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4th to 6th September 2026

"Bridging gaps in women's health through collaboration, education, training and research"

Abstracts

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CONTENTS

ORAL PRESENTATIONS (OP)

OP001. ACCURACY OF NICE 2022 INTRAPARTUM FETAL MONITORING STICKER CLASSIFICATION BY JUNIOR DOCTORS: A QUALITY IMPROVEMENT AUDIT

Chathuranga, RMT[1], Marleen, FS[1], Jawfer, MJA[1], Withanachchi, NN[2], Maryam, MM[1]

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Background: Cardiotocography (CTG) interpretation is subject to substantial inter-observer variability, particularly among less experienced clinicians. To standardise interpretation and support timely escalation, a colour-coded sticker based on the NICE 2022 intrapartum fetal monitoring guideline (White/Amber/Red) was introduced as a quality improvement (QI) intervention. This audit evaluated the accuracy of CTG classification by doctors with approximately one year of clinical experience against consultant interpretation as the gold standard.

Method: This was a retrospective observational audit with a calculated and achieved sample size of 114 intrapartum CTG traces. The sticker listed individual CTG features (baseline, variability, accelerations, decelerations) corresponding to NICE 2022 criteria; the assessing doctor encircled the feature present on each trace, guiding the overall White/Amber/Red categorisation. Traces classified by a one-year-experience doctor were compared against the corresponding consultant classification, taken as reference standard. Agreement was assessed as percentage accuracy per category and as Cohen's kappa.

Results: Junior doctor classification agreed with consultant interpretation in 97.6% of Normal traces (82/84), 87.5% of Suspicious traces (21/24) and 83.3% of Pathological traces (5/6). Overall observed agreement was 94.7% (108/114) against an expected chance agreement of 59.0%, giving Cohen's kappa of 0.87 — almost perfect agreement by Landis and Koch criteria.

Discussion: Published agreement for intrapartum CTG interpretation is generally lower than observed here, particularly for junior readers. Studies comparing junior and senior midwives against 2015 FIGO guidelines report junior agreement of only Krippendorff's α 0.57 versus α 0.72 for seniors, with overall agreement in the "unacceptable" range. Related cohorts using Fleiss' kappa report overall agreement as only fair (κ 0.35), weakest for Suspicious and Pathological categories. A multicentre FIGO-guideline study found overall classification agreement of Pa 0.60. Against this, κ 0.87 is substantially higher than typically reported junior-versus-expert figures and higher than most senior-versus-expert figures too. It may also partly reflect the small number of Suspicious and Pathological traces, limiting precision of those category estimates despite the strong overall kappa. The lowest accuracy remains in the Pathological category (83.3%), the category of greatest clinical consequence if missed, warranting targeted training despite the reassuring overall result.

Conclusion: Introduction of the NICE 2022 sticker was associated with almost-perfect agreement between junior doctor and consultant CTG classification (κ = 0.87), exceeding internationally reported figures for junior-grade readers. All CTG traces should have the completed sticker — features encircled, category marked — affixed to the Bed Head Ticket (BHT) at the time of interpretation, ensuring a permanent, contemporaneous record and supporting ongoing audit and escalation. Larger numbers of Suspicious and Pathological traces would strengthen confidence in category-specific findings.

OP002. AI IN SRI LANKAN O&G POSTGRADUATE TRAINING: AN UNREGULATED REALITY

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Introduction: Generative AI has spread quickly into medical education, yet its use by Sri Lankan postgraduate trainees remains undocumented.

Objectives: To describe the extent, patterns and perceived reliability of AI use among obstetrics and gynaecology (O&G) trainees.

Design: Descriptive cross-sectional study using an online questionnaire.

Method: Sixty-five O&G trainees completed an anonymous 24-item questionnaire on usage, expenditure, verification, errors and confidence in academic and clinical AI use.

Results: All 65 trainees reported using AI at some capacity and 84.6% did so daily. ChatGPT was used by everyone and more than half used Gemini and Notebook. Over half (53.8%) paid for AI services, usually through shared accounts (56.8%), with personal costs under LKR 3,000 per month.

Academic uses included summarising guidelines (92.3%), explaining difficult concepts (76.9%), and practicing structured clinical examinations (61.5%). Clinically, 92.3% used AI to clarify management, 53.8% to check drug doses and 38.5% to interpret investigations; 53.8% had changed or clarified a clinical decision based on AI. AI had mostly or completely replaced search engines for 69.2% of trainees and 84.6% at times preferred it to textbooks or to clarification from a senior colleague.

Everyone had received incorrect information from AI at some point, 76.9% had encountered fabricated answers and five (7.7%) reported an AI-related near miss, yet only 30.8% always verified AI output. Confidence was higher for academic than clinical answers (median 4 vs 3; p=0.009). Junior trainees (n=30) had replaced search engines more than seniors (n=35) (83.3% vs 57.1%; p=0.023), while seniors were more confident in AI clinically (median 4 vs 3; p<0.001).

Paying personally for AI was linked to replacing search engines (85.7% vs 50.0%), changing clinical decisions (71.4% vs 33.3%) based on AI inout and verifying the output less often (14.3% vs 50.0%) (p=0.002). Confidence in clinical reliability correlated with preferring AI to textbooks (ρ=0.46) and to search engines (ρ=0.53) and inversely with wanting formal training (ρ=-0.64) (p<0.001). Comfort consulting AI over a senior was linked to less verification (ρ=-0.29; p=0.015) and all five near misses occurred among trainees who used AI freely for research without verifying it (p=0.002). Everyone felt AI had improved their training and a wide majority (84.6%) wanted AI to be formally taught during postgraduate training.

Conclusion: AI is now a daily, largely self-funded, first-line resource for O&G trainees, displacing search engines, textbooks and, at times, senior colleagues despite errors. Postgraduate curriculum should include AI literacy and verification skills, with clear standards for safe clinical use and regulated access.

OP003. AN AUDIT ON THE CLINICAL NECESSITY OF INPATIENT ADMISSIONS FOR ABNORMAL UTERINE BLEEDING AND DYSMENORRHOEA

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Introduction: A considerable proportion of emergency admissions for abnormal uterine bleeding (AUB) and dysmenorrhoea involve hemodynamically stable patients who are suitable for outpatient management contributing to unnecessary inpatient bed utilization.

Objectives: 1clinically avoidable emergency admissions for abnormal uterine bleeding and dysmenorrhea using predefined standard clinical criteria.

Design: A prospective clinical audit conducted over a two-month period encompassing 16 casualty intake days.

Method: All consecutive emergency admissions for AUB and dysmenorrhoea at the Professorial Gynaecology Unit, Teaching Hospital Kurunegala were evaluated. Data on demographics, presenting complaints, hemodynamic status, baseline hemoglobin (Hb), prior to outpatient medical trials, inpatient interventions, medication routes, ultrasound findings and length of stay were analyzed. The admissions of the patients presented with hemodynamic instability, severe anemia (< 7.0g/dL), required blood transfusion, patient distress with severe pain or needed emergency surgical intervention were defined as necessary.

Results: Among 21 admitted patients, 18 (85.7%) were classified as avoidable admissions, consuming 31 of 38 total bed-days (81.6%). All 21 patients were hemodynamically stable. Pure primary dysmenorrhoea represented 28.6% (n=6); all were young (16 – 21 years), unmarried, had normal Hb (>10.0g/dL) and unremarkable ultrasound findings, requiring zero inpatient procedures. Perimenopausal

bleeding (age >45years) accounted for 38.1% (n=8), of whom 87.5% (n=7) were avoidable. Secondary dysmenorrhoea was present in 38.1% (n=8), with underlying adenomyosis (62.5%), endometriomas (25.0%), or fibroids (12.5%); none required emergency procedures. Prior to admission, 42.9% (n=9) had no trial of outpatient medical therapy. In the ward, 90.5% (n=19) received oral medications only. Only 3 patients (14.3%) required inpatient intervention (blood transfusion n=2, emergency surgery n=1).

Conclusion: A substantial proportion (85.7%) of emergency admissions for abnormal uterine bleeding (AUB) and dysmenorrhea were considered clinically avoidable. The implementation of structured casualty triage algorithms dedicated to rapid-access Gynaecology Clinics and optimization of outpatient medical management may significantly reduce unnecessary hospital admissions. A repeat audit will be conducted following the implementation of these interventions to assess their effectiveness and determine the success of the proposed changes.

OP004. ANAEMIA IN EARLY PREGNANCY: PREVALENCE AND ASSOCIATED FACTORS AMONG WOMEN ATTENDING ANTENATAL BOOKING CLINICS IN SRI LANKA

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Background: Anaemia during pregnancy remains a significant maternal health concern. Using baseline data from a prospective cohort study in Sri Lanka, this study estimated the prevalence of anaemia and identified associated factors among women attending antenatal booking clinics.

Method: A cross-sectional analysis was conducted using baseline data from pregnant women attending booking clinics at three tertiary care hospitals in Sri Lanka. Women with available haemoglobin (Hb) measurements were included. Anaemia was defined according to WHO guidelines using Hb measured at booking. Prevalence and severity were described and maternal characteristics were compared by anaemia status. Factors associated with anaemia were assessed using logistic regression, with multivariable analyses performed after multiple imputation.

Results: Among 591 pregnant women with available Hb measurements, 93 (15.7%) had anaemia. Of those with anaemia, 51.6% had mild, 47.3% moderate and 1.1% severe anaemia. Women with anaemia had a lower median period of amenorrhoea at booking compared with those without anaemia (10.6 vs 12.7 weeks, p=0.003) and anaemia status differed by booking timing (p=0.001) and BMI category (p=0.006). In univariable analysis, underweight women had substantially higher odds of anaemia compared with women with normal BMI (OR 5.74, 95% CI:2.00–16.46). Following multivariable adjustment and multiple imputation, underweight BMI remained independently associated with anaemia (adjusted OR 3.21,95% CI:1.25–8.27; p=0.016). No clear associations were observed for planned pregnancy, previous miscarriage, previous gestational diabetes or overall morbidity status.

Conclusion: Anaemia was present in approximately one in six pregnant women with available Hb measurements, with almost half of anaemic women having moderate anaemia. Maternal underweight was independently associated with increased odds of anaemia. These findings highlight the importance of nutritional assessment and early identification of women at increased risk of anaemia during pregnancy.

Keywords: Anaemia, pregnancy, booking visit, maternal morbidity, body mass index, underweight, Sri Lanka

OP005. ANALYSIS OF INTRAPARTUM CTG DOCUMENTATION AND INTERPRETATION: AUDIT AND RE-AUDIT

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Introduction: Cardiotocography (CTG) is a commonly used tool in intrapartum fetal surveillance and plays an important role in detecting fetal hypoxia. Accurate interpretation, documentation, effective communication and timely decision-making are essential to prevent adverse perinatal outcomes in labour. Conventional CTG is the standard method of fetal surveillance in Sri Lanka. However, variability in interpretation and substandard documentation result in inappropriate management and increase medico-legal risks. The National Institute for Health and Care Excellence (NICE) guidelines provide standardised criteria for CTG interpretation and documentation.

Objectives: To assess the quality of intrapartum CTG documentation and interpretation in a tertiary care obstetric unit, identify areas of deficiency to implement corrective measures and evaluate the effectiveness of interventions through re-audit.

Methodology: This clinical audit was conducted in the labour ward of Obstetrics and Gynaecology Unit B, Teaching Hospital Mahamodara, Galle. There were 110 intrapartum CTGs evaluated from 01/12/2024 to 31/12/2024. Documentation was assessed against NICE guideline standards, including patient identification details, baseline fetal heart rate, accelerations, decelerations, variability, maternal heart rate, obstetric risk factors, CTG interpretation, management plan and clinician signature. Educational sessions were conducted based on NICE guideline-based CTG interpretation and documentation to uplift identified knowledge gaps and standardised CTG stamps and documentation stickers were introduced to facilitate structured recording. A re-audit was subsequently conducted between 20/03/2025 and 20/04/2025, reviewing 92 CTG traces using the same assessment criteria.

Results: The initial audit identified deficiencies in CTG documentation and interpretation. Following implementation of the interventions, documentation of baseline fetal heart rate, accelerations, decelerations and variability improved markedly from approximately 14% to 82.6%. Documentation of maternal heart rate increased from 0% to 41.3%, while recording of obstetric risk factors improved from 0% to 40.2%. Documentation of CTG interpretation improved from 5.5% to 69.6% and documentation of the management plan increased from 21.8% to 58.7%. Clinician signatures were documented in 100% of cases during the initial audit and in 85.9% of cases during the re-audit.

Conclusion: The audit highlighted substantial deficiencies in intrapartum CTG documentation and interpretation. Educational interventions and the introduction of standardised templates of documentation improve overall quality of intrapartum fetal surveillance. Ongoing training, reinforcement of NICE guideline recommendations and regular re-auditing are recommended to sustain improvements, enhance patient safety and optimise perinatal outcomes.

OP006. AUDIT CYCLE WITH STRUCTURED FEEDBACK TO IMPROVE EPISIOTOMY ANGLE PRACTICE

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Introduction: An inadequate episiotomy incision angle increases the risk of obstetric anal sphincter injuries (OASIS). The Royal College of Obstetricians and Gynaecologists (RCOG) recommends an incision angle at crowning to minimize this risk. Because anatomical apposition during repair reduces the observable angle, a post-suturing angle corresponds to an adequate initial incision.

Objectives: To evaluate baseline compliance with recommended episiotomy angle standards and assess the impact of an educational audit cycle with structured feedback in a tertiary care labor ward.

Design: A prospective, two-phase clinical audit was conducted at Teaching Hospital, Rathnapura. Fifty cases were initially enrolled

in both the baseline pre-audit phase and the post-audit phase following an in-service training intervention. To prevent analytical bias, 3 cases with incomplete records were excluded from each phase, resulting in analyzed cases in both groups.

Method: To prioritize maternal and neonatal well-being during delivery, episiotomy angles were measured immediately after suturing using a sterile protractor/transparent angle-measuring tool. Compliance was defined as a post-suturing angle of $>45^0$. Data collected included maternal characteristics, operator category, episiotomy angle, and perineal tears. Ethical approval was obtained from the Ethics Review Committee of the Faculty of Medicine, University of Ruhuna. Data were analyzed using SPSS using independent-samples t-tests and Chi-square tests.

Results: There were no significant baseline differences between the pre-audit (n=47) and post-audit (n=47) groups regarding mean maternal age (p=0.114) or neonatal birth weight (p=0.248). Episiotomies were performed predominantly by nursing officers in both phases (Pre: 95.7%, n=45/47; Post: 100.0%, n=47/47:,).

The mean post-suturing episiotomy angle increased significantly by from the pre-audit to the post-audit phase (p<0.001). Compliance with the post-suturing standard ($>45^0$) rose significantly from 6.4% (n=3/47) pre-audit to 22.0% (n=10/47) post-audit (p=0.029). Severe (3rd/4th-degree) perineal tears decreased from 2.1% (n=1/47) to 0% (n=0/47) (p=0.317).

Conclusion: In-service training and structured feedback significantly increased mean post-suturing episiotomy angles and significantly improved guideline compliance. Visual estimation during incision remains a primary limitation, as the majority of post-suturing angles remained below. Future quality improvement cycles should introduce physical angle guides or fixed-angle scissors.

OP007. AUDIT OF SURGICAL SITE INFECTIONS FOLLOWING CHILDBIRTH

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Introduction: Surgical site infections (SSIs) remain a significant cause of complications for mothers. They lead to longer hospital stays, readmissions, and higher healthcare costs. While post-caesarean SSIs are well known, infections from episiotomies and perineal tears are often under reported, even though they have a major clinical impact.

Objectives: To assess the rate, risk factors, microbial profile, treatment and record-keeping related to postpartum SSIs following deliveries in a tertiary care hospital.

Design: Retrospective clinical audit.

Method: All women treated for postpartum SSIs in Unit B of the German Sri Lanka Friendship Hospital for women between January and July 2025 by reviewing clinical records. Delivery statistics were obtained from ward registers. Patient demographics, delivery methods, cervical ripening techniques, labor factors, microbiological results, treatment received, hospital stay duration and documentation in bed-head tickets (BHT) were reviewed.

Results: During the study period, we recorded 1,370 deliveries. This included 796 vaginal deliveries and 574 caesarean sections. A total of 32 women developed postpartum SSIs, resulting in an overall incidence of 2.33%. Perineal wound infections after vaginal delivery accounted for 17 cases (2.13%), while 15 cases occurred after caesarean sections (2.61%). Deep incisional SSIs made up 80% (12 out of 15) of infections. Among post-caesarean infections, 46.6% followed emergency caesarean sections. In the vaginal delivery group, 35.29% had Foley catheter cervical ripening, 23.5% labored for more than 11 hours and 23.5% had more than three to five vaginal exams in the antenatal ward and labor room. Wound swab cultures were done in all cases with Escherichia coli was found in 43.75% of cultures, while methicillin-resistant Staphylococcus aureus (MRSA) was found in 25%. A prolonged hospital stay of over seven days occurred in 26.6% of patients with SSI after

LSCS. Inadequate documentation of routine wound assessments before discharge was identified in 37.5% of cases.

Conclusion: Postpartum SSIs still represent a significant clinical challenge. Perineal wound infections account for more than half of all cases. Common associated factors include emergency caesarean delivery, failed induction, Foley catheter cervical ripening, prolonged labor and multiple vaginal examinations. Poor documentation of routine wound assessments is a key area for improvement. Implementing a structured daily wound assessment form and a pre-discharge wound checklist could enhance documentation, help detect infections early and lower complications for mothers.

OP008. BEFORE AND AFTER IMPLEMENTATION STUDY OF POSTPARTUM BLOOD TRANSFUSION PRACTICES AND THE IMPACT OF STANDARDIZED ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOUR USING THE E-MOTIVE APPROACH ON REDUCING POSTPARTUM ANAEMIA AND TRANSFUSION REQUIREMENTS

(E-MOTIVE stands for E - Early identification, M - Massage, O - Oxytocic drugs, T - Tranexamic acid, IV - Intravenous fluids, E - Examination, E - Escalation)

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Introduction: Postpartum haemorrhage (PPH) remains one of the leading causes of maternal morbidity worldwide and contributes significantly to postpartum anaemia and blood transfusion requirements. Variations in third stage management practices and delayed recognition of excessive bleeding increase maternal complications. The E-MOTIVE approach, is an evidence based medical care package recommended by the World Health Organization (WHO) which incorporates early detection of blood loss using calibrated drapes and a standardized bundle-based management protocol, has demonstrated effectiveness in reducing severe PPH.

Objectives: To assess postpartum blood transfusion practices in a secondary care obstetric unit and evaluate the impact of implementing standardized active management of the third stage of labour using the EmOTIVE approach on postpartum anaemia and transfusion requirements.

Method: A retrospective pre-intervention and prospective post-intervention study was conducted over 12 months.The pre-intervention phase comprised 6 months, followed by implementation/training and a 6-month post-intervention phase. The intervention included routine prophylactic uterotonic administration, calibrated blood collection drapes, early recognition of PPH, uterotonics, tranexamic acid, intravenous fluid resuscitation, uterine massage, escalation to senior staff and standardized documentation.

Results: A total of 834 deliveries were included: 464 in the pre-intervention phase and 370 in the postintervention phase. Blood transfusion was required in 21 women (4.5%) before implementation and 12 women (3.2%) after implementation. Mean blood units transfused decreased from 1.5 to 1.25 units. Early recognition of bleeding and prompt administration of uterotonics improved clinical outcomes and reduced avoidable transfusions.

Conclusion: Following implementation of the E-MOTIVE-based standardized approach, postpartum transfusion requirements and reported postpartum anaemia measures decreased. Routine adoption of evidence-based PPH prevention and management bundles may improve maternal outcomes in resource-limited settings.

Keywords: Postpartum haemorrhage, postpartum anaemia, blood

OP009. BEYOND CLASSICAL PRESENTATION: HERLYN–WERNER–WUNDERLICH SYNDROME IN AN ADOLESCENT WITH REGULAR MENSTRUAL CYCLES

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Objectives: Herlyn–Werner–Wunderlich syndrome (HWWS), also known as obstructed hemivagina and ipsilateral renal anomaly (OHVIRA) syndrome, is a rare congenital Müllerian anomaly characterised by uterine didelphys, obstructed hemivagina and ipsilateral renal agenesis. Although classically presenting with primary amenorrhoea and cyclical

pelvic pain, atypical presentations may result in delayed diagnosis. This case highlights the importance of recognising subtle clinical features despite preserved menstruation.

Case report: A 16-year-old girl presented with acute urinary retention secondary to a large pelvic mass. She had attained menarche and reported regular but scanty menstrual flow without significant dysmenorrhoea or cyclical pelvic pain. Abdominal examination revealed a pelvic mass corresponding to approximately 20 weeks' gestation.

Transabdominal ultrasonography demonstrated a large cystic pelvic lesion with non-visualisation of the uterus. Contrast-enhanced computed tomography revealed a large haematometrocolpos causing compression of the urinary bladder and right ureter. The left kidney was absent, with associated right hydroureter and hydronephrosis, raising suspicion of HWWS.

Diagnostic laparoscopy with drainage of the obstructed left uterine compartment and resection of the obstructing longitudinal vaginal septum was performed. Intraoperative findings confirmed uterine didelphys with an enlarged left uterine horn and a small right uterine horn. The left hemivagina was obstructed by a longitudinal vaginal septum. The right fallopian tube and ovary appeared normal. The left fallopian tube was enlarged, consistent with haematosalpinx and the left ovary appeared enlarged. Adequate drainage of the obstructed compartment was achieved following septal resection.

Postoperative imaging demonstrated reduction of the hydroureter following decompression of the pelvic collection. Persistent enlargement of the left fallopian tube consistent with haematosalpinx was noted. In view of the patient's young age, absence of significant symptoms and the aim of preserving fertility, conservative management with close surveillance was planned, with salpingectomy reserved for future indications.

Discussion: HWWS results from abnormal development of the Müllerian and Wolffian ducts and may remain undiagnosed when classical symptoms are absent. Menstruation through the unobstructed hemivagina can result in apparently regular cycles, while subtle abnormalities such as scanty menstrual flow may be overlooked. Delayed diagnosis may lead to haematometrocolpos, endometriosis, tubal dilatation and pelvic adhesions.

Conclusion: HWWS should be considered in adolescents presenting with pelvic masses or urinary symptoms, even with regular menstruation. Accurate anatomical assessment and fertility-preserving management are essential to optimise long-term outcomes.

OP010. BEYOND THE HYPERCOAGULABLE STATE; A RARE CASE OF PROTEIN C DEFICIENCY IN PREGNANCY

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Objectives: Thrombophilia are rare conditions which affect pregnancy with significant maternal morbidity and mortality. Protein C deficiency (PCD) is one of the conditions which is inherited as autosomal dominant pattern caused by mutation takes place in PROC gene, which predisposes venous thromboembolism (VTE) via several mechanisms. Pregnancy is a hypercoagulable state, due to physiological changes in the maternal systems. Recurrent pregnancy loss, placental insufficiency, fetal growth restriction, stillbirth and maternal thrombotic events are well known adverse outcomes due to PCD. Early diagnosis, appropriate anticoagulation and multidisciplinary management are essential to have favorable maternal and fetal outcomes.

Case report: A 27-year-old Gravida 4, para 3 with one living child admitted on her 36 weeks of her fourth pregnancy for specialist antepartum and postpartum management of complications and known protein C deficiency. She had a complicated obstetric history with two neonatal deaths and third child diagnosed with PCD. Her marriage was non-consanguineous at the age of 16. She had her first child (16 years of age), second (17 years of age) and third (19 years of age while on intrauterine contraception device) as a full-term uncomplicated vaginal delivery; yet her infants developed purpureal rash on day 3, day 5 and day 13 respectively. The first neonate passed away at the age of 2 months due to undetected hematological condition and second passed away

at the age of 5 months due to cerebral venous thrombosis. The third child was subsequently diagnosed with PCD. This child is 5 years of age now and stable with regular Hematology clinic follow-up. A retrospective analysis and extensive evaluations done following second neonate death and diagnosis of maternal Protein C Deficiency was made. Her husband was identified as carrier. Her fourth pregnancy was unplanned despite oral contraceptive use and complicated through iron deficiency anemia requiring double-dose oral iron and Pregnancy induced hypertension at 35+6 weeks, controlled with oral antihypertensives. She was offered GDM screening with OGTT and serial growth scans. EFW was just above the 10th centile and Doppler studies were normal. An MDT including Hematologist, Anesthetists, Physician and Neonatologist along with obstetrics developed an individualized plan focusing on anticoagulant adjustment, timing and mode of delivery, neonatal care and future contraception options were too discussed. At MDT it is agreed upon vaginal delivery at term (37+ weeks) to minimize immobility and thrombotic risk. Next, permanent sterilization was agreed upon following counselling. Enoxaparin 40mg daily was continued until 12 hours prior to delivery, restarted postpartum at a reduced dose of 20mg daily and to increase 40mg daily from day two for six weeks. And planned to extract cord blood for PCD assessment and hematological investigations including APTT, D-Dimer, PT and fibrinogen.

Discussion and Conclusion: This case recognizes the substantial maternal and neonatal risks associated with PCD during pregnancy. To achieve favorable maternal and neonatal outcomes and minimizing obstetric and thrombotic complications, early recognition, close antenatal surveillance, individualized anticoagulation and multidisciplinary care are crucial.

OP011. BEYOND THE TUMOR MARKER: A CASE SERIES ON ENDOMETRIOMA WITH CA 125 LEVELS EXCEEDING 1000 IU/L MIMICKING OVARIAN MALIGNANCY

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Objectives: Serum Cancer Antigen 125(CA-125) is frequently elevated in endometriosis but has limited specificity for ovarian malignancy in premenopausal women. Although concentrations above 1000 IU/L commonly raise concerns for malignancy, markedly elevated values have been reported in histologically benign endometriomas. The elevation may be related to extensive disease, dense adhesions, cyst rupture and peritoneal inflammation. We describe three women managed at teaching hospital Jaffna with ovarian endometriomas and CA-125 levels exceeding 1000 IU/L

Case report:

Case 1 A 29-year-old mother of two children presented with abdominal pain, distension and dysmenorrhea for three months. CA-125 was initially above 1000 IU/L and 592 IU/L before surgery. Ultrasonography demonstrated a large ovarian cyst with septation in the pouch of Douglas. Bilateral cystectomy revealed unruptured endometriomas measuring 15×10cm on the left and 5×3cm on the right, with complete obliteration of the pouch of Douglas. Histology confirmed bilateral endometriomas

Case 2 A 35-year-old multiparous woman presented with abdominal pain and dysmenorrhea. CA-125 exceeded 1000IU/L. Imaging showed a 4×3cm thick-walled right ovarian cyst, omental stranding, indeterminate peritoneal deposits, raising suspicion of ovarian malignancy. Laparoscopy demonstrated a ruptured right endometrioma with brown material over the bowel, Omentum and uterus and endometriotic deposits over the pelvic wall and diaphragm. Histology confirmed endometrioma. Omental biopsy was normal. CA-125 declined to 78.2 IU/L after surgery.

Case 3 A 29-year-old nulliparous woman with fertility wish presented with abdominal pain and dysmenorrhea. CA-125 was 1193 IU/L. ultrasound and computed tomography demonstrated a 5×6cm left ovarian cyst without malignant features, likely endometrioma. Fertili-

ty-preserving cystectomy was performed and Histology confirmed endometrioma.

Discussion: These cases demonstrate that extreme CA-125 elevation is not synonymous with ovarian malignancy. In case 1, extensive bilateral disease and dense adhesions probably contributed to the elevation. In case 2, cyst rupture and peritoneal irritation explained the malignant appearing image findings. Case 3 showed disproportionate elevation despite apparently localized disease. Therefore, CA-125 should be interpreted alongside expert ultrasound morphology, cross sectional imaging and operative findings. Conservative surgery should be considered when imaging and intraoperative assessment do not support malignancy.

Conclusion: Markedly elevated CA-125 may occur in benign endometriomas. Irrespective of cyst size or rupture, Multimodal assessment is essential to avoid unnecessary radical surgery while ensuring appropriate oncological evaluation.

OP012. BIRTH PREFERENCES AMONG PRIMIGRAVIDA MOTHERS IN RATNAPURA

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Introduction: Caesarean section (CS) rates in Sri Lanka have increased substantially despite vaginal birth remaining the recommended mode of delivery for most low-risk pregnancies. Understanding delivery preferences among primigravida mothers and the factors influencing these preferences is essential to promote woman-centred maternity care and reduce unnecessary CS.

Objectives: To determine the preferred mode of delivery among primigravida mothers attending Teaching Hospital Ratnapura and to identify socio-demographic and obstetric factors associated with these preferences.

Design: Hospital-based descriptive cross-sectional study.

Method: A total of 392 primigravida mothers with pregnancies beyond 20 weeks of gestation attending antenatal clinics and obstetric wards at Teaching Hospital Ratnapura between May and November 2025 were recruited. Participants completed a pre-tested structured questionnaire assessing socio-demographic characteristics, obstetric factors, preferred mode of delivery and factors influencing their choice. Data were analysed using descriptive statistics and Chi-square tests. Statistical significance was set at $p<0.05$.

Results: Overall, 75% of participants preferred vaginal delivery, while 25% preferred CS. Maternal age, educational attainment and monthly household income were significantly associated with delivery preference ($p<0.001$). Although 65.3% of participants had received antenatal education, this was not significantly associated with their preferred mode of delivery ($p>0.05$). Similarly, family or partner influence, cultural or religious beliefs and financial considerations were not significantly associated with delivery preference. Most women preferred to make autonomous decisions regarding their mode of birth.

Conclusion: Three out of four primigravida mothers preferred vaginal birth despite Sri Lanka's high national CS rate. This suggests potential gaps in antenatal counselling and intra-partum care. Strengthening informed decision-making through interactive antenatal education, enhanced healthcare provider training and shared decision-making strategies may help align clinical practice with maternal preferences. These findings support the provision of woman-centered maternity care that respects women's choices and ensures balanced, evidence-based information throughout pregnancy, with the aim of reducing unnecessary Caesarean sections.

OP013. BLEEDING VAGINAL NODULE AS THE INITIAL PRESENTATION OF GESTATIONAL TROPHOBLASTIC NEOPLASIA: A CASE REPORT

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Objectives: Gestational trophoblastic neoplasia (GTN) includes invasive mole, chori-

ocarcinoma, placental site trophoblastic tumor and epithelioid trophoblastic tumor. It commonly follows a molar pregnancy, but it can occur after any pregnancy event. Serum beta human chorionic gonadotropin (β-HCG) is used for diagnosis, monitoring of treatment and follow-up. Vaginal metastasis is uncommon. They are highly vascular and biopsy may cause torrential bleeding. We report a woman who presented with a bleeding vaginal nodule was found to have high risk metastatic GTN.

Case report: A 44-year-old multiparous woman was admitted with acute vaginal bleeding. Examination showed a tender vaginal nodule with contact bleeding. Urine pregnancy test was positive and serum β-HCG was more than 450,000 IU/L. GTN with vaginal metastasis was suspected. Suction evacuation was conducted, resulting in uncontrolled hemorrhage. Considering the bleeding, invasive nature of the disease and completion of the family, a total abdominal hysterectomy with bilateral salpingectomy was performed.

Post operative serum β-HCG dropped to 8975 IU/L. The histology confirmed invasive hydatidiform mole. Contrast enhanced computed tomography showed vaginal deposit with multiple pulmonary nodules without brain metastasis. Her modified world health organization/International Federation of Gynecology and Obstetrics prognostic score was 11. She received multi agent chemotherapy. Her serum β-HCG was normalized after 6 cycles. The vaginal nodule disappeared and she remained disease free during 18 months of follow-up.

Discussion: This is an unusual presentation of GTN in a perimenopausal woman. A bleeding vaginal nodule with a positive pregnancy test should prompt an urgent quantification of serum β-HCG. Biopsy of a suspected vaginal metastasis is best avoided as bleeding can be difficult to control. Hysterectomy stopped the hemorrhage and reduced the tumor burden in our patient, but chemotherapy was still needed because of the lung and vaginal deposits. Her response to treatment reflects well known chemosensitivity of this tumor.

Conclusion: A bleeding vaginal nodule may be the first sign of metastatic GTN. Prompt serum β-HCG, avoidance of biopsy, proper staging, risk scoring and multiagent chemotherapy can achieve complete remission even in high-risk disease.

OP014. BOTULINUM TOXIN AS A NEWER TREATMENT MODALITY FOR VAGINISMUS: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Introduction: Vaginismus, classified within genito-pelvic pain/penetration disorder, is characterised by involuntary pelvic-floor contraction, penetration-related fear and avoidance. Conservative psychosexual and pelvic-floor interventions are conventionally used as treatments. Botulinum toxin type A (BoNT-A) has emerged as a targeted adjunct, but the comparative effectiveness remains uncertain.

Objectives: To evaluate the effectiveness and safety of BoNT-A injections and psychotherapeutic interventions, including cognitive behavioural therapy, sex therapy and multimodal psychological approaches, for the treatment of vaginismus.

Method: A systematic review and meta-analysis was conducted according to PRISMA 2020 and Cochrane guidance. MEDLINE/PubMed, Scopus, Web of Science, CENTRAL, Google Scholar, WHO ICTRP and ClinicalTrials.gov were searched up to 1 November 2025. The primary outcome was successful vaginal penetration after treatment. Secondary outcomes included pain, anxiety, Female Sexual Function Index (FSFI), treatment satisfaction, recurrence and adverse events. Risk of bias was assessed using RoB 2 and certainty of evidence using GRADE.

Results: Twelve studies involving 826 participants were included. Exposure-based and desensitisation interventions achieved the highest penetration-success rates, reaching 97.7%. Conventional CBT showed limited immediate intercourse success in one trial (14%) but improved broader sexual functioning. BoNT-A studies reported success rates of 75–100% in refractory cohorts. Across BoNT-A studies, the pooled random-effects success rate was 78.8% (95% CI 68.5–86.4%). However, the only direct comparative RCT favoured comprehensive physiotherapy over BoNT-A for

successful intercourse (92.9% vs 66.7%; P=0.014). For psychotherapy, the pooled odds ratio for successful penetration was 10.27 (95% CI 0.79–133.51; P=0.075), with substantial imprecision. Multimodal programmes combining BoNT-A, dilation and counselling also demonstrated high success rates. Evidence was limited by heterogeneity, small samples and risk of bias.

Conclusion: Psychotherapeutic and exposure-based interventions remain the preferred first-line management for vaginismus. BoNT-A provides a clinically relevant adjunct for selected women with severe or refractory disease, but current evidence does not establish superiority. Larger, standardised RCTs are required, particularly in low- and middle-income settings.

Keywords: Vaginismus; botulinum toxin; psychotherapy; cognitive behavioural therapy; genito-pelvic pain/penetration disorder; meta-analysis.

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OP015. BURDEN AND CASCADING EFFECTS OF HYPERTENSIVE DISORDERS OF PREGNANCY IN SRI LANKA

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Introduction: Hypertensive disorders in pregnancy (HDP) affect 2-8% of pregnancies globally and are a leading cause of maternal and perinatal mortality. HDP comprises a diverse spectrum of clinical conditions and feto-maternal complications.

Objectives: This study highlights the prevalence and impact of HDP and further examines their natural progression across subsequent pregnancies within a Sri Lankan cohort.

Design: A retrospective cohort study was conducted at three tertiary care hospitals in Sri Lanka to evaluate 1350 pregnancies, focusing on the antenatal, delivery and postpartum periods.

Method: Data were collected anonymously from discharged bed head tickets in postnatal obstetric wards using checklists. Past obstetric history was thoroughly reviewed to assess disease progression and recurrence. Gestational hypertension (GHT), chronic hypertension (CHT) and adverse outcomes were confirmed using written diagnoses. Quantitative data were analysed using chi-square tests for trend and analysis of variance (ANOVA), with a significance level set at 5%.

Results: The prevalence of GHT and CHT in multiparous women was 11.8% and 2.6%, respectively, while it was 10.2% and 2.5% in primiparous women. Among women with a previous history of GHT, 43.9% developed GHT again in the current pregnancy, while 3.0% went on to develop CHT. Among women with no prior HDP, the majority (89.9%) remained normotensive during the current pregnancy. However, 1.1% developed CHT and 8.9% developed GHT. Women with HDP have higher rates of concurrent obesity, gestational diabetes and heart disease with statistically significant differences compared to women without HDP. However, factors such as age, marital status, anaemia and hypothyroidism did not show strong associations with HDP in this cohort. Incidence of caesarean delivery, placental abruption and preterm delivery were statistically significant among women with HDP ($p = 0.001$). The occurrence of any adverse neonatal outcome was significantly higher in pregnancies complicated by hypertension, affecting 48% of GHT and 65.0% of CHT compared to 26.8% in normotensive women ($p = 0.001$). Low birth weight, low 5-minute Apgar score, need for respiratory support after birth and neonatal sepsis were notable adverse neonatal outcomes.

Conclusion: History of HDP in previous pregnancies is a strong predictor of hypertension during the index pregnancy. The overall burden of HDP is high, leading to a wide array of adverse feto-maternal outcomes. Early detection, continuous antenatal surveillance, optimum pharmacological therapy and timely

obstetric decision-making are the cornerstones of management. Holistic care ensures the less incidence of CHT and overall cardiovascular risk reduction.

Keywords: hypertension, pregnancy outcome

OP016. CAESAREAN SECTION RATES AND INDICATIONS: A ROBSON TEN-GROUP CLASSIFICATION AUDIT

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Introduction: Globally, the caesarean section (CS) rate has risen to 21.1% of all births and is projected to reach 28.5% by 2030. Sri Lanka has seen a steep rise, from around 9% in 1986 to 40.2% in 2022, raising concern over the over-medicalisation of childbirth. The WHO recommends the Robson Ten-Group Classification System (RTGCS) to monitor and benchmark institutional CS rates, yet facility-level Robson data from Sri Lankan secondary care hospitals remain scarce.

Objectives: To determine the CS rate, classify the caesarean cases by Robson group and analyse the contributing indications.

Design: A descriptive cross-sectional study using retrospective data.

Method: Data were collected from all women who delivered in one of the two obstetric units at NDGH between 1 August and 31 October 2025. Records were extracted from bed head tickets and the labour room register using a structured data extraction form. Caesarean cases were classified by Robson group and each group's relative contribution to the total CS pool was determined. Vaginal deliveries were not classified into Robson groups, so group-specific CS rates were not calculated. Analysis was performed in IBM SPSS Statistics version 23.

Results: Of 418 deliveries, the CS rate was 48.3% (202/418). Among caesareans, Robson Group 5 (previous CS, single cephalic, term) was the largest contributor at 47.5%, followed by Group 2 (nulliparous, single cephalic, term; induced or pre-labour CS) at 16.3% and Group 1 (nulliparous, single cephalic, term, spontaneous labour) at 10.4%. Groups 1, 2 and 5 together accounted for 74.2% of all caesareans. The leading indication was previous uterine scar (52.0%), followed by fetal distress (11.9%), meconium-stained liquor (8.9%), malpresentation (7.4%) and failed induction or unfavourable cervix (5.9%).

Conclusion: Nearly half of all deliveries were by CS, well above the 9–16% threshold beyond which population-level analyses have found no further reduction in maternal or neonatal mortality. The large share of Group 5 indicates that repeat caesareans are the dominant contributor to the CS pool, reflecting how each primary CS drives later repeat procedures. This suggests that reducing primary caesareans is the most promising route to lowering the overall rate at this institution, though group-specific rates would be needed to confirm where primary CS is most concentrated. Institutional Robson classification remains a useful tool for auditing obstetric practice and merits wider use in Sri Lankan maternity services.

