

Main indications for blood/blood product transfusion in obstetrics include uncorrected anaemia closer to delivery, haemoglobinopathies, bleeding disorders, obstetric haemorrhage and prior to interventions with high bleeding risk. There are no firm criteria for giving blood transfusions in pregnancy, and the decision to transfuse does not depend on the haemoglobin level or other laboratory parameters alone but is based on both clinical and haematological grounds.

Postpartum haemorrhage (PPH) is the most common cause of maternal mortality globally, accounting for 27% of annual postpartum deaths worldwide. Optimum management of PPH requires well-developed evidence-based local protocols and the involvement of a multidisciplinary team, including obstetricians, transfusion physicians, and anaesthesiologists who work collaboratively to determine the underlying cause of bleeding, provide targeted treatments to control the bleeding, and supply blood/blood product transfusions.

Patient blood management (PBM) initiatives are increasingly adopted across the world as part of the standard of care, which involves a patient-centered, systematic, evidence-based approach to transfusion practice, aiming for improved patient outcomes. The three pillars of obstetric PBM include prediction and correction of prenatal anaemia, prevention and reduction of haemorrhage during delivery and limited use of blood transfusion, and optimizing treatment of postpartum anaemia. All professionals taking care of obstetric patients should be aware of PBM and should work towards improving pregnancy outcome and resource utilization by ensuring that blood is used responsibly and ethically.

SYMPOSIUM 10:
BY PERINATAL SOCIETY

Panel Discussion: Responsibility of the Community and the Government in Managing the Burden of Prematurity

Dr Surantha Perera (Moderater) - Consultant Paediatrician, RDHS Office Kalutara/Base Hospital, Panadura, Western Province, Sri Lanka

Dr U.D.P. Ratnasiri - Consultant Obstetrician & Gynaecologist
Vice President, SAFOG, Past President, SLCOG
Dr Susie Perera - Deputy Director General, Public Health Services II, Ministry of Health, Sri Lanka

Dr Himali Herath - Consultant Community Physician

SYMPOSIUM 11: MISCELLANEOUS

Navigating the Complexities of Large Fibroids in Pregnancy: Key Strategies

Dr Amila Rubasinghe - Consultant Obstetrician and Gynaecologist, District General Hospital, Nuwara Eliya, Sri Lanka

Introduction: Fibroids are the most common tumours among women of reproductive age. Despite the widespread belief that fibroids interfere with fertility, some women with even “giant” or “massive” fibroids may still conceive. They may experience several complications during pregnancy, rendering these pregnancies high-risk. Despite these complications, the standard approach to managing giant fibroids detected during pregnancy has been largely conservative, given that any intervention poses risks to both the fetus and the mother.

However, an approach tailor-made to the individual patient with input from relevant specialities will give the best outcome.

Methodology: We have performed a thorough literature survey to identify case reports and case series that describe pregnancies complicated with giant fibroids. We analysed all these cases individually and developed a general management pathway that can be used in the management of giant fibroids in the Sri Lankan context.

Results: In addition to the complications that are common to smaller fibroids, giant fibroids can cause a wide range of unique additional problems in the pregnancy. These include deep venous thrombosis, Pseudo-Meigs syndrome, mechanical bowel obstruction, intra-abdominal bleeding, and fetal arthrogryposis. Essentially, they make delivery and the postpartum period more high-risk and more challenging.

We suggest managing such pregnancies in tertiary care units. MRI can be used as an adjunct for fibroid mapping. Optimization of haemoglobin, nutritional status, pain management, and screening and prompt treatment for infections should happen with the inputs from the specialists. Detailed counselling is essential. Place for antenatal myomectomy is not well established. Vaginal delivery can be offered for selected patients. Where abdominal delivery is indicated, three main options are available. They are caesarean section without any intervention to the fibroid, caesarean section followed by caesarean hysterectomy, and caesarean section followed by myomectomy at the same time. Emerging evidence suggests that caesarean myomectomy is a safer option in the appropriate setting. We suggest an approach similar to morbidly adherent placenta, when planning delivery for women with giant fibroids.

Screening for Fetal Cardiac Abnormalities

Dr Achintha Dissanayake - Senior Lecturer in Obstetrics and Gynaecology, General Sir John Kotelawala Defence University, Ratmalana, Sri Lanka
Consultant Obstetrician and Gynaecologist, General Sir John Kotelawala Defence University, Ratmalana, Sri Lanka

Fetal cardiac defects occur in 5 in 1000 live births and are one of the commonest congenital abnormalities. Nearly 20% of cardiac defects are complex abnormalities with lethality in the 1st year of life. However, the antenatal detection rates are 50-60% or even less. Diagnosis of fetal cardiac defects may be challenging due to changing fetal position, rapid fetal heart rate, maternal body habitus, time constraints, as well as lack of pattern recognition of common cardiac abnormalities. Detection of fetal cardiac defects will ensure an appropriate multi-disciplinary approach to perinatal care with timely counselling of parents.

Optimizing the image is of paramount importance in screening for cardiac abnormalities. Using a high-frequency probe with a narrow angle, increasing the depth and contrast which are usually available in the cardiac preset will enable better visualization of cardiac structures. Colour flow assessment by optimizing pulse repetition frequency and colour gain is important. Utilizing cine loop, split screen, and replaying with reduced speed will aid in cardiac assessment. Ensuring a systematic approach to assessing the fetal heart as outlined by the ISUOG guidelines by obtaining abdominal circumference, 4 chamber, left ventricular outflow, right ventricular outflow, and 3 vessel trachea (3VT) views will improve detection rates.

One of the commonest abnormalities detected in the 4 chamber view are ventricular septal defects (VSD), which occur in 1 in 1000 live births and should be assessed in a lateral 4 chamber view to reduce false positives due to artifacts. VSDs are isolated in only 32%, and detection should prompt assessment for other cardiac abnormalities. Assessing the offset of the tricuspid and mitral valves will aid in the diagnosis of atrioventricular septal defects. Colour flow will provide information of any mitral or tricuspid regurgitation. Assessing the area behind the heart will aid to detect total anomalous pulmonary venous drainage.

Four chamber view may be normal in conditions such as tetralogy of fallot (TOF), double outlet right ventricle, transposition of great vessels, aortic coarctation; therefore, 3VT view will aid in detection of such abnormalities. From left to right, the main pulmonary artery, aorta, and superior vena cava can be appreciated. The main pulmonary artery with duct and aorta lies to the left of the trachea. Flow should be in the same direction. Thymus can be evaluated in the same view. Upon detection of an abnormality, a fetal echocardiography will enable further detailed evaluation. Routine systematic screening for cardiac abnormalities with timely referral will aid in improved outcomes.

Cosmetic Gynaecology: Not a Taboo and FGM Anymore

Dr Prabath Randombage - Senior Lecturer in Obstetrics and Gynaecology, Faculty of Medicine, University of Kelaniya, Sri Lanka
Consultant Obstetrician and Gynaecologist, Colombo North Teaching Hospital, Ragama, Sri Lanka

Cosmetic gynaecology, an evolving field in gynaecological practice, focuses on the aesthetic and functional enhancement of the female genitalia. In contrast, Female Genital Mutilation (FGM) is a harmful cultural practice that involves the non-medical alteration or excision of female genital organs. The World Health Organization (WHO) has recognized FGM as a violation of human rights, and it is associated with health risks, including chronic vulval pain, complications during childbirth, dyspareunia, urinary tract injuries, and psychological trauma to women. Although the data regarding the existence of FGM in Sri Lanka is lacking, many gynaecologists agree with the WHO and global standards.

In recent years, cosmetic gynaecology has gained visibility and acceptance in many countries. Procedures such as labiaplasty, vaginoplasty, and other postpartum aesthetic treatments form the main part of the growing trend. This field is supported by ethical medical practices and informed consent, fostering a positive approach to women's health.
Training in cosmetic gynaecology has developed significantly to suit the growing global trend. This evolution reflects a broader shift towards patient-centered care in medicine, highlighting the importance of holistic approaches to women's health and well-being. Further researches are required for in-depth analysis of patient requirements, acceptance, and training opportunities in Sri Lanka.

Key words: Cosmetic gynaecology, Female Genital Mutilation

SYMPOSIUM 12: INFERTILITY

Right Time Right Choice for Infertility Treatments

Prof Dr Jaideep Malhotra - Immediate Past Chairman, Committee on Reproductive Medicine, Endocrinology and Infertility, FIGO
Managing Director, ART Rainbow IVF, India
Infertility poses a significant challenge for many couples, requiring nuanced approaches to treatment. The lecture "Right Time, Right Choice" will explore strategies for optimizing outcomes in Assisted Reproductive Technologies (ART). This presentation will emphasize the critical interplay of timing, choice, and technique to enhance fertility results.

A key focus will be on the concept of “Time to Birth" (TTLB), a comprehensive metric that integrates cost, time, and outcomes. TTLB provides a patient-centric approach to measure ART success, stressing the importance of selecting the right couple, determining the optimal timing, and employing the appropriate techniques to maximize the chances of pregnancy. This approach fosters transparency and patient engagement in fertility treatment discussions.
It will highlight several critical factors:

1. Impact of Female Age: Evidence shows that age is a strong predictor of IVF success, with chances of natural conception, IUI, or IVF decreasing as age advances.

2. Role of AMH Levels and Obesity: High AMH levels in young women correlate with a higher risk of early miscarriage, while obesity negatively affects fertility and obstetric outcomes, increasing risks of miscarriage and compromising pregnancy and live birth rates.

3. Lifestyle Factors: Pre-conceptional lifestyle modifications, such as reducing smoking, alcohol intake, and managing weight, significantly improve pregnancy chances.

The lecture will also cover advanced diagnostic and therapeutic techniques, including pre-evaluation, hysteroscopy, fibroid management, and endometrial receptivity analysis. By integrating clinical evidence and patient-centred approaches, "Right Time, Right Choice" aims to enhance fertility treatment efficacy, ensuring that couples receive optimal care at the right time and make informed choices for successful outcomes.

PCOS; From Infertility to Pregnancy

Dr Bharti Kalra - Consultant Gynaecologist, Bharti Hospital, Karnal, India

Polycystic ovary syndrome (PCOS) is a multifactorial, multifaceted condition, with multiple clinical presentations. Of the various complaints, concerns and challenges that a woman with PCOS may face, infertility, or subfertility, is one of the most important.

The 2023 International Evidence based guidelines highlight the need to manage PCOS in a person-centric manner. This includes a focus on lifestyle modification, psychosocial support, menstrual regulation and weight management. All these, especially weight optimization, are essential aspects of preconception counselling. If weight is reduced with liraglutide or semaglutide, or by bariatric surgery, appropriate contraceptive coverage must be ensured, for at least 3-6, and 12-18 months respectively. Other metabolic parameters, such as glucose, lipids and blood pressure should also be managed using non-teratogenic drugs.
Once a complete evaluation for infertility has been done, the causative factors should be addressed. Induction of ovulation may be achieved by metformin, inositols or weight loss per se. Letrozole is the drug of choice for induction of ovulation. Gonadotropins such as human chronic gonadotropin (HCG), and laparoscopic ovarian drilling are alternatives.
With a comprehensive, person-centred, and couple-centred approach, marked by empathy and understanding, most women with PCOS can journey from infertility to a successful pregnancy.

Recurrent Implantation Failures

Dr Chaminda Hunukumbure - Senior Lecturer and Head, Department of Obstetrics and Gynaecology, Faculty of Medical Sciences, University of Sri Jayewardenepura
Consultant Gynaecologist and Fertility Specialist, Colombo South Teaching Hospital, Sri Lanka

Implantation signifies the initiation of crosstalk between the embryo and the endometrium, the successful culmination of which should eventually produce ultrasonic evidence of a viable intrauterine pregnancy. However, this is not the case in about 10% of the couples undergoing in-vitro fertilization (IVF), where the female fails to conceive despite having been transferred good-quality embryos. Hence, it has become an important clinical entity in relation to Assisted Reproduction Technologies (ART).

Despite its widespread existence, the variations in ART practices across the world have made it difficult for the researchers to come to a consensus on the definition of recurrent implantation failure (RIF). This not only hampers any effort to conduct research and to formulate management strategies, but also leaves room for the injudicious use of various add-ons in this desperate and hence highly vulnerable group of patients. Therefore, the good practice recommendation put forward by the European Society for Human Reproduction and Embryology (ESHRE) is indeed a step in the right direction. Accordingly, RIF is diagnosed when a particular patient below the age of 40 years undergoes IVF but fails to achieve a positive pregnancy result after a number of transfers with good-quality embryos when the cumulative chance of implantation success is expected to exceed 60%. In more practical terms, this can be defined as the failure to achieve a clinical pregnancy after the transfer of at least four high-quality embryos in a minimum of three fresh or frozen cycles in a woman under 40 years old.

Key recommendations for the management of RIF include thorough pre-treatment evaluation, focusing on both maternal and embryonic factors, such as uterine abnormalities, genetic testing, and endometrial receptivity. ESHRE advocates individualized treatment plans, including the judicious use of pre-implantation genetic testing for aneuploidy (PGT-A) and personalised embryo transfer strategies. Additionally, it discourages the routine use of add-ons such as immunological treatments, anticoagulants, or empirical therapies without strong supportive evidence. Such recommendations are essential to enhance the diagnostic accuracy and therapeutic efficacy when managing RIF, ultimately improving the chances of successful implantation and pregnancy.

SYMPOSIUM 13: PAEDIATRIC AND ADOLESCENT GYNAECOLOGY

Navigating Premature Menarche: Causes, Health Implications, and Management Strategies

Prof Sumudu Seneviratne - Professor in Paediatric Endocrinology, Department of Paediatrics, Faculty of Medicine, University of Colombo, Sri Lanka
Director, Centre for Complex Hormonal Disorders, Faculty of Medicine, University of Colombo, Sri Lanka
Honorary Consultant Paediatric Endocrinologist, Professorial Paediatric Unit, Lady Ridgeway Hospital for Children, Colombo, Sri Lanka

Puberty is the process of transitioning from childhood to adulthood and involves both physical and psychosocial changes. In young females, the first sign of onset of puberty is breast budding/thelarche, which normally occurs between the ages of 8 to 13 years. Menarche typically occurs within 2-3 years of thelarche, when breast development is around Tanner stage 4.

Premature menarche is generally associated with precocious puberty, when breast budding and other secondary sexual characteristics occur in a young girl before 8 years of age. If untreated, precocious puberty may lead to psychosocial distress and a reduction of final adult height. Isolated premature menarche is a less defined entity referring to isolated or recurrent vaginal bleeding in a prepubertal female in the absence of secondary sexual characteristics. It is most often a transient condition with no acceleration in growth velocity or skeletal maturation. It is a diagnosis of exclusion, and there is limited literature on its causation or management.

Precocious puberty in girls, which occurs due to premature central activation of the hypothalamo-pituitary-ovarian axis (idiopathic/due to organic causes), is termed gonadotropin-dependent/true/central precocious puberty [CPP]. Precocious puberty can also occur without central activation (gonadotropin-independent/peripheral/pseudo precocious puberty [PPP]). Causes and investigation of CPP and PPP will be discussed.

Management includes identification/management/exclusion of organic causes and suppressing pubertal progression in CPP by long-acting GNRH analogues if necessary. Early recognition and referral is important to determine and manage any underlying organic causes and institute medical therapy to defer further pubertal progression when indicated. Providing age- and maturity-appropriate education/counselling and support for the young girl and family is also important.