Keywords: cesarean section; Robson classification; Sri Lanka; obstetric audit; primary cesarean prevention

OP017. CANDIDA COLONISATION AND ANTIFUNGAL SUSCEPTIBILITY IN NON-PREGNANT WOMEN WITH VAGINITIS

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Introduction: Vulvovaginal candidiasis is a common cause of vaginitis and vaginal discharge among women of reproductive age. Antifungal resistance complicates its management, particularly in resource limited settings such as Sri Lanka.

Objectives: To determine the rate of Candida species isolation, identify the isolated species, characterise their antifungal susceptibility pattern and assess risk factors for colonisation among patients presenting with vaginitis and vaginal discharge.

Design: Descriptive cross-sectional study.

Method: Patients presenting with vaginitis or vaginal discharge to the Gynaecology clinics

of a tertiary care hospital were recruited. An interviewer-administered questionnaire was used to collect demographic and behavioural risk-factors of the patients. High vaginal swabs were examined by wet-mount microscopy and cultured on Sabouraud Dextrose Agar (SDA). They were speciated on CHROMagar. Antifungal susceptibility was tested against nystatin, itraconazole, clotrimazole, fluconazole and miconazole. It was determined by disc diffusion method. Data were analysed with $p<0.05$ taken as significant.

Results: This is an interim analysis of an ongoing study. 41 non-pregnant participants have been recruited. Candida species were isolated in 29.3% (12/41). Candida albicans accounted for 83.3% (10/12) of the isolates and non-albicans yeasts represented 16.7% (2/12). Resistance was highest to itraconazole (66.7%) and miconazole (41.7%). Lowest resistance was shown by nystatin (16.7%). 58.3% (7/12) of isolates were resistant to two or more agents. Candida-positive women were significantly younger than Candida-negative women (mean age 35.4 vs 44.3 years, $p=0.022$). No other demographic or behavioural factor showed a significant association.

Conclusion: Candida colonisation was present in almost a third of non-pregnant women with vaginitis, predominantly due to C. albicans. Substantial resistance to itraconazole and miconazole was identified. Younger age was associated with a higher likelihood of Candida colonisation. Substantial itraconazole and miconazole resistance and the high proportion of isolates being resistant to two or more agents highlight the need for susceptibility-guided antifungal prescribing over empirical azole therapy. For resource limited environments like Sri Lanka, these results highlight the need for a stronger focus on lab-guided treatment. By combining reliable testing with continuous tracking of emerging resistance, we can shape better local treatment guidelines and use antifungals more responsibly.

OP018. CERVICAL CANCER SCREENING UPTAKE AND AWARENESS AMONG WOMEN AT BASE HOSPITAL ELPITIYA

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Introduction: Although cervical cancer is largely preventable through screening, it remains one of the leading cancers affecting Sri Lankan women. According to the World Health Organization (WHO) the Age-Standardized Incidence rate in Sri Lanka was 8.3 per 100,000 women. In 2019, 1194 new cases reported and 690 women die due to cervical cancer per year and majority detected in advanced stage.

Sri Lanka has a structured national cervical cancer screening programme that using cytology (Pap smear) targeting women aged 35–45 years. Although these services are provided free of charge, through well structured MOH and Well- Women clinics, only 24% of women of aged 30–49 years have ever undergone cervical cancer screening.

Objectives: To assess the uptake of cervical cancer screening and the level of awareness regarding the National Cervical Cancer Screening Programme among women aged over 30 years attending the Gynaecology Clinic at Base Hospital Elpitiya.

Design: A descriptive cross-sectional clinical audit.

Method: ology Data were collected from 100 women attending to Gynecology clinic, over 30 years, using an interviewer-administered questionnaire. The participants' was assessed with 3 questioner 1)cervical cancer screening history, 2) awareness of the National Cervical Cancer Screening Programme and 3) understanding of the importance of cervical screening related to cancer prevention.

Results: Among the 100 participants, only 19 women had previously undergone cervical cancer screening.

The age distribution of screened women was as follows:

30–40 years: 9/33women 40–50 years: 7/38women Over 50 years: 3/29women Overall, 67% of participants were aware of the National Cervical Cancer Screening Programme.

However only 32 women (47.8%) understood the importance of cervical cancer screening in preventing cervical cancer.

Conclusion: Audit data demonstrated that cervical cancer screening uptake among women attending Base Hospital Elpitiya remains suboptimal.

National Human Papillomavirus (HPV) vaccination programme was started Sri Lanka in 2017, targeting girls aged 10–11 years and was achieved about 70% vaccination coverage in 2020. WHO Cervical Cancer Elimination Strategy is aming to achieve 90% HPV vaccination coverage and 70% screening coverage by 2030.

Even though having awareness of the national screening programme, understanding of the importance of cervical cancer screening remains inadequate. Community-based health education, Enhanced counselling at the clinic level and opportunistic cervical cancer screening during routine gynaecological visits are the strategies to improve uptake.

OP019. COLPOTOMY FOR SPECIMEN RETRIEVAL IN LAPAROSCOPIC MYOMECTOMY: CASE SERIES IN A LOW RESOURCE SETTING

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Introduction: Laparoscopic myomectomy is the preferred approach for women with symptomatic fibroids who desire future fertility. However, specimen retrieval remains a significant challenge in low resource settings where morcellators and specimen retrieval endo bags are unavailable. Posterior colpotomy offers a minimally invasive alternative for extraction of fibroids while avoiding laparotomy. There is limited evidence in colpotomy for specimen retrieval.

Objectives: To evaluate the feasibility, safety, surgical outcomes and reproductive outcomes of laparoscopic myomectomy followed by posterior colpotomy for specimen retrieval in the absence of a morcellator and specimen retrieval endo bag.

Design: Retrospective case series.

Method: Study participants were women undergoing laparoscopic myomectomy with posterior colpotomy for fibroid retrieval at Teaching Hospital Ratnapura. Specimens were extracted through posterior colpotomy in the absence of morcellator and specimen retrieval endo bags through using locally modified techniques. Demographic characteristics, fibroid size and number, operative duration, perioperative complications, conversion to laparotomy, duration of hospital stay and subsequent fertility outcomes were analysed.

Results: In the case series which was conducted, 13 cases were operated during this period. Median surgery duration was 90 minutes (IQR: 60 - 120 minutes.) There were no intraoperative or postoperative complications recorded in the cases. Cases were cumulatively followed up to 9 years. Overall conception rate of those with fertility wishes was 43%. In the first 3 cases, median surgery duration was 110 minutes (IQR: 90-120 minutes) and in the last 3 cases, median surgery duration was 60 minutes (IQR: 60-120 minutes)

Conclusion: In low resource settings where morcellators and specimen retrieval endo bags are unavailable, the lack of an effective tissue extraction method often limits the use of laparoscopic myomectomy, favouring conventional laparotomy. This case series demonstrates that posterior colpotomy is a feasible, safe and cost-effective technique for specimen retrieval following laparoscopic myomectomy and tilts the balance in favor of laparoscopic myomectomy. It preserves the benefits of minimally invasive surgery despite the absence of morcellators and specimen retrieval bags and provides superior cosmetic outcomes by avoiding extension of abdominal incisions. Furthermore, encouraging reproductive outcomes were observed, with a conception rate of 43% among women with fertility wishes. These findings support posterior colpotomy as a practical and effective specimen retrieval technique that facilitates laparoscopic myomectomy in resource limited settings while maintaining favourable surgical and fertility outcomes.

OP020. COMPARATIVE OUTCOMES OF REPEAT PROSTAGLANDIN E2 VERSUS FOLEY CATHETER INDUCTION

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Introduction: Induction of labour (IOL) is a medical procedure used to initiate uterine contractions before spontaneous labour when the benefits outweigh the risks. Following failed initial induction with vaginal prostaglandin E2 (PGE2), both repeat PGE2 and Foley catheter balloon are used as second line methods, but evidence comparing these strategies remains limited.

Objectives: To describe the clinical course, maternal experience and clinical outcomes associated with a second cycle of PGE2 induction compared with Foley catheter balloon induction among women with a persistent unfavourable cervix following initial vaginal PGE2 induction.

Design: A descriptive cross-sectional study comparing two second line induction methods.

Method: The study was carried out at the Professorial Obstetrics and Gynaecology Unit, De Soysa Hospital for Women, Colombo. Using consecutive sampling, 210 pregnant women with a persistent unfavourable cervix (Bishop score ≤6) after an initial cycle of vaginal PGE2 induction were enrolled. Participants subsequently underwent either a second PGE2 induction cycle or Foley catheter balloon induction, per routine clinical practice. Data on socio demographic characteristics, induction process, maternal satisfaction, maternal outcomes and early neonatal outcomes were collected using a pre tested structured questionnaire and hospital records and analyzed using SPSS version 26.

Results: With a 95.5% response rate, repeat PGE2 showed better labour dynamics than Foley catheter induction, with a significantly shorter induction to delivery interval (17.98±4.79 vs 24.34±5.58 hours; $p<0.001$), higher progression into labour (68.2% vs 53.8%; $p=0.038$) and lower oxytocin requirement (40.2% vs 66.7%; $p<0.001$). Favourable Bishop score achievement and caesarean section rates were similar between groups. Maternal adverse outcomes, mean APGAR scores and neonatal antibiotic use were comparable, although low 5-minute APGAR was more frequent with repeat PGE2. Maternal satisfaction, assessed using the Childbirth Experience Questionnaire (CEQ) and Visual Analogue Scale (VAS), was similar between groups.

Conclusion: Compared with Foley catheter induction, repeat PGE2 induction was associated with a shorter induction to delivery interval and lower requirement for oxytocin augmentation. No significant differences were observed in caesarean section rate, uterine hyperstimulation, maternal satisfaction, or early neonatal outcomes. Repeat PGE_2 may be a preferable second-line option in women with a persistent unfavourable cervix following PGE_2 IOL. However, further randomised studies are needed.

OP021. COMPARATIVE STUDY ON BLOOD PRESSURE CHANGES IN PREGNANCY BY PRE-ECLAMPSIA RISK STATUS

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Introduction: Hypertensive disorders of pregnancy (HDP) are a leading cause of maternal and perinatal morbidity and mortality throughout the world. Among HDPs, preeclampsia stands out as the most dangerous condition, affecting approximately one in twenty-five pregnancies globally. During the course of normal pregnancy, blood pressure (BP) undergoes characteristic physiological changes. However, whether these adaptations differ in pregnant women with increased risk of preeclampsia is not well established.

Objectives: To compare changes in systolic and diastolic BP in the first (T1) and second (T2) trimesters among pregnant women with increased risk and without increased risk of preeclampsia.

Design: This was a comparative cross-sectional study conducted to compare BP between pregnant women with and without increased risk of preeclampsia.

Method: The study included 24 pregnant women with at least one high-risk factor for preeclampsia and 29 age and period-of-gestation (POG) matched pregnant women without risk factors for preeclampsia. BP recorded at the booking visit was taken as the BP in T1. BP was measured in duplicate in T2. Comparisons between groups were performed using the Mann-Whitney U test. The significance level was set at $\alpha < 0.05$ and data are presented as median (interquartile range) and percentages.

Results: Women with increased risk of preeclampsia and without increased risk were matched for age [31(6) vs 30(7) years, p=0.149], POG in T1 [7(1) vs 7(1) weeks, p=0.458] and POG in T2 [17(1) vs 17(1) weeks, p=0.578]. Majority (88%) of the risk group consisted of pregnant women with pre-pregnancy BMI >30kg/m2 and only 13% (n=3) had chronic hypertension. Systolic BP(SBP) and Diastolic BP(DBP) in both trimesters were significantly higher in pregnant women with increased risk of preeclampsia compared with pregnant women without increased risk (T1 SBP: 118(18) vs 103(10) mmHg, p=0.001; DBP: 78(10) vs 68(8) mmHg, p=0.001; T2 SBP: 115(16) vs 98(16) mmHg, p<0.001; DBP: 77(9) vs 68(10) mmHg, p<0.001). There was no statistically significant difference between groups for the change in BP from T1 to T2 (p > 0.050 for SBP and DBP).

Conclusion: Despite having BPs within the normotensive range, BP is higher during early pregnancy in women with increased risk of preeclampsia compared to women without increased risk of preeclampsia. These findings suggest that cardiovascular alterations are likely present even in early pregnancy in women with increased risk of preeclampsia and highlight the importance of identifying risk group-specific BP cut-off values in pregnancy to decide on early interventions.

OP022. COMPLIANCE WITH NATIONAL STANDARDS FOR TIMELY COMPLETION OF ANTENATAL BOOKING INVESTIGATIONS: A CLINICAL AUDIT

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Introduction: Early completion of booking investigations enables management. The National Maternal and Newborn Strategic Plan of Sri Lanka (2017–2025) recommends antenatal syphilis screening before 12 weeks at 99%, anaemia screening before 12 weeks at 98%, and hyperglycaemia screening before 12 weeks at 95%.

Objectives: To assess completion of syphilis, anaemia and hyperglycaemia screening among pregnant women attending the antenatal clinic at 12 weeks of period of amenorrhoea (POA) and compare completion.

Design and Methods: A descriptive clinical audit was conducted among 92 consecutive pregnant women attending the antenatal clinic at 12 weeks of POA. Completion of VDRL, full blood count (FBC) or Haemoglobin level and post-prandial blood sugar (PPBS) was assessed using a structured data collection form. Investigations were classified according to whether reports were obtained from Medical Officer of Health (MOH)/government laboratories or private laboratories. Investigations without an available report at 12 weeks were considered incomplete. Targets were used as benchmarks, recognizing that they represent population-level antenatal coverage and are not directly comparable with completion among women attending a hospital clinic at 12 weeks.

Results: Among 92 women, VDRL was completed in 29 (31.5%), including 26 (28.3%) through MOH laboratories and 3 (3.3%) through private laboratories; 63 (68.5%) were incomplete. FBC or Haemoglobin level was available in 52 (56.5%), including 16 through MOH laboratories and 36 through private laboratories; 40 (43.4%) were incomplete. PPBS had the highest completion, with 62 (67.4%) completed, including 12 (13.0%) through MOH laboratories and 50 (54.3%) through

private laboratories; 30 (32.6%) were incomplete. All completion proportions were below the corresponding targets.

Conclusion: Completion of booking investigations among women attending the clinic at 12 weeks was substantially below the targets, particularly for syphilis screening. Private laboratory use requires further investigation and does not establish limitations in government laboratory services. The re-audit should assess laboratory choice and evaluate interventions and service delivery.

Limitations and Ethical Considerations: The study limits generalizability. Women initiating antenatal care after 12 weeks were not represented; therefore, the clinic population does not reflect population-level antenatal coverage, and comparison with targets should be interpreted cautiously. The audit used clinical information available. Ethics approval was obtained from the Ethics committee of National Hospital, Kandy.

OP023. CONGENITAL ANOMALY PREVALENCE AND ANTENATAL DETECTION ACROSS MATERNAL AGE IN NICU ADMISSIONS

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Introduction: Congenital anomalies account for a major part of neonatal deaths and advanced maternal age has been recognized as an important risk factor. Local evidence regarding antenatal detection effectiveness is lacking. This study provides a description of congenital anomalies among patients admitted to a tertiary NICU and evaluates the antenatal detection by maternal age.

Objectives: Among patients admitted to a tertiary NICU, this study intended to assess the prevalence of congenital anomalies, the proportion who required genetic testing and the in-hospital mortality rate; and to measure the antenatal detection rate of congenital anomalies and compare it between advanced maternal age (AMA; ≥35 years) and younger mothers.

Design: A retrospective descriptive study.

Method: Data regarding all new cases admitted to the NICU in 2025 at Teaching Hospital Peradeniya were collected through bed-head tickets from the Medical Records Unit by applying the investigator-designed data collection tool. Information collected were of maternal age, antenatal suspicion of structural anomalies, congenital malformation/phenotype, indication for genetic testing and discharge status. Congenital abnormality involved isolated structural abnormalities, suspected syndromic presentation and confirmed genetic disorders. Relationship was tested using the Chi-square/Fisher's Exact test (Jamovi v2.3). Significant value was $p<0.05$. Administrative clearance for data collection was obtained from the Director, Teaching Hospital Peradeniya.

Results: Among 478 NICU admissions in 2025, 132 (27.6%) were found to have congenital anomalies – isolated structural malformations in 37 (7.7%), suspected syndromic conditions in 79 (16.5%) and confirmed genetic diagnosis in 16 (3.3%). Genetic testing was indicated for chromosomal abnormalities in 20 (15.2%) patients with anomaly. In-hospital mortality was higher in patients with anomaly (14.4%, 19/132) compared to those without (3.5%, 12/344; odds ratio (OR) 4.65, $p<0.0001$). In the cohort of 409 admissions where maternal age was known, prevalence of anomalies was numerically greater in AMA mothers (32.3%, 32/99) compared to younger women (25.8%, 80/310; OR 1.37, $p=0.26$). Antenatal suspicion was noted in 33 of 132 (25.0%) anomaly cases. In the group of 108 anomaly cases with known maternal age and antenatal suspicion data, antenatal detection was less frequent in older mothers (20.0%, 6/30) than in younger mothers (32.1%, 25/78; OR 0.53, $p=0.24$).

Conclusion: This NICU cohort showed a substantial burden of congenital anomalies, with associated in-hospital mortality considerably higher than among unaffected infants. Both anomaly prevalence and antenatal detection varied by maternal age, with detection somewhat lower among older mothers despite higher prevalence. These findings offer local baseline data that may help inform future antenatal screening practices.

OP024. INITIAL PRESENTATION OF JUVENILE GRANULOSA CELL TUMOUR AS ACUTE ABDOMEN: A CASE REPORT OF A CHILD WITH PRIOR ISOSEXUAL PRECOCIOUS PUBERTY

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Background: Ovarian granulosa cell tumour is an ovarian sex cord-stromal tumour. It has a prevalence of 2%–5% of ovarian tumours. There are two distinct histological subtypes: the adult subtype (95%) and the juvenile subtype (5%). Usually, granulosa cell tumour arises prior to puberty and its endocrine function causes isosexual precocious puberty.

Case report: An 8-year-old girl presented to the emergency department with a one-day history of acute abdominal pain. She had a background history of isosexual precocious puberty at age 5 years, which had not been previously investigated. Urgent ultrasonography was done and she was found to have a large bilocular ovarian cyst on the left side, without evidence of torsion or haemorrhage. Subsequent CECT revealed a large pelvic soft tissue lesion extending up to the epigastrium with an enlarged uterus, raising suspicion of dysgerminoma. Later, CECT-guided aspiration was done.

Following the cyst aspirate, which was negative for malignant cells, laparotomy was performed, which revealed a large mass (approximately 25 × 30 × 20 cm) arising from the right ovary and fallopian tube, with otherwise normal pelvic organs. Histopathology confirmed juvenile granulosa cell tumour. Immunohistochemistry showed cytokeratin 7 and 20 negativity, strong CD99 positivity, with inconclusive PLAP and CD117 staining. The post-operative period was uneventful and she was planned for follow-up with annual inhibin-A, estradiol and USS.

Discussion and Conclusion: This case highlights the importance of early suspicion of ovarian pathology in precocious puberty; otherwise, it may result in ovarian cyst accidents. The initial imaging findings pointed towards a diagnosis of dysgerminoma due to the size and presentation. When analysing the initial immunohistochemical panel, CD99 positivity with inconclusive PLAP and CD117 did not definitively exclude dysgerminoma. However, elevated inhibin levels are suggestive of a sex cord tumour, as inhibin is one of the most sensitive and specific markers for granulosa cell tumours. Calretinin and FOXL2 would have strengthened histological confirmation, as well as helped distinguish the adult from the juvenile subtype. Long-term surveillance with tumour markers and USS remains important, though the risk of recurrence is low.

OP025. DIFFUSE UTERINE LEIOMYOMATOSIS: AN UNEXPECTED INTRAOPERATIVE DILEMMA IN SECONDARY SUBFERTILITY

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Objectives: To present a rare case of diffuse uterine leiomyomatosis discovered during a routine myomectomy for secondary subfertility and focusing on the intraoperative strategies used to reconstruct the uterus and protect the patient's fertility.

Case report: A 29-year-old multiparous lady with a 10-year-old child presented with history of regular, heavy menstrual bleeding and secondary subfertility for 5 years. On examination, she had a bulky, irregular uterus with the size of 10-week size gravid uterus. Two fibroids in size10×8 cm on the posterior wall and a 3×4 cm one on the anterior wall was identified through transvaginal ultrasound scan. With the aim of restoring her fertility and controlling the bleeding, she was planned for an elective abdominal myomectomy.

However, once the surgery was performing, beyond the two known fibroids, the entire myometrial wall was completely packed with hundreds of tiny, poorly defined, merging leiomyomas. Because the patient strongly wants to preserve her fertility, removing every single nodule was impossible and would have destroyed the uterus. Instead, maximum debulking of the largest masses was performed to safely reduce the uterine volume. The endometrial cavity was carefully repaired and an intrauterine Foley catheter was inserted as a tamponade to prevent severe bleeding. She re-

covered smoothly and the histology confirmed a rare diagnosis of diffuse uterine leiomyomatosis.

Discussion: Diffuse uterine leiomyomatosis is an incredibly rare, benign condition where the normal muscle layer of the uterus is entirely crowded out by endless tiny fibroids. Diagnosing it before surgery is bit difficult and standard ultrasound scan will appear as multiple fibroids or adenomyosis. When encountered in a young patient who still wants children, it creates a massive surgical challenge. A hysterectomy is out of the management, yet over-aggressive cutting can leave the uterus too weak to carry a pregnancy. This case demonstrates that the best approach is to adapt mid-surgery focusing on reducing the overall mass, carefully reconstructing the endometrium and using a mechanical tamponade to protect the uterus for future pregnancies.

Conclusion: Diffuse uterine leiomyomatosis is a rare cause of subfertility that easily mimics routine fibroids on a scan. Surgical teams must remain flexible, shifting their goals from complete removal to smart tissue debulking and proper repair to safeguard a woman's chance at future conception.

Keywords: Diffuse uterine leiomyomatosis, Secondary subfertility, Heavy menstrual bleeding, Uterine reconstruction, Fertility preservation.

OP026. DYSMENORRHEA: KNOWLEDGE, ATTITUDES AND COPING STRATEGIES AMONG COLOMBO UNIVERSITY FEMALE ATHLETES

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Introduction: Dysmenorrhea is a common but often neglected problem among female athletes. This leads to poor coping practices, reduced performance and psychological distress to the athletes. In Sri Lanka, cultural taboos regarding menstruation influence their menstrual health behaviours leading to additional complexity. Female athletes at the University of Colombo represent a distinct group as they have to balance their academic work alongside with sports. Even though female participation in sports is rapidly growing, there is little knowledge about the athletes' understanding regarding their menstrual health and their coping strategies.

Objectives: Our study assessed the levels of knowledge and attitudes regarding menstrual pain among female athletes at the University of Colombo. It also aims to identify different coping strategies used and factors which influence their usage such as individual sociodemographic characteristics, familial support structures, academic environment and sport specific variables.

Design: We conducted a descriptive cross-sectional study to evaluate menstrual health awareness and coping behaviours among female university athletes.

Method: Total of 118 female athletes aged 20–28 years representing different sports participated in our study. Participants completed a validated self-administered questionnaire which was based on Working ability, Location, Intensity, Days of pain and Dysmenorrhea (WaLIDD) criteria. We assessed Knowledge and attitude scores using Likert-scale scoring systems. Coping strategies were categorized as pharmacological, non-pharmacological, combined, or none. Statistical Package for the Social Sciences (SPSS) was used to analyse data. Associations between categorical variables were assessed using Chi-square or Fisher's exact tests, while independent sample t-tests and Pearson's correlation were used for continuous variables. $p<0.05$ was considered as statistically significant.

Results: The mean age of participants was 22.5 years (SD=1.4). Moderate-to-severe menstrual pain was reported by 76.7% (n=89). Combined pharmacological and non-pharmacological coping strategies were used by 41.4% (n=48). Participants utilizing coping strategies demonstrated significantly higher knowledge scores ($p=0.011$) and more positive attitudes ($p<0.001$). A weak but significant positive correlation was observed between knowledge and attitude scores ($r=0.203$, $p=0.03$).

Conclusion: Higher knowledge and positive attitudes were significantly associated with better coping practices. Therefore, improving

menstrual health literacy and positive attitudes may improve health seeking behaviour and pain management in this population. Further, conducting multi-centred studies across universities or regions to assess cultural, institutional, or regional variations in menstrual health knowledge, attitudes and coping strategies is needed to increase generalizability.

Keywords: Dysmenorrhea, University athletes, Knowledge, Attitudes, Coping strategies

OP027. ECHOCARDIOGRAPHY UNVEILS POSTPARTUM DENGUE SHOCK: A CASE REPORT ON TIMELY DIAGNOSIS

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Objectives: Dengue infection can be asymptomatic or manifest with dengue fever, dengue hemorrhagic fever (DHF) or dengue shock syndrome (DSS). Dengue shock has a rapid onset over a short time span and could be due to leaking, bleeding or both. The physiological changes in the puparium can mask or mimic the clinical manifestations of dengue, thus the diagnosis and fluid management becomes challenging.

Case report: A 22 year old postpartum mother admitted with a history of one day fever on postpartum day 26 following her second delivery. She was previously healthy, had an uncomplicated perinatal period and delivered a baby girl at term via an Elective Lower Segment Cesarean Section(LSCS). The postpartum period was otherwise uneventful. On admission she had a high-grade fever (1030F), severe arthralgia and headache. She was normotensive but had tachycardia. Initial investigations were normal and Dengue NS1 antigen done on day 2 of illness was positive.

While in the ward, a rapid drop in platelet count was noted (105,000 to 45,000) with a rise in hematocrit (38.5% to 40.1%) where DHF was suspected. However, the ultrasound scan did not show evidence of leaking. Cardiac assessment was considered due to persistent tachycardia. The 2D Echocardiogram showed preserved left ventricular function with impaired Right ventricular (RV) function (TAPSE 1.2) and a thin rim of pericardial effusion along with a left sided pleural effusion. Inferior Vena Cava (IVC) was collapsed with poor respiratory variation (0.9cm).

Urgent fluid resuscitation was done and due to the dropping hematocrit, a blood transfusion was done with close monitoring in the Intensive Care unit. The scan was repeated and confirmed of pericholecystic fluid, mild ascites at hepatorenal pouch and pelvis with bilateral pleural effusions. Mild elevation of liver enzymes was noted. Following the critical phase management the patient became stable and the repeat echocardiogram showed improved RV function with resolving pericardial and pleural effusions.

Discussion: The massive fluid shifts in puparium, blood loss and platelet changes can mask the assessment of clinical parameters eventually hiding the evidence of plasma leakage and/or bleeding. In such circumstances, 2D echocardiography can be aided in early diagnosis of Dengue shock syndrome in addition to the routine diagnostic workup to avoid delays in detection.

Conclusion: Bedside Point of Care Echocardiography with measurement of IVC dimensions can be used as a guide to assess the fluid status in dengue patients for early detection of complications.

OP028. EXPLORATORY FACTOR STRUCTURE AND INTERNAL CONSISTENCY OF THE SINHALA-ADAPTED WIJMA DELIVERY EXPECTANCY/EXPERIENCE QUESTIONNAIRE (W-DEQ-A-S)

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Introduction: Fear of childbirth (FOC) is a common and significant concern during pregnancy and is associated with adverse psychological outcomes. It is one of the main causes for increased requests for caesarean delivery in the absence of an indication. The Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ-A) is the most widely used instru-

ment internationally for measuring FOC. It has not been validated after being translated to Sinhalese for use in Sri Lankan clinical or research settings.

Objectives: To determine the underlying factor structure and internal consistency of a Sinhala-adapted version of the W-DEQ-A (W-DEQ-A-S) among pregnant women in Sri Lanka.

Design: Cross-sectional, instrument-validation study.

Method: Following translation and cultural adaptation, the 33-item W-DEQ-A-S was administered to 303 pregnant women beyond 34 weeks of gestation, attending the antenatal clinic of a tertiary referral hospital. Exploratory factor analysis (Principal Component Analysis with Promax oblique rotation) was performed to examine dimensionality. Cronbach's alpha and McDonald's omega were used to assess the internal consistency of the extracted factors.

Results: Sampling adequacy was confirmed using the KMO test (KMO = 0.805; Bartlett's test of sphericity, $\chi^2 = 5738.18$, df = 528, $p < 0.001$). Six items had to be removed from the original questionnaire as two failed to load on any factor and four had significant cross-loading across factors. This left 27 of the original 33 items. Six factors were isolated, which accounted for 61.69% of total variance. The factors were lack of self-efficacy (5 items), negative appraisal (7 items), fear (4 items), concerns about the delivery and losing control (5 items), loneliness (3 items) and lack of security and support (3 items). Internal consistency was good for lack of self-efficacy ($\alpha = 0.816$, $\omega = 0.869$), negative appraisal ($\alpha = 0.784$, $\omega = 0.880$), fear ($\alpha = 0.811$, $\omega = 0.870$) and loneliness ($\alpha = 0.784$, $\omega = 0.812$). The concerns about the delivery and losing control factors showed acceptable to good consistency ($\alpha = 0.705$, $\omega = 0.795$). However, the lack of security and support factor showed the weakest internal consistency with a marginally acceptable fit. ($\alpha = 0.662$, $\omega = 0.671$).

Conclusion: The W-DEQ-A-S demonstrates a clear, interpretable six-factor structure consistent with international evidence for the multidimensionality of fear of childbirth. The internal consistency was acceptable across the isolated factors, with 5 of the 6 factors showing a very good fit. These findings support the early psychometric promise of the W-DEQ-A-S as a culturally appropriate tool for assessing fear of childbirth among Sinhala-speaking women.

Keywords: Fear of childbirth; W-DEQ-A; validation; exploratory factor analysis; Sri Lanka

OP029. FEASIBILITY AND OUTCOMES OF VAGINAL MORCELLATION FOR SPECIMEN EXTRACTION IN LAPAROSCOPIC HYSTERECTOMY

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Introduction: Laparoscopic hysterectomy is increasingly preferred by patients over abdominal hysterectomy as there is reduced blood loss, shorter hospital stay and faster recovery. However, specimen extraction through the small incision remains a challenge. Morcellation of the specimen is usually necessary when large uteri need extraction. While power morcellation has raised safety concerns regarding tissue dissemination, manual vaginal morcellation can be considered as a potentially safer alternative. However, data on its feasibility and outcomes are limited.

Objectives: The objective of the study was to evaluate the feasibility, safety and surgical outcomes of manual vaginal morcellation for specimen extraction during laparoscopic hysterectomy and to assess the impact of uterine size on operative outcomes.

Design: Retrospective observational study

Method: The study was carried out at a tertiary care gynaecological center. A total of 364 patients who underwent laparoscopic hysterectomy with attempted manual vaginal morcellation in between January 2021 and December 2025 were included in the study. Patients who did not prefer vaginal morcellation and patients who had an unfavorable vaginal anatomy for the procedure were excluded from the study. Manual vaginal morcellation was carried out for specimen extraction in all eligible patients who underwent laparoscopic hysterectomy.

Results: Vaginal morcellation was successfully performed in all 364 cases. The mean uterine weight was 305.2 ± 137.6 g and the mean time taken for surgery was 48.9 ± 22.4 minutes. A weak but statistically significant positive correlation was seen between uterine weight and operative time. The complications were minimal and they were limited to minor events. No major intraoperative and postoperative complications were reported.

Conclusion: Manual vaginal morcellation is a feasible and safe technique for specimen extraction during laparoscopic hysterectomy. As uteri of large sizes were successfully retrieved, the size should not be considered a contraindication in patients even when they undergo minimally invasive gynaecological surgery.

OP030. IMPROVING TIMELY INITIATION OF BREASTFEEDING WITHIN THE FIRST HOUR: A COMPLETE CLINICAL AUDIT CYCLE AT DISTRICT BASE HOSPITAL DICKOYA IN SRI LANKA

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Introduction: Initiating breastfeeding within the first hour after birth is an important part of essential newborn care, with benefits for neonatal survival, establishment of breastfeeding, and early mother–infant bonding. Although the World Health Organization (WHO) recommends breastfeeding within this first hour, maintaining consistent practice can be challenging in busy maternity settings in Sri Lanka. We undertook this audit to identify gaps in our practice and determine whether practical changes within the existing service could improve timely breastfeeding initiation.

Objectives: To assess compliance with the WHO recommendation for initiation of breastfeeding within one hour after birth and to evaluate whether a targeted quality improvement programme could achieve the predefined audit standard of ≥90%.

Design: Prospective complete clinical audit cycle.

Method: The initial audit was conducted at District Base Hospital Dickoya from December 2025 to February 2026, followed by a re-audit from April to June 2026. Eligible live-born infants were included. Home deliveries, vehicle deliveries and infants requiring immediate admission to the Special Care Baby Unit were excluded. Following the initial audit, several practical interventions were introduced to address identified gaps. These included staff education, a standardized golden-hour breastfeeding protocol, labour room checklists and reminders, promotion of immediate skin-to-skin contact, modifications to the theatre recovery pathway and regular multidisciplinary feedback. The primary outcome was initiation of breastfeeding within one hour after birth.

Results: A total of 764 eligible mother–infant pairs were analysed: 389 during the initial audit and 375 during the re-audit. The proportion initiating breastfeeding within one hour increased significantly from 78.1% (304/389) to 91.7% (344/375). This was an absolute improvement of 13.6 percentage points, with timely initiation being 17% more likely during the re-audit period. Improvements were also seen in immediate skin-to-skin contact (82.6% to 94.8%), breastfeeding assistance (76.6% to 89.5%) and documentation of breastfeeding initiation (48.6% to 98.3%). Timely initiation was highest following vaginal birth (86.8%) and lowest following emergency Caesarean section (69.1%). Staff shortages, neonatal observation and delays related to theatre recovery were the main barriers identified during the initial audit.

Conclusion: A focused programme of practical changes within routine maternity care improved timely initiation of breastfeeding and enabled the unit to achieve its predefined audit standard. Improvements were also seen in skin-to-skin contact, breastfeeding support and documentation. This audit shows that staff engagement, clear protocols and regular feedback can lead to meaningful improvements without relying on complex interventions, offering a practical approach that could be adapted by other maternity units in Sri Lanka.

OP031. INDEPENDENT PREDICTORS OF LOW BIRTH WEIGHT IN HYPERTENSIVE DISORDERS OF PREGNANCY

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Introduction: Globally, low birth weight (LBW, < 2500g) is characterized as a significant determinant of newborn morbidity and mortality. According to global evidence LBW is more prevalent among pregnancies complicated with hypertensive disorders of pregnancy (HDP). Therefore, identifying its independent predictors is vital for planning appropriate care from antenatal period.

Objectives: To identify the independent predictors of LBW among neonates born to mothers with HDP at Teaching Hospital Peradeniya (THP) Sri Lanka.

Design: Cross-sectional analytical study.

Method: A study was conducted from January 2016 to April 2019 among 302 pregnant mothers with HDP at gestation age ≥ 30 weeks at THP. The sample was selected using consecutive sampling method. Data collected using a validated structured interviewer administered questionnaire (IAQ), clinical records and performing a brief physical examination to obtain blood pressure measurement at seated position and data analysis performed using SPSS 27.0. The IAQ consisted with socio-demographic characteristics, obstetric history, antenatal complications, clinical measurement and neonatal outcomes. The prevalences determined using descriptive statistics while the associations assessed using fisher's exact test due to small, expected cell counts ($p \leq 0.05$). The variables achieving $p<0.20$ in the univariate analysis were included into multivariable logistic regression model to identify the independent predictors of LBW ($p \leq 0.05$). Adjusted odd ratios (aOR) with 95% confidence intervals (CI) were used to report the findings of multivariable logistic regression. Ethical clearance obtained from Ethics Review Committee, Faculty of Medicine, University of Peradeniya (2015/EC/69).

Results: 39.1% (n=93) neonates reported as LBW. Statistically significant associations were found between LBW and intrauterine growth restriction (IUGR) (p=0.04) and maternal body mass index (BMI) (p=0.026). On multivariable analysis, IUGR emerged as the strongest independent predictor of LBW (aOR=10.26, 95% CI: 2.47-42.58, p=0.001). Higher BMI category (aOR=0.66, 95% CI: 0.46-0.93, p=0.017), family history of diabetes mellitus (aOR=0.32, 95% CI: 0.16-0.66, p=0.002) and severe pregnancy-induced hypertension / hypertensive crisis (aOR=0.27, 95% CI: 0.08-0.98, p=0.046) showed statistically significant protective associations.

Conclusion: The strongest independent predictor of LBW in this population was IUGR and it is highlighting the clinical significance of regular fetal growth surveillance. The observed protective associations may be due to optimized care received to those subgroups in this population during their antenatal period. Therefore, in all HDP complicated pregnancies regular fetal growth surveillance is essential to early IUGR detection and initiate appropriate care to reduce LBW burden among neonates.

Keywords: Hypertensive disorders, low birth weight, intra-uterine growth restriction

OP032. NEONATAL SURVIVAL GAPS AND INTERNATIONAL VIABILITY LIMITS AT TEACHING HOSPITAL RATNAPURA

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Introduction: Neonatal survival rates serves as a key indicators of maternal and newborn care quality. The World Health Organization (WHO) defines the threshold of clinical viability at 22 weeks of gestation. Yet, clinical out-

comes within the periviable window (22 to 24 weeks) remain highly variable, depending on advanced intensive care technology and specialized multidisciplinary teams. This dependency creates a survival disparity between high-resource and low-resource healthcare settings. Sri Lanka has successfully reduced its national neonatal mortality rate over recent decades. Despite this progress, individual clinical outcomes remain highly dependent on gestational age at birth and regional tertiary resource capacity.

Objectives: To determine survival outcomes among neonates at THR from January 2023 to December 2024, and to evaluate the relationship between period of gestation (POA) and both survival rate and Neonatal Intensive Care Unit (NICU) admission rate.

Design: Analytical cross-sectional study.

Methods: The study included all live births at THR, and neonates transferred from other hospitals, between January 2023 and December 2024. Neonates transferred out for further management and not returned were excluded. Data were collected from the Labour Room birth register and Bed Head Tickets from the NICU, Emergency Treatment Unit, and antenatal wards. Ethical approval was obtained from the Ethics Review Committee, Faculty of Medicine, Sabaragamuwa University of Sri Lanka. Data were analyzed using IBM SPSS software, using frequency distributions and the relationship between gestational age and outcomes.

Results: Of 9,511 live births, the overall survival rate was 98.99%. Survival rose steadily with gestational age, consistently exceeding 95% from 32 weeks onward (96.77%). In contrast, periviable gestations faced much lower survival, dropping to 50.00% at 25 weeks. NICU admission was required for 26.56% of neonates (2365/8906), declining sharply after 32 weeks. Among NICU-admitted neonates, the survival rate was 96.79% (2289/2365), also crossing the 95% threshold at 32 weeks (96.08%), matching the point where admission rates fell.

Conclusions: Survival at THR varies by gestational age and by the level of neonatal care available. WHO defines the limit of viability as 22 weeks. However, THR only reached consistently high survival (above 95%) from 32 weeks of gestation onward. This shows a gap between the international viability cutoff and real-world survival at this center. The gap likely reflects limits in resources and care for extremely preterm infants. Considerable investment in resources will be required to reduce the gap between the ideal standard and actual reality.