Primary Amenorrhoea: Unveiling the Mystery in Clinical Practice and Charting the Path to Treatment

Dr Prabodhana Ranaweera – Senior Lecturer, Department of Obstetrics and Gynaecology, Faculty of Medicine, University of Colombo, Sri Lanka
Honorary Consultant Obstetrician and Gynaecologist, De Soysa Maternity Hospital for Women, National Hospital of Sri Lanka

Primary amenorrhoea, the absence of menarche by age 15 or within three years of breast development, presents a complex challenge in clinical practice. This condition may result from a variety of aetiologies, including genetic abnormalities, anatomical defects, or endocrine disorders. Early and accurate diagnosis is crucial as it can reveal underlying conditions such as Turner syndrome, androgen insensitivity, or hypothalamic dysfunction. A comprehensive evaluation, including a detailed medical history, physical examination, and targeted investigations, is essential to unravel the cause. Treatment strategies are guided by the specific diagnosis, ranging from hormone replacement therapy for hypogonadism to surgical intervention for structural anomalies. Multidisciplinary management involving endocrinologists, gynaecologists, and genetic counsellors is often required to optimize outcomes. This short discussion highlights the importance of individualized care in managing primary amenorrhoea, emphasizing a systematic approach to diagnosis and tailored treatment pathways to improve patient quality of life and reproductive potential.

Congenital Gynaecological Problems of the Lower Genital Tract: Expert Insights from a Pelvic Surgeon

Prof Hemantha Senanayake - Emeritus Professor in Obstetrics and Gynaecology, University of Colombo

The female genital tract is formed by the Mullerian ducts, which fuse to form the uterus, cervix, and the upper two-thirds of the vagina, while the lower third is formed by the urogenital sinus. The fusion and connections that are required to form the normal female genital tract open the potential for a myriad of congenital abnormalities. Also, the formation of the normal genital tract will depend on exposure to hormones in utero. For example, in the case of androgen insensitivity, the genital tract will develop along female lines, due to the absence of the actions of testosterone.

These may result in a wide array of presentations, varying from primary amenorrhea to crypto menorrhea, severe dysmenorrhea, or a pelvic lump due to collection of blood.

The road to diagnosis will require careful history and examination, genetic studies, ultrasound, and magnetic resonance imaging. This is important since a proper understanding of the anomaly is needed to offer correct treatment. The psychological and social aspects of these conditions cannot be underestimated and must be addressed during treatment.

The interventions needed vary depending on the diagnosis. For example, in a girl with androgen insensitivity, it is important to remove intra-abdominal testes due to the risk of malignancy. Those with vaginal atresia will need treatment depending on whether the atresia is partial or complete, or if the uterus is functioning. The latter is the most challenging. In those who have hematocolpos in the upper third of the vagina, usually referred to as a vaginal septum, anastomosis of the lower and upper segments will suffice. There are methods described to lengthen the vagina, varying from the use of dilators to the Vechietti technique, a laparoscopic method. Other methods of creating a neovagina are the use of an amnion graft, and using bowel grafts. The latter may be used when there is a functioning uterus. A non-communicating uterine horn may give rise to severe cyclic abdominal pain or dysmenorrhea. This may be treated by creating an opening in the distended non-communicating horn using a hysteroscope. In situations where the cervix is atretic, treatment is difficult, since preventing ascending infections becomes a problem.

ABSTRACTS OF GUEST LECTURES

DAY 01

GUEST LECTURE 1
GLOBAL HEALTH 2024

Dr Gillian Gibson - President, Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG)

Women face avoidable health challenges in Asia, Oceania, and the Pacific. The leading women's health disparities in low- and middle-income countries include maternal mortality, child marriage, infection (HIV, TB, Malaria, and HPV), violence against women, and cervical cancer deaths. Initiatives will be discussed that aim to reduce maternal mortality and the elimination of cervical cancer. RANZCOG is committed to its ongoing relationship with O&G partners, working towards positive outcomes for women's health.

GUEST LECTURE 2
CHALLENGES FACED BY CERVICAL SCREENING AND HOW TO ADDRESS THIS IN OUR OWN SETTING

Dr P. P. Kandanaerachchi - Consultant Obstetrician and Gynaecologist, Hywel Ddd University Health Board, Wales, United Kingdom

Cervical cancer is a leading cancer, second only to breast cancer, in women in Sri Lanka. In Sri Lanka, 9–10% of all cancer deaths are attributed to cancer cervix. Despite various measures, every year nearly 800 women die due to the dreadful disease in their productive years of life. Conventional cytology-based screening has posed several challenges, and despite adhering to WHO recommended screening of 35 and 45-year-olds, the cancer incidence is increasing gradually. HPV primary screening has been introduced recently, mostly in the developed world and in some middle- and low-income countries, with promising results replacing conventional cytology screening. With the introduction of HPV screening, a new set of challenges is inevitable, and the discussion is primarily based on this.

GUEST LECTURE 3
REDUCTION IN MATERNAL MORTALITY AND VISION FOR THE FUTURE

Prof Shyam Desai – President, SAFOG

At the start of this century, India had an infant mortality rate of 92 per thousand live births and a Maternal mortality rate of roughly 400/1000000 live births.

In fact, both in India and the global maternal mortality rates have seen a decline. This has been achieved through a combination of focused policies and interventions backed by advancements in science, technology, and healthcare facilities. The maternal mortality rate in India has declined from 384 in the year 2003 to 103/100000 live births in 2020.

According to the latest figure, India has achieved the Millennium Development Goal. MDG5 is a reduction in maternal mortality by three quarters between 1990 to 2015. The target was to achieve 139 maternal deaths per hundred thousand live births. It is still a long way to go because the goal is not just a reduced mortality rate but a reduction in the actual number of deaths, an overall holistic well-being, a positive experience, and an overall high-quality of life for mother and child.

If you go to see the statistics, in India, 1,300,000 maternal deaths occurred between 1997 and 2020, but most occurred in the poorest states, almost 63% of them.

We have three or four states where the maternal mortality is still very high. Bihar: 230, Assam: 215, Uttar Pradesh: 192, and Madhya Pradesh: 170.

The tribal areas of north-east and northern states are also showing figures which require improvement.

The highest cause of maternal death was obstetric haemorrhage (47%), pregnancy-related infections (12%) and hypertensive disorders of pregnancy (7%).

India could achieve the United Nations 2030 MMR goals if the average rate of reduction is maintained as it is; however, without further intervention, the poorest states will still lag behind.

In the Hindu newspaper in August 2023, it is quoted that India has shown substantial improvements in reducing maternal and child mortality over the decades, but much more remains to be done in terms of bringing more people into institutional systems, reducing anaemia, and changing the inequality in healthcare.

It has been found that India is still far behind the desired level of utilisation of the facilities; the least inequality was recorded in skilled birth-assisted deliveries and institutional deliveries. In contrast, the highest inequality was recorded in receiving iron and folic acid tablets for hundred days and four antenatal care visits.

Among the states, Kerala, Tamil Nadu, Andhra Pradesh, Orissa, and Delhi are among the best performers, while Bihar, Jharkhand, Uttar Pradesh, and Assam are among the worst performers.

This indicates that the government's single-minded focus on enhancing institutional deliveries and skilled health assist deliveries is detracted from the other essential interventions related to maternal health.

Antenatal care is deemed to be of great importance.

The most significant importance of antenatal care is its role in reducing maternal and neonatal mortality rates.
Regular check-ups and timely interventions can identify and address potential complications, thereby significantly reducing the risk of complications. During pregnancy, WHO recommends a minimum of four antenatal visits for the review of the effectiveness of different models of antenatal care.

The Indian government has launched certain programs to address this problem of maternal mortality in the country. There is a program called Surakshit Matritva Ashwasan, which provides assured dignified, respectful, and quality healthcare at no cost with a zero tolerance for denial of services for every woman and newborn visiting public health facilities.

Similarly, we have a Pradhan Mantri Surakshit Matritva Abhyan program, which takes care of an assured and quality antenatal check-up on the ninth day of every month.

Monthly village health, sanitation, and nutrition programs are an outreach activity at the Anganwadi centres, provision of maternal and childcare, including nutrition; in convergence with the ICDS there are several other programs that aim to deliver the same benefit to the population.

In fact, we have a program called “Reproductive maternal, newborn, and child and adolescent health program.”

It aims to address the major causes of mortality and morbidity amongst women and children. It is important because it takes care of the adolescent girl in 5 pillars of thematic areas: reproductive, maternal, neonatal, child, and adolescent well-being.

Oona Campbell and Wendy Graham on behalf of the Lancet Maternal steering group, recommended the following:

1. The important aspect of reducing maternal death is that one should focus on the particular problem in areas where the mortality burden is high.