OP033. INITIAL RESULTS OF ART SERVICES MANAGED BY LOCALLY TRAINED TEAM IN NORTHERN SRI LANKA

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Introduction: Access to assisted reproductive technology (ART) remains limited outside major cities in Sri Lanka creating significant barriers for couples seeking fertility treatment. Establishing regional fertility services can improve equitable access to care. Evaluating the outcomes of newly established centers is essential to assess their effectiveness and guide future service development.

Objectives: To assess the clinical and embryological outcomes of this newly established center, which operates with locally trained personnel in the northern part of Sri Lanka.

Design: Institutional Retrospective cohort study evaluating the first-year reproductive treatment cycles and outcomes.

Method: Clinical and embryological outcomes of all couples (N = 81) who underwent fresh or frozen embryo transfer at Northern Central Hospital, Jaffna were recruited during the first year of the program, after obtaining informed written consent. Statistical associations with beta-hCG results were analyzed using independent-samples t-tests and Pearson Chi-Square tests via SPSS.

Results: Most patients were Sri Lankan Tamil (97.5%). Treatment using the couple's own gametes was performed in 53.1% of cycles,

while donor gametes were used in 46.9%. Moderate or poor sperm quality was observed in 77.7% of cycles and all semen samples underwent density gradient centrifugation before fertilization. The mean number of oocytes retrieved was 8.46, with an average of 2.69 blastocysts formed per cycle. Frozen embryo transfer was performed in 93.8% of treatment cycles. Women receiving donor gametes were significantly older than those using their own gametes among both beta-hCG-positive (42.1 vs 34.0 years; p=0.001) and beta-hCG-negative cycles (39.4 vs 34.7 years; p=0.007). A positive beta-hCG result was also significantly associated with sperm quality (p=0.018), with the highest positive rate observed in cycles using good-quality sperm (61.1%). No significant association was found between pregnancy outcome and Poseidon classification, embryo quality, or type of embryo transfer. The overall positive beta hCG rate was 30.9% (25/81). Among those pregnancies, four results came in live births, three ended with miscarriage and the remains are ongoing.

Conclusion: This regionally developed ART center run by locally trained staff, achieved a pregnancy rate consistent with reported outcomes despite operating in a resource limited setting. Better sperm quality was associated with improved pregnancy outcomes. women who achieving beta-hCG positive with donor gametes were significantly older than those using their own gametes. Highlighting the role of donor gametes in overcoming age related reproductive limitation. These findings demonstrate that high-quality ART services can be successfully delivered by a locally trained regional team.

OP034. KNOWLEDGE AND COMPLIANCE OF HEALTHCARE WORKERS ON CERVICAL CANCER SCREENING IN SRI LANKA AT NATIONAL HOSPITAL, KANDY

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Introduction: Cervical cancer is a leading cause of cancer-related morbidity and mortality among women, particularly in low- and middle-income countries. In Sri Lanka, a national cervical cancer screening programme is available through Well Woman Clinics. Healthcare workers play a key role in patient education, recommending screening and implementing national guidelines. Their knowledge and compliance with screening recommendations are essential for the success of the programme.

Objectives: To assess the knowledge, attitudes and compliance of healthcare workers with the national cervical cancer screening programme.

Design: Descriptive cross-sectional study.

Method: The study included healthcare workers at the National Hospital, Kandy, comprising medical officers, nursing officers, midwives and allied health staff. A sample size of 420 was calculated. Data were collected using a self-administered structured questionnaire and analyzed using SPSS. Educational leaflets in English and Sinhala were distributed after the completion of the study.

Results: Among participants, 6% were below 30 years, 20% were 30–34 years, 30% were 35–44 years, 26% were 45–54 years and 18% were above 55 years. Nursing officers constituted 64% of the sample, while doctors and midwives each accounted for 13% and allied health staff 10%. Only 12% had worked at a Well Woman Clinic.

All participants were aware of the national screening programme and 87% had received professional education on the subject. All correctly identified the Pap smear as the screening test. While 87% knew that routine screening begins at 35 years, only 24% correctly identified 45 years as the recommended age for the second screening; 57% incorrectly selected 40 years. Only 35% recognized that the primary purpose of screening is to detect precancerous lesions, whereas 40% believed it was to detect cervical cancer only. Human Papillomavirus was identified as the causative agent by 90%.

773% of participants had undergone the first recommended screening at 35 years, while only 48% had completed the second recommended screening at 45 years. Overall, 49% had undergone a Pap smear within the previous 5 years, 17% within 5–10 years and 12% more than 10 years ago. Lack of time was the

commonest barrier to screening, followed by embarrassment, difficulty accessing clinics, fear of the results and absence of symptoms. Despite this, all participants agreed that Pap smear screening is essential for cervical cancer prevention and that healthcare workers should adhere to national recommendations.

Conclusion: Although healthcare workers demonstrated good awareness of the national cervical cancer screening programme, important knowledge gaps and suboptimal compliance with recommended screening were identified. Strengthening education and promoting adherence to national screening recommendations among healthcare workers may improve screening uptake and reinforce their role in cervical cancer prevention.

OP035. KNOWLEDGE, PERCEPTION, ACCESSIBILITY AND USAGE OF CONTRACEPTIVES AMONG ESTATE WOMEN IN TALAWAKELLE

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Introduction: Women in Sri Lanka's estate communities face significant barriers to contraceptive use, including limited knowledge, cultural norms and restricted access to services. Evidence regarding contraceptive use and sexual and reproductive health practices in these communities remains limited.

Objectives: This study aimed to assess the knowledge, perception, accessibility and usage of contraceptives among women aged 18–49 years in tea estate community in Talawakelle, Nuwara Eliya district and to estimate Contraceptive Prevalence Rate (CPR) and modern Contraceptive Prevalence Rate (mCPR). The study was guided by a research question on contraceptive patterns and a hypothesis that women have limited knowledge and barriers to use, resulting in CPR and mCPR differing from national estimates.

Design: A descriptive cross-sectional study with an analytical component was conducted.

Method: The study was conducted among 128 married women residing in four selected tea estates (Galkanda-Bearwell, Mattekelle, Waltrim and Lindula) within the Talawakelle MOH area. A multistage sampling approach was used, involving purposive selection of PHM areas, cluster identification and consecutive recruitment of eligible women, with one participant per household. Data were collected via a structured interviewer-administered questionnaire and analyzed using SPSS with descriptive and inferential statistics. Knowledge was assessed across awareness, hormonal and factual domains using scored responses based on Bloom's cut-offs. Perceptions were evaluated using Contraceptive Acceptance Score and reliability was assessed using Cronbach's alpha. Predictors of knowledge were identified using multiple linear regression and qualitative data were analyzed thematically. CPR and mCPR were estimated with 95% confidence intervals.

Results: Participants were predominantly Indian Tamil (56.3%) and Hindu (68%), with most marrying early and having 1–2 children. Contraceptive knowledge was low (mean score 39.5/100), with 85.9% demonstrating poor knowledge. Education was the strongest predictor ($p=0.045$), while younger, educated women had higher knowledge ($p=0.006$). Health workers were the primary information source (39.6%). Attitudes were neutral to positive and varied by religion and ethnicity ($p<0.05$). Contraceptive services were widely available (93%) with high utilization; CPR was 81.3% and mCPR was 68.8%. Implants (27.1%) and DMPA (23.1%) were most commonly used, though side effects (41%) contributed to discontinuation.

Conclusion: Married women in Talawakelle estate communities demonstrated limited contraceptive knowledge, while distance, transport costs and side effects hindered consistent use. These findings highlight the need for culturally sensitive, community-based interventions to improve knowledge, address misconceptions, engage men and strengthen access to contraceptive services.

Keywords Estate Community, Contraceptive knowledge, Reproductive health, Contraceptive prevalence

OP036. LETROZOLE WITH MISOPROSTOL VERSUS MISOPROSTOL ALONE FOR MISSED MISCARRIAGE: RANDOMISED CONTROLLED TRIAL

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Introduction: An estimated 10-15% of pregnancies are complicated by missed miscarriages. Letrozole, an aromatase inhibitor with minimal side effects, may enhance misoprostol efficacy through oestrogen suppression. To our best knowledge, no randomized trial of this combination for missed miscarriage has been conducted in South Asia.

Objectives: To compare rates of complete expulsion, treatment success without surgical intervention, adverse effects, patient-reported pain and satisfaction between letrozole-misoprostol combination and misoprostol alone in women with missed miscarriage.

Design: This is an interim analysis of an ongoing parallel-group, open-label, randomised controlled trial. To date, 68 of a target 134 participants have been enrolled (34 per arm).

Method: We recruited women aged 18-45 years with ultrasound-confirmed missed miscarriage (gestational age 12 weeks or less) who were admitted to gynaecology wards at Colombo North Teaching Hospital. Women in group 1 received letrozole 10mg orally twice daily for three days. It was followed by misoprostol 800mcg vaginally three-hourly up to a maximum of two doses, if retained products of conception (RPOC) remained 15mm or more on transvaginal ultrasound scan. Women in group 2 received misoprostol alone. We measured the complete expulsion of RPOC (less than 15mm) without surgical intervention, supported by negative urine hCG at three weeks' follow-up as our primary outcome.

Results: The two groups were demographically similar, supporting the validity of randomization in our study. Mean maternal age (32.2 versus 30.0 years, p=0.885) and other baseline characteristics were comparable between groups. Complete expulsion occurred in 28 out of 34 (82.4%) participants with letrozole-misoprostol combination. 20 out of 34 (58.8%) women had complete expulsion with misoprostol alone [(p=0.033), risk difference 23.5% (95% CI 2.6-44.5), relative risk 1.40 (1.02-1.93) (95% CI 1.02-1.93)]. Women who received letrozole-misoprostol combination required less surgical intervention than misoprostol alone (17.6% versus 41.2%; p=0.033). 29.4% (10/34) participants who received letrozole showed complete expulsion with letrozole alone, without the need for misoprostol. Excessive bleeding was less frequent with the letrozole-misoprostol combination (23.5% versus 47.1%, p=0.042). No serious adverse events occurred in either group. Median pain scores were lower with the letrozole-misoprostol combination at 24 hours from initiation of treatment (4.5 versus 7.0, p=0.033) and at three weeks' follow-up (0 versus 3, p<0.001). Participant satisfaction at discharge was higher with letrozole-misoprostol combination compared to misoprostol alone (73.5% versus 23.5%, p<0.001). Urine hCG was negative in all participants at three weeks.

Conclusion: In this interim analysis, letrozole pretreatment significantly increased complete expulsion and reduced surgical intervention requirement and the need for misoprostol. Bleeding and pain were less and patient satisfaction was higher with letrozole pretreatment. These findings support letrozole as an adjunct to misoprostol in the management of missed miscarriage.

OP037. MAFLD IN PREGNANCY: A FIBROSCAN-BASED COMPARATIVE COHORT STUDY IN SRI LANKA

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Introduction: Metabolic-associated fatty liver disease (MAFLD) has emerged as an important maternal health concern. Pregnancy-related physiological changes may influence

hepatic fat accumulation and liver stiffness but longitudinal data describing these changes are limited. To our knowledge, this represents the first such study conducted in a South Asian population.

Objectives: To compare changes in hepatic steatosis, liver stiffness and biochemical markers between pregnant women with and without hepatic steatosis between the first (T1) and third (T3) trimesters of pregnancy using FibroScan®

Design: Prospective observational cohort study.

Method: We recruited ninety pregnant women before 20 weeks of gestation from the antenatal clinic of the Professorial Obstetrics Unit, North Colombo Teaching Hospital. All were followed up until the third trimester. Controlled Attenuation Parameter (CAP) and Liver Stiffness Measurement (LSM), along with serum AST, ALT and total cholesterol were measured at both visits.

Results: These are the preliminary results of an ongoing study. Women were classified based on T1 CAP into non-steatosis (CAP < 248 dB/m, n = 65) and steatosis (CAP ≥ 248 dB/m, n = 25) groups. Mean maternal age didn't differ between groups (28.3±5.4 vs 29.1±5.4 years). Mean booking BMI was significantly higher in the steatosis group (28.1±5.2 vs 22.0±4.8 kg/m^2; p<0.0001). Mean liver stiffness increased from T1 to T3 and was higher in the steatosis group (4.54±1.00 to 5.12±1.22 kPa) compared to non-steatosis group (4.03±0.91 to 4.61±1.10 kPa). A significant positive correlation was found between T1 and T3 LSM (p=0.022). Among women with steatosis, mean CAP decreased from 284.8 ± 33.6 dB/m to 249.4 ± 46.4 dB/m and increased from 191.0 ± 33.6 dB/m to 197.5 ± 42.3 dB/m in the non-steatosis group. Serum AST and ALT showed similar patterns; rising in the non-steatosis group (AST: 18.0±3.7 to 18.4±7.4 U/L, ALT: 17.2±6.9 to 18.6±7.7 U/L) and falling in the steatosis group (AST: 20.1±4.3 to 19.2±5.7 U/L, ALT: 21.9±8.0 to 20.8±13.7 U/L). Total cholesterol rose in both groups, with a greater rise in the steatosis group (173.0±24.5 to 197.3±56.6 mg/dL vs 167.4±44.2 to 177.4±60.5 mg/dL). Of women with steatosis at booking, 15 (60%) no longer had it by T3, while 8 (12.3%) without steatosis at the start developed it by T3.

Conclusion: Women with a higher BMI carry a greater risk of hepatic steatosis, elevated liver stiffness and higher total cholesterol than those without, while liver enzymes remained largely unchanged. Liver stiffness significantly increases from the first to the third trimester of pregnancy.

OP038. REDEFINING MATERNAL CARE: ESTABLISHING A MATERNITY DAY UNIT FOR CLINICAL EFFICIENCY AND PATIENT CONVENIENCE AT DGH MATALE

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Introduction: The increasing demand for maternity services at District General Hospital Matale has led to unnecessary ward admissions for minor procedures. This project proposes the establishment of a Maternity Day Unit (MDU) to reduce inpatient admissions, improve patient convenience, and enhance clinical efficiency.

Objective: To establish a Maternity Day Unit at DGH Matale that provides same-day maternal services, reducing unnecessary admissions, improving patient satisfaction, optimizing manpower, lowering costs, and enhancing clinical efficiency.

Method: The MDU was established by assessing service needs, planning protocols, and allocating essential staff and resources. It delivers same-day maternal procedures through streamlined workflows, with continuous monitoring of admissions, patient satisfaction, cost savings, and clinical efficiency to ensure sustainable improvement.

Results: Since implementation, the MDU has successfully delivered multiple maternal services: Marina coil insertions (13), Vitamin B12 injections (2), colposcopies (5), GnRH administrations (9), Ovidac injections (13), pessary insertions (428), Pap smears (58), and pipelle biopsies (79). These figures demonstrate significant utilization of the unit and reduction in unnecessary inpatient admissions.

Discussion: The MDU streamlines minor maternal procedures into a same-day service model, reducing hospital costs and admissions. This approach enhances patient convenience and satisfaction while improving manpower utilization and overall clinical efficiency.

Conclusion: The MDU modernizes maternal care by reducing admissions, improving convenience, enhancing satisfaction, and ensuring cost-effective clinical efficiency.

Recommendation: It is recommended that DGH Matale sustain the MDU with clear protocols, adequate staffing, and continuous monitoring to ensure reduced admissions, improved patient satisfaction, optimized resource use, and sustainable clinical efficiency.

Keywords: Redefining, Maternity Day Unit, Clinical efficiency, Patient convenience

OP039. MATERNAL EXPERIENCE WITH LABOUR COMPANIONSHIP AT CASTLE STREET HOSPITAL FOR WOMEN, COLOMBO: A CROSS-SECTIONAL STUDY

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Introduction: Having someone with you during labour is a key part of respectful maternity care. The World Health Organisation suggests having a labour companion to make childbirth better for women. While Sri Lanka has policies for this, we don't know much about how mothers experience it in big maternity hospitals or what makes them happy with it. This study looked at mothers' experiences with labour companions at Castle Street Hospital for Women (CSHW) in Colombo and found out what parts of care led to good childbirth experiences.

Objectives: To determine the maternal experience of labour with companionship among postpartum mother at Castle Street Hospital for Women (CSHW), Colombo

Design: A hospital-based descriptive analytical cross-sectional study among postpartum mothers who experienced labour with a companion at Castle Street Hospital for Women, Colombo.

Method: We talked to 384 women who had recently given birth at CSHW with a companion present during labour. We used systematic random sampling to pick participants and interviewed them with a structured questionnaire. The questionnaire asked about emotional support, information given, respect and privacy, how well needs were met and overall satisfaction. The scale for the companionship experience was very consistent. We analysed the data using descriptive statistics, chi-square tests, Pearson correlation, multiple linear regression and binary logistic regression to find what independent factors predicted a positive maternal experience and satisfaction.

Results: On average, the companionship experience score was 4.40 ± 0.76 out of 5 and the overall satisfaction score was 9.31 ± 1.15 out of 10. Most women, 79.7%, had a very positive companionship experience and 82.3% were very satisfied. The highest scores were for emotional support, respect and privacy and wanting a companion again. Better experience scores were linked to the companion being there the whole time, having enough privacy, hospital staff telling the companion information, staff being friendly and less crowded wards. Logistic regression also showed that having a companion present throughout, adequate privacy, staff updating companions, friendly staff and not too crowded wards greatly increased the chance of very high maternal satisfaction. On the other hand, labour lasting over 12 hours significantly lowered satisfaction.

Discussion: Labour companionship seemed to lead to very positive maternal experiences when it was part of respectful maternity care. How the hospital was organised, like allowing companions to stay the whole time, how staff interacted with patients and companions, protecting privacy and preparing companions properly, had a bigger impact on the maternal experience than the women's own characteristics. Improving hospital policies to better support labour companionship could significantly make childbirth better for women and improve the overall quality of maternity care in Sri Lankan hospitals.

OP040. MATERNAL MULTIMORBIDITY AMONG PREGNANT WOMEN ATTENDING BOOKING ANTENATAL VISITS IN SRI LANKA: PREVALENCE, PATTERNS AND CHARACTERISTICS

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Background: Maternal multimorbidity (MM), defined as the presence of two or more pre-existing long-term conditions, is increasingly recognized as a contributor to adverse maternal and neonatal outcomes. Evidence on its burden and patterns in Sri Lanka remains limited. This study examined the prevalence, patterns and characteristics of pre-existing MM among pregnant women attending antenatal booking visits in Sri Lanka.

Method: This cross-sectional analysis used baseline data from a prospective cohort study conducted in three tertiary hospitals in Sri Lanka. We analyzed data from 2,041 pregnant women. Women were classified as having no morbidity, one morbidity, or multimorbidity (≥2 morbidities). We described prevalence and patterns of multimorbidity and examined factors associated with increasing morbidity burden using ordinal logistic regression. Missing height and weight data were multiply imputed to derive BMI.

Results: Among 2,041 women, 386 (18.9%) had one morbidity and 80 (3.9%) had multimorbidity. The most prevalent conditions were bronchial asthma (9.0%), other endocrine disorders (5.4%), diabetes mellitus (3.2%) and migraine (3.0%). The most common combinations were migraine with asthma (13.8%) and diabetes with other endocrine disorders (11.2%). Women with multimorbidity were older than those without morbidity (median 31.5 vs 27.7 years; p<0.001). In adjusted analyses, previous miscarriage (aOR 1.49, 95% CI 1.15-1.94), previous gestational diabetes (aOR:2.12,95%CI:1.36-3.31), previous preterm delivery (aOR:2.74,95% CI:1.29-5.8), family history of diabetes (aOR:1.81,95% CI:1.41-2.31) and family history of hypertension (aOR:1.39,95%CI:1.08-1.79) were associated with increasing morbidity burden.

Conclusion: Approximately one in 25 pregnant women had pre-existing multimorbidity at booking. Asthma, endocrine disorders, diabetes and migraine accounted for much of the burden, with respiratory-neurological and endocrine-metabolic combinations most frequently observed. Previous adverse obstetric outcomes and a family history of diabetes or hypertension were independently associated with greater morbidity burden. Early identification of women with multimorbidity may support risk stratification and targeted antenatal care in Sri Lanka.

Keywords: Maternal multimorbidity; pregnancy; antenatal booking visit; chronic conditions; maternal health; Sri Lanka.

OP041. MATERNAL, NEONATAL MORTALITY AND MORBIDITY IN PLACENTA-ACCRETA SPECIALIZED CENTRE IN SRI LANKA

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Introduction: Placenta Accreta Spectrum (PAS) is a life-threatening obstetric condition associated with severe maternal and neonatal morbidity and mortality. Its incidence has increased worldwide in parallel with rising caesarean section rates. Optimal outcomes depend on early antenatal diagnosis, meticulous delivery planning and coordinated multidisciplinary management. However, these resources are often unavailable in decentralized healthcare

systems, particularly in low- and middle-income countries. To address this gap, a dedicated multidisciplinary PAS centre in Sri Lanka was established at Colombo South Teaching Hospital.

Objectives: To evaluate maternal and neonatal mortality and morbidity following the establishment of centralized multidisciplinary PAS centre in Sri Lanka.

Design: Prospective observational study.

Method: A prospective observational study was conducted over a period from 2024 august and continued up to now at the multidisciplinary PAS centre in Colombo South Teaching Hospital. All consecutive women with antenatally diagnosed or intraoperatively confirmed PAS were included. Patients received protocol-based multidisciplinary care followed by collection of data including maternal and neonatal outcomes into a pre-tested interviewer administered questionnaire. Descriptive statistics were analyzed using SPSS.

Results: Twenty-five women with PAS were managed during the study period, including four direct admissions and twenty-one referrals from hospitals across Sri Lanka. Out of this, 4 (16.7%) were from Puttalum district, 3 (12.5%) from Ampara district, 2 (8.3%) from Rathnapura district and the remaining patients were referred from various districts throughout Sri Lanka. No maternal deaths occurred. Maternal morbidity included peripartum hysterectomy in 9 women (37.5%), massive postpartum haemorrhage in 12 (50.0%) and bladder injury in 7 (29.2%). There was one neonatal death. Among surviving neonates, one (4.2%) experienced very severe morbidity requiring neonatal intensive care for more than 10 days, eight (33.3%) had moderate morbidity, five (20.8%) had mild morbidity and two (8.3%) had no morbidity.

Conclusion: Establishment of centralized multidisciplinary PAS centre was associated with excellent maternal survival, acceptable maternal and neonatal morbidity despite resource limitations. This model highlights the importance of centralized care, multidisciplinary collaboration, standardized protocols and timely referral in improving outcomes for women with PAS and provides a practical framework for similar resource-limited healthcare settings.

OP042. MEDICO-LEGAL ADMISSIONS OF MINORS TO A GYNAECOLOGY UNIT: A DESCRIPTIVE STUDY

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Introduction: Minors admitted for medico-legal reasons require care at the intersection of forensic, psychiatric and child protection services. Sri Lankan information on these admissions, care processes and documentation quality is limited.

Objectives To describe the characteristics and medico-legal, psychiatric and child protection care processes among minors admitted for medico-legal reasons and assess documentation completeness.

Design: Retrospective descriptive study.

Method: All consecutive medico-legal admissions of minors to one gynaecology unit at Teaching Hospital, Kandy, during six months in 2026 were included (n=23). Data were extracted from clinical records using a structured proforma and analysed descriptively.

Results: Twenty-three girls were included, median age 15 years (range 7–16); seven (30%) were below 13 years. Twenty-two (96%) were referred by police. Admissions followed alleged sexual abuse in 10 (43%), consensual under-age sexual activity in 9 (39%) and elopement in 4 (17%). In eight alleged abuse cases, the suspected perpetrator was known to the child. Penetrative sexual contact was suspected in nine (39%); all pregnancy tests were negative.

Judicialmedical assessment was completed within two days in 21 (91%). STI screening was performed in 17 (74%) and forensic biological samples were collected in 15 (65%) within 24 hours. Twelve (52%) were referred for psychiatric assessment. Notification to the National Child Protection Authority was not consistently documented and therefore could not be assessed. Twenty (87%) stayed three days or less; longer stays were related to multiple referrals and social placement difficulties. Twenty-two (96%) were discharged home with family. Documentation was incomplete or absent for parents' marital status in 17

(74%) and psychiatric history in 20 (87%) records. Prior self-harm was not documented in any of the 23 records (100%), highlighting a major gap in assessment of this risk factor. Follow-up arrangements were incomplete or absent in 11 (48%) records.

Conclusion: Most admissions involved adolescent girls following consensual under-age sexual activity or alleged abuse, often involving known persons. Although forensic processes were generally timely, gaps existed in psychosocial assessment and documentation, particularly the complete absence of documented prior self-harm history. A structured multidisciplinary pathway with standardised documentation and follow-up planning is recommended. Limitations include the small sample, single-unit design and reliance on clinical records to assess documentation quality; care may have been provided but not recorded.

OP043. MICROBIAL CONTAMINATION AND DISINFECTION PRACTICES OF TRANSVAGINAL ULTRASOUND PROBES IN SRI LANKA

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Introduction: The transvaginal ultrasound (TVUS) probe is a reusable, semi-critical/ medium-risk medical device that poses a potential risk for cross-infection transmission. Although international guidelines mandate strict handling and disinfection protocols, practices in Sri Lankan gynaecology clinics vary, as examinations are routinely conducted by general gynaecologists and trainees without a standardized national framework.

Objectives: To explore the current TVUS probe handling and disinfection practices across selected gynaecology clinics in Sri Lanka and assess microbial contamination of TVUS probes with current practices with a specific focus on Group B streptococcus (GBS).

Design: A cross-sectional analytical study was conducted over a four-month period.

Method: The study was carried out at the gynaecology clinics of four tertiary teaching hospitals in the Western Province of Sri Lanka. Following routine clinical disinfection protocols, surface samples were collected from TVUS probes using sterile Amies swabs. Swabs were cultured on blood agar, incubated overnight and subjected to biochemical testing for definitive species identification. Concurrently, a three-part interviewer-administered questionnaire was used to collect data on handling practices and safety perceptions from the doctors performing ultrasound scans, clinic assistants and a selected sample of patients. Data were compiled using Microsoft Excel and analyzed using IBM SPSS Statistics.

Results: A total of 147 probe surface samples were collected. Microbial growth was detected in 28 samples (19%). The analysis identified two Methicillin-resistant Staphylococcus aureus (MRSA) isolates alongside 39 non-pathogenic environmental contaminants. No GBS was isolated from any of the samples. Survey data revealed substantial variation in probe handling and disinfection methods, which relied primarily on individual provider preference rather than institutional or national standards. Despite these variations, patient satisfaction regarding cleanliness and safety of the procedure remained high.

Conclusion: Current TVUS probe handling and disinfection practices in the evaluated centers vary widely and present a potential risk for the transmission of pathogens, including multi-drug resistant organisms like MRSA. This highlights an imminent need to develop, standardize and implement cost-effective, feasible national guidelines for TVUS probe handling and disinfection for the Sri Lankan setting.

OP044. NAVIGATING TRIPLE COMPLEXITY: A PREGNANCY COMPLICATED WITH NEUROFIBROMATOSIS, KYPHOSCOLIOSIS AND SHORT STATURE

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Objectives: Neurofibromatosis type 1 (NF1) is an autosomal dominant disorder characterized by proliferation of cells derived from neural crest. Kyphoscoliosis (KS) is the most common skeletal manifestation of NF1. Physiological changes in pregnancy cause significant musculoskeletal and respiratory burden. Severe KS is associated with reduced respiratory reserve, excess risk of malpresentation, labour difficulties and anaesthetic complications. This report presents successful multidisciplinary management of a pregnant woman with NF1, severe KS and short stature with poor orthopaedic follow-up.

Case report: A 28-year-old woman in her second pregnancy with a history of first-trimester miscarriage presented at 32 weeks of gestation with worsening back pain and exertional dyspnoea (NYHA II). Physical examination revealed short-stature (119 cm, 25.9 kg; BMI 18.3 kg/m^2), multiple café-au-lait spots and cutaneous neurofibromas. Severe thoracolumbar KS (Cobb's angle ~ 80°) was noted with mediastinal shift. Her pregnancy was additionally complicated with gestational diabetes (on insulin), anaemia, bronchial asthma and paracetamol allergy.

Maternal oxygenation and arterial blood gas (ABG) analysis were normal. 2D echocardiography showed no pulmonary hypertension. Fetal assessment was reassuring. Magnetic resonance imaging demonstrated severe KS without canal stenosis or mass lesions in central nervous system. She was optimized through multidisciplinary care which included chest physiotherapy, glycaemic optimization, blood transfusion and antenatal corticosteroids for fetal lung maturation.

An elective caesarean section under general anaesthesia was planned at 37 weeks due to progressive respiratory compromise in late pregnancy, inadequate pelvis and transverse lie. Precautions were taken for difficult airway management. A live male infant (2295 g) was delivered. Postoperative period was complicated by postpartum haemorrhage which was successfully managed with Bakri balloon tamponade and blood transfusion. Neonatal examination revealed café-au-lait patches, glandular hypospadias and possible facial asymmetry, requiring specialised observation. Maternal recovery was uneventful with stable cardiorespiratory status and adequate analgesia. She was mobilized early, established breastfeeding and discharged on postoperative day nine.

Discussion: Pregnancy exacerbates the spinal deformity and cardiorespiratory compromise in uncorrected KS. Higher Cobb's angle increases the risk of restrictive lung disease and respiratory failure. Monitoring with pulse oximetry and ABG is preferred over pulmonary function tests. Physiotherapy helps to prevent complications. NF1 poses anaesthetic challenges such as difficult airway, raised intracranial pressure, severe restrictive lung disease and pulmonary hypertension. Preoperative optimization and ERAS are important. Although regional anaesthesia is generally preferred, general anaesthesia was used due to distorted anatomy, difficult neuraxial access and risk of unpredictable high spinal block in this patient.

Conclusion: Uncorrected KS is associated with significant morbidity in pregnancy and labour. Careful monitoring, assessment and individualized delivery planning ensure favourable outcomes in affected patients.

OP045. OUTCOMES OF NEONATES BORN TO MOTHERS WITH PLACENTA ACCRETA SPECTRUM

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Introduction: Incidence of Placenta accreta spectrum (PAS) disorders are increasing in Sri Lanka due to rising cesarean section rates. Neonates born to mothers with PAS are at increased risk of prematurity related complications and neonatal intensive care unit (NICU) admission. While maternal outcomes are studied and recognized, neonatal outcomes are inadequately studied locally.

Objectives: To assess neonatal outcomes with placenta accreta spectrum and to compare these outcomes with neonates born to mothers without PAS in a tertiary care setting in Sri Lanka.

Design: A retrospective hospital based case-control study was conducted in Colombo South Teaching Hospital to compare neonatal outcomes between pregnancies complicated by PAS and those without PAS. A case control design was done because PAS is an uncommon condition and this approach gives an efficient method for determining its association.

Method: The study included 75 live born neonates, which includes 25 neonates born to mothers with PAS and 50 neonates born to mothers without PAS in a 1:2 case-control ratio. Neonatal outcomes assessed in this study are small-for-gestational-age (SGA) status, APGAR scores, need for resuscitation at birth, respiratory distress, neonatal intensive care unit (NICU) admission, duration of NICU stay and neonatal morbidities. Variables with $p < 0.05$ in univariate analysis were included into multivariable logistic regression to identify outcomes which are independently associated with PAS after adjustment for gestational age at delivery and birth weight.

Results: The mean gestational age at delivery among PAS pregnancies was 34.28 ± 1.48 weeks, the mean birth weight was 2.26 ± 0.44 kg, the mean duration of NICU admission was 6.6 ± 4.29 days, the mean time taken to achieve full enteral feed was 4.88 ± 2.48 days and the median duration of respiratory support was 4.33 ± 4.00 days.

In multivariable logistic regression, Neonates born to mothers with PAS had significantly higher odds of requiring NICU admission (AOR 38.54; 95% CI: 3.26–455.79; $p = 0.004$), neonatal resuscitation at birth (AOR 8.10; 95% CI: 1.94–33.77; $p = 0.004$) and respiratory distress at birth (AOR 12.81; 95% CI: 22.83–58.10; $p = 0.001$) compared with neonates born to mothers without PAS. In contrast, small-for gestational-age (SGA) status was significantly less frequent among neonates in the PAS group after adjustment for gestational age at delivery (AOR 0.07; 95% CI: 0.01–0.62; $p = 0.016$). These findings indicate that PAS is an independent predictor of NICU admission, need for neonatal resuscitation and respiratory distress at birth.

Conclusion: Neonates born to mothers with placenta accreta spectrum were more likely to require NICU admission, need for resuscitation at birth and presence of respiratory distress compared to controls.

These findings highlight the need for multidisciplinary antenatal planning, delivery in specialized centers and enhanced neonatal support to improve outcomes in pregnancies complicated by PAS.

OP046. PATHOLOGICAL UPSTAGING FOLLOWING RADICAL HYSTERECTOMY FOR EARLY CERVICAL CANCER: A RETROSPECTIVE STUDY

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Introduction: The radical hysterectomy combined with pelvic lymphadenectomy continues to be the gold-standard treatment modality in select cases of early-stage cervical carcinoma. The definitive histopathological evaluation can detect some hidden negative pathological parameters causing stage migration based on FIGO 2018 classification of cervical cancer stages and hence affecting the necessity for adjuvant treatment after surgery.

Objectives: To identify the frequency and etiologies of upstaging during radical hysterectomy for early cervical carcinoma and to describe the related clinicopathological features.

Design: Single-centre retrospective observational cohort study of patients who underwent radical hysterectomy for cervical carcinoma.

Method: Histopathological records of sequential cases of women undergoing radical hysterectomy with pelvic lymph node dissection surgery in the period from November 2024 to July 2026 in National Hospital-Kandy were analyzed. The following demographic, clinical and histopathological parameters were extracted: age, histologic subtype, maximum tumour diameter, FIGO stage, LVSI, parametrial invasion, margins status and lymph node metastases. Pathological upstaging was based on FIGO 2018 criteria.

Results: Forty patients with cervical carcinoma were analysed. Patient age range was from 29 to 78 years. Squamous cell carcinoma was the most frequent histological type and adenocarcinoma was the second one. Clinically early-stage disease was more prevalent and the leading stages were IB1 and IB2 according to FIGO classification. Among patients with analysable tumour size information, the median tumour maximum diameter was 25 mm (range – 5 to 80 mm); 14.8% of patients (4) had tumours larger than 4 cm. The pathological upstaging followed surgery was seen in 12.5% (5) patients. Parametrium involvement was revealed in 4 patients (10.0%), resulting in pathological disease stage of II-B and in one case (2.5%) the tumor spread into the pelvic and para-aortic lymph nodes, the stage of III-C2. None of the patients had positive surgical margins. Overall, 8 females (20%) required adjuvant therapy postoperatively in the form of chemoradiotherapy in case of high risk (n=5) and pelvic radiotherapy in case of intermediate risk meeting Sedlis criteria (n=3).

Conclusion: One out of every eight women who underwent radical hysterectomy on suspicion of having early cervical cancer turned out to have been up-staged on the basis of pathological assessment. This shows the significance of carrying out an extensive pathological evaluation after radical hysterectomy in order to have accurate staging and decide on adjuvant treatment.

OP047. PATIENT PERCEPTION ON VIDEO SHARING FOLLOWING OUTPATIENT HYSTEROSCOPY: A PROSPECTIVE OBSERVATIONAL STUDY

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Introduction: Outpatient hysteroscopy is the gold standard for the evaluation and management of intrauterine pathology. Contemporary hysteroscopic systems permit high-quality video recording; however, routine sharing of these recordings with patients is not standard practice in Sri Lanka. Providing patients with procedure videos has the potential to improve understanding, facilitate communication, enhance recall of clinical information and promote patient-centred care. Evidence regarding patient perception of hysteroscopy video sharing remains scarce in South Asia, with none from Sri Lanka.

Objectives: To evaluate patient perception regarding routine sharing of outpatient hysteroscopy video recordings by assessing patient satisfaction, perceived improvement in understanding and privacy concerns.

Design: Prospective descriptive observational study.

Method: Women undergoing outpatient hysteroscopy at the Colombo South Teaching Hospital professorial unit were recruited consecutively over three months. Following the procedure, participants received a digital copy of their hysteroscopy video recording. A structured, pilot-tested self-administered questionnaire comprising demographic characteristics and ten five-point Likert-scale items evaluated satisfaction, perceived improvement in understanding and privacy concerns. Composite domain scores were calculated by summing individual item scores. Descriptive statistics summarized participant characteristics, questionnaire responses and domain scores. Internal consistency of the questionnaire domains was assessed using Cronbach's alpha coefficient.

Results: A total of 187 women were recruited, with a mean age of 48.5 ± 10.2 years. Overall, 89.7% agreed or strongly agreed that they were satisfied with receiving their hysteroscopy video, while 96.5% preferred receiving procedure recordings during future procedures. Furthermore, 62.1% reported that the recording improved their understanding of the findings explained by the doctor and 89.6% believed it would assist in recalling important clinical information. Mean satisfaction and understanding domain scores were 13.8 ± 2.9 (possible score 3–15) and 15.9 ± 4.4 (possible score 4–20), respectively. Although 10.3% expressed concerns regarding confidentiality of digital recordings, the overall mean privacy concern score remained low at 4.4 ± 2.6 (possible score 3–15).

Conclusion: Sharing of outpatient hysteroscopy recordings was well accepted, with high levels of satisfaction, strong willingness to receive future recordings and minimal privacy concerns as it's shared via end-to-end whatsapp messages. Although improved understanding was reported by approximately two-thirds of participants, most perceived the recordings as valuable for reinforcing clinical information and improving recall. Routine hysteroscopy video sharing may represent a feasible, low-cost, patient-centred strategy to enhance communication, patient engagement and continuity of care. Further multicentre studies are warranted to evaluate its impact on long-term clinical outcomes, health literacy and shared decision-making.

OP048. PATTERN OF SEMINAL FLUID PARAMETERS AMONG SUBFERTILE MEN IN NORTHERN SRI LANKA

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Introduction: Subfertility affects one in six couples globally. While national prevalence is ~15%, Northern region reported as 23.1%. Male factors contribute to 40-50% of cases. Evidence suggests that male partner investigations are undervalued by couples.

Objectives: To assess the pattern of seminal fluid parameters and associated factors of subfertile men attending subfertility clinic at professorial unit, Teaching Hospital Jaffna.

Design: This is an institutional based cross-sectional descriptive study

Method: We studied 222 Sub-fertile males at Andrology division of professorial unit and Women's Health Centre at Teaching Hospital Jaffna. Data collection consisted of interviewer administered questionnaire, anthropometric measurements and Semen analysis by trained personnel with WHO 2010 criteria. Data was analyzed with IBM SPSS-V21 and associations were examined using non-parametric and logistic-regression methods.