2. Not one single intervention alone can reduce the rate of maternal mortality in a population.

3. You have to have strategies that will work by having component packages and the means used for their distri bution where there is a high coverage of the intended target group.

4. The epidemiology of maternal mortality requires prioritization of the intrapartum period. Hence, a centre that has an intrapartum case strategy can be justified.

5. There are further opportunities to alter the risk of maternal death outside the intrapartum period, such as ante natal care, postpartum care, family planning, and safe abortions, being some of them.

6. Pre-existing ill-health is a risk factor for maternal mortality, particularly from indirect causes. Thus, improve ments in the general health of women should help prevent some complications and deaths.

These arguments the most widely made for nutrition status were improvement of women's haemoglobin, calcium, and vitamin supplements, prevention or treatment of infections, for example, streptococcal infections, which cause Rheumatic heart disease, or HIV syphilis, malaria, chronic diseases like diabetes and asthma could help reduce indirect maternal deaths.

Anaemia has been associated with severe maternal morbidity and mortality. Antepartum or postpartum thrombosis, haemorrhage during labour and the postpartum period leading to hysterectomy, and ICU admissions, identification and treatment of iron deficiency is critical for reducing maternal mobility.

India has a number of programs like the integrated child development scheme, the national nutritional anaemia control program, weekly iron, and folic acid supplementation.

The national iron plus initiative to combat anaemia, and there is a program called anaemia viral strategy to reduce anaemia in the various age groups. Young children: 5 to 9 years, adolescence: 10 to 19 years, pregnant and lactating women, and women of the reproductive age group: 15 to 49 years, life cycle approach, implementation of interventions.

In 2015, the Cochrane review demonstrated that the use of iron supplements reduces iron deficiency anaemia by 57%.

The intravenous route is also recommended for pregnant individuals with severe iron deficiency in the latter part of pregnancy and those who cannot tolerate oral iron. The intravenous line avoids internal absorption, and it has been demonstrated to have higher maternal haemoglobin at full term. IV iron also has fewer adverse reactions and a greater likelihood of achieving a target haemoglobin compared to oral treatments. We have the FCM (Ferric Carboxymaltose) intravenous dose which can provide up to 1500 mg of iron, and just to admission, an administration of 750 mg, each given at least a week apart.

So going ahead, what measures will really help?

1. Promote positive involvement of men as fathers and partners during pregnancy and delivery.

2. Women should attend healthcare appointments, communicate with healthcare professionals, and learn how to identify physical and mental warning signs during and after pregnancy.

3. Women should communicate with healthcare professionals.

4. Healthcare professionals also should be able to understand the factors that contribute to women's overall health to identify and mitigate potential pregnancy complications.

Every medical appointment or interaction with healthcare professions is an opportunity to ensure the standards of care and the full needs of women are being met.

In conclusion:
Given the diversity and geography, economy, and the racial and ethnic makeup of communities specific strategies should be set up.

Healthcare professions can ensure that the care they provide is scientifically sound and culturally appropriate to individuals, and their respective communities.

Professional associations play a role in developing standards of care to provide guidance, screenings and preventive care.

Prenatal and postpartum Care and management of emergencies.

These associations are valuable resources for developing evidence and guidelines on areas important to maternal health. We should use preventive healthcare and wellness visits to conduct screenings, assess risk factors, provide support for family planning, offer immunizations, and provide education and counselling to promote optimal health: include topics like folic acid supplementation for all women who are planning or capable of pregnancy, breastfeeding, nutrition, physical activity, sleep, oral health, substance use and injury, and violence prevention.

The health systems, hospitals, and birthing facilities should be updated. Telemedicine and linking facilities can help, and facilitating prompt consultation and safe transportation is the appropriate level of maternal care.

GUEST LECTURE 4
ABNORMAL UTERINE BLEEDING IN PERIMENOPAUSAL WOMEN

Prof. Deepal Weerasekara - Professor and Head of Obstetrics and Gynaecology, Department of clinical sciences, General Sir John Kotelawala Defence University, Ratmalana, Sri Lanka

Menopausal transition is due to a decline in ovarian function. Around this time, due to anovulatory cycles, hormonal fluctuations occur. FSH, serum oestradiole, and anti-mullerian hormone levels can be used as measures of ovarian aging. Abnormal uterine bleeding (AUB) is a frequent symptom in perimenopausal women. This is the leading cause of (one-third) all out patient gynaecological visits in the perimenopausal period. Endometrial hyperplasia, malignancy, and cervical cancer can present with AUB in perimenopausal women. Therefore, it is important for the woman to be investigated to exclude pre-malignancy.

Bleeding patterns among women in the perimenopause vary. This makes the identification of “abnormal” bleeding difficult from "normal." In the early menopause transition, short cycle intervals are more common, while long cycle intervals occur later in the transition.

Abnormal types of bleeding include intermenstrual bleeding, postcoital bleeding, irregular cycles, and prolonged heavy bleeding.

Evaluating a woman with AUB should include a thorough history, assessment for endocrine dysfunction, examination including BMI, thyroid, speculum, and bimanual assessment of the uterus, cervix, and adnexae. This should be followed by transvaginal ultrasonography (TVUSS). In TVUSS, mainly look for endometrial thickness, endometrial and endocervical polyps, and focal endometrial thickenings. When indicated, pipelle endometrial sampling is extremely useful in low resource settings where access to hysteroscopy is limited. Histology provides a definitive diagnosis, but pipelle can miss up to 20% of focal endometrial lesions. Hysteroscopy is considered the gold standard technique for diagnosis and managing pathological conditions affecting the uterine cavity. Office hysteroscopy can be done on an outpatient basis depending on patient preference and available infrastructure. Hysteroscopy is useful in the “see and treat” approach of the uterine cavity, inspection of the endometrial canal, and targeted endometrial and endocervical biopsies.

The first principle in the management of AUB is the exclusion of endometrial hyperplasia and malignancy. In 2014, WHO revised the classification of endometrial hyperplasia to hyperplasia without atypia and atypical hyperplasia.

In hyperplasia without atypia, treatment with progestogens has a higher disease regression rate compared to observation alone. Levonorgestrel intrauterine system is the first-line medical treatment. When compared to oral progestogens, it has a higher disease regression rate, a more favourable bleeding profile, and fewer systemic side effects. Cyclical progestogens should not be used, as they are less effective in inducing regression of hyperplasia. Following continuous progestogen therapy for 6 months, an endometrial biopsy is recommended. At least two consecutive six-monthly biopsies should be obtained prior to stopping progestogen therapy. A hysterectomy is indicated in progression to atypical hyperplasia during the follow-up period, no histological regression despite 12 months of treatment, relapse of endometrial hyperplasia after completing progestogen treatment, persistent bleeding, and in women who decline to undergo endometrial surveillance.

GUEST LECTURE 5
"THE UNPREDICTABLE UNFORGIVING THIN LINE"- A CLINICAL GOVERNANCE ANALYSIS BETWEEN NEAR MISS AND CATASTROPIC ADVERSE EVENTS

Dr Sumith Warnasuriya- Consultant Obstetrician & Gynaecologist, Base Hospital, Dambadeniya, Sri Lanka
Fellowship in Minimal Access Surgery

Objectives: Analysis of two adverse events from a clinical governance point of view

Methods: Emergency Obstetrics Case Analysis

Introduction: Discussion and analysis of Near Miss Incidents in Obstetrics is as important as inquiries into Maternal Deaths due to the thin line that separates the event horizon between life and death during an adverse obstetric outcome. The author wishes to discuss two such identical incidents presented with secondary postpartum haemorrhage (PPH) at Teaching Hospital Kuliyapitiya, Sri Lanka.

Case Report 1: The Fatal Delay
A 29-year-old lady who had delivered her 2nd child by normal vaginal delivery on postpartum day 8 was brought to the Emergency Treatment Unit (ETU) with a history of ongoing secondary PPH for three days at home. She was rushed to the postnatal ward with tachycardia and a low haemoglobin count. However, ninety minutes into haemodynamic stabilisation, she develops a cardiac arrest and could not be resuscitated.

Case Report 2: Recurrence with an extremely bad timing!
Within ten days of the above incident, a 32-year-old lady on postpartum day 16 following delivery of her second child was admitted with an episode of secondary PPH. She responded to initial fundal massage along with manual removal of clots of altered blood and had an uneventful recovery. She was observed in the ward for 5 days under multi-disciplinary care and was discharged.

The patient was re-admitted three days following discharge with a recurrent episode of severe PPH. Massive blood transfusion protocol was initiated, and uterine exploration followed by laparotomy and application of brace sutures to the uterus was performed. She had an uneventful recovery and was observed in the ward for 7 days under multi-disciplinary care.

However, just prior to the planned day of discharge, she developed yet another episode of torrential PPH, coinciding with a weekend where the hospital was unprepared to tackle such an eventuality due to a multitude of problems, including staffing and clinical governance issues.

This challenging situation was compounded by the rapid deterioration of the patient's haemodynamic status, and crunch decisions had to be made with fate hanging between life and death. Salvage plans were executed as a lifesaving measure

with the initiation of a repeat massive blood transfusion protocol without the regular blood bank staffing along with no haematology cover. Most crucially, with the patient in a non-fasting state and in haemodynamic instability and deteriorating, it was decided to go ahead with an emergency hysterectomy despite the non-availability of on-site Consultant Anaesthetist cover. Her vital parameters held steady during the surgery, and the patient was saved in the nick of time from an imminent maternal death.

Discussion: PPH is defined as blood loss of >500 ml or more from the genital tract within 24 hours of childbirth. A blood loss of >1000 ml is classified as major PPH, which is subdivided into moderate (1000–2000 ml) or severe (>2000 ml). Secondary PPH is abnormal excessive bleeding from the birth canal between 24 hours and 12 weeks postnatally.

Each year, about 14 million women experience PPH, resulting in about 70,000 maternal deaths globally. The incidence of secondary PPH is 0.2%–0.8%, with recurrent episodes being quite rare. Causes for recurrent secondary postpartum haemorrhage include delayed placental bed involution, endometritis, congenital coagulopathies, cervical cancer, submucous fibroids, adherent placenta, caesarean scar dehiscence/isthmoceles, uterine pseudoaneurisms, and uterine rupture. When we compare the two incidences, the most obvious factor is the extreme similarity of the presentation, though the two outcomes were poles apart and that there was a very thin margin that separated between life and death between the two cases.

However, when the two events are analysed, it is quite evident with regard to the absence of implementation of strict clinical governance protocols. With the firstly mentioned catastrophic adverse event, it is evident that there had been deficiencies in monitoring, patient and public involvement, and information management until it was too late. With the latter near-miss incident, deficiencies in staffing were compensated by satisfactory implementation of backup services for risk management, prior education and staff training, prudent decision-making, and clinical effectiveness.

At present, the scope for reporting and follow-up of such incidents, along with audit cycles, to improve on and prevent similar incidents happening in the future on an island-wide basis, irrespective of geographical areas, is restricted due to a lack of proper protocol.

Conclusion: There is very little margin of difference between catastrophic adverse events and near-miss incidents. There is a strong indication that we need to pay more attention to near-miss events in obstetrics along with the application of strict clinical governance protocols at all times to bring down the maternal mortality rate in Sri Lanka.

GUEST LECTURE 6
TO INDUCE LABOUR OR NOT: A DILEMMA TO MANY

Dr Romanie Fernando - Senior Lecturer (Grade 1), Department of Obstetrics and Gynaecology, Faculty of Medicine, Kotelawala Defence University, Ratmalana, Sri Lanka

Induction of labour (IOL) is the artificial stimulation of cervical ripening and progressive uterine contractions to facilitate birth.

In 2008, Sri Lanka was estimated to have the highest rate of IOL in the world, 35.5%.

There is renewed interest in elective IOL following the publication of the ARRIVE trial (A Randomized Trial of Induction Versus Expectant Management), which demonstrated benefits of IOL at 39 weeks' gestation on rates of caesarean birth and hypertensive disorders of pregnancy among low-risk, nulliparous women in some settings. There has been a surge in rates of induction in light of these new data, and recent reports show induction rates of 34% in the UK and 23% in the USA. Although findings of the ARRIVE trial have fuelled conversations about routine IOL, the expert opinion continues to recommend waiting for spontaneous onset of labour in the absence of fetal or maternal complications.

Women have labour induced often without an urgent indication, and apparently low-risk pregnancies are transformed into high-risk labours. Pharmacologically induced labours are at higher risk of uterine hyperstimulation, fetal distress,

and uterine rupture. Further complications include intrapartum vaginal bleeding, presence of meconium-stained amniotic fluid, umbilical cord prolapse, pain not relieved with regional anaesthesia, perineal lacerations, postpartum haemorrhage, chorioamnionitis, and postpartum endometritis.

An audit done at Ward 01, University Hospital Kotelawala Defence University (UHKDU), with Robson's classification of CD, found the second highest percentage (25%) of CD were in the category of primiparous women who underwent IOL at term. Women who had a CD following IOL, the majority (49%) of them had prostaglandin induction. Only 2.6% had CD in the category of multiparous women who underwent IOL at term. The majority (98.5%) of primiparous women with spontaneous onset of labour had a vaginal delivery.

The findings from the above audit made us initiate another audit on IOL in Ward 01 UHKDU. This audit is ongoing and will give us more details regarding the IOL and the outcome of the methods used for induction.

More and more women have labour induced, and indications are often not urgent. This considerable heterogeneity in IOL success supports the need for greater use of evidence to determine the ideal methods for cervical ripening and contraction stimulation. We need to encourage the primiparous woman with a normal pregnancy to have a spontaneous onset of labour and support the natural progression.

There is a need to revisit IOL national guideline and to allow regular audits to overcome unnecessary interventions in apparently healthy women with a normal pregnancy.

GUEST LECTURE 7
DIAGNOSING ADENOMYOSIS; HOW MUCH DO WE MISS

Dr Chandana Jayasundara - Head of Department and Senior Lecturer in Obstetrics and Gynaecology, Faculty of Medicine, University of Colombo, Sri Lanka
Consultant Obstetrician and Gynaecologist, De Soysa Maternity Hospital for Women, Colombo

Introduction: Adenomyosis is a benign gynaecological condition characterised by the presence of ectopic endometrial tissue within the myometrium, leading to uterine enlargement and associated symptoms such as dysmenorrhea, menorrhagia, chronic pelvic pain, and infertility. Diagnosing adenomyosis has evolved from a purely histological approach to the use of non-invasive imaging techniques like ultrasound and Magnetic Resonance Imaging (MRI). However, missed diagnoses remain a concern, highlighting the need for standardized diagnostic criteria and guidelines.

Body: The current diagnosis of adenomyosis relies primarily on imaging modalities such as transvaginal ultrasound (TVUS), the first-line technique, but MRI is considered the gold standard, with sensitivity and specificity rates ranging from 88%–93% and 67%–91%, respectively, nearly equal to that of TVUS. However, both methods have limitations in detecting subtle or early-stage adenomyosis, leading to under-diagnosis. Furthermore, histopathological confirmation is typically only obtained post-hysterectomy, limiting pre-operative diagnosis.

The existing guidelines emphasize the use of specific criteria for diagnosing adenomyosis, such as uterine enlargement, asymmetric myometrial thickening, and the presence of myometrial cysts. However, these criteria often miss cases of diffuse or focal adenomyosis, especially in younger women or those without typical symptoms. Studies suggest that adenomyosis is underdiagnosed in up to 40% of cases, particularly in patients with co-existing gynaecological conditions like fibroids or endometriosis.

To improve diagnostic accuracy, the adoption of the Morphological Uterus Sonographic Assessment (MUSA) consensus, published in 2015, provides guidance on diagnosing and reporting adenomyosis using TVUS. It recommends assessing seven key items: presence, location, distribution, presence of cysts, layer of uterine involvement, extent, and lesion size. Despite these advancements, missed diagnoses of adenomyosis remain a concern.