Results: Among the men mean age was 35.0 (IQR:32.0–39.0) with majority (63.1%) were in the age 30-39years category which signifies delayed fertility care seeking. About two in five reported at least one occupational related risk exposure, where high heat exposure predominated (23.0%). Median BMI was 25.0 kg/m2 while 43% and 26.7% men were overweight and obese and it showed a weak inverse correlation in sperm concentration. Waist-hip ratio threshold was exceeded in 85.9% men. Semen volume (median:2.0 mL, IQR:1.0–3.0) and concentration (median:36M/mL, IQR:10.0–62.0) were adequate according to WHO 2010 lower limit, but the lower quartiles touched the low reference boundary. Total motility (median:39.0 %, IQR:11.25–50.0) showed wide IQR resonating reduced progressive motility (median:10%, IQR:2.0-20.8) below 32% reference range. Total progressively motile count (TPMC) had a low median (6.9M) with a very widespread (IQR:0.2–27.4) mirroring the progressive-motility deficit. Overall, 65.3% men had at least one semen abnormality, the commonest being asthenozoospermia (50.0%), followed by low volume (29.3%), leucocytospermia (24.3%), oligozoospermia (20.3%) and azoospermia (9.5%). Positive family history of subfertility significantly associated with reduced values in five of six semen parameters; erectile dysfunction showed similar, yet fragile association limited by small number of affected men.

Conclusion: Abnormal semen parameters are highly prevalent in sub-fertile men in Northern Sri Lanka with impaired progressive motility and associated with erectile dysfunction though it requires confirmation in larger cohorts.

Keywords: Seminal fluid parameters, Male subfertility, Associated factors.

OP049. POTENTIAL FOR OUTPATIENT MANAGEMENT OF MISCARRIAGE: A RETROSPECTIVE STUDY

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Introduction: Miscarriage is a common cause of hospital admission. While medical treatment is often effective, some women may still need longer hospital stays or surgery. This study looked at how many women with miscarriage could be safely and successfully managed as outpatients, avoiding prolonged admission or surgical intervention

Objectives: To assess the potential for outpatient management of miscarriage by evaluating the interventions required and duration of hospital stay during patint care.

Method: A retrospective observational study was conducted using hospital records of women diagnosed with miscarriage over a three-month period at BH Mawanell. Data were collected regarding the type of miscarriage, treatment administered, requirement for further interventions and duration of hospital stay. The primary outcome was successful completion of medical management without the need for surgical evacuation or further inpatient intervention.

Results: During the study period, 17 women were diagnosed with threatened miscarriage. The shortest hospital stay was 5 hours, the longest stay was 72 hours and 40 minutes and the mean hospital stay was 31 hours and 20 minutes.

A total of 44 women were diagnosed with missed miscarriage. Ten women were successfully managed with a single cycle of misoprostol and discharged home. Among the remaining women, six were successfully discharged home following a repeat cycle of misoprostol, while the others required surgical evacuation of retained products of conception (ERPC). Therefore, 16 of 44 women (36.4%) with missed miscarriage were successfully managed medically without requiring surgical evacuation.

Additional inpatient interventions included parenteral analgesia in five women, blood transfusion in two, VE with removal of clots in two and IV tranexamic acid administration in one. Among women treated with a single cycle of misoprostol, the shortest hospital stay was 5 hours and 40 minutes, the longest was 50 hours and the mean hospital stay was 20 hours and 40 minutes.

Conclusion: In this retrospective study, 36.4% of women with missed miscarriage were successfully managed medically without requiring surgical evacuation. These findings suggest that outpatient medical management may be a feasible option for appropriately selected women with miscarriage. A structured outpatient pathway, with careful patient selection, clear counselling, appropriate follow-up and safety-netting instructions, may reduce unnecessary inpatient hospitalisation. Larger prospective studies are required to further evaluate the safety, acceptability and cost-effectiveness of outpatient management of miscarriage.

OP050. PREVENTING OBSTETRIC ANAL SPHINCTER INJURIES THROUGH MULTIDISCIPLINARY LABOUR WARD QUALITY IMPROVEMENT INITIATIVE

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Introduction: Obstetric anal sphincter injuries (OASIS) are an important cause of maternal morbidity following vaginal birth. In May 2026, an unexpected increase in severe perineal tears was noted in our labour ward, prompting review of intrapartum practices and a multidisciplinary quality improvement initiative.

Objectives: To assess changes in labour ward staff knowledge following a structured educational intervention and to examine early changes in OASIS incidence.

Design: Prospective before-and-after quality improvement audit.

Method: During May 2026, six OASIS occurred among 29 vaginal births. Separate pre- and post-intervention questionnaires were completed by doctors, nursing officers and midwives. Teaching addressed risk factors for

OASIS, perineal support, appropriate mediolateral episiotomy, assisted vaginal birth, avoidance of fundal pressure, systematic perineal examination and recognition and classification of OASIS. Doctors additionally received supervised hands-on training in assisted vaginal birth. Paired scores were analysed using the Wilcoxon signed-rank test. Clinical outcomes were reviewed for June 2026.

Results: Six doctors and ten nursing officers/midwives completed both assessments. Doctors' mean scores increased from 10.0/12 to 10.8/12. Among nursing officers and midwives, mean scores increased from 7.6/11 (69.1%) to 9.6/11 (87.3%) (p=0.008). Initial knowledge gaps included risk factors for OASIS, the relative risk associated with operative vaginal birth, inappropriate use of fundal pressure and indications for episiotomy. In May, six OASIS occurred among 29 vaginal births (20.7%): three grade 3B, two grade 3A and one grade 3C. In June, there were 32 vaginal births and one grade 3A OASIS (3.1%).

Conclusion: A multidisciplinary approach combining targeted teaching, practical training and assessment was associated with improved staff knowledge and an early reduction in OASIS. The small number of participants and one-month clinical follow-up limit interpretation of these findings. A repeat knowledge assessment and clinical re-audit at three months are planned to assess retention of knowledge and determine whether the observed reduction in OASIS is sustained.

Ethical considerations:

This was conducted as a clinical audit using routinely collected clinical data and anonymised staff assessment scores; ethical clearance was not required for this audit.

OP051. PROGRESS TOWARDS WHO CERVICAL CANCER SCREENING TARGETS: A BENCHMARK ASSESSMENT AT A TERTIARY CARE CENTRE

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Introduction: The World Health Organization (WHO) aims to achieve 70% cervical cancer screening coverage among eligible women by 2030 as part of its global strategy to eliminate cervical cancer. Sri Lanka has adopted these targets in its National Strategic Plan. Periodically assessing the ongoing adherence towards cervical screening is important to identify gaps in implementation andto understand measures that can be used to improve participation in cervical cancer screening programs.

Objectives: To assess cervical cancer screening coverage among women attending a tertiary care hospital, compare it with the WHO 2030 target and identify barriers to participation in screening.

Method: A descriptive cross-sectional study was conducted among women aged 30–65 years attending gynaecology clinics at the National Hospital, Kandy. Participants were recruited using consecutive sampling. A self-administered questionnaire was used to collect information on cervical cancer screening status, knowledge regarding cervical cancer screening and reasons for not undergoing screening. Screening coverage was compared with the WHO target of 70% and the screening gap was calculated. Data were analyzed using descriptive statistics.

Results: Among women aged ≥35 years (n=102), 57 (55.8%) had undergone cervical cancer screening at the recommended age, giving a screening gap of 14.2% compared with the WHO target of 70%. Among women aged ≥45 years (n=52), only 25 (48.0%) had undergone screening at 45 years, corresponding to a screening gap of 22%.

Knowledge regarding cervical cancer screening was moderate. Overall, 61.6% of participants knew that Pap smear screening was available through Well Woman Clinics, 66.4% correctly identified its purpose in detecting

precancerous and cancerous cervical lesions and 52.8% knew that cervical cancer is largely preventable.

Among eligible women who had never undergone screening, 49.0% did not report a reason. The most commonly identified barrier was lack of awareness about Pap smear screening (25.0%), followed by the belief that screening was unnecessary (9.8%), fear of the results (5.5%), anticipated pain (4.4%), embarrassment (3.3%) and lack of time (2.2%).

Conclusion: Cervical cancer screening coverage among women attending this tertiary care hospital remains below the WHO 2030 target despite the availability of a free national screening programme. There were screening gaps of 14.2% for initial screening and 22% for repeat screening. Increasing awareness, promoting opportunistic screening during hospital visits and strengthening counselling within the national screening programme may help improve screening uptake and support progress towards Sri Lanka's cervical cancer elimination goals.

OP052. REDISCOVERING THE TURNER–WARWICK INCISION IN GYNAECOLOGY AND GYNAEONCOLOGY: FORGOTTEN INCISION WITH MODERN RELEVANCE

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Objectives: To demonstrate the utility of the Turner–Warwick incision in complex pelvic gynaecological surgery through a high-risk anaesthetic case and to advocate for greater awareness of this versatile incision among gynaecologists and gynaecological oncologists.

Case report: A 42 year old patient with severe restrictive lung disease secondary to Charcot–Marie–Tooth disease and scoliosis required major pelvic surgery. Given the high risk associated with general anaesthesia, the procedure was successfully performed under combined spinal–epidural anaesthesia. A Turner–Warwick incision was used to obtain wide pelvic and abdominal exposure while preserving the advantages of a low transverse incision. The operation was completed without difficulty, with excellent visualization of the pelvis and satisfactory operative access. The postoperative course was uncomplicated, with effective analgesia, preservation of respiratory function and an excellent cosmetic outcome.

Discussion: Despite its versatility, the Turner–Warwick incision remains infrequently used in contemporary gynaecology and gynaecological oncology. By combining a low transverse skin incision with vertical extension of the anterior rectus sheath while preserving the rectus muscles, it provides exposure approaching that of a midline laparotomy while maintaining the cosmetic and functional benefits of a transverse incision.

It is particularly well suited for carefully selected patients with large fibroid uteri, benign or malignant ovarian tumours confined to the pelvis, fertility-preserving procedures and pelvic oncological surgery where upper abdominal exploration or cytoreduction is not anticipated. In young women, avoidance of a permanent midline scar represents an additional advantage.

Successful outcomes depend on meticulous surgical technique, particularly accurate identification and anatomical approximation of the fascial angles at the junction of the transverse and vertical components during closure, thereby minimizing the risks of wound dehiscence, incisional hernia and poor wound healing.

Conclusion: The Turner–Warwick incision is an under-recognized yet highly versatile approach that deserves wider adoption in modern gynaecological practice. For selected women with large pelvic pathology not requiring upper abdominal access, it offers exposure comparable to a midline laparotomy while preserving abdominal wall integrity and providing superior cosmetic outcomes. Familiarity with the operative anatomy and meticulous fascial closure are essential for successful implementation.

Increased training and experience with this incision may allow more gynaecologists and gynaecological oncologists to expand its use in appropriately selected patients.

OP053. REVITALISING THIN ENDOMETRIUM: PLATELET RICH PLASMA - HYPE OR HOPE?

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Introduction: Thin endometrium indicates the unresponsiveness to growth stimuli (refractory state) and represents an important clinical indicator for cancellations of embryo transfer (ET) cycles.

Several treatments, including exogenous estrogen, vitamin E, vaginal sildenafil and pentoxifylline, were clinically used but did not result in a definitive response from patients with a refractory thin endometrium. Platelet-rich plasma (PRP) has been extensively used as a cutting-edge technique for regeneration in different fields of medicine. A beneficial effect of PRP on endometrial thickness (EMT) and improvement of pregnancy outcome after hysteroscopic sub-endometrial infusion of platelet-rich plasma (PRP) has been suggested.

Objectives: The Primary Objective of the study is to see the effect of PRP on the endometrial thickness, while the secondary objective is to check the Clinical pregnancy rate.

Design: We conducted an interventional prospective cohort study. Women who had a history one previous IVF failure due to of refractory thin endometrium that remain unresponsive to conventional treatment were enrolled in this study. We included 50 patients (with informed consent) in the study.

Mehod- platelet rich plasma was prepared from autologous blood. Total 4ml of PRP is instilled under hysteroscopy guidance 1 ml into each wall of uterus.

Results: The endometrial thickness on the day of hcg trigger or at the end of estrogen priming day in frozen ET cycles was 5.0 ± 1.2mm and after intrauterine PRP instillation 6.7 ± 1.3mm, which suggest a statistically significant (< 0.001) increase in endometrial thickness after PRP instillation.

The clinical pregnancy rate before PRP instillation was 3.3% while after PRP instillation and transfer it went upto 31.9% which was significantly higher after PRP instillation.

To conclude, PRP can increase ET and improve pregnancy rate by providing a local milieu rich in growth factors. For women with thin endometrium, PRP is a treatment modality that is safe, easy to prepare, free of adverse effects and cost-effective, with no risk of immunologic reactions because it is prepared from autologous blood.

OP054. RISING INCIDENCE OF OVARIAN CANCER IN SRI LANKA: AN 18-YEAR TREND ANALYSIS

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Introduction: Ovarian cancer is the eighth most common cause of cancer and cancer death in women worldwide. It was the second most common gynecological cancer in Sri Lanka. In 2022, 1112 new cases of ovarian cancer were diagnosed in Sri Lanka. At diagnosis, approximately 95% of patients experience nonspecific symptoms such as abdominal pain, bloating and urinary urgency and frequency. This leads to diagnosis at advanced stages with limited treatment options and poor outcomes. Therefore, timely and accurate incidence data are essential for sound resource allocation decisions and effective public health planning.

Objectives: This study aimed to quantify temporal trends in ovarian cancer incidence in Sri Lanka from 2005 to 2022 and determine whether this burden has shifted differentially across age groups.

Design: A population-based retrospective trend analysis was conducted using national cancer registry data from 2005–2022.

Method: Newly diagnosed ovarian cancer patients recorded in the National Cancer Registry of Sri Lanka from 2005 to 2022 were analyzed. Age-standardized incidence rates (ASRs) per 100,000 females were calculated overall and by age subgroup. Temporal trends were assessed using Joinpoint regression software and the estimated annual percentage change (EAPC) with 95% confidence intervals (CIs) was computed to quantify trend magnitude and significance.

Results: A total of 15,765 ovarian cancer cases were identified, with a mean age at diagnosis of 54.3 years. The ASR increased from 6.4 per 100,000 females in 2005 (95% CI: 5.9 – 6.9) to 8.9 per 100,000 in 2022 (95% CI: 8.4-9.5), with an EAPC of 2.59 (95% CI: 1.45 – 3.74). A steeper increase occurred among women older than 50 years (18.9 to 28.2 per 100,000; EAPC: 2.8, $p < 0.001$) compared to those younger than 50 years (3.0 to 3.6 per 100,000; EAPC: 2.4, $p > 0.05$). Within the >50 group, the rise was concentrated in women aged 60-74 years, who showed a rise from 18.7 to 36.7 per 100,000 (approximately a 2-fold rise; EAPC: 4.3, $p<0.001$).

Conclusion: Ovarian cancer incidence in Sri Lanka has risen significantly over the past two decades. This rise is predominantly seen among postmenopausal women, particularly those aged 60 to 74 years. However the incidence among women under 50 is largely stable. As there is currently no national population-based screening programme for ovarian cancer, strengthening clinical suspicion within this at-risk group is imperative. Particularly with Sri Lanka's ageing population, clinicians bear a crucial responsibility in the care of these older women. Further research needs to be conducted to clarify the biological drivers causing this trend.

Keywords: ovarian cancer, incidence trends, age-standardized rates

OP055. SENTINEL LYMPH NODE MAPPING WITH INDOCYANINE GREEN IN EARLY ENDOMETRIAL CARCINOMA: A TWO-CASE EXPERIENCE

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Introduction and Objectives: Endometrial cancer (EC) is the second most common gynaecological malignancy worldwide, with a rising incidence in Sri Lanka (SL), partly due to the higher rates of obesity. Hysterectomy, bilateral salpingo-oophorectomy (BSO) and pelvic lymphadenectomy (PL) is the standard primary management in SL following diagnosis. However, PL is associated with high operative morbidity. Lymphadenectomy is required for accurate staging. Sentinel lymph node (SLN) biopsy is an acceptable alternative to PL in early EC. Here, we report two cases of SLN mapping using indocyanine green (ICG) in a resource limiting setting.

Patient 1 A 53-year-old postmenopausal woman presented with first episode of postmenopausal bleeding. Transvaginal scan demonstrated irregularly thickened endometrium with cystic spaces. Endometrium thickness (ET) was 15 mm. Hysteroscopy revealed a polypoid endometrial lesion suspicious for malignancy. Histopathological examination showed FIGO grade 1 endometrioid type endometrial carcinoma (EEC).

Patient 2 A 49-year-old perimenopausal woman presented with abnormal uterine bleeding. ET was 25 mm. Histopathological examination of the endometrial curettage specimen showed FIGO grade 1 EEC.

Contrast-enhanced computed tomography of the chest, abdomen and pelvis demonstrated no evidence of nodal spread or distant metastases in either case. Both patients underwent surgical staging comprising total laparoscopic hysterectomy, BSO and SLN biopsy. A total of 4 mL of ICG was injected into the cervix using superficial and deep injections at the 3'O and 9'O clock positions. Near-infrared fluorescence imaging was then used to identify the lymphatic channels and bilateral SLNs. Retroperitoneal spaces were evaluated. Sentinel drainage pathways originating from parametria were identified. Grossly enlarged or suspicious nodes were not seen. Successful bilateral SLN mapping was achieved in both patients and the identified nodes were harvested. The postoperative period was unremarkable in both.

Histopathology confirmed EEC with < 50% myometrial invasion. Bilateral SLNs were reactive and tumour-free, with no lymphovascular space invasion. Both patients were assigned a final surgical stage of FIGO IA and remained recurrence-free at 1-year follow-up.

Discussion: Nodal status is an important prognostic factor that determines the need for

adjuvant chemoradiotherapy. However, systematic PL is associated with prolonged operative time, increased blood loss, soft tissue injury, lymphocele formation and long-term lower limb lymphoedema.

The SENTI-ENDO, FIRES, SHREC and FILM trials collectively established that ICG-guided SLN biopsy is a highly accurate and oncologically safe alternative to systematic PL in EC, with superior detection rates and reduced surgical morbidity, supporting its incorporation into international staging guidelines.

Conclusion: Fluorescence imaging-guided SLN mapping for early EC enables less extensive surgery while improving postoperative quality of life. Wider availability of fluorescence imaging systems and ICG is essential to support its implementation in SL.

OP056. SUCCESSFUL DELIVERY OF A MOTHER AFFECTED BY METHEMOGLOBINEMIA

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Introduction: Methemoglobinemia is a rare disorder where hemoglobin is oxidized from its normal ferrous (Fe2+) state to the ferric(Fe3+) state causing reduced oxygen transport and causing tissue hypoxia. This condition can be congenital or acquired. During pregnancy, it causes maternal and fetal risks, making early diagnosis critical. Methylene blue is the standard treatment for symptomatic patients and it is generally avoided in pregnancy due to potential fetal risks and it requires alternative management.

Case report: A 33 year old pregnant lady (G4P3C3) at 20 weeks of gestation was admitted after an accidental fall. She was incidentally found to have low oxygen saturation (SpO2 of 90%) on room air, despite normal arterial partial pressure of oxygen (PaO2) and hemoglobin level (12 g/dL). She complained of exertional dyspnea but lacked cardiovascular or respiratory symptoms. Laboratory tests showed an initial methemoglobin level of 19.6% and the repeated methemoglobin levels 14.01% and 20.0%.

Brewer's test was done G6PD deficiency and found to be negative. Due to the fetal risks of methylene blue, she was treated with oral ascorbic acid. Fetal well-being and growth were monitored two weekly ultrasonography. Methemoglobinemia aggravating factors were avoided, drugs such as Metoclopramide, sulfonamides and few local anesthetics such as Benzocaine and Lidocaine. Baby was delivered via Lower segment cesarian section resulting delivery of a healthy neonatal outcome. Follow-up was arranged for both mother and baby right after delivery at hematology unit.

Discussion: Methemoglobinemia should be ruled out in pregnant patients with unexplained low oxygen saturation and normal arterial oxygen levels. Early intervention and avoidance of oxidizing agents prevent worsening hypoxia. Maternal hypoxia can lead to fetal hypoxemia, which increases risks for fetal growth restriction, oligohydramnios, preeclampsia, placental abruption, preterm birth and infant mortality.

Due to the safety of methylene blue remains uncertain due to potential teratogenic effects, ascorbic acid is preferred during pregnancy. Managing this condition requires regular methemoglobin monitoring, close fetal surveillance and multidisciplinary team care to achieve good maternal and neonatal outcome.

Conclusion: Early detection, early diagnosis and conservative management are vital for pregnancies complicated by methemoglobinemia. Replacing methylene blue with safer alternatives like ascorbic acid, combined with rigorous maternal and fetal monitoring, minimizes complications and ensures successful outcomes.

OP057. TEMPORAL TRENDS OF CERVICAL CANCER INCIDENCE IN SRI LANKA: AN 18-YEAR TREND ANALYSIS (2005–2022)

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Introduction: Cervical cancer is the fourth commonest cancer among women globally as well as in Sri Lanka. Cancer of uterine cervix is the second commonest in women in Asia and In Sri Lanka it is the commonest gynecological malignancy. There were 1227 new cases reported in 2022. Early detection and treatment of precancerous lesions (cervical intraepithelial neoplasia/CIN) has been central to Sri Lanka's prevention efforts since ap smear screening began nationwide in 1996. Still a majority of our patients are diagnosed at an advanced stage of the disease leading to poor outcomes. Updated incidence data are instrumental in ascertaining whether preventive interventions have measurable epidemiological impact.

Objectives: This study aimed to assess temporal trends in cervical cancer incidence in Sri Lanka from 2005 to 2022 and determine whether this burden has shifted differentially across age groups.

Design: A population-based retrospective trend analysis was conducted using national cancer registry data.

Method: Newly diagnosed cervical cancer patients recorded in the National Cancer Registry of Sri Lanka (2005–2022) were analyzed. Age-standardized incidence rates (ASRs) per 100,000 females were calculated overall and by age subgroup. Temporal trends were assessed using Joinpoint regression, with estimated annual percentage change (EAPC) and 95% confidence intervals (CIs) computed to quantify trend magnitude and significance.

Results: A total of 17,940 cervical cancer cases were identified, with a mean age at diagnosis of 58.5 years. The ASR remained largely unchanged, from 9.7 per 100,000 females in 2005 (95% CI: 9.1–10.4) to 9.8 per 100,000 in 2022 (95% CI: 9.2–10.3), corresponding to a statistically insignificant EAPC of 0.25 (95% CI: -0.76–1.29). No age subgroup (below 45, 45–59, 60–74, 75+, younger than 50, or older than 50 years) showed a statistically significant rise. However, the steepest increase was observed among women aged 75 years and above, rising from 29.3 to 41.1 per 100,000, a 1.4-fold increase (EAPC: 1.39, $p<0.05$).

Conclusion: Overall cervical cancer incidence in Sri Lanka has remained essentially stable over the past two decades, reflecting the sustained benefit of long-standing precancerous lesion detection through screening. The concern is greater for women who are outside of screening recommendations and too old to have been vaccinated, representing an ageing cohort at risk of being overlooked. As vaccinated cohorts have not yet reached peak-risk age, a vaccine-attributable decline may not yet be evident, though this could not be confirmed without individual-level vaccination data

Keywords: cervical cancer, incidence trends, age-standardized rates

OP058. TRENDS IN VULVO-VAGINAL CANCER INCIDENCE IN SRI LANKA: AN 18-YEAR POPULATION-BASED ANALYSIS

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Introduction: Vulval and vaginal cancers are uncommon gynecological malignancies. No specific screening exists for these cancers and the most effective strategy to reduce the incidence is the opportune treatment of predisposing and preneoplastic lesions associated with thie development. Diagnosis is frequently delayed due to vague symptoms such as vulval pruritus or pain. Misdiagnosis as benign dermatological or infective conditions is not uncommon, delaying biopsy to exclude invasive disease. Globally it accounts for 4% of gynecological malignancies and considered primarily as a disease of postmenopausal women. Hence it is important to examine incidence trends in Sri Lanka for better resource allocation as well as clinical decision making.

Objectives: To characterize temporal trends in vulvo-vaginal cancer incidence in Sri Lanka

between 2005 and 2022 and to evaluate whether these trends differ by age subgroup.

Design: A population-based retrospective trend analysis using national cancer registry data spanning 2005–2022.

Method: All histologically confirmed vulval and vaginal cancer cases recorded in the National Cancer Registry of Sri Lanka between 2005 and 2022 were included. Age-standardized incidence rates (ASRs, per 100,000 females) were calculated for the overall cohort and by age subgroup Joinpoint regression was used to model incidence trends over the study period and the estimated annual percentage change (EAPC) with 95% confidence intervals (CIs) was derived to quantify the magnitude of trend change.

Results: A total of 1592 vulvo-vaginal cancer cases were identified, with a mean age at diagnosis of 63.3 years. Of these, 47.3% (n=752) were vulval cancers and 52.7% (n=839) were vaginal cancers. The ASR increased from 0.61 per 100,000 females in 2005 (95% CI: 0.4-0.8) to 1.0 per 100,000 in 2022 (95% CI: 0.8 – 1.2), with an EAPC of 4.25 (95% CI: 2.36 – 6.18). The greatest rise occurred in women aged 60- 74 years, increasing from 2.72 to 5.24 per 100,000 (approximately a 2-fold rise; EAPC: 4.8, $p<0.001$). A significant increase in incidence was observed among women older than 50 years (2.2 to 3.9 per 100,000; EAPC: 4.7, $p < 0.001$), whereas women younger than 50 years showed a statistically non-significant decline (0.2 to 0.1 per 100,000; EAPC:2.80, $p>0.05$).

Conclusion: Vulvo-vaginal cancer incidence in Sri Lanka rose significantly over the study period. This has been driven almost entirely by women aged 60 and above. However the incidence under 50 remained largely unchanged. This likely reflects a gap in postmenopausal gynecological care rather than a true biological trend, as older women have less contact with gynecological services. Given that these lesions are directly visible, lowering the threshold for examination and biopsy in older women is a practical priority. Further research is needed to assess whether the rise reflects true rise in disease burden or improved case ascertainment.

Keywords: vulvo-vaginal cancer, incidence trends, age-standardized rates

OP059. TURNING AUDIT INTO ACTION: ENHANCING THE NEONATAL RESUSCITATION COMPETENCE THROUGH CLINICAL GOVERNANCE

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Objectives: To assess the standard practices in neonatal resuscitation among health care professionals working in the maternity care unit and improve self-confidence and knowledge.

Method: ology A clinical audit was conducted in ward 17 antenatal and postnatal ward staff; doctors, nursing officers and midwives using a structured self-administered questionnaire comprising multiple-choice questions and single-best-answer questions based on the Sri Lanka Neonatal Resuscitation Training Manual (2019) and Neonatal Resuscitation Programme (NRP),8th Edition. Knowledge scores were categorised as good (> 75%), satisfactory (50-75%) and poor (< 50%).

Results: Among the 36 participants, only one achieved a score of more than 75%, while 15 participants (41.7%) got a satisfactory score. The majority, 20 participants (55.6%), scored below 50%, revealing a significant knowledge gap. The audit findings were shared with the participants and we organised a comprehensive one-day Neonatal Resuscitation workshop at Colombo North Teaching Hospital, Ragama, in collaboration with the Perinatal Society of Sri Lanka on 4th March 2026.

This workshop consisted of evidence-based lectures by Consultant Neonatologists, simulation stations and hands-on skills sessions. There were 41 participants, including doctors, nursing officers and midwives working in all three maternity units in Colombo North Teaching Hospital, Ragama. Continuing Professional Development (CPD) accredited certificate was given upon successful completion of the course. Following this successful programme, there was a significant improvement in the day-to-day practice.

Conclusion: The knowledge and skills on neonatal resuscitation of the staff members working in the maternity care unit are a critical determinant of neonatal survival and the long-term outcome. Clinical audit is one of the pillars of clinical governance practices to im-

prove the quality of care. Therefore, identification of the knowledge gap and the implementation of continuous professional development is important for quality improvement in neonatal care.

OP060. WHEN SHE CANNOT CHOOSE: PREGNANCY, BRAIN INJURY AND A LEGAL VOID

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Objectives: Hyperemesis gravidarum complicated by Osmotic Demyelination Syndrome (ODS) is rare. We describe a woman who was permanently incapacitated by ODS and the ethical and legal challenges when there is no law exists for substitute decision making.

Case report: A 33-year-old woman (Gravida 3 para 1), living with a new partner and legally unmarried, developed severe hyperemesis gravidarum with fluctuating hyponatremia (serum sodium 113-136 mmol/l) in the first trimester. She became comatose following hyponatremic status epilepticus, likely due to rapid correction of serum sodium. Combined central pontine and extrapontine demyelination was confirmed on serial magnetic resonance imaging and persistent poor consciousness warranted tracheostomy and gastrostomy. As her partner has no legal standing, neither advanced directive available, her parents requested termination of pregnancy.

Termination was not beneficial or lawful and not what she would have chosen had she retained capacity. Conversely, the unborn fetus, unable to stand for his own rights, would be born without a family willing to assume his care.

A Multidisciplinary team was involved in best interest decision making, including specialists from obstetric, intensive care, general medicine, rehabilitation, the hospital director, hospital legal team and the child probation services. Her parents' consent was legally accepted for all medical care and investigations except termination.

Following preterm pre-labour rupture of membranes at 33 +4 gestation, she delivered a healthy baby boy weighing 1.9 kg, by caesarean section. The infant was sent to government probation as the family declined responsibility. Following two months of rehabilitation, mother was transferred to a local hospital closer to her residence.

Discussion: 0.2-0.7% of ODS reported in hyponatremia management among general population, whereas in pregnancy it is described only in isolated case reports. Controlled sodium correction with a rate < 8mmol/L/24hrs is the main preventive measure. Most challenges were legal and ethical, as the relatives' requests did not represent her interests. Many countries have capacity legislations like best interest standards, independent advocacy and judicial review through a court of protection while we must invent a solution "ad hoc, institution level, as Sri Lanka still follows the archaic Mental Disease Ordinance.

Conclusion: This case highlights meticulous sodium management to prevent ODS in hyponatremia following hyperemesis. There is an urgent need for national legislation and guidance on substitute decision making for the incapacitated pregnant woman together with clinical ethics committees and integrated child welfare.

E-POSTER PRESENTATIONS (EP)

EP001. A CASE OF SUPERIMPOSED PRE-ECLAMPSIA IN A RENAL TRANSPLANT RECIPIENT: CHALLENGES IN DIAGNOSIS AND MANAGEMENT

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Introduction: Pregnancy in a renal transplant recipient is a high-risk situation, which require a delicate balance between graft preservation and feto-maternal well-being. Here is a case of donor renal transplant with superimposed preeclampsia in a 32-week primigravida, highlighting the diagnostic dilemmas and multidisciplinary management.

Case report: A 32 year old primigravida at 32 weeks of gestation, with a history of living-donor renal transplantation for chronic kidney disease was on post-transplant immunosuppressive regimen. It included Tacrolimus, Azathioprine and prednisolone. At 28 weeks, she was admitted with new onset hypertension with blood pressure of 160/100 mmHg. Labetalol was initiated and titrated to control blood pressure.

There was an initial suspicion of graft rejection, but renal biopsy was not done due to risks in pregnancy. Serial monitoring revealed a progressive rise in serum creatinine from a baseline of 1.2 mg/dL to 1.8 mg/dL at 30 weeks, together with new onset proteinuria. Additionaly, fetal ultrasound demonstrated symmetric intrauterine growth restriction with an estimated fetal weight below the 3rd centile. A diagnosis of superimposed preeclampsia on underlying chronic kidney disease was made with that.

Due to worsening maternal renal function and fetal compromise, a decision was made at 32 weeks to deliver the baby. Dexamethasone was given for fetal lung maturation. A lower segment cesarean section (LSCS) was performed under spinal anesthesia, with careful surgical technique to avoid injury to the transplanted kidney which was located in the right iliac fossa. A live female infant of 1.2 kg was delivered with good Apgar scores.

Following delivery, the patient's blood pressure normalized within 48 hours and labetalol was gradually tapered. Her immunosuppressive regimen was continued and serum creatinine stabilized at 1.3 mg/dL by day 5. The diagnosis of preeclampsia was confirmed by the classic postpartum resolution of hypertension and proteinuria. Both mother and baby had an uneventful recovery.

Discussion: This case highlights the challenge of distinguishing preeclampsia from graft rejection or worsening chronic kidney disease in transplant recipients. The presence of new-onset proteinuria, rising creatinine and hypertension after 20 weeks, together with IUGR, pointed towards preeclampsia. The decision to avoid renal biopsy, empirical management, timely LSCS, with meticulous surgical planning to protect the graft, contributed to a favorable outcome. This case highlights the importance of a multidisciplinary approach involving obstetricians, nephrologists and neonatologists in managing such complex pregnancies.

Conclusion: Superimposed preeclampsia in renal transplant recipients requires a high index of suspicion and multidisciplinary care. Early diagnosis and planned delivery can optimize maternal and neonatal outcomes.

EP002. A HIDDEN CULPRIT OF HEMOPERITONEUM: SPONTANEOUS UTERINE VENOUS PLEXUS RUPTURE IN PREGNANCY

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Objectives: Spontaneous rupture of the uterine venous plexus is a rare but life-threatening cause of hemoperitoneum in pregnancy. It mimics placental abruption closely and may occur with no identifiable risk factor. We report such a case and how the diagnosis was reached.

Case report: A 39-year-old para 2 at 29+5 weeks presented with sudden, severe right-sided abdominal pain, peritonism and shoul-

der-tip pain, yet remained hemodynamically compensated. Ultrasound showed a viable pregnancy with an anterior placenta and no abruption - but moderate free intra-abdominal fluid, suggesting hemoperitoneum. Haemoglobin was 10.5 g/dL.

Emergency laparotomy found an intact uterus and approximately 1 litre of hemoperitoneum. Hysterotomy delivered a live 1300 g male infant (Apgar 4, 6, 8) who required neonatal intensive care for prematurity. The source was active bleeding from a ruptured right uterine venous plexus within the broad ligament - no uterine tear, no arterial involvement, no endometriosis or adnexal pathology. Figure-of-eight suture ligation controlled it. Estimated blood loss was approximately 1.5 litres, requiring 4 units of packed red cells and postoperative haemoglobin was 9.8 g/dL. She was monitored in intensive care for 4 days, hemodynamically stable with no further bleeding and discharged once the neonate was stable. Follow-up at 6 weeks was uneventful.

Discussion: Spontaneous hemoperitoneum in pregnancy is rare - fewer than 200 cases reported worldwide - with maternal mortality around 5% and fetal mortality exceeding 30%. Vaginal bleeding is characteristically absent, which distinguishes it from placental abruption and ultrasound cannot reliably localize the bleeding source. Diagnosis is therefore usually made at laparotomy. One series recorded presumptive preoperative diagnoses of hemoperitoneum of unknown cause (37%), placental abruption (26%), uterine rupture (11%) and appendicitis (7%). Endometriosis, advanced maternal age, assisted reproduction and multiple pregnancy are the recognised risk factors. This patient had none of them. Prompt resuscitation and laparotomy with vessel ligation, as performed here, remain the mainstay.

Conclusion: Spontaneous uterine venous plexus rupture belongs in the differential of an acute abdomen in mid-to-late pregnancy, even where vaginal bleeding and risk factors are both absent - as they were here. Ultrasound got as far as free fluid; laparotomy supplied the diagnosis and figure-of-eight ligation secured it. Mother and infant both survived.

EP003. A NEW WAY TO PLACE PELVIC DRAINS USING THE BIKINI LINE IN FRONT OF THE ANTERIOR RECTUS SHEATH FOR DIFFICULT GYNAECOLOGICAL SURGERY: FIRST RESULTS FROM A FEW CASES

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Background: Pelvic drains are sometimes used after major gynaecological and obstetric surgeries. They help doctors quickly spot bleeding after surgery, keep an eye on fluid buildup in the pelvis and stop fluid from collecting. Usually, drains are put in through a separate cut in the abdomen that goes through the rectus muscle. This can make patients feel more pain after surgery, hurt the abdominal wall, leave a noticeable scar and potentially damage blood vessels. We're sharing our first experience with a new method for placing drains. It uses the bikini line area and goes in front of the rectus muscles. This aims to cause less muscle damage and put the drain exit where it's hidden and looks better.

Method: We looked back at the records of five patients who had pelvic drains placed using this new bikini-line technique after complex open obstetric and gynaecological surgery. The drain was inserted through a small opening in the tissue in front of the rectus muscles, just below the main surgical cut, along the bikini line. It was then guided into the pelvis through the natural space between the rectus muscles, without going through the muscle itself. We reviewed patient information, why they had surgery, what happened during surgery, any problems with the drain, how they recovered and how the scars looked.

Results: The technique worked well for all five patients without any issues. The surgeries included one emergency C-section with a tear on the side of the uterus, three total hysterectomies where both ovaries and fallopian tubes were removed along with extensive removal of stage IV endometriosis and one open surgery to remove large fibroids. All drains worked as they should and were removed easily. There was no bleeding at the drain site, no damage to blood vessels, no infections at the surgical site, no blocked drains and no need for more surgery because of the drain placement. Patients

reported little discomfort at the drain site after surgery, which helped them move around sooner. All drain sites healed well with barely noticeable scars hidden below the bikini line and in the pubic hair area, leading to very good cosmetic results.

Ethical considerations: Written informed consent was obtained from the patient for drain placement in case of complex surgeries, as a routine process. Then, retrospectively, written informed consent was obtained for publication of this case series and accompanying clinical information/images.

Conclusion: This first look at a few cases shows that placing pelvic drains in front of the rectus muscles along the bikini line can be a safe and workable option instead of the usual way for certain complex gynaecological and obstetric surgeries. This method might help patients feel more comfortable and look better by not going through the rectus muscle and by hiding the drain exit along the bikini line, all while the drain still works properly. These initial results are promising, but since it's a small group of patients, they should be viewed with some caution. We need larger studies that compare this method to the standard ones to see if it really reduces pain after surgery, lowers the need for pain medication, makes patients happier with the results, improves how the scars look and is safe in the long run.

EP004. A PROSPECTIVE AUDIT ON TECHNIQUE OF IRON ADMINISTRATION IN PREGNANT WOMEN IN A TERTIARY CARE HOSPITAL IN SRI LANKA

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Introduction: Iron deficiency anaemia remains a global public health concern among pregnant women. In low- and middle-income countries, anaemia affects nearly 50% of pregnant population and increases maternal and fetal risks such as postpartum haemorrhage, preterm labour, low birth weight, small for gestation and maternal and perinatal death3. As Iron deficiency remains the leading cause for nutritional anaemia with an estimated prevalence of 35.36% in pregnant women in Sri Lanka4, supplementation is a key preventive strategy. Daily supplementation of 30-60mg of elemental Iron is recommended in pregnancy,3. However, incorrect practices such as taking iron with meals or alongside calcium supplements or concomitant intake of food or drugs affecting Iron absorption such as proton pump inhibitors, antacids, thyroxine, tea, coffee, milk, soy and eggs can significantly impair absorption. Therefore, it is recommended to administer 1 hour before or 2 hours after meals or inhibitors of iron absorption. Administration of vit. C to enhance Iron absorption can be considered; however, evidence for this is debatable.

Objectives: To assess knowledge and practices related to iron administration among pregnant women.

Design: A prospective audit

Method: A prospective audit was conducted among 64 pregnant women attending antenatal clinic with a period of gestation 20 weeks or more, using an interviewer-administered questionnaire. Data was analyzed using SPSS statistics.

Results: Although 87.5% of participants had received advice on iron intake, only 68.8% followed correct timing practices. While 90.6% reported taking iron with vitamin C, only 53.1% avoided interfering foods and medications. Proper spacing between calcium and iron was observed in 75% of participants.

These findings demonstrated gaps between recommended and actual iron administration practices among participants. Based on the findings, counseling on iron administration were arranged during monthly antenatal counseling sessions including advices on separation of iron and calcium supplements and avoidance of food types that interfere iron absorption. Posters on correct iron administration in Sinhala and Tamil were displayed at antenatal clinics for further continuity of education.

Conclusion: The baseline audit identified that significant gaps remain in correct iron administration practices among pregnant women. Strengthening antenatal education is essential for effective Iron administration to prevent anaemia related health consequences in pregnant women.

The findings helped in developing targeted measures to improve antenatal counseling. A repeat audit cycle after the interventions will be undertaken to assess improvement of the practices and complete the audit cycle.

EP005. A RARE CASE OF A FINGERTIP ENDOMETRIOSIS

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Objectives: To report a rare presentation of extra-pelvic cutaneous endometriosis involving the fingertips and to identify the importance of recognising cyclical cutaneous symptoms in relation to menstruation.

Case report: This is a case of a previously healthy 20-year-old girl who presented with a painful swelling and violaceous discoloration of the dorsal parts of her right index and ring fingers for the three months. The symptoms showed a typical cyclical pattern, beginning one day prior to menstruation and resolving on the final day of menstrual flow. She also reported secondary dysmenorrhea for two years without any pelvic pain, dyschezia, dysuria, prior surgical history, or sexual activity.

Upon general examination she was healthy and hemodynamically stable and it revealed a well-demarcated hyper-pigmented periungual lesions over the ring and index finger. Basic laboratory investigations, abdominal and pelvic ultrasonography, chest radiography and echocardiography showed no abnormal findings. She underwent a punch biopsy of the lesion which showed endometrial glands within the dermis surrounded by spindle-cell stroma with adjacent hemosiderin deposition. Further testing showed heterogeneous oestrogen receptor positivity in the glandular epithelium and CD10 positivity in the surrounding stromal cells, confirming the diagnosis of cutaneous endometriosis. Complete surgical excision was performed, resulting in full recovery and complete resolution of symptoms.

Discussion: Endometriosis is a phenomenon characterized by the presence of endometrial tissue outside the uterus, most commonly seen in other pelvic organs but occasionally presenting in extra-pelvic sites. Cutaneous endometriosis is a rare subset entity, classified as primary or secondary, with proposed mechanisms including retrograde menstruation, coelomic metaplasia, Müllerian remnants and lymphovascular dissemination. Fingertip involvement represents an exceptionally rare manifestation. Clinically, it often presents with cyclical pain, swelling, or discolouration in relation to menstruation, which serves as a key diagnostic clue. Histopathological examination remains the gold standard for diagnosis. Surgical excision is both diagnostic and curative, while hormonal therapy may be used as an adjunct. Early recognition is crucial, particularly in women presenting with cyclical painful finger lesions even without prior surgery or known pelvic endometriosis.

Conclusion: In this case, a rare presentation of an extra-pelvic cutaneous endometriosis can be easily misdiagnosed due to its uncommon location and presentation. This case underscores the importance of identifying the cyclical patterns of this phenomenon. Histopathological diagnosis remains the gold standard diagnosis for this whilst surgical excision remains as both diagnostic and curative modes with excellent clinical outcomes. This raises awareness of such diseases to avoid diagnostic dilemmas and early identification and facilitates appropriate management.

EP006. A RARE CASE OF A FOREIGN BODY INCARCERATED IN THE UTERUS

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Objectives: Awareness of the diagnostic challenges and management of foreign bodies in the female genital tract and the importance of a sensitive, multidisciplinary approach, particularly in cases involving vulnerable populations or potential abuse.

Case report: We present a 35-year-old woman already diagnosed with athetoid cerebral palsy with a 3-month history of foul-smelling vaginal discharge and chronic pelvic pain. No history of fever or other symptoms of sepsis. She has had regular menstruation. General examination was unremarkable and a vaginal examination revealed a hyperemic, enlarged cervix with a grey-green mass incarcerated at the cervical os, associated with copious malodor-

ous discharge. Ultrasound was done which showed an irregular hyperechoic uterine mass. Examination under anesthesia identified an empty plastic balm container (40 × 40 × 50 mm) lodged in the uterus, with necrotic tissue and purulent discharge. The object was removed, the cavity irrigated and intravenous Cefuroxime, Metronidazole, Gentamicin were administered for 48 hours. The patient recovered well, with a normal postoperative ultrasound and was discharged on day 3 after family counseling.

Discussion: Female genital tract foreign bodies are often underdiagnosed and overlooked and can present across all age groups with varied objects, from toys in children to tampons, medical devices, or illicit items in adults. Patients may present with pelvic pain, discharge, or bleeding, requiring exclusion of malignancy, infections and pregnancy or even with severe forms of sepsis. Evaluation includes detailed history, genital examination and imaging or endoscopy when needed. Consent is essential, especially in children or suspected abuse cases. Retained objects can cause severe complications such as infection, infertility, necrosis, fistulas, or rarely toxic shock syndrome. Management involves removal, possible surgical input, antibiotics and addressing psychosocial factors for comprehensive care.

Conclusion: This case depicts the rarity of its presentation and it is important In patients with persistent, foul-smelling vaginal discharge accompanied by pelvic pain, a retained foreign body should always be considered as a possible cause. While imaging studies can be helpful, the diagnosis is best confirmed through vaginoscopy or hysteroscopy.

EP007. A RARE CASE OF BARTHOLIN DUCT CYST LEADING TO POSTERIOR VAGINAL WALL LUMP MIMICKING RECTOCELE

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Introduction: Bartholin duct cyst is a fluid filled lump develops closer to the vaginal opening. It usually asymptomatic lump and becomes painful following infection and abscess formation. Rarely it causes local, symptoms due to increase in size. It is common around sexually active premenopausal age group ranging from 20-50yrs. Often associated with bacterial infection such as E. coli and chlamydia, gonorrhoea like sexually transmitted infections (STI). Although the diagnosis is usually straightforward because of their characteristic anatomical location, atypical presentations may pose a significant diagnostic challenge and mimic other pelvic floor or vaginal pathologies.

Case report: A 46 years old premenopausal lady who is a mother of 2 presented with lump at vulva for more than 1 year duration with gradually increase in size leading to sexual dysfunction without any pain, bleeding, discharges, bladder and bowel symptoms. On further inquiry she denies any risk factors for pelvic floor weakness and utero-vaginal prolapse except 2 uncomplicated vaginal deliveries. On vaginal examination, there was a lump arising from the middle part of the posterior vaginal wall which was irreducible, not become prominent with Valsalva manoeuvre & vaginal mucosa was freely mobile over the lump. On further assessment there was no coexisting perineal defects, anterior and apical vaginal prolapses. Digital rectal examination revealed lump possibly arising from rectovaginal septum with freely mobile rectal mucosa. Ultrasound evaluation revealed well defined thin-walled cyst with echogenic fluid containing diffuse fine internal echos without increased vascularity. Thus, she was undergone lump excision under spinal anaesthesia. She had a cyst filled with pus like material was send for culture and cyst wall sent for histology. It revealed cyst arising from Bartholin duct and negative culture. She was completely improved following surgical excision and postoperative antibiotics.

Discussion: Even though Bartholin duct cyst is a common gynaecological condition, in the given scenario the location of the cyst is an atypical presentation. It mimicked the cyst arising from the rectovaginal septum, directing towards the atypical Gartner's cyst, which develops from the remnants of the mesonephric ducts. Other possible differential diagnoses were inclusion cyst, endometriotic nodule and dermoid cyst. But they were unlikely due to her presentation, signs and symptoms. As it

carried an uncertainty about the underlying pathology, histology provided the definitive diagnosis. Culture was needed to rule out infection as it commonly associated with E. Coli and STIs. Complete enucleation and excision of cyst wall was done to prevent the recurrence of condition.

Conclusion: As this is an unusual presentation of Bartholin duct cyst, there was a diagnostic dilemma which was confirmed by histological assessment. Complete excision of the cyst wall with a course of anti-microbials completed the recovery.

EP008. A RARE CASE OF LARGE FETAL MEGACYSTIS COMPLICATED BY UROPERITONEUM

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Introduction: Fetal megacystis is defined as bladder diameter > 7 mm between 11+0 and 13+6 weeks of gestation, with a male-to-female ratio of 8:1. It occurs approximately 1 in 1600 - 3000 pregnancies. The commonest causes are obstructive uropathy, including posterior urethral valve and urethral atresia or stenosis, while non-obstructive cases are usually associated with chromosomal abnormalities. We report a rare case of large fetal magacystis complicated by uroperitoneum.

Case report: A 27-year-old woman in her second pregnancy presented for the booking visit at 15 weeks of gestation. Ultrasound demonstrated a single live fetus appropriate for gestational age with a 5X4X4cm 3 large abdomino-pelvic cystic lesion. Fetal medicine assessment revealed gross megacystis, bilateral hydronephrosis suggestive of obstructive uropathy, gross fetal ascites consistent with uroperitoneum, pleural effusion, a single umbilical artery and a large atrial septal defect. The patient received regular antenatal follow-up and was counseled regarding the poor fetal prognosis.

At 36+3 weeks, she presented with prelabour rupture of membranes and abdominal pain. Ultrasound confirmed intrauterine fetal death with overlapping skull bones and marked abdominal distention of approximately 20 cm in diameter. Following counseling, a trial of vaginal delivery was undertaken. Labour became obstructed by the enlarged abdomen, requiring ultrasound-guided aspiration of around 2 L of fetal ascitic fluid to facilitate the delivery. A macerated fetus with severe abdominal distension was delivered. Postmortem examination demonstrated a ruptured and markedly distended urinary bladder with multiple congenital anomalies.

Discussion: Fetal magacystis is associated with obstructive uropathy and chromosomal abnormalities, while progression to uroperitoneum is rare. Prognosis depends on the underlying cause, degree of urinary tract obstruction and availability of fetal interventions. In cases of massive abdominal distension, decompression of the fetal abdomen can facilitate vaginal delivery and reduce maternal morbidity.

Conclusion: Fetal megacystis with multiple congenital anomalies should raise suspicion of an underlying chromosomal abnormality. Early diagnosis enables appropriate counseling, prognostication and individualized management of the pregnancy.

EP009. A RARE CASE OF TRANSMIGRATION OF A COPPER INTRAUTERINE CONTRACEPTIVE DEVICE INTO THE ANTERIOR ABDOMINAL WALL

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Introduction: Copper intrauterine contraceptive device (Cu-IUCD) is a commonly used non-hormonal long-acting reversible contraceptive method. It is a highly effective method with a very low failure rate. Transmigration of IUCD is a common complication; it can lead to a spectrum of presentations and complications according to the site of entrapment. Transmigration to the anterior abdominal wall is a rare site of entrapment reported in the available literature.

Case report: A 50-year-old mother of 3 children who had undergone 2 previous caesarean sections presented with swelling in the anterior abdominal wall for 2 months' duration with recent inflammatory features over the lump. On

further inquiry, she had been on a copper intrauterine contraceptive device (Cu-IUCD) for 7 years and her last child is 12 years old. On examination, there was an inflamed area noted over the midline of the suprapubic region of the anterior abdominal wall and no IUCD thread was seen in speculum examination. On ultrasound evaluation, her uterus was retroverted and no IUCD was in situ. A further echogenic object was identified in the fat layer of the anterior abdominal wall suggestive of Cu-IUCD and planned to be explored under anaesthesia. During the surgery, a transmigrated Cu-IUCD was identified in the fat layer of the anterior abdominal wall.

Discussion: Common adverse effects of Cu-IUCD are expulsion, perforation, pelvic inflammatory disease, ectopic pregnancy, heavy menstrual periods and irregular spotting. Transmigration of Cu-IUCD is a rare but catastrophic complication; usually it occurs at the time of insertion. Reported incidence is between 1 and 3 per 1000 IUCD insertions. The patient may develop clinical features according to the site of transmigration. Transmigration of IUCD can be diagnosed using ultrasonography, X-ray and rarely with MRI & CT imaging. Usually, it may need surgical extraction via laparoscopic or open surgical approaches. General surgical, urology and gastrointestinal surgical opinion may be required depending on the site of transmigration. In the given scenario, it migrated to the subcutaneous fat layer of the anterior abdominal wall. This is a very rare site of transmigration of a Cu-IUCD. According to the available literature, incorrect technique, inadequate assessment of the uterus, retroversion and presence of uterine comorbidities such as fibroids, scar tissue and myometrial defects are common underlying factors behind the IUCD transmigration.

Conclusion: Transmigration of IUCD can lead to a wide spectrum of symptoms depending on the site of entrapment. It can be minimised by using correct technique, timely removal and proper patient selection and preprocedural assessment. Further, patients need to be clearly educated regarding the follow-up of the intrauterine systems.

EP010. A RARE PRESENTATION OF COMPLETE TRANSVERSE VAGINAL SEPTUM WITH AN ASSOCIATED IMPERFORATE HYMEN CAUSING MASSIVE HAEMATOCOLPOS IN AN ADOLESCENT GIRL: A CASE REPORT

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Objectives: Our primary aim here is to share the diagnostic difficulties and initial management steps for a highly unusual obstructive Müllerian anomaly. The patient presented with cryptomenorrhoea and amenorrhoea and we want to highlight, why recognizing these complex, dual structural issues early and making an early tertiary care referral is so important.

Case report: A 15-year-old girl came to our unit experiencing primary amenorrhoea alongside worsening, cyclical lower abdominal pain that strongly suggested cryptomenorrhoea. She also had a noticeable, progressively growing mass in her lower abdomen. When we performed an ultrasound, we found two large haematocolpos cavities, pointing clearly to a distal genital tract obstruction.

We took her to theatre for an examination under anaesthesia. Interestingly, we discovered a complete transverse vaginal septum and located right on the upper aspect of that septum was an imperforate hymen. Because we did not have access to an MRI prior to the intervention, we proceeded with a hymenectomy. This successfully drained the trapped menstrual blood and immediately relieved her symptoms. We also thoroughly checked for any associated urinary tract anomalies and found none. After stabilizing the patient, we referred her to a tertiary centre for the definitive excision of the vaginal septum.

Discussion: A transverse vaginal septum happens when the Müllerian ducts fail to canalise properly with the urogenital sinus, which is rare enough on its own. Finding one coexisting with an imperforate hymen is exceptionally uncommon. While ultrasound is excellent for spotting the obstructed blood collections, we really prefer using an MRI to map out the exact septal anatomy before attempting major surgery. To fix this permanently, the patient needs a complete excision of the septum at a specialised centre, combined with strict post-

operative measures to prevent restenosis (scarring and narrowing).

Conclusion: Dealing with two obstructive genital tract anomalies at once is a major clinical challenge. By diagnosing the massive haematocolpos early and performing a prompt decompression, we successfully relieved the patient's pain, ruled out urinary issues and arranged a safe tertiary referral. Taking these rapid steps is essential to protect a young patient's future reproductive and menstrual function.

EP011. A RARE PRESENTATION OF PEDIATRIC BURKITT LYMPHOMA MIMICKING BILATERAL MALIGNANT OVARIAN TUMORS IN AN 11-YEAR-OLD GIRL: A RARE CASE REPORT

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Objectives: Primary or secondary ovarian involvement by Non-Hodgkin Lymphoma (NHL) accounts for less than 1% of childhood ovarian tumors in the pediatric population. The clinical and radiological picture often overlaps with the features of advanced epithelial or germ cell ovarian malignancies, with considerable diagnostic errors. This case report emphasizes the need for analysis and further evaluation of childhood tumors.

Case report: An 11-year-old girl presented with a two-month history of intermittent, pricking abdominal pain and worsening pelvic pain that limited her mobility. She exhibited progressive weight loss, lowgrade fever and constitutional symptoms. Examination revealed a large, non-tender, palpable abdominopelvic mass.

Investigations revealed microcytic anemia (Hb 7.6g/dL), elevated ESR (53mm/1st hr) and normal renal function. Tumor markers showed significantly elevated Lactate Dehydrogenase (LDH 2486 U/L) and CA-125 (217U/mL), while alpha-fetoprotein and beta-hCG were within normal limits. Ultrasound and Contrast-Enhanced Computed Tomography (CECT) identified massive, bilateral solid malignant ovarian masses (12times 6 times 7cm) with moderate ascites, alongside secondary deposits on the right lateral pelvic wall and left external iliac lymphadenopathy. The patient underwent an exploratory laparotomy, bilateral oophorectomy, tumor debulking and pelvic lymph node dissection. Histopathology confirmed a high-grade, diffuse ovarian Non-Hodgkin Lymphoma. Following oncological referral, a staging bone marrow biopsy reclassified the malignancy as Burkitt Lymphoma. The patient was promptly commenced on a multi-agent chemotherapy regimen (COP+R).

Discussion: Pediatric ovarian Burkitt lymphoma is extremely rare and it's presentation is quite similar to advanced germ cell or epithelial tumors. Despite the presentation of bilateral masses, ascites and elevated CA-125 indicate gynecological cancer. However markedly elevated LDH provided critical insight towards a diagnosis of hematological malignancy. Even though the surgery enabled definitive tissue diagnosis, Burkitt lymphoma is primarily treated with aggressive multi-agent chemotherapy, not radical debulking. This case highlights the diagnostic complexity of adolescent pelvic masses and emphasizes the necessity to include LDH in initial evaluations to facilitate accurate and timely diagnosis to avoid unnecessary fertility-compromising surgeries and initiate life-saving systemic treatments promptly.

Conclusion: Pediatric ovarian Burkitt lymphoma is a rapidly progressing and its presentation resembles an advanced gynecological malignancy. This case emphasizes the necessity of checking serum LDH in atypical pediatric pelvic masses. Prompt histopathological evaluation and bone marrow staging are critical to initiating correct, life-saving systemic chemotherapy.

EP012. A RARE VULVAL SARCOMA PRESENTING AS A RECURRENT BARTHOLIN-LIKE LESION

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Objectives: To highlight the diagnostic challenge of a recurrent Bartholin-like lesion and emphasize the high index of suspicion in a young patient to avoid delaying the definitive management.

Case report: A 32-year-old, Para2, otherwise healthy patient presented with a recurrent painless lump on the right side of the vulva for two months and underwent two marsupialisa-

tions. There were no associated lymphadenopathy and no skin Ulceration or changes of the overlying skin. Despite the surgical treatments, she had experienced similar recurrent swellings. As she had recurrent presentations, the specimen was sent for histopathological evaluation, which revealed angiomyofibroblastoma, a benign mesenchymal tumour in the vulva. Following these findings, she had undergone Wide Local Excisions (WLE) three times due to recurrent presentation for this benign condition.

The most recent histology report came with three differential diagnoses of undifferentiated pleomorphic sarcoma, pleomorphic rhabdomyosarcoma and embryonal rhabdomyosarcoma. Contrast-enhanced CT was performed due to the unavailability of Magnetic Resonance Imaging (MRI); it showed vulval carcinoma without involvement of paravaginal tissues. This patient had undergone Wide Local Excision at Apeksha Hospital, Maharagama

Discussion: Primary vulval carcinomas are very rare conditions, accounting for less than 5% of gynaecological malignancies. They have a nonspecific presentation, such as recurrent Bartholin-like lesions.

Vulval sarcomas are comprising of heterogenous group of histological subtypes, including Leiomyosarcomas, epithelioid sarcomas, liposarcomas, fibrosarcoma, rhabdomyosarcoma, angiosarcoma, malignant hemangiopericytomas, neurogenous sarcomas, dermatofibrosarcoma protuberans, Ewing sarcomas, synovial sarcomas, clear cell carcinomas and aggressive angiomyxomas. Embryonal sarcomas are present commonly in girls less than 8 years. The rhabdomyosarcomas follow a bimodal age distribution which most commonly in girls under 5 years of age and showing a second peak during adolescence. But the presence of rhabdomyosarcomas in adults is extremely rare (1%) and shows atypical presentations. The lesions are most commonly misdiagnosed as Bartholin cysts or abscesses, resulting in delayed diagnosis.

Vulval sarcomas are aggressive tumours with distal metastasis, which require complete surgical excision followed by Chemotherapy with targeted Radiotherapy.

Conclusion: Recurrent Vulval lesions should be carefully evaluated by an experienced person and in general, there should be a low threshold for possible carcinoma in younger patients. Management of recurrent malignant lesions should be planned in a multidisciplinary team with Gynaecological and Clinical Oncology specialists to avoid suboptimal management.

EP013. A SUCCESSFUL PREGNANCY IN SEVERE CALCIFIC RHEUMATIC MITRAL STENOSIS AND SEVERE PULMONARY HYPERTENSION; A CASE REPORT

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Objectives: Severe rheumatic mitral stenosis (MS) with pulmonary hypertension (PHT) confers a modified WHO (mWHO) Class III to IV risk in pregnancy. This case is presented to describe the importance of a multidisciplinary approach to continue pregnancy of a woman with severe calcific MS and PHT, who is no longer suitable for balloon valvotomy.

Case report: A 33-year-old primiparous woman presented at 11 weeks of gestation with dyspnoea and nocturnal cough. On examination, she was hypoxic and tachycardic. Auscultation revealed a loud P2 and echocardiography confirmed rheumatic MS with moderate PHT; she was transferred to the intensive care unit and underwent emergency percutaneous transvenous mitral commissurotomy. Her course was complicated by acute kidney and lung injury and her pregnancy ended as a spontaneous miscarriage. A subdermal contraceptive implant was inserted following counseling. A year later she requested to conceive and echocardiography showed persistent but improved valve disease and pregnancy was permitted under close multidisciplinary surveillance. In her second pregnancy, serial echocardiography demonstrated progressive valve calcification with a Wilkins score of 10 out of 16, precluding repeat valvotomy. At 18+6 weeks of gestation, she was admitted with difficulty in breathing and found to have pulmonary oedema secondary to a respiratory

infection superimposed on severe MS and PHT.

She was managed with antibiotics, diuretics, thromboprophylaxis and avoidance of tachycardia-provoking bronchodilators. A multidisciplinary team comprising obstetrician cardiologist, anaesthetist and general physician agreed a structured plan of fortnightly review, elective admission at 30 weeks and delivery at 32 to 34 weeks. She underwent lower-segment caesarean section at 32 weeks and required postpartum intensive care, post delivery echocardiography findings were unchanged from her last antenatal assessment. Cardiology follow-up was arranged in accordance with RCOG/ ESC recommendations for postpartum surveillance.

Discussion: This case highlights the poor tolerance of fixed orifice MS to pregnancy-induced tachycardia and volume expansion and the value of the Wilkins score in determining suitability for balloon valvotomy. Structured medical management within a dedicated multidisciplinary team is central to safe outcomes where percutaneous intervention is not feasible, with vigilance extending into the postpartum period.

Conclusion: With proactive multidisciplinary planning, a woman with severe calcific rheumatic MS and severe PHT who is unsuitable for percutaneous intervention can still be carried safely to a planned delivery. This case reinforces the value of pre-pregnancy counseling, mWHO risk stratification, individualized medical management and continued postpartum surveillance in high-risk maternal cardiac disease.

EP014. ACCESSORY CAVITATED UTERINE MALFORMATION: CASE REPORT

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Background: Accessory cavitated uterine malformation (ACUM) is a rare problem with the uterus. It's when there's a separate, hollow space inside the uterus that has a functional lining, but the rest of the uterus is normal. It usually shows up in young women who have really bad period pain that gets worse over time. This pain often doesn't get better with medicine, so it takes a while to figure out what is wrong. Doctors sometimes mistake it for fibroids that are breaking down or for adenomyosis.

Case report: We saw a 26-year-old woman who hadn't had children. She had period pain that kept getting worse, even though her periods were regular and the flow was normal. The pain had been building up for years and was making it hard for her to live her life, do daily activities and go to work. She tried several treatments with hormones and painkillers, but nothing really helped. An ultrasound showed a fluid-filled lump, about 5 by 4 cm, inside the muscle of her uterus. An MRI suggested it could be a degenerating fibroid or an ACUM. Because her symptoms were so bad and the scans weren't clear, she had surgery to look inside. During the surgery, they found a well-defined cyst inside the uterine muscle. They removed it completely, keeping the rest of the uterus intact. Tests on the removed tissue showed the cyst wall was lined with glands and tissue similar to the uterine lining and it was surrounded by muscle. This confirmed it was an ACUM. After the surgery, her period pain went away completely. Her quality of life improved a lot and she could get back to her normal daily and work routines.

Conclusion: If a young woman has severe period pain that doesn't get better with treatment, even with normal periods and imaging shows a distinct cyst within the uterine muscle, ACUM should be considered. It's important to tell the difference between ACUM, cystic adenomyosis and degenerating fibroids, though it's hard to diagnose before surgery. Removing the cyst completely not only confirms the diagnosis but also fixes the problem, relieving symptoms while keeping the uterus healthy.

Keywords: Accessory cavitated uterine malformation; ACUM; secondary dysmenorrhea; Müllerian anomaly; intramyometrial cyst; laparotomy; uterine-sparing surgery.

EP015. ACTIVE MANAGEMENT OF THIRD STAGE OF LABOUR ON REDUCING POSTPARTUM ANAEMIA: AUDIT IN A TERTIARY CARE HOSPITAL

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Introduction: Postpartum haemorrhage (PPH) remains a leading cause of maternal morbidity and mortality globally. In Sri Lanka, despite robust healthcare infrastructure, PPH contributes significantly to maternal anaemia, increasing the need for blood transfusions and prolonged hospital stays. The Active Management of the Third Stage of Labour, particularly the administration of prophylactic uterotonics with the delivery of the anterior shoulder, is a cornerstone of PPH prevention. However, adherence to this protocol can vary in busy clinical settings.

Objectives: To assess the impact of a targeted educational intervention on the compliance with active management of third stage of labour protocols and its subsequent effect on the incidence of symptomatic postpartum anaemia requiring blood transfusion in a tertiary care labour room.

Method: ology A two-cycle clinical audit was conducted at the Ward 7 Labour Room, National Hospital Kandy. The baseline audit (Cycle 1) retrospectively reviewed 246 consecutive vaginal deliveries over three months to identify risk factors and current practices. A re-audit (Cycle 2) was performed in the subsequent month (Month 4) following a structured lecture and reinforcement of active management of third stage of labour guidelines for the midwifery and nursing staff. Data collected included patient parity, timing of Syntocinon administration, controlled cord traction practices, time to episiotomy suturing and the rate of symptomatic anaemia requiring transfusion.

Results: Baseline data (Cycle 1) revealed that 11% of postnatal mothers required blood transfusions due to symptomatic anaemia, with 62% of these being primigravida. While controlled cord traction was performed in 100% of cases, the critical protocol of administering Syntocinon with the delivery of the anterior shoulder was followed in only 12% of deliveries. In the remaining cases, administration was delayed. The mean time from delivery to episiotomy repair was 35 minutes. Following the educational intervention (Cycle 2), compliance with the correct timing of Syntocinon administration dramatically improved to 86%. Concomitantly, the rate of symptomatic anaemia requiring blood transfusion dropped significantly to 4%.

Conclusion: This audit demonstrates a strong correlation between the timely administration of Syntocinon during the third stage of labour and a substantial reduction in severe postpartum anaemia. A simple, low-cost educational intervention targeting nursing and midwifery staff significantly improved adherence to active management of 3rd stage of labour protocols and led to a marked decrease in the need for blood transfusions. Regular training and re-audits to sustain this practice, particularly focusing on primigravida mothers who appear to be at higher risk, to further enhance maternal outcomes in resource-limited settings will be beneficial.

EP016. ACUTE ABDOMEN: RECTUS SHEATH HEMATOMA

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Objectives: Importance of considering RSH in the differential diagnosis of acute abdominal pain during pregnancy.

Case report: A 30-year-old gravida 2, para 1+1 woman at 30+4 weeks' gestation presented with sudden-onset severe right-sided abdominal pain following repeated episodes of forceful coughing associated with an untreated lower respiratory tract infection. She was haemodynamically stable but clinically pale and febrile. Ultrasonography demonstrated a large, well-defined anterior abdominal wall mass consistent with a rectus sheath haematoma, while the pregnancy appeared otherwise uncomplicated. Shortly after admission, maternal clinical deterioration and a non-reassuring fetal cardiotocograph necessitated emergency exploratory laparotomy and lower

segment caesarean section. Intraoperatively, a massive rectus sheath haematoma was identified, with complete transection of the right inferior epigastric artery and rupture of the rectus abdominis muscle. Surgical evacuation of the haematoma, arterial repair, muscle reconstruction, blood transfusion and postoperative intensive care resulted in a favourable maternal outcome. The respiratory infection resolved with appropriate medical treatment and the patient was discharged on the eleventh postoperative day.

Discussion: Rectus sheath hematoma (RSH) is a rare but potentially life-threatening cause of acute abdomen in pregnancy, most commonly occurring during the third trimester. It is usually precipitated by coughing, vomiting, trauma, or straining, resulting in rupture of the inferior epigastric vessels or rectus muscle fibers. Pregnancy-related stretching of the abdominal wall further increases susceptibility. Clinical features include sudden localized abdominal pain, a palpable abdominal wall mass, anemia and, in severe cases, hypovolemic shock, making RSH a diagnostic challenge because it can mimic other obstetric emergencies such as placental abruption, uterine rupture and HELLP syndrome. Ultrasonography is the preferred first-line imaging modality during pregnancy, while MRI is valuable when ultrasound findings are inconclusive. Management is guided by the patient's hemodynamic status. Stable patients with non-expanding hematomas are usually managed conservatively with analgesia, fluid resuscitation and close observation. In contrast, patients with ongoing hemorrhage, enlarging hematomas, or hemodynamic instability require arterial embolization or surgical evacuation with definitive haemostasis.

Conclusion: Spontaneous rectus sheath haematoma due to inferior epigastric artery rupture is an exceptionally rare cause of acute abdomen in pregnancy. A high index of suspicion, early imaging and prompt multidisciplinary surgical intervention are crucial when maternal or fetal compromise develops. This case highlights the importance of considering RSH in the differential diagnosis of acute abdominal pain during pregnancy, particularly following episodes of vigorous coughing.

EP017. ACUTE ABDOMEN: SPONTANEOUS HAEMOPERITONEUM IN PREGNANCY (SHIP)

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Objectives: Red herring of Acute Abdomen with the diagnostic difficulty and life-threatening nature of SHiP, particularly in the third trimester.

Case report: This is a 32-year-old primigravida with a history of multiple treatments for primary subfertility for seven years presented to us at 31+3 weeks of gestation with severe lower abdominal pain accompanied with reduced fetal movements. Following admission there was a progressive clinical deterioration.

Upon examination it revealed that she was pale, with significant tachycardia and generalized abdominal tenderness. Laboratory investigations showed significant anemia with hemoglobin of 7.3 g/dL. Ultrasound demonstrated a live fetus with moderate to gross free intraperitoneal fluid, without evidence of placental abruption or uterine rupture. Cardiotocography showed features of fetal compromise.

Due to a suspected hemoperitoneum from the aforementioned presentation, an emergency laparotomy with lower segment cesarean section was performed. Approximately 2 liters of hemoperitoneum were excavated and multiple actively bleeding endometriotic deposits were identified on the uterine surface; there were no features of uterine rupture. A live preterm neonate was delivered and admitted to the neonatal intensive care unit. Hemostasis was achieved with electrocautery and hemostatic sutures and the patient required intraoperative blood product transfusion. Her postoperative recovery was uneventful.

Discussion: Spontaneous hemoperitoneum in pregnancy (SHiP) is a rare, potentially fatal obstetric emergency, most commonly occurring in the third trimester. Early pregnancy cases are due to ectopic or heterotopic pregnancy, while in the later part of trimester the presentations result from rupture of fragile uterine vasculature, often associated with Endometriosis. Patients typically present with acute abdominal pain, hypovolemia, or fetal distress, mimicking other obstetric emergencies. Diagnosis is very challenging and often is

confirmed intraoperatively. Immediate hemodynamic resuscitation and surgical intervention is critical. Third-trimester cases usually require cesarean delivery, while second-trimester cases carry a high miscarriage risk and require careful multidisciplinary management and follow-up.

Conclusion: Spontaneous hemoperitoneum in pregnancy (SHiP) is a rare, life-threatening obstetric emergency with high maternal and perinatal morbidity. Often misdiagnosed as diagnosis is difficult due to nonspecific symptoms and inconclusive imaging. A high index of suspicion is essential in pregnant women with acute abdominal pain and hypovolemia. Prompt resuscitation and surgical intervention is very important. Timely laparotomy improves outcomes, while multidisciplinary care in specialized centers is recommended to optimize maternal and fetal survival.

EP018. ACUTE ABDOMINAL PAIN IN SECOND TRIMESTER OF PREGNANCY: A CASE OF COMPLETE OVARIAN TORSION

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Objectives: Ovarian torsion represents a complex gynaecologic emergency characterised by the rotation of the ovary on its vascular axis, which can lead to ischemia, haemorrhagic infarction and necrosis. While it primarily affects women of reproductive age, its occurrence during pregnancy is particularly challenging due to non-specific clinical features. Timely diagnosis and intervention are essential to protect ovarian viability and future fertility.

Case report: A 32, year-old primi-gravida, who had a history of polycystic ovaries and conceived with ovulation induction, at 13+1 weeks of gestation presented with a sudden onset of worsening right-sided groin pain, nausea and vomiting over a 24-hour period. Physical examination revealed right lower quadrant tenderness and muscular guarding.

An initial ultrasound (USG) showed a heterogeneous enlarged right ovary and free fluid in the pouch of Douglas, with Doppler studies indicating normal blood flow.

Following clinical deterioration, an urgent laparotomy was performed, confirming a right ovarian torsion. Due to the presence of gangrene and oedema, a right oophorectomy was executed. Histopathological examination validated the diagnosis. The woman went on to have a successful pregnancy after the surgical procedure.

Discussion: The incidence of adnexal torsion during pregnancy is estimated at 1 in 5,000 women, occurring most frequently during the first and early second trimesters. Right-sided torsion is more common, possibly because the right utero-ovarian ligament is longer or the sigmoid colon limits movement on the left side of the pelvis. Diagnosis remains difficult as the condition often mimics other pathologies such as ectopic pregnancy, appendicitis, or ruptured ovarian cysts. USG is a critical diagnostic tool, often revealing ovarian enlargement, oedema, or the "whirlpool sign," though normal Doppler findings do not entirely rule out the possibility of torsion. While conservative detorsion is a treatment option, it carries a potential recurrence risk of 20% during the same pregnancy, making adnexectomy necessary in cases where the tissue is non-viable.

Conclusion: Ovarian torsion is a demanding and serious condition during pregnancy that necessitates high clinical suspicion and immediate medical or surgical intervention to ensure effective management.

EP019. ADVANCED GESTATIONAL TROPHOBLASTIC DISEASE: A CASE REPORT OF OPTIMIZATION OF SURGICAL MANAGEMENT

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Objectives: To describe the presentation, diagnostic workup and management of complete hydatiform mole in 54-year-old woman presenting with life threatening vaginal bleeding and to emphasize the importance of individualized surgical management and postoperative β-human chorionic gonadotropin (β-hCG) surveillance in women with completed childbearing.

Case report: 54-year-old multiparous woman presented with heavy vaginal bleeding for 10 days after six weeks of amenorrhea. She also

complained of lower abdominal pain, dizziness and symptoms suggestive of anemia. On examination, she was pale but hemodynamically stable with an enlarged uterus corresponding to approximately 20 weeks' gestation. Laboratory investigations revealed severe anemia (hemoglobin 7.8 g/dL) and a markedly elevated serum β-hCG concentration (>273,200 mIU/mL). Pelvic ultrasonography demonstrated diffuse echogenic intrauterine material with multiple cystic spaces, consistent with a complete hydatidiform mole. Though blood transfusion was started, the patient developed sudden heavy vaginal bleeding with passage of grape like vesicles, necessitating emergency resuscitation. A total abdominal hysterectomy with bilateral salpingo-oophorectomy was performed considering her age, completed parity, persistent hemorrhage and the possibility of gestational trophoblastic neoplasia. Then histopathology report confirmed a complete hydatidiform mole without myometrial invasion. The patient recovered well after surgery and was placed on serial serum β-hCG follow-up to exclude persistent trophoblastic disease.

Discussion: Although hydatidiform mole is more commonly seen in younger women, it can also occur after the age of 50. This case shows the importance of maintaining a differential diagnosis when evaluate abnormal uterine bleeding in perimenopausal and postmenopausal women. Markedly elevated β-hCG levels together with characteristic ultrasonographic findings facilitate early diagnosis. However, histopathological examination remains the definitive method of confirmation. Hysterectomy can be offered as an effective treatment for carefully selected patients who no longer desire fertility and presenting with severe bleeding or suspected malignant transformation. Serial β-hCG monitoring remains essential because postoperative gestational trophoblastic neoplasia can still occur.

Conclusion: Complete hydatidiform mole should remain a differential diagnosis in women presenting with abnormal uterine bleeding and uterine enlargement, irrespective of age. Early diagnosis, prompt stabilization and timely surgical intervention can be lifesaving in patients with severe hemorrhage. Serial postoperative β-hCG surveillance is critical to ensure early detection of persistent trophoblastic disease and achieve favorable long-term outcomes.

EP020. ADVERSE PERINATAL OUTCOMES ASSOCIATED WITH DELAYED DIAGNOSIS OF MYOTONIC DYSTROPHY IN PREGNANCY

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Introduction and Objectives: Myotonic dystrophy type 2 (DM2) is an autosomal dominant multisystem disorder caused by a mutation in a single gene located on chromosome 3q21. The onset of DM2 typically occurs in the third decade of life, while myotonia (90%) and muscle weakness (82%) are its hallmark features. This report describes the challenging diagnosis of DM2 during the third trimester and its multidisciplinary management.

Case report: A 32-year-old woman in her third pregnancy, with a history of molar pregnancy (G1) and emergency hysterotomy complicated by early neonatal death (G2), presented at 30 weeks of gestation with worsening breathlessness, bilateral thigh pain and proximal muscle weakness. Her biological sister had experienced similar but milder symptoms during pregnancy. Examination revealed bilateral partial ptosis, percussion and grip myotonia, myopathic facies and laboured breathing. Her pre-pregnancy BMI was 17 kg/m^2. Previous assessment for visual disturbances had demonstrated posterior subcapsular cataracts.

Initial investigations showed markedly elevated creatine phosphokinase levels (10,015 U/L) and raised inflammatory markers. Arterial blood gas analysis demonstrated type II respiratory failure. Chest ultrasonography showed symmetrical diaphragmatic movements, while electrocardiogram revealed sinus rhythm without conduction abnormalities. Owing to worsening lower respiratory tract infection, she was transferred to the obstetric intensive care unit and successfully managed with intravenous antibiotics and supportive therapy.

Further evaluation with electromyography demonstrated characteristic "dive bomber" myotonic discharges, confirming myotonic dystrophy. Fetal assessment showed appropriate growth with polyhydramnios. Her course was further complicated by hyperglycaemia requiring insulin therapy. Following the onset of preterm uterine contractions, an emergency caesarean section under combined spinal–epidural anaesthesia was performed at 33+2 weeks. A floppy female infant weighing 1560 g was delivered and intubated for poor respiratory effort. Despite intensive neonatal care, the infant died on day five from respiratory failure. The maternal postoperative course was uneventful. Bereavement and genetic counselling were provided. Phenytoin was for prescribed for symptomatic treatment. Specialised neurology follow-up was arranged.