Conclusion: Adenomyosis remains under-diagnosed due to reliance on non-standardized criteria and limitations in current imaging techniques. By incorporating MUSA guidelines into routine practice, clinicians can enhance diagnostic precision, reducing missed diagnoses and improving patient outcomes.

DAY 02
GUEST LECTURE 8
CONFIDENTIAL ENQUIRY IN TO MATERNAL DEATHS: GAINING INSIGHT TOWARDS A NATIONAL RESPONSE

Dr Lakshmen Senanayake - Retired Consultant Obstetrician and Gynaecologist, Past President, SLCOG

The death of a woman in the process of giving birth is exceptional for many reasons, one being that she dies in the process of ensuring the continuity of the human race. Therefore, the prevention of maternal deaths becomes the responsibility of the governments and society at large. The Convention on Elimination of All Forms of Discrimination on Women (CEDAW) in 1979, the Safe Motherhood Initiative in 1987, and the inclusion of targets on maternal mortality in the Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs) were global policy responses in safeguarding women in childbirth

Maternal Death Surveillance and Response (MDSR) processes were initiated in many countries as a result of the publication of the WHO manual “Beyond the Numbers: Reviewing Maternal Deaths and Complications for Making Pregnancy Safer”. Sri Lanka introduced a Maternal Death Surveillance and Response System (MDSR) in 1981 with mandatory notification of maternal deaths gazetted in 1985. A structured review of maternal deaths was initiated by the Family Health Bureau (FHB) in 1995 together with the Sri Lanka College of Obstetricians and Gynaecologists with other Professional Colleges joining in later. The final step of the MDSR methodology practiced in Sri Lanka till recently was a National Level Review of the information by a group of experts (Desk Review) followed by a consultation with experts and the Health Care Providers involved in care in an open discussion.

Recently, this process was up scaled into a Confidential Enquiry into Maternal Deaths (CEMD) with the information on women anonymized beyond the point of the institutional inquiry. This has been piloted in two provinces and is expected to be expanded to other provinces soon.

CEMD can ensure that the staff has a confidential avenue to communicate actually what happened, and what they think should have happened, in order to prevent a death which leads to recommendations that could be system-targeted, unbiased, untainted, and without reservations. Such recommendations would make changes of a more general policy nature, applicable across the national care delivery system rather than to a single individual or an institution.

The value of a CEMD depends on the trust placed on the system by the providers and the frank response made by them in divulging information, the strength of the recommendations made by the Expert Committee, and the effort taken to implement them by the state parties and other organizations identified.

GUEST LECTURE 9
WHY MOTHER'S DIE DUE TO SEPSIS: AN EVOLVING CHALLENGE

Dr Ananda Ranathunga – Retired Consultant Obstetrician and Gynaecologist, Past President, SLCOG

Maternal sepsis is "a life-threatening condition defined as an organ dysfunction caused by an infection during pregnancy, delivery, puerperium, or after an abortion." It has a mortality rate of 20 to 40%, which increases to 60% if septic shock develops. One tenth of the global burden of maternal deaths is due to maternal sepsis. Most of the cases are from low-income countries, but sepsis is an important direct cause of maternal deaths in high income countries too. Pre-existing maternal conditions like malnutrition, diabetes, obesity, severe anaemia, bacterial vaginosis, and group B Streptococcus infections may increase the risk of infection. Spontaneous or caregiver-initiated conditions during labour and childbirth may contribute to the maternal infection.

Sadly, substandard care was identified in many of the cases, in particular lack of recognition of the signs of sepsis and due to delayed response. Undetected or poorly managed maternal infections can lead to severe sepsis, death, or disability of the mother. Reviews reveal that in most of the instances, these maternal deaths are potentially preventable.

Physiological, immunologic, and mechanical changes that occur in pregnancy make pregnant women more susceptible to infections than non-pregnant women; unfortunately, the very same reasons may obscure signs and symptoms of maternal sepsis. The clinicians should exercise a high degree of suspicion to consider the diagnosis of sepsis in pregnant or postpartum patients with otherwise unexplained end-organ damage or an altered mental state in the presence of a possible infectious process, regardless of the presence of fever. The sepsis and septic shock should be considered medical emergencies, and the investigations, treatment, and resuscitation begin immediately. Globally, the most common intervention for preventing morbidity and mortality related to maternal sepsis is the use of correct antibiotics for prophylaxis and treatment, avoiding misuse.

Essential factors in improving maternal sepsis outcomes include rapid recognition and response with multidisciplinary input, appropriate investigations, and the commencement of anti-microbials early. Involvement of senior staff members is of paramount importance.

National guidelines for management of sepsis should be developed and updated. The local hospitals may adapt and have their own protocols. Management protocol implementation during the first hour of treatment will be the most important determinant factor for the reduction of maternal mortality.

Due to the associated long-term disability and problems in survivors of sepsis and septic shock, a well-planned adequate follow-up program should be established.

GUEST LECTURE 10
KNOWING THE BOUNDARIES DURING SURGERY FOR ENDOMETRIOSIS

Prof Rasika Herath - Professor in Obstetrics and Gynaecology, Faculty of Medicine, University of Kelaniya, Sri Lanka

Endometriosis is a chronic inflammatory condition effecting 2-10% of women of reproductive age, 20-50% of infertile women, and 30-80% of women with chronic pelvic pain. Surgery remains a cornerstone of treatment once alternative, non-invasive methods fail in achieving desired therapeutic aims. However, surgery for endometriosis carries potential risks, including reduced ovarian reserve and the possibility of injuries to the bladder, bowel, and ureters.

Comprehensive preoperative assessment and planning, including transvaginal ultrasound and MRI to understand the extent of endometriotic lesions, would help in planning a minimally invasive approach that minimizes ovarian manipulation and possible injuries. During cystectomy, developing meticulous dissection planes and gentle tissue handling to avoid unnecessary excision of healthy ovarian tissues and use of selective haemostasis is essential. Use of medical therapy adjunctively before and after surgery to manage disease burden and reduce recurrence may possibly extend ovarian function longevity. Further, voiding extensive coagulation and ensuring haemostasis through finely calibrated energy devices to protect the ovarian blood supply can help preserve ovarian perfusion. It is important to appreciate the delicate balance between the severity of the condition, the expectations of the patient, and what modern medicine can offer, which may never be achieved. Understanding and adhering to the boundaries and limitations of surgical intervention, along with employing strategies to minimize harm, are essential in offering treatment to endometriosis-associated complications.

GUEST LECTURE 11
CRITICAL ISSUES FOR SUSTAINING PROGRESS IN MATERNAL AND NEWBORN HEALTH IN SOUTH ASIA

Dr Sudha Sharma - Co-Director at CIWEC Hospital Pvt. Ltd, Kathmandu, Nepal
Chair of International Representative Committee, Royal College of Obstetricians and Gynaecologists (RCOG) in Nepal

Between 2000 and 2020, the maternal mortality ratio dropped by about 34% worldwide, with the burden of almost 95% of maternal deaths in low and lower middle-income countries. South Asia had an impressive decline in MMR of 67%, but it still accounted for around 16% (47,000) of maternal deaths in 2020. In the South Asia region, Sri Lanka continues to outperform all other countries. Its MMR has improved further from 61 per 100,000 live births in 2000 to 29 in 2020. The presentation will be based on the results of the 'Exemplar Study' that focused on seven countries that surpassed average progress in maternal and newborn mortality reduction between 2000-2020, relative to their socio-economic progress. Three of these seven countries—Bangladesh, India, and Nepal—are in the South Asia region. These countries made remarkable progress in the last two to three decades, mainly through

- Increasing contact with maternity services;
- Improving the quality of those services;
- Reducing fertility and increasing access to safe abortion; and
- Strengthening government commitment, resources, financing, and progressive implementation and learning.

There were some unique features that made each of the countries progress faster. Bangladesh's multi-sectorial and persistent focus on maternal and newborn health, along with economic and infrastructural improvements, allowed for rapid gains. India's National (Rural) Health Mission's financial and administrative flexibility allowed states to tailor health system reforms. Nepal's success was due to adaptive, evidence-informed, and inclusive policy-making, effective implementation, and a focus on reducing inequalities.