Discussion: Myotonia and muscle weakness in DM2 often worsen during pregnancy, particularly in the third trimester and improve postpartum. Maternal risks include impaired ventilation, arrhythmias, dysfunctional labour, uterine atony and postpartum haemorrhage. Magnesium sulphate should be used with caution in preterm labour and pre-eclampsia. Fetal myotonia relates to complications related to reduced fetal swallowing and movements; polyhydramnios and breech presentation.

Conclusion: DM2 is a rare genetic disorder with significant feto-maternal morbidity and mortality. Timely diagnosis, genetic counselling, multidisciplinary care of patients and families are the cornerstones of management.

EP021. ADVERSE PREGNANCY OUTCOMES AND ASSOCIATED FACTORS AMONG PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS IN SRI LANKA

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Introduction: Systemic lupus erythematosus (SLE) mainly affects women of reproductive age and is associated with increased risk of adverse pregnancy outcomes. Only limited data is available from the South Asian region regarding adverse pregnancy outcomes in SLE patients.

Objectives: This study evaluated pregnancy outcomes and associated clinical and serological factors in women with SLE.

Design: A retrospective study was conducted using data from the University of Colombo Lupus Cohort (COL-LUPUS). This cohort provided adequate longitudinal clinical, serological and pregnancy data suitable for evaluating pregnancy outcomes and associated risk factors.

Method: Ethical approval for the study was obtained from the Ethics Review Committee of Faculty of Medicine, University of Colombo. Patient consent was obtained prior to data collection. Study period was from November 2025 to April 2026. All female patients who attended University nephrology and rheumatology clinics at National Hospital of Sri Lanka during the time period, who met appropriate diagnostic criteria for SLE were included in the study. Patients who had overlap syndromes or were not ethnically Sri Lankan were excluded. Adverse pregnancy outcomes studied included fetal loss (miscarriages, intrauterine deaths and therapeutic abortions), fetal growth restriction, preeclampsia and eclampsia. Data on pregnancy outcomes, clinical and serological parameters related to SLE were collected using clinic records and patient history. Data was analyzed using SPSS version 26 and associations were assessed using independent t-tests and chi-square tests. Missing data were handled using multiple imputation.

Results: Of 111 patients, 94.6% (n=105) were female and 59.0% (n=62) had at least one pregnancy, accounting for a total of 148 pregnancies. Fetal loss occurred in 29.7% (n=44) pregnancies with 23.64% (n=35) miscarriages, 5.40% (n=8) intrauterine deaths and 0.67% (n=1) therapeutic abortion. Preeclampsia and fetal growth restriction occurred in 10.1% (n=15) and 14.9% (n=22), respectively. Biopsy proven lupus nephritis was significantly associated with adverse pregnancy outcomes ($p = 0.016$). Mean age at diagnosis, antiphospholipid antibody and anti-dsDNA positivity, presence of diabetes, hypertension and number of SLE related flares were not associated with adverse pregnancy outcomes ($p > 0.05$).

Limitations include the retrospective design, potential selection and recall bias, limited sample size and single-center setting, which may restrict the generalizability of the findings.

Conclusion: Adverse pregnancy outcomes are common in women with SLE with miscarriages being the commonest. Renal involvement was found to be significantly associated with adverse pregnancy outcomes.

EP022. AN UNDIAGNOSED AORTO-PULMONARY WINDOW WITH SEVERE PULMONARY HYPERTENSION PRESENTING WITH HYPOXEMIA IN LATE SECOND PREGNANCY: A CASE REPORT

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Background: Aorto-pulmonary window (APW) is a rare congenital cardiac anomaly that usually presents in infancy due to early development of pulmonary hypertension and heart failure. Presentation during pregnancy is exceptionally uncommon, particularly in previously asymptomatic women.

Case report: We report a 37 years old G2 P1 C1 woman at 37+1 weeks of gestation who presented with spontaneous rupture of membranes and severe hypoxemia with oxygen saturation of 69% on room air. Initial investigations suggested pneumonia with pulmonary hypertension, while pulmonary embolism and cardiomyopathy were excluded. During labour, worsening hypoxemia necessitated emergency lower segment caesarean section and intensive care management. Persistent desaturation despite treatment prompted further multidisciplinary evaluation. Specialist echocardiography performed by a paediatric cardiologist revealed a large 3 cm aorto-pulmonary window with severe pulmonary hypertension. The patient was managed with sildenafil therapy and ambulatory oxygen support, resulting in gradual clinical improvement.

Outcome: The patient gradually improved with Phosphodiesterase inhibitor therapy, oxygen supplementation and multidisciplinary care. She was discharged on postpartum day 25 with home oxygen support and continues follow-up under cardiology and respiratory teams for management of severe pulmonary hypertension secondary to Aortopulmonary window.

Conclusion: This case highlights the diagnostic challenges of previously undiagnosed congenital heart disease presenting during pregnancy and emphasizes the importance of multidisciplinary management and specialist congenital cardiac assessment in patients with unexplained hypoxemia and pulmonary hypertension.

EP023. AN UNEXPECTED POSTPARTUM SPIRAL: MRSA TOXIC SHOCK SYNDROME PRESENTING WITH BLISTERING DERMATOSIS

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Introduction and Objectives: Toxic shock syndrome (TSS) is a potentially fatal, exotoxin-mediated, multi-organ dysfunction syndrome caused by specific strains of Staphylococcus aureus or Streptococcus pyogenes. Postpartum women are at higher risk of invasive bacterial infections due to disruption of mucosal barriers, retained products of conception, invasive procedures and relative immunosuppressed state. TSS is a preventable cause of maternal mortality. This report outlines the early recognition and successful management of postpartum TSS.

Case report: A 31-year-old primigravida underwent an elective caesarean section on maternal request following an uneventful antenatal period. On postpartum day seven, she presented with vaginal bleeding and ultrasonography demonstrated retained products of conception, for which uterine evacuation was performed. On postpartum day eight, she developed high fever, perineal rash and lower limb oedema. Examination revealed a diffuse erythematous "sunburn-like" rash with blister formation and shallow ulceration over the perineum and lower limbs. An inflamed pharynx was also noted. Due to haemodynamic instability, she was transferred to the obstetric in-

tensive care unit. Investigations showed anaemia (haemoglobin – 7.9 g/dL), marked neutrophilic leucocytosis, elevated inflammatory markers, direct hyperbilirubinaemia, transaminitis and elevated serum creatinine. The coagulation profile was normal, with no evidence of haemolysis or disseminated intravascular coagulation (DIC). A clinical diagnosis of TSS secondary to blistering cellulitis was made. She was commenced on intravenous meropenem, clindamycin and linezolid, with aggressive fluid resuscitation and supportive therapy. Penicillins were avoided due to a history of allergy. Blood and urine cultures yielded no growth. Methicillin-resistant Staphylococcus aureus (MRSA) was isolated from perineal skin and high vaginal swabs. Clindamycin was continued according to antibiotic sensitivity results. Classic skin desquamation was first noted on postpartum day eighteen and managed with topical emollients. She achieved complete recovery after fourteen days of intravenous antibiotics.

Discussion: TSS is a rare entity caused by well-known pathogens. The diagnosis of TSS should always be considered in the clinical context of postpartum pyrexia, especially in the presence of suggestive dermatological manifestations. Staphylococcal TSS is characterised by blister formation. Exotoxins act as superantigens, triggering massive, non-specific T-lymphocyte activation and cytokine release. This results in systemic vasodilation, capillary leakage, organ hypoperfusion and shock. Apart from their antimicrobial effects, both clindamycin and linezolid inhibit exotoxin synthesis, thereby helping to prevent fatal complications such as DIC and acute respiratory distress syndrome.

Conclusion: The diagnosis of TSS remains clinical. Postpartum TSS is a medical emergency. Early recognition and prompt treatment ensure a favourable maternal outcome.

EP024. ANTENATAL KNOWLEDGE AMONG TERM PREGNANT WOMEN: DESCRIPTIVE CROSS-SECTIONAL STUDY AT NATIONAL HOSPITAL KANDY

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Introduction: Antenatal education equips pregnant women with knowledge required to make informed decisions throughout pregnancy, labour and the postpartum period. Knowledge regarding preconception health, labour induction, pain relief, breastfeeding, postpartum contraception and maternal mental health is important for informed decision-making. Identifying gaps in maternal knowledge can guide targeted antenatal education. This study assessed antenatal knowledge among term pregnant women admitted to an obstetrics ward at the National Hospital Kandy, with the areas assessed informed by recommendations from the National Maternal and Newborn Strategic Plan of Sri Lanka (2017–2025), the National Institute for Health and Care Excellence (NICE) and the Family Health Bureau (FHB) of Sri Lanka.

Objectives: To assess antenatal knowledge among term pregnant women admitted to an obstetrics ward at the National Hospital Kandy.

Design: Descriptive cross-sectional study.

Method: Forty-seven term pregnant women admitted to an obstetrics ward were recruited consecutively. Participants who could understand Sinhala or Tamil were included. An anonymous, structured, self-administered questionnaire assessed knowledge regarding preconception folic acid supplementation, labour induction, episiotomy, labour analgesia, postpartum contraception, breastfeeding and postpartum mental health. Data were analysed using descriptive statistics and presented as frequencies and percentages.

Results: Awareness of episiotomy (89.4%) and adequacy of breastfeeding education (97.9%) were high. However, important knowledge gaps were identified regarding labour analgesia and postpartum mental health. Only 21.3% of women were aware of pethi-

dine analgesia and 14.9% of epidural analgesia, while 57.4% could not identify any method of labour analgesia. Only 19.1% reported receiving adequate information regarding epidural analgesia, with lack of information being the most commonly reported reason for declining epidural analgesia. Awareness of postpartum depression was 80.9%, while 83.0% were aware that medical help could be sought for postpartum mental health conditions. Knowledge of specific labour induction methods was limited, with 36.1% identifying prostaglandin tablet insertion, 36.1% syntocinon infusion and 2.8% mechanical methods. Although 91.5% were aware that folic acid should be taken for three months before conception, only 53.2% reported taking it for the recommended duration.

Conclusion: This study identified important gaps in antenatal knowledge, particularly regarding labour analgesia, specific methods of labour induction and postpartum mental health. Although knowledge was relatively good regarding episiotomy, breastfeeding and preconception folic acid recommendations, reported preconception folic acid use remained lower. These findings support the need for structured, targeted antenatal education, including patient information leaflets and dedicated education sessions addressing labour analgesia, labour induction and postpartum mental health.

EP025. ANTERIOR ABDOMINAL WALL NECROSIS MIMICKING CRYPTIC POSTPARTUM SEPSIS FOLLOWING CAESAREAN SECTION

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Objectives: To report a rare case of anterior abdominal wall necrosis presenting as postpartum fever after an uncomplicated cesarean section.

Case report: A 28-year-old primi mother with an uncomplicated antenatal history underwent a Lower Segment Cesarean Section (LSCS) at term due to failed induction of labour. On postopertive day two, she developed a high-grade fever with high inflammatory markers (high white blood cell count and C-reactive protein). A complete septic screening was done. The investigations including blood cultures, high vaginal swabs, chest radiographs and a 2D echocardiogram was negative. There were no evidence of deep intra-abdominal or pelvic collections in combined transabdominal and transvaginal ultrasound scan.

Her fever did not settle with empirical antibiotic treatment with cephalosporin. After obtaining medical and surgical team opinion, she was treated with intravenous piperacillin-tazobactam escalating antibiotics. A contrast-enhanced computed tomography (CECT) scan of the abdomen and pelvis was done following surgical opinion. The scan revealed localized inflammatory changes and necrosis within the anterior abdominal wall, with an omental patch underneath the surgical entry site. The team agreed for conservative management and continue intravenous antibiotics for 14 days. The patient responded to the treatment and inflammatory markers came in to normal range.

Discussion: Postpartum fever following a Cesarean section usually caused by endometritis, pelvic abscesses, or systemic infections. Rare causes like focal abdominal wall necrosis should be considered when routine septic screens are negative, It typically arises from localized tissue ischemia, microvascular thrombosis, or low-grade deep tissue inflammation along the surgical incision. As seen in this case report, an omental patch naturally forms to localize the inflammation, protecting the deeper peritoneal cavity. Severe abdominal wall necrosis often needs aggressive surgical debridement. Early radiological detection helps to non-invasive successful treatment with broad-spectrum antibiotics alone.

Conclusion: In patient with persistent postpartum fever, rare causes like anterior abdominal wall necrosis should be suspected with elevated inflammatory markers and negative septic screening. Early CECT imaging can help in definitive diagnosis and to prevent unnecessary surgical interventions that can be managed safely and conservatively.

Keywords: Abdominal wall necrosis, Postpartum pyrexia, Cesarean section complication, Computed tomography, Conservative management

EP026. "ARE WE READY WHEN SECONDS MATTER?" A SURVEY OF OBSTETRIC EMERGENCY MANAGEMENT KNOWLEDGE AND SKILLS

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Introduction: This survey was carried out to assess the knowledge and confidence in selected obstetric emergencies, including Postpartum Haemorrhage (PPH), Shoulder dystocia, Cord prolapse, Uterine inversion, Maternal collapse and Eclampsia.

Objectives: To evaluate the knowledge and confidence of health care providers in managing obstetric emergencies and identifying the deficiencies to improve the quality of care.

Method: ology We have used a self-administered questionnaire in English and Sinhala medium regarding the identification, management and individualised role in each obstetric management: Postpartum Haemorrhage, Shoulder dystocia, Cord prolapse, Uterine inversion, Maternal collapse and Eclampsia. The survey was carried out in ward 17 antenatal ward, postnatal ward and labour room health care staff during 1st of October to 31st of October 2025 with 36 participants. The confidence level was assessed using a 5-point Likert scale.

Results: There were 36 participants; among them, 12(33%) were doctors, 16 (44%) were nursing officers, while the rest of 8 were midwives. 72% of them had more than 5 years of experience in obstetric care. We assessed the knowledge in each category in each selected emergency. When considering the overall performance, there were poor scores in management of maternal collapse, eclampsia, uterine inversion and shoulder dystocia. Regarding the Management of PPH and cord prolapse, they had satisfactory knowledge. We assessed the confidence level and individual role in each situation. The majority had 65% moderate confidence level, while 10% had very good confidence, but the rest of the 25% had a poor confidence level considering the overall scenarios.

Following the identification of gaps in each emergency, we organised a standard two-day emergency obstetric workshop including lectures, simulation stations and hands-on skills sessions. Finally, the knowledge and the skills were assessed and it revealed significant improvements in each category. Standard Emergency Algorithms for the above emergencies were prepared for future reference at the ward.

Conclusion: The management guidelines and practices of the obstetric emergencies are changing day by day. New knowledge should be introduced to have optimised care in the routine practice. The skills should be simulated routinely; continuous professional development, following clinical governance, is very important to improve the quality of maternity care; furthermore, it will improve the confidence level of the health care providers, leading to better clinical outcomes.

EP027. ASEPTIC OR BACTERIAL MENINGITIS? A DIAGNOSTIC DILEMMA FOLLOWING SPINAL ANAESTHESIA FOR CERVICAL CERCLAGE: A CASE REPORT

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Objectives: Meningitis is a rare complication of spinal anaesthesia. Overlapping clinical and cerebrospinal fluid (CSF) findings often make difficulty in differentiation between bacterial and aseptic meningitis. We report a pregnancy associated case highlighting the diagnostic uncertainty and management challenges.

Case report: A 34-year-old woman in her second pregnancy, with a previous second trimester miscarriage, underwent an elective McDonald cervical cerclage at 13 weeks of gestation under spinal anaesthesia. The procedure was uneventful. On postoperative day two, she developed severe back pain, headache, vomiting, irritability and confusion. Magnetic Resonance Imaging (MRI) brain showed diffuse leptomeningeal enhancement without focal abnormalities. CSF analysis revealed red blood cells 18,800/mm^3, polymorphs 1,743/mm^3, lymphocytes 483/mm^3, protein 185 mg/dL and glucose 11 mg/dL, with a blood glucose of 122 mg/dL. Gram stain and CSF cultures were negative. Empirical ceftriaxone was commenced and later

changed to meropenem as bacterial meningitis could not be excluded. She recovered completely within 48 hours without further neurological sequelae. Meropenem continued for 14 days. A repeat lumbar puncture at the end of treatment showed normal CSF with no biochemical or microbiological evidence of ongoing bacterial infection. The main management dilemma was whether extending antibiotics to 21 days was necessary despite sterile cultures, rapid clinical recovery and normalized CSF findings.

Discussion: This case illustrates the difficulty of distinguishing aseptic meningitis from culture negative bacterial meningitis after spinal anaesthesia. The rapid complete recovery, negative cultures strongly suggested aseptic meningitis. However, the profound reduction in CSF glucose, neutrophilic pleocytosis and elevated protein were more consistent with bacterial meningitis, making it unsafe to discontinue antibiotics early. Culture negative bacterial meningitis is commonly seen, particularly after partial treatment or when bacterial load is low. In such situations, treatment decisions must depend on the overall clinical picture rather than culture results alone.

Conclusion: Post spinal meningitis remains a diagnostic challenge, particularly when microbiological confirmation is lacking. Early recognition, prompt empirical antibiotic therapy and close clinical reassessment are essential.

EP028. AUDIT ON PRACTICING DATING ULTRASOUND SCANS

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Background: Accurate determination of gestational age is an essential component of antenatal care as estimated date of delivery (EDD) influences the pregnancy Plan and management of the pregnancy surveillance and timing the delivery. Even though we are calculating it from her last regular menstrual period we have to confirm correct dates by early ultrasound scans. Currently available evidence has proven that expected delivery date (EDD) calculation by early ultrasound scan (dating ultrasound scan) is superior to calculation by last menstrual period (LMP) dating is uncertain and unreliable. Benefits of dating ultrasound scan includes better EDD prediction, lesser past dates inductions, lesser premature deliveries, earlier detection of multiple pregnancies, better accuracy of serum screening for aneuploidy, etc. According to updated ISUOG practice guideline on "Performance of 1st trimester fetal ultra sound scans" published in 2023, pregnant women should be offered an early ultrasound scan between 11weeks + 0 days and 14weeks +0days to determine gestational age. Whereas NICE recommended as 11+2 to 14+1. but these are essentially overlapping windows

Objectives: To audit the practice of early pregnancy dating ultrasound scan against the recommended timing in current NICE and ISUOG guidance and identify the gaps in implementing at GSFHW/THM

Method: A clinical audit was conducted among 100 antenatal mothers admitted to Antenatal Ward 4, Teaching Hospital Mahamodara /(GERMAN SRI LANKA FRIENDSHIP HOSPITAL FOR WOMEN). Data were collected regarding gestational age at booking, timing of the first ultrasound scan and whether gestational age was subsequently revised following ultrasound assessment.

Results: OF the 100 mothers were included in the audit, 82% (82) of mothers belong to age category of 20 – 34 years, 3 % (3) was teenage mothers and 15 % (15) was elderly mothers. Majority of mothers (38%- 38) were primi mothers, whereas 31 % (31) of mothers in their second pregnancy and 31% (31) of mothers in their third or subsequent pregnancy. Out of 100 mothers, 42% (42) mothers had booking visit before the 11th week of pregnancy and another 21 % (21) mothers had booking visit between 11 – 14 weeks. Only 30% (30) mothers had undergone dating scan at due time (11 weeks + 0 days to 14 weeks + 0days). Out of 100 mothers, 61% (61) mother's dates were corrected by dating scan. Forty-three percent mothers had a ultrasound scan prior to 11 weeks and another 17% (17) had scans between 14 weeks to 20 weeks. Only 10 % (10) had their first scan after 20 weeks and they were due to late diagnosis of pregnancy.

Conclusion: Although 63% of women had their antenatal booking before 14 weeks, only 30% underwent an ultrasound examination within the recommended dating-scan window. Furthermore, gestational age was revised in 61% of women following ultrasound assessment, highlighting the potential importance of timely ultrasound assessment in establishing accurate gestational age.

This audit demonstrates a significant gap between early antenatal booking and timely ultrasound assessment in antenatal mothers. Improving access to and uptake of an ultrasound examination during the recommended first-trimester window should be considered to improve the accuracy of pregnancy dating and facilitate appropriate antenatal care which should be addressed at primary health care level.

Recommendations A standardized local pathway should be developed to ensure that women are offered an ultrasound examination within the recommended first-trimester window during by 1st encountered primary health care provider. Documentation of the gestational age at booking, date of ultrasound, ultrasound-based gestational age and final EDD should be incorporated into the antenatal record to make correct decision making. A re-audit following implementation should be encouraged.

EP029. BEYOND GLYCEMIC CONTROL: AUDIT ON EVALUATION OF DIABETES EDUCATION FOR PREGNANT WOMEN

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Introduction: The prevalence of Diabetes in pregnancy has increased in Sri Lanka and worldwide. It has a significant impact on maternal and fetal short-term and long-term outcomes. It is important to enhance care by proper education and counselling to get better outcomes.

Objectives: To evaluate the adequacy and effectiveness of diabetes education and counselling given to pregnant and postnatal mothers with gestational or pre-existing diabetes

Method: ology We evaluated 34 antenatal and postnatal patients with gestational or pre-existing diabetes more than 30 weeks of gestation from 01st of July 2025 to 31st of October 2025 in Wards 6 and 17 of Colombo North Teaching Hospital, Ragama. An interviewer-administered questionnaire was used to assess knowledge and experiences. The audit findings were shared with the ward staff and an awareness programme was carried out covering pre-conceptional counselling up to the postpartum contraceptive usage and long-term complications and management strategies. An educational leaflet was prepared in Sinhala, English and Tamil. Re-audit was performed after 3 months of intervention from 5th of February to 28th of May 2026.

Results: When analyzing the data, only 10% of patients had pre-conceptional counselling, most obtained from social media. Satisfactory knowledge of Folic acid was observed in 60% of the cohort. 55% followed the standard method of Oral Glucose Tolerance Test (OGTT), either at the booking visit or in the second trimester. Knowledge regarding fetal and maternal complications was poor; 40% of patients became aware of fetal complications through MOH clinic staff and 20% were aware of maternal complications during their antenatal period. 40% of patients had at least one long-term complication awareness. Medical Nutrition therapy or dietary advice was given to 50% of the patients and they had better adherence to Dietary advice. The insulin techniques assessed, including storage and timing, 80% of them had unsatisfactory practice. Only 30% of them were advised regarding the symptoms, signs and immediate action. Furthermore, 90% of mothers were unaware of the targeted blood sugar values. Following the intervention, the re-audit demonstrated significant improvement across all the assessed domains. (Detailed comparative results will be presented)

Conclusion: The audit and re-audit findings revealed that effective communication and diabetic education can substantially improve the quality of care and can strengthen the self-management practices to avoid short- and long-term complications.

EP030. BEYOND THE LUNGS: INTESTINAL TUBERCULOSIS MASKED AS SECOND-TRIMESTER PYREXIA

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Objectives: To present a case of atypical intestinal tuberculosis that presented as a pyrexia of unknown origin during the second trimester and to highlight the clinical necessity of starting empirical treatment when histological proof is unavailable.

Case report: A 29-year-old multigravida in her second pregnancy at 24 weeks and 5 days of gestation presented with history of a productive cough, burning abdominal pain and high evening fever for 11 days. Her initial blood tests showed a neutrophilic leucocytosis and a rising erythrocyte sedimentation rate (ESR) that icreased from 51 to 112 mm/hour. Isolated sputum culture grew Moraxella catarrhalis and treating it did not resolve her worsening fevers according to ABST pattern. Extensive investigations were performed to identify underlying cause.

A shielded chest X-ray showed unexplained fibrotic bands. Mantoux test and three consecutive early-morning sputum smears were negative for acid-fast bacilli although pulmonary tuberculosis was strongly suspected. An abdominal ultrasound initially showed bilateral hydronephrosis, which was thought to be a normal physiological effect of the growing uterus. Because her burning upper abdominal pain persisted, gastroenterology input was taken. An upper GI endoscopy performed and it was completely normal. During a follow-up abdominal ultrasound localized bowel wall thickening and fatty tissue inflammation clustered around the ileocecal junction was identified. Based on this radiological evidence and the strong clinical picture she was started on empirical anti-tuberculosis therapy. The patient responded, becoming completely fever-free with full resolution of her symptoms.

Discussion: Extrapulmonary intestinal tuberculosis is difficult to diagnose during pregnancy because its abdominal symptoms easily blend in with common gestational complaints. Pregnancy naturally downregulates the cell-mediated immunity, which frequently triggers false-negative Mantoux tests and masks typical signs. When standard respiratory smears are negative, finding the source requires looking elsewhere. As this case shows, an upper endoscopy can easily miss the disease because intestinal tuberculosis preferentially hides in the lymphoid-rich ileocecal valve. High-resolution ultrasound provides a safe, invaluable way to visualize these deep tissue changes. Because of pregnancy performing definitive biopsy is not recommended and starting timely empirical treatment based on sound clinical suspicion can be reduce maternal morbidity.

Conclusion: Intestinal tuberculosis should be considered in any pregnant patient with unexplained, refractory fever and abdominal pain. When standard diagnostic tools has no place in state like pregnancy characteristic ultrasound findings at the ileocecal junction fully justify the early initiation of empirical treatment.

Keywords: Intestinal tuberculosis, Pyrexia of unknown origin, Pregnancy complication, Ileocecal thickening, Empirical antituberculosis therapy

EP031. BEYOND THE PELVIS: HEPATIC ENDOMETRIOSIS – CASE REPORT

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Background: Endometriosis in the liver is very rare and hard to diagnose. It often looks like more common liver problems, such as abscesses, cysts, or tumors, making it difficult to figure out. Because it's so uncommon and doesn't have clear signs, it often takes a long time to diagnose, usually until a biopsy confirms it. We're sharing a case of a woman with liver endometriosis, confirmed by biopsy, who also had stage IV endometriosis and adenomyosis. Her condition appeared as a recurring collection in her liver. This case shows why it's important for different medical specialists to work together and tailor treatment to the individual.

Case report: A 43-year-old woman, who had been pregnant before, came in with pain in her upper right abdomen that kept coming back.

She also had painful periods, heavy bleeding and pain during sex. Over about 15 months, scans showed a large, recurring fluid-filled spot under the capsule of her right liver. It was treated several times like a bacterial liver abscess by draining it with a tube, which helped for a short time. But the collection kept coming back and getting bigger. Pelvic ultrasounds showed fluid in her fallopian tubes, her ovaries were stuck to the sides of her pelvis and there was increased blood flow in the area, all signs of severe endometriosis. A liver biopsy, guided by ultrasound, found endometrial tissue in the liver lining and tests showed it responded to estrogen, confirming liver endometriosis. After a team discussion involving liver surgeons, gynecologists, radiologists and pathologists, the patient was treated with 6 months of medication to stop her periods, given as monthly injections. Then, she had surgery to remove her uterus, ovaries and fallopian tubes. The tissue removed showed endometriosis in her ovaries and adenomyosis, with no signs of cancer. Six months after treatment, a follow-up scan showed the liver collection had shrunk significantly. Since she felt fine and her liver and gynecological symptoms were gone, they decided not to do the planned liver surgery. She is now being monitored with check-ups and scans.

Discussion: This case shows how liver endometriosis can easily be mistaken for recurring liver abscesses, leading to repeated drainage procedures and a delayed diagnosis. If a liver problem keeps coming back even after being drained properly, especially in a woman with monthly pain and other signs of endometriosis in her pelvis, doctors should consider endometriosis outside the pelvic area. If imaging results aren't clear, a biopsy is still the best way to confirm the diagnosis. The substantial reduction in the hepatic collection following hormonal and pelvic surgical treatment suggests that a multidisciplinary, individualised approach may be considered in selected patients and may potentially avoid extensive hepatic surgery.

Limitations: This is a single case report and therefore the findings cannot be generalised.

Ethical considerations: Written informed consent was obtained from the patient for publication of this case report and accompanying clinical information/images.

Conclusion: Doctors should think about liver endometriosis in women who have recurring fluid collections or lesions under the liver capsule, particularly if they also have symptoms that could be endometriosis. Getting an early tissue diagnosis, having different specialists work together and planning treatment specifically for each patient are key to avoiding unnecessary procedures, making sure they get the right care and achieving good results.

Keywords: Liver endometriosis; endometriosis outside the pelvis; adenomyosis; recurring liver collection; liver biopsy; teamwork in medical care.

EP032. BEYOND THE SIGNATURE: AUDIT OF CAESAREAN SECTION CONSENT DOCUMENTATION AT A TERTIARY CARE CENTRE

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Introduction: Informed consent for caesarean section (CS) should document the intended benefits, serious and frequent risks, additional procedures that may become necessary, mode of anaesthesia and alternative options, as recommended by the Royal College of Obstetricians and Gynaecologists (RCOG) Consent Advice No. 7. In many Sri Lankan units, consent is obtained by junior medical officers on unstructured, handwritten forms.

Objectives: To audit the documentation of CS consent against the RCOG standard and to compare completeness of consent by grade of the consent taker.

Design: A cross-sectional clinical audit of consecutive CS consent forms, conducted as the first cycle of an audit loop.

Method: All CS consent forms at Sri Jayewardenepura General Hospital during June 2026 (n=33) were reviewed against a checklist derived from RCOG Consent Advice No. 7: documentation of the procedure, benefits, mode of anaesthesia and its complications, serious risks (haemorrhage, visceral injury, infection, thromboembolism), additional procedures (hysterectomy, blood transfusion, repair of bowel, bladder or ureteric injury, intensive care admission), alternative options, consent for concurrent tubal sterilization

where planned and signatures. The grade of the consent taker and category of CS were recorded.

Results: Of the 33 consents (elective 14, urgent 7, emergency 12), 28 (84.8%) were obtained by HOs, two by SHOs and three by registrars. The procedure (97.0%), mode of anaesthesia (97.0%), patient signature (100%) and consent-taker signature (97.0%) were well documented.

Major gaps were benefits (12.1%), alternative options (0%), consent for sterilisation (9.1%), serious risks (75.8%) and additional procedures (72.7%). All eight forms lacking risk documentation were emergency (Category 2) sections: risks were documented in 33.3% (4/12) of emergency versus 100% (21/21) of elective CS. No form quantified risk frequencies.

Deficiencies occurred across all grades: benefits were documented in 7.1% (2/28) of HO-taken, 100% (2/2) of SHO-taken and 66.7% (2/3) of registrar-taken consents and alternative options were omitted by all grades. Given the very small SHO and registrar denominators (n=2 and n=3), these grade-specific proportions should be interpreted with caution.

Conclusion: CS consent is largely delegated to intern HOs and falls short of the RCOG standard, particularly regarding benefits, alternative options and risk disclosure in emergencies. A unit-specific pre-printed CS consent form incorporating the RCOG-recommended information and these audit findings has been introduced, with re-audit planned to complete the cycle.

Limitations: Single-centre, one-month audit with small SHO/registrar subgroups limiting comparison. Registered as an institutional clinical audit using anonymised forms; formal ethics committee approval was not required.

EP033. BILATERAL OVARIAN SEROUS ADENOCARCINOMA PRESENTING WITH ASCITES AND BILATERAL PLEURAL EFFUSION: A CASE REPORT

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Objectives: To describe the clinical presentation, diagnostic evaluation, surgical management and histopathological findings of bilateral ovarian serous adenocarcinoma in a perimenopausal woman and to emphasize the diagnostic challenges associated with its non-specific presentation as well as the importance of timely multidisciplinary management.

Case Study: A 47-year-old perimenopausal woman without significant past medical history presented with a one-month history of progressive abdominal distension, breathlessness, high-grade fever, abdominal and back pain and anorexia without significant weight loss. Physical examination revealed bilateral, ill-defined, non-mobile abdominal masses above the umbilicus, shifting dullness and bibasal crepitation. Ultrasound showed complicated bilateral ovarian masses with solid components. The level of CA-125 was normal. Contrast-enhanced computed tomography (CECT) showed large, irregular bilateral adnexal masses (right 8.5×11.7 cm, left 7.1×8.8 cm) with extensive ascites and bilateral pleural effusion with no signs of metastatic illness. The patient was severely anaemic (nadir haemoglobin 5.4 g/dL) requiring 5 transfusions and had raised inflammatory markers and hypoalbuminaemia which improved with supportive treatment. Preoperative peritoneal cytology and ascitic fluid examination were negative for malignant cells. She was subjected to midline laparotomy with bilateral cystectomy and oophorectomy, total abdominal hysterectomy and omentectomy. Intraoperatively no peritoneal deposits were seen. The postoperative course was uneventful except for brief gastrointestinal discomfort. Histopathology confirmed poorly differentiated serous adenocarcinoma bilaterally with bilateral capsular invasion with AE1/3 and p53 positive. The uterus, fallopian tubes and omentum were not affected. The patient was referred to oncology for adjuvant treatment.

Discussion: Bilateral serous ovarian adenocarcinoma is uncommon and is generally a manifestation of advanced stage illness from transcoelomic spread. Diagnosis is challenging due to nonspecific symptoms and, as in this case, normal CA-125 and negative preoperative cytology with histologically proven cancer. This highlights that normal tumor markers and cytology should not delay definitive surgical staging when imaging findings are strongly suggestive of malignancy. Ascites and pleural effusion in this patient are due to peritoneal irritation, vascular endothelial growth factor (VEGF)-mediated vascular permeability and transdiaphragmatic lymphatic spread and are an often a sign of FIGO stage IV disease. Best management is cytoreductive surgery and platinum-based chemotherapy. Prognosis is closely related to the stage of the disease at diagnosis and the completeness of the tumor resection.

Conclusion: This case highlights the aggressive nature and the diagnostic problem of bilateral ovarian serous adenocarcinoma in light of the limits of CA-125 and cytology in ruling out cancer. A high index of suspicion for clinical complaints in perimenopausal women backed by imaging is critical for rapid diagnosis and appropriate multimodal therapy.

EP034. BLEEDING AGAINST THE CLOT: LNG-IUS FOR MENSTRUAL HAEMORRHAGE IN ANTICOAGULATED PULMONARY HYPERTENSION

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Objectives: To highlight the challenges of managing heavy menstrual bleeding (HMB) in a woman requiring lifelong anticoagulation, in whom both the bleeding and its conventional surgical treatment carry substantial risk and to illustrate the value of a multidisciplinary, patient-centered approach.

Case report: A 47-year-old nulliparous woman presented with regular HMB and dysmenorrhoea due to an adenomyotic uterus. Management was complicated by protein C deficiency, which had caused pulmonary hypertension and necessitated lifelong warfarin (9mg/9mg/8mg alternating).

Anticoagulation both aggravated her menstrual blood loss and rendered surgical options hazardous. Bleeding partially responded to tranexamic acid, mefenamic acid and norethisterone but remained significant. Gynaecology, anaesthesia and haematology met jointly and the plan was built around her own preferences.

Hysterectomy was considered and rejected - haemorrhage on anticoagulation and the anaesthetic mortality of pulmonary hypertension. A levonorgestrel-releasing intrauterine system (LNG-IUS) was chosen instead, uterus-preserving and lower-risk. Her INR was 2.1 on the day, so the device went in without regional anaesthesia, avoiding neuraxial haematoma. Response at six months was good, with complete amenorrhoea over the preceding two.

Discussion: Anticoagulation creates the bleeding and then closes off the usual answers to it. Hysterectomy would have meant interrupting warfarin, with perioperative haemorrhage on one side and thrombosis on the other and her pulmonary hypertension carried its own anaesthetic mortality. Regional anaesthesia was relatively contraindicated at a therapeutic INR - spinal or epidural haematoma.

The LNG-IUS avoided each of these problems. It controlled the bleeding, needed no interruption of warfarin and required neither general nor regional anaesthesia - and it left the uterus in place. Insertion at an INR of 2.1 proved both feasible and safe.

Conclusion: Where surgery and regional anaesthesia both carry prohibitive risk, the LNG-IUS offers bleeding control that costs neither. Here it was inserted at a therapeutic INR of 2.1 without anaesthesia and produced amenorrhoea by six months in a woman for whom hysterectomy was not a safe option.

EP035. BODY MASS INDEX AND SEMEN PARAMETERS AMONG MALE PARTNERS OF INFERTILE COUPLES

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Introduction: Obesity is associated with many adverse reproductive outcomes, not only in females but by affecting male infertility through hormonal dysregulation, oxidative stress and impaired spermatogenesis. The relationship between body mass index (BMI) and semen quality remains inconsistent across populations.

Objectives: To evaluate the association between BMI and semen parameters among infertile men attending a tertiary fertility centre.

Design: Cross-sectional study.

Method: Male partners of infertile couples attending Subfertility clinic at Castle Street Hospital for Women, during 2022 - 2023 were included. Clinical, anthropometric, hormonal and semen analysis data were extracted from medical records. BMI (kg/m^2) was calculated and classified according to World Health Organization (WHO) criteria. Semen volume, sperm concentration, motility, morphology and azoospermia status were assessed per laboratory protocols. Associations between BMI categories and semen characteristics were evaluated using appropriate statistical tests, with multivariable analysis to adjust for potential confounders; $p<0.05$ was considered significant.

Results: A total of 296 men were included (mean age 35.4 ± 6.0 years; mean BMI 26.0 ± 4.8 kg/m^2). Overall, 36.0% were overweight and 8.9% obese. Abnormal semen parameters were common, with azoospermia in 17.9% and abnormal sperm morphology in 51.7%. Men with elevated BMI showed a trend towards poorer semen quality, including reduced sperm concentration and more frequent abnormal morphology. However, BMI was not independently associated with azoospermia after adjustment for age and hormonal factors (odds ratio 0.93, p=0.186).

Conclusion: Overweight and obesity were common among infertile men and were associated with a greater burden of abnormal semen characteristics. Although BMI did not independently predict azoospermia, excess body weight may impair reproductive health through adverse effects on semen quality. Even though further prospective studies are needed to evaluate the improvement on sperm quality with lifestyle modifications to optimize the BMI, male partners deserve proper advice and guidance on this matter as same as female partners to improve fertility outcome.

Keywords: male infertility; body mass index; obesity; semen parameters; sperm morphology.

EP036. CAESAREAN SCAR ECTOPIC PREGNANCY – A CASE REPORT

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Objectives: Caesarean scar pregnancy (CSP) is a rare form of ectopic pregnancy resulting from implantation of the blastocyst within the myometrial defect at the site of a previous caesarean section. Its incidence is estimated at approximately 1 in 2000 pregnancies and is increasing with the rising global rates of caesarean section deliveries. Early diagnosis and appropriate management are essential to prevent significant maternal morbidity, including severe haemorrhage, uterine rupture and loss of fertility.

Case report: 33-year-old woman in her second pregnancy presented at 6-weeks of period of amenorrhea (POA) for early antenatal care. Her obstetric history was notable for a prior caesarean section performed at 33 weeks of POA due to oligohydramnios and breech presentation. She was asymptomatic, reporting no abdominal pain or vaginal bleeding.

Early viability transvaginal ultrasound scan (TVUSS) revealed a 9.3mm gestational sac with a 1.9mm crown-rump length implanted over the previous caesarean scar without an initial fetal heartbeat. The diagnosis of CSP was confirmed based on the Royal College of Obstetricians and Gynaecologists (RCOG) ultrasound criteria.

On Day 1, with a baseline serum -hCG of 11,790 mIU/ml, (>5000) combined medical management was initiated with oral mifepristone and two doses of intramuscular methotrexate. Serial -hCG levels monitored on Day

4 and Day 7 rose to 18,830 & 19,050 mIU/ml respectively, alongside the new appearance of a fetal heartbeat on Day 4.

Due to the failure of medical therapy and biochemical progression, surgical intervention was pursued. Laparotomy revealed a retroverted, 8-week-sized uterus with a visible bulging mass towards serosa at the previous caesarean scar. Following bladder dissection, a fusiform incision allowed successful resection of the ectopic pregnancy and the thinned myometrium. Postoperative ultrasound confirmed a well-healed scar without an isthmocele. Patient was discharged with comprehensive contraceptive counselling and instructions for early ultrasound imaging in future pregnancies.

Discussion: CSP is categorized into two types: Type 1 (endogenic), in which the pregnancy progresses towards the uterine cavity and Type 2 (exogenic), in which the pregnancy extends deeply into the myometrium towards the bladder. A noteworthy feature in this case was the history of a previous preterm breech caesarean section. Caesarean delivery at an earlier gestation may involve a relatively less developed lower uterine segment requiring large incisions and subsequent poor healing. The retroverted uterine position may also have influenced the mechanical forces acting on the previous scar. However, its contribution to scar dehiscence and subsequent CSP remains uncertain. These factors have been proposed as potential contributors to scar implantation, although a direct causal relationship cannot be established in this case.

TTVUSS remains the gold standard imaging modality for the diagnosis of CSP, while MRI may be considered when ultrasound findings are inconclusive. Treatment should be individualized according to fertility wishes, gestational age, myometrial thickness, extent of implantation and clinical stability. Medical management with systemic or local methotrexate is an established treatment option in selected patients, while surgical intervention, including laparoscopic or open resection, may be required in cases of treatment failure, significant haemorrhage, or a high risk of uterine rupture.

Conclusion: CSP is associated with significant maternal morbidity & mortality. Hence, early diagnosis & timely intervention is of paramount importance in preventing life threatening complications.

Ethical Considerations and Consent Written informed consent was obtained from the patient for publication of this case report and any accompanying clinical information and images. All identifying information was removed to maintain patient confidentiality. Institutional ethical approval was not required for publication of an individual case report, in accordance with local institutional policy.

EP037. CAESAREAN SECTION PRACTICES AT SRI JAYAWARDENEPURA GENERAL HOSPITAL: AN AUDIT USING THE ROBSON CLASSIFICATION SYSTEM

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Introduction: Caesarean section (CS) rates continue to rise worldwide, frequently above the 10-15% the WHO considers optimal. Sri Lanka has followed, with national rates climbing sharply over the past decade and projected to exceed 50% by 2030 - and unindicated CS carries avoidable maternal and neonatal risk. The WHO-endorsed Robson Ten-Group Classification System audits CS practice against a standard framework and identifies the groups worth targeting. We applied it to Ward 2 of Sri Jayawardenepura General Hospital (SJGH).

Method: We collected data retrospectively from the antenatal registry on all CS performed in Ward 2, SJGH, over three months in 2026. Each case was assigned to one of the ten Robson groups. Descriptive statistics gave each group's contribution to the overall workload and a chi-square test assessed variation in elective versus emergency CS across groups.

Results: Of 120 CS classified, Group 2 (nulliparous, term, singleton, cephalic, induced or pre-labour CS) was the largest contributor, accounting for 52 cases (43.3%), followed by Group 5 (previous CS, term singleton cephalic) with 42 (35.0%) and Group 10 (preterm singleton cephalic) with 10 (8.3%). Groups 1, 4, 6, 7, 8 and 9 together accounted for the remainder. Overall, 69 CS (57.5%) were elective and 51 (42.5%) emergency, with significant variation across groups (χ^2 = 35.3,

$p < 0.001$). Group 5 was predominantly elective (83.3%), whereas Group 10 was entirely emergency and Group 2 was evenly split between induced labour and pre-labour CS. The commonest indications were previous CS (41 cases, 34.2%), maternal request (14, 11.7%), lack of progression, fetal distress and failed induction (9 each, 7.5%).

Discussion: Prior local audits are led by repeat CS. Here Group 2 led instead, at 43.3% against Group 5's 35.0% - primary CS driven by induction practice and maternal request rather than by repeat surgery. That 83.3% of Group 5 was elective points to limited VBAC uptake. Group 10 being entirely emergency is what appropriate intervention for preterm complications looks like.

Conclusion: Groups 2 and 5 together accounted for 78.3% of caesarean sections in SJGH Ward 2. Induction protocols, counselling around maternal-request CS and VBAC uptake are therefore where any reduction has to come from and each can be addressed without compromising maternal or fetal safety.

EP038. CASE REPORT ON ACUTE URINARY RETENTION DUE TO IMPERFORATE HYMEN IN AN ADOLESCENT

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Objectives: To report imperforate hymen as a rare cause of acute urinary retention with primary amenorrhoea in an adolescent girl and to show what genital examination contributes to the diagnosis.

Case report: A previously healthy 12-year-old girl presented with inability to pass urine, urinary urgency and cramping lower abdominal pain, suggesting acute retention. She had not attained menarche, though she described intermittent cyclical lower abdominal pain over the preceding two to three months. Abdominal palpation revealed a distended bladder. On vaginal examination the hymen was tense, bluish and bulging, with no opening; examination was otherwise unremarkable. Pelvic ultrasound showed a large fluid-filled vaginal cavity of 128 × 72 × 60 mm, approximately 297 mL, with echogenic contents - haematocolpos, with no hydroureter or hydronephrosis. Renal function and full blood count were normal and pregnancy was excluded. Catheterisation drained 800 mL of urine and relieved her pain. With imperforate hymen and haematocolpos confirmed, she underwent hymenotomy through a cruciate incision under general anaesthesia the following day. The retained menstrual blood drained successfully, her urinary symptoms resolved and bladder function returned. She was discharged some days later on oral antibiotics, without complication.

Discussion: Acute urinary retention is an uncommon presentation of imperforate hymen and the mechanism is mechanical - the distended vagina compresses the urethra. The diagnosis is easily delayed where no genital examination is performed, which is why history, abdominal palpation and perineal inspection matter here more than elsewhere. Pelvic ultrasonography then confirms it. In this girl the interval from presentation to hymenotomy was a single day and early correction of this kind prevents haematometra, endometriosis, hydronephrosis and infertility.

Conclusion: Imperforate hymen belongs in the differential when an adolescent girl presents with urinary retention and primary amenorrhoea. Here the diagnosis was made at the bedside on inspection of a tense, bulging hymen and confirmed on ultrasound and hymenotomy resolved her symptoms within a day. The examination that settles it takes moments; omitting it is what delays these girls.

EP039. CATASTROPHIC ANTIPHOSPHOLIPID SYNDROME IN AN MCDA TWIN PREGNANCY PRESENTING AS MULTI-ORGAN FAILURE

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Objectives: To report a fatal case of pregnancy induced catastrophic antiphospholipid syndrome (CAPS) complicated by severe multi-organ damage in an MCDA twin pregnancy and to highlight the extreme diagnostic hardships faced during its rapid progression.

Case report: A 35-year-old nursing officer (G5P0C0) with four previous first-trimester miscarriages admitted at 17 weeks of gestation with an MCDA twin pregnancy with vomiting and loose stools for 2 days duration. She was diagnosed to have 13 years history of ITP and known APLS. She initially managed as acute gastroenteritis, but quickly developed severe acute kidney injury, refractory hypertension and escalating breathlessness.

Her condition quickly worsened while she was in the intensive care unit. Laboratory tests revealed bicytopenia (platelets fluctuating down to 22×10^9/L), increased inflammatory markers, acute liver failure and high serum creatinine (reached 5,19 mg/dL) Haemodialysis was initiated. Subsequently the ultrasound confirmed the fetal demise of twins. The patient received a comprehensive treatment from the multidisciplinary team, including pulsed steroid therapy, rituximab and immunoglobulins. Nephrology team performed a renal biopsy, which showed diffuse proliferative glomerulonephritis with vasculitis. However, her condition still deteriorated as she developed vasculitis affecting multiple organs. Despite of continuous renal replacement therapy (CRRT) in the ICU, she progressed in to catastrophic pulmonary haemorrhage leading to death.

Discussion: CAPS is an accelerated form of APLS characterized by simultaneous small-vessel occlusions across multiple organs.Pregnancy is a known physiological trigger for this thrombotic storm. This case illustrates an diagnostic hardship: the early symptoms perfectly mirrored severe hyperemesis. Furthermore, the patient's longstanding history of ITP easily masked the microangiopathic platelet consumption driven by CAPS. The presence of diffuse proliferative glomerulonephritis and full-blown vasculitis on biopsy underscores that CAPS causes widespread endothelial devastation. When the pulmonary vasculature becomes involved, diffuse alveolar hemorrhage can occur, which carries an exceptionally poor prognosis despite optimal immunomodulation and mechanical support.

Conclusion: Pregnancy-induced CAPS represents a catastrophic clinical emergency that requires a very high index of suspicion. Rapidly progressive multi-organ failure, severe cytopenias and fetal loss in a patient with a history of auto-antibodies should trigger immediate, aggressive immunosuppressive and intensive therapy to treat the systemic thrombotic cascade.

Keywords: Catastrophic Antiphospholipid Syndrome, MCDA twin pregnancy, Diffuse proliferative glomerulonephritis, Pulmonary hemorrhage, Diagnostic hardship.

EP040. CEREBRAL TUBERCULOMA PRESENTING IN PREGNANCY: A NEUROLOGICAL DILEMMA

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Objectives: To present a case of cerebral tuberculoma presenting with focal neurological signs during the third trimester of pregnancy. It is a rare manifestation of extrapulmonary tuberculosis with diagnostic challenge, as clinical and radiological features can mimic other conditions.

Case report: A 35-year-old woman presented at 28 weeks of gestation with the first episode of focal seizure involving the right upper limb with spontaneous resolution. She also had four episodes of transient mouth deviation to the left side and right upper limb monoparesis for the past two weeks. Antenatal period was uneventful. She had two lower segment cesarean sections in the past.

On examination, there were no neurological deficits. An urgent NCCT brain was performed, which showed no gross abnormalities. However, as the neurological symptoms were recurrent, a contrast-enhanced MRI with angiography was done, which showed multiple ring-enhancing focal lesions involving the supratentorial white matter and cerebellum with surrounding oedema. Differential diagnoses included tuberculoma and toxoplasmosis.

After a multidisciplinary discussion, a working diagnosis of CNS tuberculosis was made. CSF analysis could not be performed because there was no clinical or imaging evidence of elevated ICP and fluid was collected for TB cultures and PCR. She was started on anti-tuberculous therapy, intravenous dexamethasone for the

cerebral edema and Levetiracetam for seizure prevention. There was marked clinical improvement, with no further neurological symptoms seen, supporting the diagnosis. Follow-up MRI showed resolution of the lesions and reduction in perilesional edema.

She delivered a healthy neonate at term by LSCS with an uneventful postpartum period. Further follow-up was arranged at the chest clinic for the continuation of the drug regimen.

Discussion: CNS tuberculosis is a rare but important manifestation of extrapulmonary TB. Presentations include sensory symptoms, seizures and features of intracranial space-occupying lesion. Imaging findings should be differentiated from toxoplasmosis and cerebral abscess. Immunosuppression needs to be ruled out by HIV screening and raised ESR suggests a good immune response. Management should include involvement of relevant specialties including obstetrician, neurologist, respiratory physician, infectious disease specialist and neonatologist where appropriate. Treatment is by the anti-TB drug regimen for extra-pulmonary tuberculosis. Post-partum strict surveillance needed for flare of lesions.

Conclusion: In low- and middle-income countries, tuberculosis is still not so uncommon; therefore, it should be considered, especially extra-pulmonary manifestations. Constitutional symptoms may be lacking and early imaging is necessary for deciding the management plan. Cerebral tuberculoma should be considered in pregnant women presenting with recurrent focal neurological deficits. Prompt treatment will improve both maternal and neonatal outcomes.

EP041. CERVICAL CANCER AWARENESS, RELATED FACTORS AND UPTAKE OF SCREENING AMONG SRI LANKAN WOMEN

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Background: Cervical cancer remains a public health concern in Sri Lanka despite being largely preventable. Awareness is a key determinant of screening behavior, yet uptake of free national screening services is suboptimal.

Objectives: To describe the level of awareness on cervical cancer, identify the factors influencing it and to determine the proportion underwent cervical cancer screening among women aged 35 to 49 years attending Out Patient Department, National Hospital of Sri Lanka

Method: A descriptive cross-sectional study with an analytical component was conducted among 151 women selected via systematic sampling. Data were collected using an interviewer-administered questionnaire. Awareness was scored (0 -22) with pre-determined cut off >/=11 indicating good awareness. Chi- square tests identified associated factors ($p<0.05$).

Results: The mean age was 43.1 years. Only 50.3% women had good overall awareness on cervical cancer. Only 9.3% knew HPV as a cause and only 22.5% knew about sexual transmission. Although 68.2% were aware of an early detection test, only 41.1% had undergone screening. Among unscreened women, the commonest barrier was lack of awareness (39.4%), yet 62.9% expressed future willingness for screening. Significant predictors of good awareness included Buddhist religion, Sinhala ethnicity, higher education and income, delayed first intercourse (>24 years) and ever being pregnant ($p<0.05$). Good awareness was associated with higher screening uptake (57.9% Vs 24%).

Conclusion: and implications: Awareness and screening uptake are low among target aged women attending a major urban hospital. Targeted health education is urgently needed, especially given the high willingness to screen among unscreened women.

Keywords: Cervical cancer, screening, awareness, factors

EP042. CHIKUNGUNYA INFECTION IN PREGNANCY WITH SEVERE SYSTEMIC INFLAMMATORY RESPONSE & HEMODYNAMIC INSTABILITY

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Objectives: To highlight the diagnostic challenges in chikungunya infection associated with severe systemic inflammatory response

and maternal hemodynamic instability in a critically ill pregnant woman.

Case report: A 30-year-old primigravida at 32+5 weeks of gestation presented with a one-day history of fever associated with chills and rigors, bilateral ankle swelling, arthralgia and myalgia. On examination, her blood pressure was 90/60 mmHg, tachycardic at 128/min and Respiratory rate was 20/min with 96% saturation on room air. Generalised febrile erythema was noted. Cardiotocography (CTG) revealed fetal compromise with fetal tachycardia and reduced variability.

Initial investigations showed a white blood cell count of 14000/µL, a platelet count of 116000/µL and an elevated C-reactive protein level (77 mg/L). Despite the initial treatment, the patient developed sudden onset of hemodynamic instability within a few hours, requiring inotrope support. Prophylactic broad-spectrum antibiotics were started, suspecting sepsis and urgent echocardiography was performed, which excluded viral myocarditis and peripartum cardiomyopathy. Emergency caesarean section was performed following a multidisciplinary discussion.

A small retroplacental clot was noted during the caesarean section; the patient was transferred to the intensive care unit for further monitoring and supportive management. Blood Culture was negative, but chikungunya IgM and IgG antibodies became positive on day 7 of fever, confirming chikungunya infection.

The neonate was admitted to the special intensive care unit, managed as sepsis and there was no evidence of vertical transmission of chikungunya infection. Both the mother and baby showed clinical improvement with supportive care and were discharged after recovery.

Discussion: Chikungunya virus (CHIKV) is a mosquito-borne arbovirus transmitted via Aedes aegypti and Aedes albopictus mosquitoes worldwide. This infection can cause adverse outcomes in both the mother and the neonate due to vertical transmission (50% risk) if the infection appears prior to delivery. Although most infections are self-limiting, pregnancy-related physiological changes in immunity may contribute to more severe adverse effects. This case demonstrated an unusual presentation with a sepsis-like picture; however, negative blood culture and subsequent positive chikungunya viral studies suggested the viral aetiology.

Acute deterioration despite initial management brought the consideration of other life-threatening conditions, including peripartum cardiomyopathy and viral myocarditis. The prompt action with a multidisciplinary approach ultimately helped to avoid the maternal and neonatal adverse outcomes.

Conclusion: Chikungunya in pregnancy can have an atypical presentation, causing severe adverse effects. A multidisciplinary team approach is essential to manage this challenging situation and improve maternal and neonatal outcomes.

Please Note: This case is reported with the relevant patient's consent for educational purposes.

EP043. CHRONIC MYELOID LEUKAEMIA: DIAGNOSIS AND SUCCESSFUL MANAGEMENT DURING PREGNANCY

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Objectives: Although Chronic myeloid leukaemia (CML) is a relatively common occurrence in hematology, concurrent pregnancy is rare, with difficulty in management considering both maternal and foetal safety. Tyrosine kinase inhibitors used in cytoreductive therapy has limited value in pregnancy due to teratogenicity. Complications such as thrombosis needs meticulous management. Multidisciplinary planning is fundamental in this complex clinical scenario. In this challenging situation, a superimposed viral infection would mandate a robust approach with careful plan for interventions.

Case report: Our patient was a 26-year-old primigravida who had an incidental finding of marked leucocytosis during a routine full blood count (FBC). Her white blood cell count was 200,000/μL at 20 weeks' gestation. Apart from this finding her pregnancy was otherwise uncomplicated and she was asymptomatic. A peripheral blood film was performed which reported a myeloproliferative neoplasm, favouring chronic myeloid leukaemia. An ultrasound scan of abdomen was performed which detected mild hepatomegaly and moderate splenomegaly. As the diagnostic test, a bone marrow aspiration and trephine biopsy was performed which confirmed the above diagnosis. Then onwards the management involved a multidisciplinary team comprising of haematologists, oncologists, obstetricians, anaesthetists, neonatologists and physicians. As the initial step, cytoreductive therapy with hydroxyurea along with leucopharesis for rapid reduction of leukocyte count was performed. The thrombotic risk was mitigated with low molecular weight heparin. A primary varicella infection during her treatment, was successfully managed with intravenous Aciclovir. As her response to hydroxyurea was satisfactory, pregnancy was continued upto 32 weeks with close monitoring of the mother and foetus. Following corticosteroid and magnesium sulphate administration, a healthy baby was delivered via caesarian section weighing 2.2 kg. Imatinib therapy was commenced post partum alongside Cabergoline for lactation suppression. On subsequent follow up both mother and the infant remained well.

Discussion: This case demonstrates the successful outcome following a holistic approach towards a pregnancy complicated with CML. Early involvement of a multidisciplinary team with close surveillance had a synergistic effect. Rapid cytoreduction with leucopharesis was key in improving the efficacy of hydroxyurea. Although immunoglobulin was not available, intravenous Aciclovir still proved sufficient for the management of her concurrent primary varicella infection.

Conclusion: In routine full blood counts, leucocytosis should further be investigated to arrive at a diagnosis. Once haematological conditions are diagnosed, early involvement of a multidisciplinary team with appropriate interventions would minimise foetal and maternal risks. Successful maternal and foetal outcomes can be aimed for even in most challenging situations.

EP044. CLINICAL AUDIT: POST-OPERATIVE WOUND INFECTION RATES & IMPLEMENTATION OF INFECTION PREVENTION MEASURES

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Background: Surgical site infections (SSIs) contribute to postoperative morbidity, prolonged hospitalisation, antibiotic use and healthcare costs. An increased number of postoperative wound infections was noted at Teaching Hospital Mahamodara compared with previously observed rates, prompting this audit.WHO and other Published data shows SSI rate for Gynecological surgeries 11% which varies 10-13.5 and for post Caesarean section it was 5-15% but some date 20% depends on risk factors and surgical settings.

Objectives: To determine increased SSI numbers and compare rates with published reference values and identify opportunities to improve infection prevention practices.

Method: A clinical audit was conducted during 15th March to 15th May 2023. Patients undergoing total abdominal hysterectomy, laparotomy, vaginal hysterectomy and Caesarean section were identified from the ward patient registry. The total number of procedures performed during the audit period was taken from theatre registry. No systematic post-discharge surveillance was undertaken. The SSI case defined as per WHO definition of, infection that happens in the part of the body where surgery took place, occurring within 30 days of the operation or up to one year if an implant was left inside. Patient identification details was not included and confidentiality was maintained.

Results: A total of 236 procedures were reviewed. Infection rates were 25.0% (5/20) following total abdominal hysterectomy, 33.3% (4/12) following laparotomy, 22.2% (4/18) following vaginal hysterectomy and 11.8% (22/186) following Caesarean section. Approximate 95% confidence intervals were 11.1–46.8%, 13.3–64.6%, 9.8–44.2% and 7.7–

17.0%, respectively. Major abdominal procedures demonstrated particularly high infection rates.

Interventions and follow-up: Findings prompted recommendations for standardised SSI prevention, including surgical hand hygiene education, appropriate antibiotic prophylaxis, WHO Surgical Safety Checklist compliance, theatre environmental surveillance and collaboration with microbiology & infection-control teams. A subsequent follow-up audit was performed by a separate audit group to assess implementation and outcomes.

Limitations: The short two-month audit period limits generalisability. Audit was performed on documentations and errors and variations may have caused over or under estimation. Absence of post-discharge surveillance may have resulted in under validation. No risk adjustment was performed for comorbidities, emergency surgery, or operative duration.

Conclusion: The audit identified high postoperative wound infection rates, particularly after laparotomy and hysterectomy. The audit results emphasise the importance of consistent perioperative infection prevention measures, including timely prophylactic antibiotics, appropriate skin antisepsis, surgical hand preparation and maintenance of theatre sterility and continued follow up audit are warranted to assess success of implementations.

EP045. CLINICAL PROFILE OF COUPLES FOR LEVEL THREE CARE FOR SUBFERTILITY

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Introduction: Assisted conception treatment (IVF) is a level 3 care for subfertility offered at the dedicated fertility treatment centre. The objective of the clinical audit was to determine the clinical profile of the and common etiological factors among the subfertile couples who need IVF for infertility.

Method: Clinical audit was carried out at the infertility clinic of the Castle street hospital for women. Subfertile couples were recruited and both partners had a detailed clinical interview. The women underwent a baseline pelvic ultrasound scan, assessment of ovulation and a hormone profile. Tests for tubal patency were carried out when clinically indicated.

Results: 719 couples were included. mean age of the female partner was 35.6years (SD 6.1 range 38 and male partner was 37.8 (SD 6.0 range 32).

There were 644 (89.6%) couple with primary subfertility and 74 (10.4%) couples with secondary subfertility. Mean duration of the marriage was 5.5 years (SD 4.1). Mean age and duration of the marriage were significantly higher among the primary subfertile group than secondary subfertile group ($p<0.05$).

2211 (29.4%) had detectable abnormalities in either partner. The abnormity detected among the females was tubal block 130 (18.1%) (unilateral 60 (8.3%), Bilateral 70 (11%) followed by endometriosis 1 (18.1%). 18 (2.5%) had of males had azoospermia and 44 (6.1%) oligospermia. Female factors 19.3%, male factors 8.6% and both 0.2% presented with abnormalities.

Conclusion: IVF is one of the important treatment modality which should be freely available in government hospital where sub fertile patients treating.

EP046. CLINICOPATHOLOGICAL CHARACTERISTICS AND OUTCOMES OF VULVAL CANCER: A RETROSPECTIVE COHORT STUDY

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Introduction: Vulval carcinoma is a rare gynecological cancer where there are very few studies that have been published in relation to South Asia. It is necessary to understand the clinicopathological features of this cancer and its treatment to optimize management strategies.

Objectives: To present the demographics, clinicopathological features and treatment methods of patients diagnosed with vulval cancers and operated on at a private Apeksha Hospital, Maharagama, Sri Lanka and to assess their surgical outcomes, recurrent patterns, survival rates and need for adjuvant therapy.

Design: A retrospective descriptive study has been carried out using hospital records of women with vulval cancers operated on from 2014 to 2020. Retrospective descriptive design was selected for the purposes of this study.

Method: Medical and histopathological data of 51 consecutive cases of surgical management of patients with vulval malignancies were studied. Data on demographic parameters, comorbidity, symptoms at presentation, histopathology, tumour pathology, surgery procedure, surgical complications, adjuvant therapy, recurrence and survival status were obtained and described using descriptive statistics.

Results: Mean age was 63.1 ± SD 14.6 years (age range: 22 – 88 years). Most frequent comorbidity was hypertension in 43.1% of patients and diabetes mellitus in 27.5%. The most common symptoms were a vulval lump in 62.7% of cases and pruritus in 52.9% of patients. Squamous cell carcinoma constituted 66.7% of all tumours. Wide local excision was done in 45.1%, vulvectomy in 21.6% and biopsy in 11.8%. Complications following surgery developed in 15 patients (29.4%), mostly lower limb lymphoedema. Adjuvant therapy was necessary in 22 out of 49 patients (44.9%), including radiotherapy alone in 17 patients (34.7%) and chemoradiotherapy in 5 patients (10.2%), whereas no adjuvant treatment was needed in 27 out of 49 patients (55.1%). Recurrence was seen in 15 out of 51 patients (29.4%). Three-year overall survival was 80.5%, while five-year survival was 61.1%.

Conclusion: This is among the largest case series from Sri Lanka of vulval cancers from a single center. The commonest type of cancer in our series was squamous cell carcinoma and most patients were treated surgically. Almost half of the cases needed adjuvant treatment after surgery due to high risk pathologies. Though early survival was good, recurrence was a common problem.

EP047. CLINICOPATHOLOGICAL PROFILE AND PRESENTATION OF CERVICAL CANCER: A SRI LANKAN COHORT

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Introduction: Cervical cancer remains a leading cause of cancer death among Sri Lankan women, despite being largely preventable by screening and vaccination. Contemporary local data on presentation and pathology are needed to guide prevention and service planning.

Objectives: To describe demographic profile, presentation, prior screening, histopathology and stage distribution in women treated for cervical cancer at a national oncology centre.

Design: Retrospective descriptive study.

Method: Records of 138 women managed for cervical cancer at the National Cancer Institute, Maharagama (NCIM) were reviewed. Demographic, screening, clinical, radiological, operative and histopathological data were extracted using a structured proforma and analysed descriptively.

Results: The median age was 52 years (range 27-81) and median parity was 2, with most women from the Western Province. The commonest presenting complaints were postmenopausal bleeding (43, 31%), abnormal uterine bleeding (19, 14%), vaginal discharge (18, 13%), postcoital bleeding accounted for 8 (6%) and a proportion were referred following an abnormal cervical biopsy. A prior Pap smear was documented in only 23 (17%). The remainder presented symptomatically, without effective prior screening.

Squamous cell carcinoma predominated (59%), followed by adenocarcinoma (19%) and adenosquamous carcinoma; most tumours were moderately differentiated (grade 2). By FIGO staging, 68 (49%) were stage I, 15 (11%) stage II, 22 (16%) stage III and 3 were stage IV, with the remainder incompletely staged.

Lymphovascular space invasion was present in 43 (36%) of assessed cases and deep (>50%) stromal invasion was common. Among those who underwent surgery, parametrial involvement was documented in 12 (approximately

10%) and pelvic lymph node metastases in approximately 23% of the surgically staged.

Most underwent radical hysterectomy with pelvic node dissection - margins clear in 85 (62%). The remainder had close, involved or unassessable margins, several requiring adjuvant chemoradiotherapy.

Conclusion: These women had a median age of 52 and presented most often with abnormal vaginal bleeding, 68 (49%) at operable stage I. Against that, a prior Pap smear was documented in only 23 of 138. Disease that is largely preventable is therefore being detected symptomatically rather than by screening, which is the argument for strengthening organised cervical screening and HPV vaccination.

EP048. CLINICOPATHOLOGICAL PROFILE OF BORDERLINE OVARIAN TUMOURS: A SRI LANKAN TERTIARY CENTRE EXPERIENCE

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[1]National Cancer Institute Maharagama

Introduction: Borderline ovarian tumours (BOTs) are epithelial neoplasms of low malignant potential, accounting for 10-15% of epithelial ovarian cancers. They affect younger women and carry an excellent prognosis. Sri Lankan data on their profile and management remain sparse.

Objectives: To describe presentation, tumour markers, histopathology, surgical management and staging in women with BOT at a national oncology centre.

Design: Retrospective descriptive case series.

Method: We reviewed the records of all women with histologically confirmed BOT managed at the National Cancer Institute, Maharagama (NCIM), between 2022 and 2025. Variables - demographic, clinical, biochemical, radiological, operative and histopathological - were extracted on a structured proforma and analysed descriptively.

Results: Fourteen women were diagnosed histologically with BOT. Median age was 42 years (range 16-65) and 3 (21%) were postmenopausal. Presentations were abdominal pain or distension, abnormal uterine bleeding and postmenopausal bleeding. CA-125 exceeded 35 U/mL in 8 of 12 (67%), median 113 U/mL (range 15.7-631).

Histology was serous in 7 (50%) and mucinous in 5 (36%), with one mixed epithelial and one sero-mucinous. Two tumours were bilateral (14%). Stromal microinvasion was documented in at least 5 (36%). Most were FIGO stage I - one had non-invasive omental implants (stage IIA) and one invasive implants with low-grade serous carcinoma (stage IIIA).

Surgery followed age and menopausal status - fertility-sparing procedures (unilateral salpingo-oophorectomy or cystectomy) in younger women, radical surgery (hysterectomy with bilateral salpingo-oophorectomy and omentectomy) in older or postmenopausal women.

Complete (R0) resection was achieved in every case and no stage I disease required adjuvant chemotherapy.

Conclusion: BOTs in this series were predominantly early-stage and unilateral, arising in premenopausal women, which matches international experience. Serous and mucinous subtypes accounted for 12 of the 14. CA-125 was raised in two-thirds, but with wide scatter (15.7-631 U/mL) and no specificity. R0 resection in every case, with fertility-sparing surgery in the younger women, supports that approach where staging is adequate. Recurrence and long-term outcome await longer follow-up of this cohort.

EP049. CLINICOPATHOLOGICAL PROFILE OF ENDOMETRIAL CARCINOMA AT A SRI LANKAN ONCOLOGY CENTRE

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Introduction: Endometrial carcinoma is the commonest gynaecological malignancy in many settings and obesity and ageing populations are driving its incidence upward. Sri Lankan data on its disease pattern and pathology remain limited.

Objectives: To describe presentation, histopathological subtype, tumour grade and stage distribution in women with endometrial carcinoma at a national oncology centre.

Design: Retrospective descriptive study.

Method: Records of 329 women with endometrial carcinoma managed at the National Cancer Institute, Maharagama (NCIM) were reviewed. Demographic, clinical, operative and histopathological variables were extracted using a structured proforma and analysed descriptively.

Results: The median age was 64 years (range 23-81) and median parity was 2. Postmenopausal bleeding was the presenting complaint in 206 (63%), abnormal uterine bleeding in 52 (16%) and vaginal discharge in 34 (10%).

Endometrioid carcinoma was the predominant subtype (approximately 78%); non-endometrioid, high-risk histologies included carcinosarcoma (21), serous (18) and clear cell or mixed carcinomas. Tumours were well differentiated (grade 1) in 156 (53%), moderately differentiated (grade 2) in 98 (33%) and poorly differentiated (grade 3) in 44 (15%).

Deep myometrial invasion (50% or more) was present in a substantial proportion of cases. By FIGO stage, disease was stage I in approximately 234 (72%), stage II in 26 (8%) and stage III in 45 (14%), with the remainder incompletely recorded. Lymphovascular space invasion was present in about 32% of assessed cases. Pelvic and para-aortic node dissection was performed in 231 women (70%), of whom 16 (6%) had nodal metastases; omental involvement was documented in approximately 16%.

Most women were postmenopausal, though the youngest was 23. Preoperative sampling usually reported endometrioid histology and a subset was upgraded to a high-risk subtype on the hysterectomy specimen. Treatment was total hysterectomy with bilateral salpingo-oophorectomy and nodal assessment - adjuvant radiotherapy or chemotherapy according to stage and histological risk.

Conclusion: Postmenopausal bleeding brought 63% of these women to attention and most had stage I (72%), grade 1 (53%) endometrioid disease with a correspondingly favourable outlook. A minority did not - 44 tumours were grade 3 and carcinosarcoma and serous carcinoma together accounted for 39. Prompt evaluation of postmenopausal bleeding and surgical management stratified by that risk, follow directly from this distribution.

EP050. CLINICOPATHOLOGICAL PROFILE OF PRIMARY OVARIAN CANCER: THE SRI LANKAN EXPERIENCE

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Introduction: Ovarian cancer is the most lethal gynaecological malignancy, chiefly because non-specific symptoms delay presentation until the disease is advanced. Sri Lankan data on presentation and pathology are needed to inform earlier diagnosis and service planning.

Objectives: To describe presentation, serum CA-125, histopathology, stage distribution and surgical approach in women with primary ovarian cancer at a national oncology centre.

Design: Retrospective descriptive study.

Method: Records of 340 women with primary ovarian cancer managed at the National Cancer Institute, Maharagama (NCIM) were reviewed. Demographic, clinical, biochemical, operative and histopathological data were extracted using a structured proforma and analysed descriptively.

Results: The median age was 59 years (range 12-82) and median parity was 1. The commonest presentations were abdominal distension (approximately 29%) and abdominal or lower abdominal pain (approximately 26%), reflecting non-specific symptomatology that contributes to delayed diagnosis.

CA-125 was raised (>35 U/mL) in 129/140 (92%), with a median of 522 U/mL (range 5.1-12,460). High-grade serous carcinoma was the predominant histology (approximately 60%), with clear cell, endometrioid, mucinous, low-grade serous and germ-cell tumours also represented. Tumours were frequently bilateral owing to the late presentation. By FIGO stage, disease was advanced (stage III-IV) in 106/186 (57%): stage III in 99 (53%) and stage IV in 7; stage I accounted for 50 (27%) and stage II for 26 (14%).

Surgical management varied - 103 women underwent primary debulking surgery, 63 neoadjuvant chemotherapy followed by interval debulking, 31 a staging laparotomy and 73 a biopsy or minilaparotomy alone. This last

group carried unresectable or bulky disease at presentation.

CA-125 was highest in advanced serous disease and lower in early-stage and non-serous tumours. The age range extended down to 12 years because a minority had germ-cell tumours, dysgerminoma among them.

Conclusion: Most women presented with advanced disease - 57% at stage III-IV - with high-grade serous histology and CA-125 raised in 92%, matching global patterns. That 63 required neoadjuvant chemotherapy before debulking and 73 were suitable for biopsy alone, argues for earlier detection and wider access to complete cytoreductive surgery.

EP051. CLINICOPATHOLOGICAL PROFILE OF VULVAL CANCER AT A SRI LANKAN ONCOLOGY CENTRE

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Introduction: Vulval cancer is an uncommon gynaecological malignancy affecting mainly older women and is often diagnosed late owing to patient embarrassment and clinician unfamiliarity. Local descriptive data are scarce.

Objectives: To describe the clinical presentation, histopathology, tumour characteristics and surgical management of women with vulval cancer at a national oncology centre.

Design: Retrospective descriptive case series.

Method: Records of 23 women with histologically confirmed vulval cancer managed at the National Cancer Institute, Maharagama (NCIM) were reviewed. Clinical, operative and histopathological variables were extracted using a structured proforma and analysed descriptively.

Results: The median age was 71 years (range 41-85). The commonest presentation was a vulval lump or mass (15, 65%), followed by ulceration (4); two women reported postmenopausal bleeding and one presented with vulval itching.

Squamous cell carcinoma was the predominant histology (20, 87%), with malignant melanoma in 3 (13%). Associated human papillomavirus (HPV) elated changes or vulval dermatoses were noted in 8 women. Lesions were central in 13 and lateral in 10, with a median clinical size of 3-4 cm and a median histological depth of invasion of approximately 6 mm and anal sphincter involvement was present in one.

Clinically suspicious groin nodes were noted in 3 women. Wide local excision was performed in 14 and vulvectomy in 9; formal inguinofemoral lymph node surgery was undertaken in only 6.

Reresection margins were involved or close (<8 mm) in 10 (45%) and lymphovascular space invasion was present in approximately 6 cases. A documented prior Pap smear was available in only 5 women. The three malignant melanomas demonstrated deep Breslow thickness (up to 25 mm), reflecting advanced local disease. Overall, the cohort was small, consistent with the rarity of this malignancy and disease was predominantly unifocal.

Conclusion: Vulval cancer affected elderly women and was predominantly squamous cell carcinoma. The high rate of involved or close margins and limited groin node assessment highlight opportunities to improve surgical completeness and adherence to guideline-based inguinofemoral node management. Earlier presentation and specialist referral are needed.

EP052. CHORIOCARCINOMA POSING AS RETAINED PRODUCTS OF CONCEPTION IN A RENAL TRANSPLANT CANDIDATE: CASE REPORT

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Introduction: Gestational trophoblastic neoplasia, particularly choriocarcinoma, is a rare but highly aggressive malignancy. Its diagnosis is challenging, especially when it mimics common obstetric complications like retained products of conception (RPOC). Here is a unique case of choriocarcinoma in a 35-year-old woman with chronic kidney disease (CKD) who was awaiting a renal transplant. It highlights the diagnostic hurdles and the complex management decisions in a patient with associated comorbidities.

Case report: A 35-year-old woman, a mother of two and a known CKD patient awaiting renal transplant, presented with an unplanned

pregnancy at 7 weeks of gestation. Following a multidisciplinary team discussion, a medical abortion using Misoprostol was performed. Urine hCG was positive even after 3 weeks following medical abortion, it prompted an ultrasound, which revealed RPOC. Evacuation of retained products of conception was done. Histology confirmed RPOC. However, even one month later, she continued to have a positive urine hCG. Further evaluation with ultrasound showed an increased endometrial thickness, highly vascular myometrium, with a normal-sized uterus. A total abdominal hysterectomy was performed. The final histopathology was diagnostic of choriocarcinoma invading the myometrium.

Due to her CKD, standard high-dose chemotherapy regimens have a significant risk of nephrotoxicity. The multidisciplinary team (MDT), including nephrologists and oncologists, formulated a dose-reduced chemotherapy protocol, balancing the need for curative treatment vs the preservation of her residual renal function. Tailored chemotherapy regimen with close monitoring of renal parameters and serum hCG levels was done.

Discussion: This case highlights several critical points. First, the importance of persistent vigilance for GTN in patients with unexplained, prolonged hCG elevation after any pregnancy event. Second, it demonstrates the diagnostic pitfall where choriocarcinoma can be initially misdiagnosed as RPOC.

Conclusion: Managing an aggressive, curable malignancy in a patient with pre-existing renal impairment is challanging. It requires a delicate balance between oncologic efficacy and nephrotoxicity, together with a collaborative MDT approach to optimize patient outcomes.

EP053. COMBINED CARDIAC AND CYTOREDUCTIVE SURGERY FOR OVARIAN CANCER WITH SEVERE AORTIC STENOSIS

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Objectives: The simultaneous presence of advanced ovarian cancer and aortic stenosis requiring intervention poses a difficult therapeutic problem, as both entities require surgical management, but pose high perioperative risks independently of each other. This case illustrates the possibility of successful combined cardiothoracic and gynaeoncologic surgery in a properly selected patient through multidisciplinary planning.

Case report: This is a 66 years old female with advanced high-grade serous ovarian carcinoma who had responded favourably to neoadjuvant chemotherapy. She is diagnosed with severe calcific aortic stenosis and early chronic liver disease as well. She had a history of dyspnoea class II, NYHA. Preoperative echocardiography showed severe calcific aortic stenosis with a dilated ascending aorta.

After the multidisciplinary meeting, a composite procedure was done. The cardiothoracic surgeon operated on her first by replacing the aortic valve through a median sternotomy using a 19 mm mechanical valve. It was then followed immediately by delayed cytoreductive surgery with extended midline laparotomy involving total abdominal hysterectomy, bilateral salpingo-oophorectomy, supracolic omentectomy, left lateral pelvic peritonectomy and appendicectomy with complete R0 resection without any intraoperative complication.