Despite progress, major challenges remain. Some of the common challenges across all countries included health system failures, including a lack of accountability that contributed to persistent shortages of trained health workers, essential medicines and supplies, inequity, and poor quality of care. Inequities were further exacerbated by poverty, poor education, difficult geography, and caste and ethnicity factors. Most of these countries have adopted the agenda of universal health coverage with a focus on minimizing inequities. But the universal health coverage agenda does not sufficiently protect and prioritize the health and nutrition of children, women, and adolescents. Further, health issues such as non-communicable diseases, epidemics, pandemics such as COVID, adverse effects of climate change, and political instability, among others, compete for limited resources.

With only six years to 2030, we need to critically think and plan how countries can make the Sustainable Development Goal of reducing MMR to less than 70 per 100,000 live births and NMR to at least 12 per 1,000 live births achievable. Collaborative action and deliberate planning could go a long way in addressing health system failures, improving the quality of care, and minimizing inequities at all levels.

GUEST LECTURE 12
VITAMIN D SUPPLIMENTATION IN PREGNANCY; WHAT'S LATEST EVIDENCE

Dr Sanjay Kalra - Consultant Endocrinologist, Bharti Hospital, Karnal, India

Vitamin D deficiency is endemic to South Asia. Vitamin D is a hormone that is synthesized in the skin by exposure to ultraviolet radiation from the sun and activated in the kidney and liver. Conventionally, Vitamin D had been thought to have only musculoskeletal effects. In recent years, the non-musculoskeletal impact of vitamin D has been recognized. Metabolic, mental, pro-immunity, and anti-mitogenic properties are some of these.

Vitamin D plays an important role before, during, and after fetal health. Adequate vitamin D ensures good bone health in both mother and fetus, preventing osteomalacia and rickets, respectively. Vitamin D helps in preventing pregnancy-induced hypertension (PIH) and gestational diabetes mellitus (GDM). Its deficiency is associated with intrauterine growth retardation (IUGR), preterm labour, and adverse fetal outcomes.

Milk, especially human milk, is a very poor source of vitamin D. Hence, vitamin D must be supplemented throughout pregnancy. Guidelines suggest 1000-2000 IU/day in pregnancy and lactation. While the guidance for use during the second and third trimesters is unequivocal, a strong recommendation can be made for use during the first trimester as well. One must also remember that a higher dose will be required in women with documented or symptomatic vitamin D deficiency.

GUEST LECTURE 13
UNDERSTANDING GENETICS FOR OBSTETRICIANS

Prof Dr Narendra Malhotra – Consultant Obstetrician and Gynaecologist, Managing Director, Global Rainbow Healthcare, India
Director, ART Rainbow IVF, India

Introduction: Genetics plays a crucial role in obstetrics, influencing prenatal care, risk assessment, and the management of inherited conditions. As an obstetrician, having a solid understanding of genetics allows for more informed decisions, better patient counselling, and improved outcomes for both mother and child. There is a general misconception that genetic diseases are rare and always inherited and not treatable. Hence, obstetricians shy away from investigating for genetic syndromes.

Basic Genetic Concepts: At the core of genetics is DNA, the molecule that carries genetic information. Humans have 23 pairs of chromosomes, with one set inherited from each parent. Genes, which are segments of DNA, serve as instructions for making proteins that perform various functions in the body. Understanding terminology is important. (Figure 1

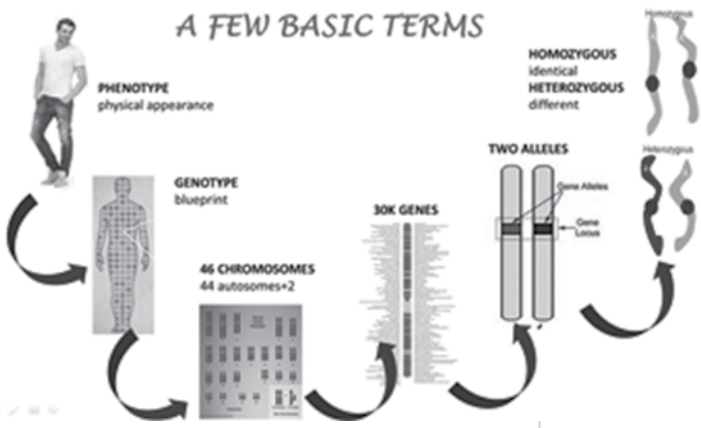


Figure 1: Basic Terms

Genetic Inheritance: Each cell in the body contains 46 chromosomes (23 pairs), half inherited from the mother (maternal) and half from the father (paternal). 22 pairs are autosomes and one sex chromosome (XX and XY). (Figure 2)

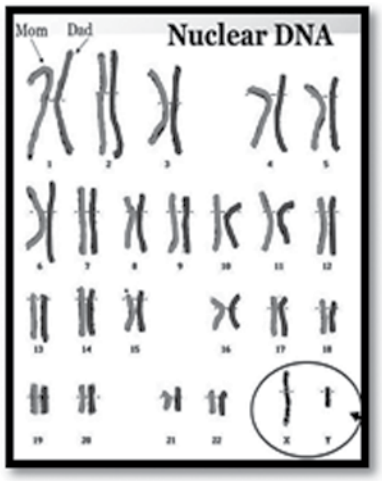


Figure 2: Karyotype Report

Genetic conditions can be inherited in several ways:

Autosomal Dominant: Only one copy of a mutated gene is needed to cause the condition (e.g., Huntington's disease).
Autosomal Recessive: Two copies of a mutated gene (one from each parent) are required (e.g., cystic fibrosis).
X-Linked: Mutations in genes on the X chromosome can affect males more severely, as they have only one X chromosome (e.g., haemophilia).

Genes are part of DNA that code for proteins (exons and introns). The human genome has 30,000–40,000 genes.

Prenatal Genetic Screening and Testing: Types of testing are shown in Figure 3.

Diagnostic	Used to confirm a diagnosis based on physical signs
Predictive	Used to detect gene mutations associated with disorders that appear later in life
Carrier Identification	Used by people with a family history of recessive genetic disorders
Prenatal testing/ screening	Used to test a foetus when there is risk of bearing a child with metal or physical disabilities / Screening tests – penta, quad etc
Newborn Screening	Used as a preventative health measure once the baby is born
Forensic testing	Used to identify an individual for legal purposes
Research testing	Used for finding unknown genes and identifying the function of a gene

Figure 3: Type of Genetic Tests

Genetic screeni
ng and testing are integral to prenatal care:

Common methods include:

Non-Invasive Prenatal Testing (NIPT): Analyses fetal DNA in maternal blood to screen for chromosomal abnor malities like Down syndrome.
Ultrasound: Can detect structural anomalies that might suggest a genetic condition.

Amniocentesis and Chorionic Villus Sampling (CVS): Invasive tests that collect fetal cells for detailed genetic analysis.

Pedigree Tree: It is important to draw a pedigree tree for every pregnancy (Fig. 4). A pedigree results in the presentation of family information in the form of an easily readable chart. It can be simply called a "family tree."

Pedigrees use a standardized set of symbols:

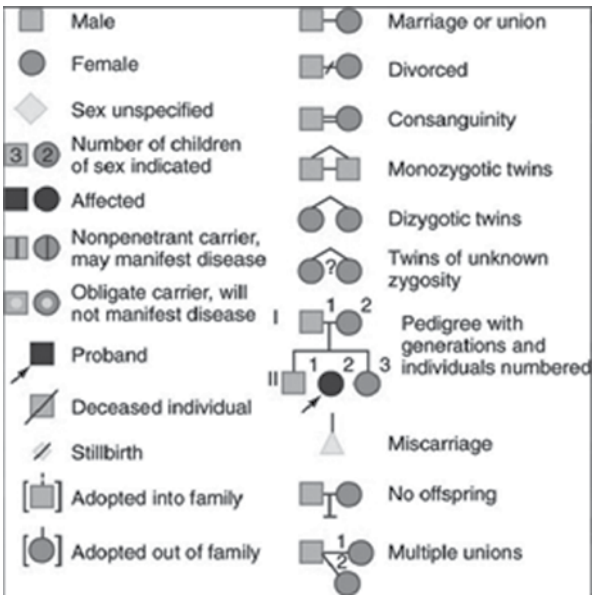


Figure 4: Pedigree Tree Symbols

Genetic Counselling: Genetic counselling is essential for interpreting test results and discussing potential risks with expectant parents. It helps in understanding the implications of genetic conditions, exploring reproductive options, and making informed decisions about pregnancy management. The clinician's (obstetrician) role as a genetic counsellor is paramount.

Primary physician (obstetrician/paediatrician): first point of contact
Good rapport: family listens!!!
First to identify cases: requiring evaluation by a clinical geneticist or other subspecialty
Reinforcing the Genetic Counselling
Evaluate stillborns- Good records of examination and autopsy are essential.

Implications for Obstetric Practice:

Risk Assessment: Identifying couples at risk for genetic disorders allows for early intervention and tailored care plans.
Early Detection: Detecting genetic abnormalities early in pregnancy facilitates timely management and prepa ration for potential complications.
Personalised Care: Genetic information can guide personalised

Take Home Message:

Genetics has entered mainstream medicine.

Able to diagnose a large number of rare conditions, it transforms options for families seeking prenatal help.
Able to identify specific risk factors for common disorders and offer targeted guidance on therapy for them.
Can identify disorders before any symptoms or signs exist.
Can assist doctors in optimal drug choices.
Exponential rate of development in terms of understanding and direct clinical application.

If family history of possible genetic condition discussion with or referral to genetics is suggested.

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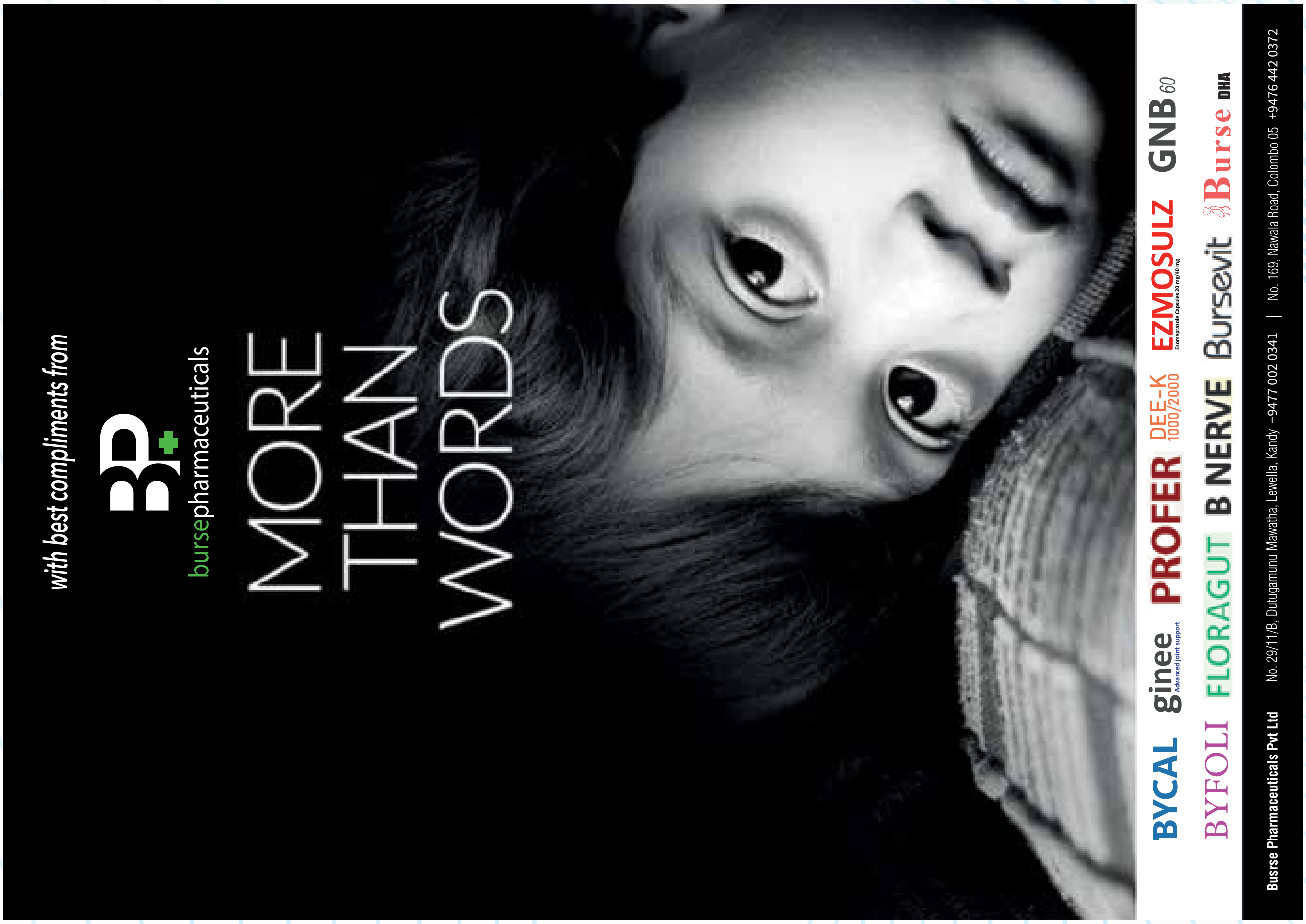
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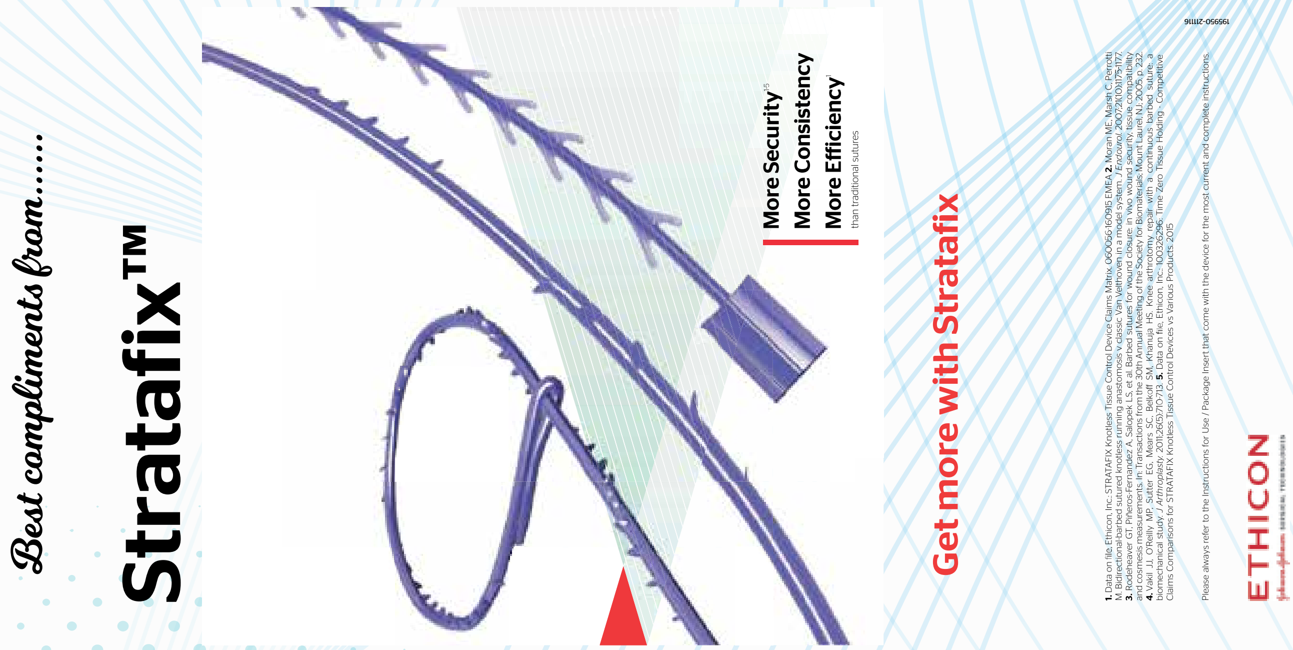
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