She did not have any postoperative complications. Her echocardiography was done and it showed good function of the prosthetic aortic valve (TRPG 23mmHg). She was discharged home on postoperative day nine in a stable condition for further oncological follow-up.

Discussion: The severity of aortic stenosis significantly raises the perioperative risk associated with major abdominal surgeries; however, postponing oncological operations poses risks as well. A combination of cardiac and oncologic surgeries will reduce the number of anesthetic procedures, shorten the therapy duration and allow treating two potentially life-threatening conditions at once. The success of this kind of therapy requires thorough patient selection, preoperative preparation and proper cooperation between cardiothoracic surgeons, gynecologic oncologists, anesthesiologists, intensive care specialists and rehabilitation teams. The patient was selected based on good functional state, good response to chemotherapy, absence of comorbidities and preoperative assessment of possible complete cytoreduction. A mechanical prosthesis was used due to high durability in light of the patient's age

with warfarin anticoagulation after surgery managed by the anaesthetics in cooperation with the oncological surgical team. The perioperative period included multidisciplinary anaesthesia management, hemodynamic monitoring, ICU care and cardiac rehabilitation. The limitations of the study are being a single case study and limited follow-up period. Follow-up care included cardiological examination including echocardiography and anticoagulation control, as well as gynaecological oncological examination for possible disease recurrence along with serum CA-125 and imaging.

Conclusion: Our case shows that combined aortic valve replacement and cytoreductive surgery are safe and possible in selected cases of advanced ovarian cancer and aortic stenosis. Multidisciplinary approach allows for proper perioperative management while adhering to oncological principles. Future research is needed in order to define the criteria of patient selection and study oncological and cardiovascular long-term outcomes in patients with such combination of diseases.

EP054. COMPARATIVE EFFECTIVENESS OF CONSERVATIVE AND SURGICAL INTERVENTIONS FOR VAGINAL LAXITY: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Background: Vaginal laxity is a heterogeneous symptom complex with poorly standardized definitions and outcome measures. Evidence for pelvic floor rehabilitation, energy-based devices and surgical tightening is expanding, but comparative effectiveness and certainty remain unclear.

Objectives: To synthesize evidence on conservative and surgical interventions for vaginal laxity and quantify effects where pooling was possible.

Method: MEDLINE/PubMed, Scopus, CENTRAL, Google Scholar, ClinicalTrials.gov and WHO ICTRP were searched from inception to 1 April 2026, supplemented by citation tracking. Two reviewers independently screened studies, assessed risk of bias and extracted data. Random-effects pairwise meta-analysis assessed study-defined no-laxity/not-loose response and Female Sexual Function Index (FSFI) scores when data were compatible. An exploratory 6-month indirect comparison evaluated sham, radiofrequency (RF) and pelvic floor muscle training (PFMT).

Results: Twenty-four studies informed the qualitative synthesis and seven contributed to quantitative models. Across three sham-controlled RF studies, active treatment increased the likelihood of a no-laxity/not-loose response (RR 3.15, 95% CI 2.17–4.58; I^2=14.6%). Across two sham-controlled RF trials, FSFI improved modestly (MD 1.64, 95% CI 0.31–2.98). A PFMT-versus-RF randomized trial showed RF noninferiority at 30 days but favored PFMT at 6 months. The exploratory PFMT-versus-sham estimate was MD 3.62 (95% CI 0.82–6.42). Surgical cohorts reported improved tightness and sexual function, but certainty was very low and clinically relevant harms included dyspareunia, over-correction, vaginismus and reoperation.

Conclusion: Low-certainty evidence suggests RF may improve subjective vaginal laxity and modestly increase FSFI scores. PFMT should receive first-line consideration and may provide more durable benefit. Surgical tightening may benefit selected women, but the magnitude of benefit remains uncertain and harms are clinically relevant. Standardized phenotypes, core outcome sets, objective anatomical endpoints and longer sham-controlled trials are required.

Keywords: Vaginal laxity; radiofrequency; pelvic floor muscle training; vaginoplasty; sexual function; meta-analysis

PROSPERO: registration: CRD420261381342

EP055. COMPLETE HEART BLOCK UNMASKED DURING PREGNANCY AND MANAGED WITHOUT PERMANENT PACING: A CASE REPORT

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Introduction: Complete heart block (CHB) in pregnancy is uncommon and poses a distinc-

tive obstetric challenge because normal maternal cardiovascular adaptation depends partly on an increase in heart rate. Although many women remain asymptomatic, pregnancy, labour and surgery may unmask hemodynamic compromise. Management must therefore be individualized and have a multidisciplinary approach.

Objectives: To describe the antenatal, intrapartum and anaesthetic management of complete heart block first diagnosed in pregnancy and to highlight the criteria supporting conservative management without pacing.

Case report: A 27-year-old woman with one previous caesarean delivery presented in the first trimester with palpitations and was found to have complete heart block for the first time. Electrocardiography demonstrated complete atrioventricular dissociation with a ventricular rate of approximately 52 beats per minute. Transthoracic echocardiography showed preserved left ventricular systolic function with an ejection fraction greater than 60%, with only mild mitral and tricuspid regurgitation and no significant ventricular dysfunction. The remainder of the antenatal period was uncomplicated. Care was provided through a multidisciplinary team comprising obstetricians, cardiologist, electrophysiologist, anaesthetist and neonatology team. At term, caesarean section was undertaken for the obstetric indication of a previous uterine scar. Spinal anaesthesia was used with full preparation for emergency cardiac intervention. No intraoperative cardiovascular instability or postoperative cardiac complication occurred.

Discussion: In a young woman with preserved cardiac structure and function, absence of syncope and stable ventricular escape rhythm, conservative management without prophylactic pacemaker may be appropriate. Vaginal birth is generally preferable in CHB and caesarean section should usually be reserved for obstetric indications. The principal intrapartum concern is sudden bradycardia, hypotension, syncope, arrhythmia or cardiac arrest; hence pacing facilities, chronotropic drugs and continuous monitoring should be immediately available.

Conclusion: This case illustrates that carefully selected pregnant women with CHB may complete pregnancy and undergo caesarean delivery safely without temporary or permanent pacing when managed in a tertiary centre with meticulous multidisciplinary planning.

Limitations: As a single-case report, findings cannot be generalised and reflect one favourable outcome; longer-term postpartum cardiac follow-up was not available. Written informed consent was obtained from the patient for publication of this case report and accompanying clinical details.

EP056. COMPLEX MULLERIAN ANOMALY PRESENTING WITH RECURRENT HAEMATOMETRA AND HAEMATOCOLPOS: A DIAGNOSTIC CHALLENGE

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Objectives: Development of the Mullerian duct system can undergo several deviations from normality. As a result, several clinical entities with significant diagnostic challenges are encountered in clinical practice. Straightforward presentations due to obstructive symptoms, sexual dysfunction and infertility are common. However, atypical presentations as well as associated renal abnormalities results in incorrect diagnosis and repeated treatments jeopardising a favourable clinical outcome. This case demonstrates the need for comprehensive analysis of Mullerian duct abnormalities with imaging followed by multidisciplinary care for a definitive cure.

Case report: A 27-year-old nullipara presented with a history of laparotomy a year ago where a hydrometra associated with a bicornuate uterus had been drained. Her symptoms had resolved temporarily following the surgery, however her symptoms of abdominal pain and distention recurred 9 months later associated with a vaginal discharge and a dyspareunia. Considering her previous history, a comprehensive imaging was done with contrast enhanced computer tomography (CT), Magnetic resonant imaging and CT intravenous urography. These imaging demonstrated a bicornuate bicollis uterus resulting in hematocolpos, hematometra and hematosalphinx along with a non functioning hydronephrotic pelvic kidney. A surgical management com-

prised of examination under anaesthesia, which revealed a complete vaginal occlusion by a thick transverse vaginal septum, followed by corrective surgery. Drainage of obstructed genital tract along with the resection of the non communicating uterine horn was performed followed by vaginal reconstruction. Her recovery was uneventful with marked improvement in her symptoms over next few months. She was satisfied with her sexual functions on further follow up.

Discussion: Analysis of gynaecological presentations with attention to basic anatomical and embryological principles is the cornerstone in diagnosis of rare Mullerian duct abnormalities. Comprehensive imaging of the whole genital and urinary tract using a wide array of imaging modalities would minimise incomplete diagnosis. Embarking on surgical management with all the clinical and radiological investigations in hand would lead to an optimum outcome. This is pivotal in preventing long term complications such as sexual dysfunction, infertility, endometriosis and infection.

Conclusion: Complex Müllerian anomalies should be in differential diagnosis of gynaecological presentation especially in younger nulliparous women. Incomplete assessment and surgical intervention should be avoided paying attention to comprehensive assessment and definitive interventions.

EP057. COMPLEX TEENAGE PREGNANCIES REQUIRING MULTIDISCIPLINARY MANAGEMENT: A CASE SERIES OF CHALLENGES AND CLINICAL LESSONS IN A SRI LANKAN TERTIARY CARE CENTRE

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Background & Objectives:

Teenage pregnancy remains a major public health concern in Sri Lanka, frequently complicated by late presentation, social stigma, psychiatric comorbidity, child protection concerns and complex medicolegal dilemmas. This case series aims to describe the spectrum of obstetric, psychiatric, neonatal and medicolegal challenges encountered among pregnant adolescents managed at Colombo North Teaching Hospital (CNTH), Ragama, highlighting the imperative role of a multidisciplinary team (MDT) in optimizing outcomes.

Method: / Case Descriptions:

We review two cases of 15-year-old primigravidae managed in a tertiary care unit:

Case 1: A 15-year-old unmarried student presented in active labor at 37+0 weeks gestation with an unbooked, unmonitored pregnancy (no dating scan, anomaly scan, or antenatal STI/blood group screening) and concurrent bronchial asthma. She experienced recent bereavement following the traumatic death of her partner 5 months prior. Following an uncomplicated spontaneous vaginal delivery of a healthy male infant (2.57 kg, Apgar 10), an MDT case conference—comprising Obstetricians, Pediatricians, Forensic Pathologists, Child Psychiatrists, the Lama Piyasa child protection team and Probation Officers—coordinated formal legal adoption proceedings, psychiatric clearance, post-partum contraception (subdermal Etonogestrel implant), DNA sampling and milk suppression with cabergoline.

Case 2: A 15-year-old unmarried adolescent with diagnosed Borderline Personality Disorder (history of self-harm and overdose) and bronchial asthma presented at 37+3 weeks. Despite initial probation intervention, she had escaped care and re-established residence with her mother. Following a spontaneous vaginal delivery of a 2.59 kg male infant, the MDT managed post-partum neonatal jaundice, adjusted maternal psychotropic therapy (Sertraline), performed court-mandated forensic DNA profiling, provided long-acting reversible contraception (subdermal Etonogestrel implant) and safely coordinated the transfer of the neonate to state child protection services.

Results: & Lessons Learned:

Both cases presented severe maternal vulnerabilities: delayed antenatal care booking, coexisting mental health conditions (grief-induced depression risk and personality disorder), low socioeconomic support and statutory rape/child abuse legal implications. Key preventable factors identified included lack of ad-

olescent sexual/reproductive health education, fragmented community surveillance and delay in early antenatal booking. Unfavorable neonatal outcomes were minimized through structured MDT case conferences, immediate postpartum mental health stabilization, long-acting reversible contraception prior to discharge and coordinated state child protection workflows.

Conclusion & Policy Recommendations:

Managing complex adolescent pregnancies requires care that extends beyond standard obstetric protocols. Early involvement of child psychiatry, forensic medicine, medical social work and child probation services is vital to address legal, mental health and child protection needs safely. Policy frameworks must prioritize strengthening school-based reproductive health education, establishing dedicated adolescent-friendly antenatal clinics and enhancing inter-agency communication between health services and community child protection networks.

Keywords: Teenage Pregnancy, Multidisciplinary Management, Medicolegal Dilemmas, Child Protection, Sri Lanka.

EP058. COMPLIANCE WITH MATERNITY PEARLS DURING PLACEMENT AND REPAIR OF EPISIOTOMY: CLINICAL AUDIT

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Introduction: Episiotomy, though uncommon in Western obstetric practice, has long been integral to intrapartum care in Sri Lanka. This practice may have stemmed from the comparatively higher risk of grade 3, 4 perineal tears in Asian women compared to Caucasians,, anatomical contributors like smaller levator hiatus, less pelvic organ mobility and a thicker pubococcygeus muscles during pregnancy, higher risk of post-partum blood transfusion. Given these considerations, it is imperative that all birth attendants receive comprehensive training in perineal assessment and repair. The Royal College of Obstetricians and Gynaecologists (RCOG) guidance on perineal trauma management, informed by the Perineal Assessment and Repair Longitudinal Study (PEARLS), provides a globally recognized standard for clinical practice.

Objectives: Assess compliance with explicit standards in assessing and repairing an uncomplicated episiotomy.

Method: A prospective audit was conducted at District General Hospital Monaragala, from January to May 2026, involving primigravida, going through a vaginal delivery. Exclusion criteria were birth weight >3.5kg, <2.5kg, previous perineal surgeries or trauma, assisted vaginal deliveries, precipitate labour, immediate postpartum bleeding, 3rd and 4th degree perineal trauma were excluded from the audit. Audit standard was 100% compliance with RCOG maternity PEARLS checklist.

Results: Eighty-seven primigravidae were included following application of exclusion criteria. Compliance with key audit parameters varied considerably. Fewer than 10% of cases documented perineal hygiene, pelvic floor exercises, or repair details such as tear grade, suture materials and instrument counts. Initial instrument counts with a colleague were observed in 10.3%. Continuous subcuticular closure of perineal skin was performed in 19.5%. Verbal consent was obtained directly by the operator in 23%, with the remainder consented by assistants. Digital rectal examination (DRE) to exclude obstetric anal sphincter injury preceded 31% of procedures, while episiotomy apex identification occurred in 87.3%. Post-repair DRE and vaginal examination were completed in 88.5%. High levels of compliance (>90%) were achieved for asepsis, appropriate suture selection, knot placement 1 cm above the apex, re-approximation of perineal muscles, avoidance of excessive tension and final instrument counts. All procedures demonstrated full adherence to standards for analgesia, patient positioning, optimal exposure and lighting, visual examination, continuous non-locked closure of vaginal mucosa, haemostasis confirmation, removal and logging of tampons/packs and provision of immediate postpartum pain relief.

Conclusion: and recommendations The audit yielded mixed compliance rates for each component of the checklist. Unit training program on MATERNITY PEARLS checklist has been conducted and re-audit is currently being conducted.

EP059. CONGENITAL METHAEMOGLOBINAEMIA COMPLICATING PREGNANCY: WHEN OXYGEN CANNOT CORRECT CYANOSIS - A CASE REPORT

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Objectives: Congenital methaemoglobinaemia is a rare disorder of impaired methaemoglobin reduction, producing chronic cyanosis and reduced oxygen-carrying capacity. Pregnancy can worsen it, maternal oxygen demand rising as gestation advances. We report a case to draw attention to refractory cyanosis in pregnancy and to the multidisciplinary input its management requires.

Case report: A 24-year-old primigravida presented to a tertiary care hospital at 33+2 weeks with acute-onset dyspnoea and central cyanosis. She was deeply cyanosed, with oxygen saturation of 76% on room air rising only to 88% on high-flow oxygen - and the cyanosis did not clear. Structural cardiopulmonary evaluation including echocardiography was normal and arterial oxygenation was preserved despite the persistent central cyanosis. That mismatch prompted evaluation for dyshaemoglobinaemia.

Methemoglobin was 20.44% (normal <2%), with a reticulocyte count of 8.73%, confirming congenital methaemoglobinaemia. She later produced records showing the diagnosis had been made years earlier during an admission to a regional base hospital, where she was evaluated and advised lifelong vitamin C and avoidance of oxidant drugs - advice she had not followed, having defaulted from follow-up for several years. She had received no preconception counselling. The fetus was small for gestational age, with normal Doppler studies. Under multidisciplinary care involving obstetrics, haematology, anaesthesia and intensive care she remained clinically stable and elective caesarean delivery was planned for 37 weeks.

Discussion: Congenital methaemoglobinaemia deserves consideration whenever central cyanosis in pregnancy is disproportionate to arterial oxygenation and does not respond to oxygen. Here it was that mismatch, rather than the cyanosis itself, that pointed to the diagnosis. Recognising it early avoids unnecessary intervention. Vitamin C remains effective in many patients, while methylene blue may be unsuitable in selected cases, particularly where glucose-6-phosphate dehydrogenase (G6PD) deficiency coexists.

Conclusion: Refractory cyanosis in pregnancy is uncommon, but congenital methaemoglobinaemia belongs in its differential. This woman had carried the diagnosis for years without follow-up and reached 33 weeks with no preconception counselling; a saturation of 76% that oxygen could not correct is what finally brought it to light. Early recognition, avoidance of oxidant agents and coordinated multidisciplinary care are what protect both mother and fetus.

EP060. CONGENITAL PULMONARY AIRWAY MALFORMATION MIMICKING DIAPHRAGMATIC HERNIA WITH ANTENATAL REGRESSION

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Objectives: Fetal congenital pulmonary airway malformations (CPAM) may mimic other thoracic lesions and pose diagnostic challenges. This report describes a case initially suspected to be congenital diaphragmatic hernia, later confirmed as CPAM with antenatal regression and favourable outcome, highlighting the role of serial ultrasound surveillance.

Case report: A 34-year-old gravida 4 para 3 with two previous Caesarean deliveries, gestational diabetes mellitus and obesity had a suspected fetal diaphragmatic hernia at 18 weeks. She was referred to the fetal medicine unit at General Sir John Kotelawala Defence University Hospital, where ultrasound showed a right-sided cystic intrathoracic lesion consistent with CPAM measuring 2.9 × 2.3 × 2.8 cm with CVR 0.59. There was no mediastinal shift, hydrops or pericardial effusion. At 24 weeks, the lesion enlarged (CVR 0.8) with mild pericardial effusion but no hydrops. Two-weekly surveillance was continued. At 28

weeks, the lesion reduced in size with resolution of the effusion. At 33 weeks, it became sonographically inconspicuous while CVR remained <1.6 throughout pregnancy. An elective Caesarean section was performed at 37 weeks after antenatal corticosteroids for planned early delivery. The neonate was well on room air. Postnatal chest radiograph showed a small right pulmonary lesion consistent with antenatal findings. The infant remained asymptomatic and was managed conservatively with paediatric follow-up and planned imaging.

Discussion: This case illustrates the dynamic natural history of CPAM and the value of CVR-based surveillance. Persistently low CVR and the absence of hydrops supported expectant management with a favourable outcome, consistent with contemporary fetal medicine literature identifying CVR <1.6 as a predictor of low hydrops risk and good perinatal outcome. Congenital diaphragmatic hernia was excluded by the absence of herniated abdominal viscera and significant mediastinal shift. Bronchopulmonary sequestration was also considered; however, no systemic arterial feeder was identified on Doppler assessment. The spontaneous antenatal regression observed in this case reflects the recognised evolution of some CPAMs, while the persistent postnatal lesion emphasises that apparent prenatal regression does not necessarily indicate complete resolution.

Conclusion: Serial fetal imaging and CVR-based surveillance are essential in CPAM for risk stratification and management. Apparent antenatal regression should be interpreted cautiously and postnatal imaging remains necessary even in asymptomatic neonates.

EP061. CONSERVATIVE MANAGEMENT OF A POST CAESAREAN SECTION BROAD LIGAMENT HEMATOMA

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Objectives: This case is to highlight the success of conservatively managed post lower segment caesarian section expanding hematoma which are usually managed surgically. This shows vigilant clinical monitoring and timely use of tranexamic acid can avoid the surgical morbidity of a secondary laparotomy.

Case report: A 30 year old mother in second pregnancy with gestational diabetes underwent a category 2 lower segment caesarean section at 38+6 weeks of gestation for fetal distress during a trial of labor after caesarean. Intraoperative a non expanding 3x4 cm hematoma was noted in the bladder plexus, with an estimated blood loss of 200mL. On postoperative day 1, hemoglobin was 8.5g/dl and ultrasonography confirmed 4*3 cm hypoechoic lesion between the bladder and uterine wall. By postoperative day 2 hemoglobin further dropped to 7.9g/dl. Clinical assessment revealed the uterus deviated to the right side, raising suspicion of an expanding hematoma. A repeat Ultrasound suggested a 9x7x10 cm broad ligament hematoma. As the patient's hemodynamically stable a conservative strategy was adopted. Regular intravenous tranexamic acid, broad spectrum antibiotics continuous catheterization and strict fluid balance monitoring were initiated. Daily hemoglobin level monitoring done with a target level for blood transfusion set at 7.5g/dL. As patient remained clinically stable and by post operative day 5 hematoma expansion ceased with stable hemoglobin level, catheter was removed, tranexamic acid withheld. Following 10 days of in ward observation, she was safely discharged with safety netting and with a plan to review in 2 weeks for the interval assessment.

Discussion: Post lower segment cesarean section retroperitoneal or broad ligament hematomas are clinically significant incidents where expanding hematomas usually prompt urgent surgical exploration. This case shows non surgical stabilization is also achievable with intensive monitoring with clinical signs like uterine deviation and hemoglobin trends and early use of tranexamic acid to control microvascular bleeding.

Conclusion: Vigilant clinical and radiological monitoring combined with regular tranexamic acid can successfully cease the progression of large post lower segment cesarean section hematomas. Conservative management serves as a safe and effective alternative to surgical re exploration in hemodynaically stable patients.

EP062. CONSERVATIVE MANAGEMENT OF TWIN REVERSED ARTERIAL PERFUSION (TRAP) SEQUENCE PRESENTING LATE IN TERTIARY CARE HOSPITAL: A RARE CASE REPORT

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Objectives: To report a case of Twin Reversed Arterial Perfusion (TRAP) sequence that was managed conservatively to late preterm delivery due to an advanced gestational age, with successful neonatal outcome without the need for in-utero surgical intervention.

Case report: A 30-year-old woman (G2P1) with a history of an emergency lower segment caesarean section (LSCS) for poor progression was transferred to our tertiary unit at 33+4 weeks of gestation. Her monochorionic diamniotic (MCDA) twin pregnancy was complicated by TRAP sequence diagnosed at mid-trimester anomaly scan. She remained normotensive with no proteinuria throughout her antenatal care. On admission, ultrasound confirmed MCDA gestation consisting of a TRAP mass and a structurally normal male pump twin. The anterior abdominal wall of the pump twin was normal without evidence of gastroschisis or omphalocele. Doppler interrogation was reassuring; middle cerebral artery peak systolic velocity (MCA-PSV) was 32 cm/s, ruling out fetal anemia. The gestation was at an advanced period (33+4 weeks) and fetoscopic laser ablation was precluded, so a conservative approach was adopted. Following antenatal corticosteroids for fetal lung maturation and an intravenous magnesium sulphate bolus for neuroprotection, an LSCS was performed at 34 weeks. Along with the removal of the TRAP mass a live, healthy male infant was delivered successfully.

Discussion: TRAP sequence is a rare complication of monochorionic pregnancies. This is expressed as a structurally normal pump twin is perfused via the placental arterio-arterial anastomoses of an acardiac twin. The twin pump is at substantial risk for high-output cardiac failure and ultimately intrauterine death because of the significant hemodynamic burden. While most of these cases are managed with interventions like radiofrequency ablation or fetoscopic laser coagulation, the cases that have continued to reach advanced gestational ages pose a medical conundrum. In our case, the pump twin showed no sonographic signs of cardiac decompensation or anemia. Thus, pregnancy was managed well under close watch and the risks of late in-utero surgery were avoided. The use of neuroprotection and corticosteroids in a strategic manner optimized the neonatal condition prior to a planned late-preterm delivery.

Conclusion: In late preterm gestations with TRAP sequence and no signs of pump-twin cardiac failure or anemia, conservative management with close sonographic surveillance is a safe and valid alternative to surgical intervention. Timed delivery with appropriate neonatal prophylaxis can result in excellent maternal and fetal outcomes.

EP063. DELAYED-INTERVAL DELIVERY OF THE SECOND TWIN IN DICHORIONIC DIAMNIOTIC TWIN PREGNANCY AFTER 99 DAYS OF LATENCY

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Introduction and Objectives: The incidence of multiple pregnancies has increased with the use of assisted reproductive technologies. Premature rupture of membranes and preterm delivery are common complications associated with significant perinatal morbidity and mortality. In selected pregnancies, delivery of the first fetus is not necessarily followed by delivery of the remaining fetus(es). However, there is no standardized management approach for such pregnancies. We report a delayed-interval delivery (DID) / asynchronous delivery of the second twin after a 99-day latency period.

Case report: A 36-year-old primigravida with history of primary subfertility for seven years was followed up in her second successful IVF pregnancy with dichorionic twins. Antenatal period was complicated by type 2 diabetes mellitus, which was well controlled with oral

hypoglycaemic agents. At 17+3 weeks of gestation, she presented with premature rupture of membranes. Following high vaginal culture and biochemical investigations, intravenous ampicillin and oral erythromycin were commenced. Eighteen hours later, the presenting twin (175 g) was delivered without placental expulsion. There was no clinical evidence of chorioamnionitis, uterine contractions subsided after delivery and ultrasonography confirmed a live co-twin with intact membranes. After detailed counselling regarding the potential neonatal benefits and possible maternal and fetal risks, DID of the second twin was decided with informed parental consent. The umbilical cord was ligated high in the uterus, the placenta was retained in situ and a modified Shirodkar cerclage was placed. The pregnancy was managed expectantly with broad-spectrum intravenous antibiotics, tocolysis, serial fetal surveillance, regular clinical and biochemical monitoring. Anomaly scan demonstrated a low-risk fetus for major anoamlies. Following a latency period of 99 days, at 31+4 weeks of gestation, an emergency caesarean section was performed for preterm labour and fetal tachycardia. Magnesium sulphate and dexamethasone were administered before delivery. A healthy male infant weighing 1473 g was delivered and received specialised neonatal care. Placental examination of the first twin showed features of extensive placental infarction and marked organization with involution related to prolonged intrauterine retention. At one year of follow-up, the child was healthy and developing well.

Discussion: The major risks associated with DID are intrauterine infection and maternal sepsis. Non-reassuring fetal status, congenital anomalies, rupture of the membranes of the remaining fetus, significant haemorrhage and maternal infection or systemic disease should be excluded prior to the decision.

Conclusion: Following thorough assessment and exclusion of risk factors, DID should be encouraged in suitable patients at tertiary care centres.

EP064. DELAYED VULVAR RECONSTRUCTION FOR COMPLETE INTROITAL OBLITERATION AFTER VULVAR CANCER TREATMENT

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Objectives: Complete obliteration of vaginal introitus as a consequence of late treatment complication in women treated for vulvar cancer is a very debilitating condition which leads to considerable urinary morbidity and decrease in quality of life. This case study emphasizes the need for delayed reconstruction of the introit for restoration of urinary function and improvement of quality of life after severe fibrosis.

Case report: A 55 year old lady with diabetes mellitus was previously operated for FIGO stage IB squamous cell carcinoma of the vulva. The patient had undergone vulvectomy followed by radiotherapy despite the histologically clear inguinal lymph nodes. After one year of completing the radiotherapy, progressive vulvar fibrosis occurred resulting in introital obliteration. In addition, her external urethral meatus could not be found requiring her to be on a continuous urethral catheterization. On further follow up, the patient was referred to us because of recurrent catheter-related urinary tract infection and subsequent renal failure.

AA multidisciplinary approach was taken and reconstruction of the vagina was done for anatomical repair and removal of urinary outflow obstruction. The dense vulval and introital fibrosis were meticulously dissected to expose the external meatus of the urethra. Dissection of the scarred tissues was performed until a sufficient amount of patency was restored. Healing of the new introitus was left to heal through secondary intention. No skin flaps and grafting were needed. The catheter was successfully removed after day 5 and she was able to pass urine spontaneously afterwards. Her renal function remained stable. There were no postoperative complications and wound healed satisfactorily.

Discussion: Severe introital stenosis or complete obliteration due to late fibrosis after therapy for vulvar cancer is very rarely described. The chronic catheterization is predisposed to

recurrent infection of the urinary tract and possibly development of renal dysfunction. The timely detection of progressive introital stenosis and the timely consultation of reconstructive specialists may help to prevent serious complications such as renal impairment in patients with the urinary diversion. The limitations are, being a single case study and difficulty to distinguish the influence of radiotherapy and diabetes on the development of the symptoms.

Conclusion: Prompt diagnosis of progressive vulvar fibrosis and introital stenosis with evaluation of urinary complaints and subsequent referral for reconstruction may help to avoid total obliteration and serious complications. Increased awareness of this very late complication, follow-up of survivors of vulvar cancer and multidisciplinary management are vital. More research is necessary in order to define optimal methods of reconstruction and prevention of severe vulvar fibrosis after treatment.

EP065. DEMOGRAPHIC, GEOGRAPHIC AND BEHAVIORAL VARIATIONS IN SEMINAL FLUID PARAMETERS: EVIDENCE FROM THE CENTRAL PROVINCE OF SRI LANKA

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Introduction: Seminal fluid parameters in subfertile men vary with demographic, geographic and behavioral factors. Global findings suggest semen quality may be reduced in men living in agricultural or industrialized areas due to pesticides and fertilizer use. This may also depend on other demographic and behavioral factors among sub-fertile men. However, no previous studies in Sri Lanka have examined the relationship between these determinants and seminal fluid characteristics.

Objectives: To assess whether there is significant demographic, geographic and behavioral variations in seminal fluid parameters among sub fertile men attending subfertility clinics in Central Province, Sri Lanka.

Design: A cross-sectional analysis.

Method: A total of 49 sub-fertile men recruited randomly from subfertility clinics operating in government hospitals in Kandy (n=26), Matale (n=9) and Nuwara-Eliya (n=14). Seminal fluid parameters including semen volume, sperm concentration, rapid progressive motility, non-progressive motility and presence of pus cells were compared with demographic factors such as age, ethnicity, maximum level of education and nature of their occupation, geographic factor as their residential district and behavioral factors including wearing tight underwear, smoking, food habits and alcohol consumption. Data collected using a validated structured interviewer-administered questionnaire and the collected data analyzed using SPSS version 26.0. The Kruskal-Wallis test, Mann-Whitney U test, Spearman correlation and Chi-square test used where appropriate. Significance level set at $p<0.05$. Ethical clearance obtained from the Ethics Review Committee, Faculty of Medicine, University of Peradeniya (2022/EC/26).

Results: There was no any significant association found between demographic and behavioral factors with seminal fluid parameters. However, geographic factor showed significant associations. The lowest rapid progressive motility (median 30%) found in Kandy compared to median 40% in both Matale and Nuwara-Eliya ($p=0.018$). Nuwara Eliya showed the highest semen volume of median 2.5ml ($p=0.049$). Presence of pus cells was higher in Kandy (52%) compared to Matale (11%) and Nuwara-Eliya (0%, $p=0.001$). Non-progressive motility and sperm concentration not showed any significant variation by district.

Conclusion: In Central Province, seminal fluid parameters including rapid progressive motility and presence of pus cells significantly varied by district, highlighting a significant association between environmental or geographical factors on semen quality. None of the demographic and behavioral factors showed significant associations with seminal fluid parameters in this population. Therefore, larger multi-center studies are required including environmental factors, to establish clear targeted interventions.

Keywords: Seminal fluid parameters, subfertile men, demographic factors, geographic factors, Central Province

EP066. DEPRESSION AND ANXIETY AMONG ANTENATAL MOTHERS IN COVID ERA: A HOSPITAL BASED STUDY

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Introduction and Objectives: The COVID-19 pandemic substantially increased the burden of mental health disorders worldwide, with anxiety and depression rising because of social isolation, fear of infection, disruptions to healthcare and economic uncertainty. Pregnant women were particularly vulnerable due to concerns about maternal and fetal health, changes in antenatal care and reduced social support, making the assessment of depression and anxiety during the pandemic a public health priority. This study was carried out to describe factors influencing anxiety and depression and their relation to COVID-19 among pregnant women not having the COVID-19 infection admitted for confinement in a teaching hospital, Sri Lanka.

Method: A cross-sectional study was carried out among 413 inward pregnant mothers from September 2021 – September 2022, who were asymptomatic for COVID-19 infection, in their period of gestation from 37 weeks to 40 + 6 weeks at Teaching Hospital, Anuradhapura, Sri Lanka. Sinhala & Tamil translated and validated Hospital Anxiety and Depression Scale (HADS) was utilized to assess the mental health status of the study population. Descriptive statistics were explained with frequency distributions while the associations were analyzed with Fisher's Exact and chi square tests with a significant level of < 0.05.

Results: Almost half of the study participants (52.2%, n=215) obtained a normal score (0-7) for anxiety component of the HADS tool with only 16.2% (n=67) of the mothers with an abnormal result. A statistically significant association was noted between level of anxiety and having other children ($\chi^2 = 7.691$; df=2, p=0.021). A majority of the pregnant mothers (82.10%, n=340) obtained a total score of 11-21 for the depression component of the tool while only 9 mothers (2.20%) obtained a normal score of less than 7. A statistically significant association was noted only between the level of depression and period of gestation (Fisher's exact test=12.153; p=0.041) among the participants.

Conclusion: A substantial proportion of term pregnant women experienced depressive symptoms during the COVID-19 pandemic despite not being infected with COVID -19. Parity had significant association with anxiety while the association of depression increased with the advancement of the period of gestation. These findings highlight the importance of routine antenatal mental health screening and timely psychological support for pregnant women, particularly during public health crises.

EP067. DETERMINANTS OF PROLONGED POSTPARTUM HOSPITAL STAY FOLLOWING UNCOMPLICATED TERM DELIVERIES

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Introduction: Duration of postpartum hospital stay is an important indicator of quality and efficiency of maternity care and has implications on healthcare resource utilization. Although discharge following uncomplicated delivery should be individualized according to maternal and neonatal wellbeing, it is influenced by clinical, institutional and social factors that vary across healthcare settings.

Objectives: To identify the maternal, neonatal and institutional determinants of postpartum hospital stay following uncomplicated vaginal and caesarean deliveries to optimize discharge practices and resource utilization.

Method: A prospective audit of 201 consecutive uncomplicated term deliveries in the Professorial Obstetric Unit, Colombo North Teaching Hospital, Ragama, was conducted over two months. Pregnancies complicated by antenatally identified maternal or foetal conditions were excluded. The audit standard was discharge within 24-hours following uncomplicated vaginal delivery and within 48-hours

following uncomplicated caesarean delivery according to unit protocol. Maternal, neonatal and institutional determinants of postpartum hospital stay were recorded and analysed using descriptive statistics.

Results: The median maternal age was 30-years (interquartile range [IQR]27-33) and 119 (59.2%) women were primiparous. The mean gestational age at delivery was 38.5±1.4 weeks. Of the study population, 94 (46.8%) underwent normal vaginal delivery, 6 (3.0%) had instrumental vaginal delivery and 101 (50.2%) underwent caesarean delivery, of which 59 (58.4%) were emergencies. The median postpartum hospital stay was 42.4 hours (IQR 31.1-71.6) following vaginal delivery and 43.7 hours (IQR 30.2-57.6) following caesarean delivery, suggesting broadly similar discharge practices irrespective of delivery mode. However, 94.0% (95% CI 87.5-97.2) of women following vaginal delivery exceeded the unit's 24-hour discharge standard compared with 34.7% (95% CI 26.1- 44.3) following caesarean delivery exceeding the 48-hour standard. Overall, 129 (64.2%) women experienced prolonged postpartum hospital stay. The majority (74/129; 57.4%) remained hospitalized because of ongoing neonatal admission, most commonly for excessive weight loss or feeding difficulties, neonatal jaundice, or suspected sepsis. System and logistical delays accounted for 20/129 (15.5%) prolonged stays.

Conclusion: The high rate of non-compliance with the intended 24-hour discharge standard following uncomplicated vaginal delivery highlights an opportunity to review discharge practices within the unit. Importantly, one-third (31.0%) of prolonged stays were attributable to potentially modifiable non-clinical factors, comprising system and logistical delays (15.5%). These become clear targets for quality improvement interventions in the second phase of the audit cycle, with planned re-audit to evaluate improvements in discharge practices, documentation and resource utilization.

EP068. DIAGNOSTIC DILEMMA IN EARLY ONSET SEVERE PRE-ECLAMPSIA WITH NEPHROTIC RANGE PROTEINURIA

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Objectives: To emphasize the diagnostic and management challenges of early onset pre eclampsia and fetal growth restriction complicated with nephrotic range proteinuria, Acute kidney injury in a precious pregnancy where maximal prolongation of pregnancy attempted and led to significant hypoalbuminaemia and postpartum complication which needed reopening.

Case report: A 35 year old primigravida conceived after 2 years of primary subfertility with intrauterine insemination presented with high blood pressure spike at 24 weeks. Despite adequate blood pressure control achieved with two antihypertensives, her renal functions deteriorated rapidly with generalized oedema and nephrotic range proteinuria (urine albumin creatinine ratio 3963 mg/g), moderate hypoalbuminaemia (22g/L).Following an acute gastroenteritis episode at 25+5 weeks, she developed acute kidney injury with oliguria which was settled with symptomatic management and hydration. But due to persistent proteinuria multidisciplinary team involving nephrologist recommended termination due to worsening renal failure. During category 3 emergency hysterotomy, a gross ascites was noted and drained. Patient developed a sudden abdominal distension with acute severe anaemia of haemoglobin 5.1g/dl with dyspnea on postpartum day 4. Emergency laparotomy revealed 3 liter blood stained fluid collection with clots, but no active macrovascular bleeding source. Hepatic and splenic rupture was excluded intraoperative with interval assessment and postoperatively with radiological assessment. The neonate died on postpartum day 6 due to extreme prematurity. At postpartum 6 week review, maternal renal function was significantly improved with urine albumin creatinine ratio dropping to 768mg/g. Blood pressure was optimized with adding Angiotensin receptor blockers.

Discussion: Early onset pre eclampsia with growth restriction complicated with nephrotic range proteinuria mimics a coexisting renal disease which makes a diagnostic and management dilemma. Timely decision making with multidisciplinary teams mandate to balance the maternal and fetal outcomes. Attempting maximal prolongation can result in significant maternal complications where vigilant monitoring and aggressive albumin correction are important to prevent unnecessary interventions.

Conclusion: Severe pre eclampsia can result in significant renal impairment and life threatening fluid shifts due to massive protein loss. Although these are reversible complications, multidisciplinary involvement is important for the decision making in termination. Vigilant monitoring and clinical assessment is important in identifying rare postpartum complications.

EP069. DIAGNOSTIC DILEMMA OF CEREBRAL LUPUS AND ANTIPHOSPHOLIPID SYNDROME COMPLICATING PREGNANCY

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Introduction: Systemic Lupus Erythematosus (SLE) is a chronic multisystem autoimmune disease affecting females at reproductive age, leading to multisystemic organ dysfunctions. It is a commonly encountered condition leading to multiple pregnancy comorbidities, including recurrent miscarriage, preeclampsia, fetal growth restriction, preterm delivery, intrauterine fetal demise and neonatal lupus. Presence of Antiphospholipid antibodies leads to increased pregnancy morbidity and thrombotic complications. The given scenario highlights the diagnostic dilemma of cerebral lupus with antiphospholipid syndrome complicating pregnancy.

Case report: A 33-year-old mother in her 6th pregnancy with 5 previous first trimester miscarriages transferred from a local hospital due to preterm prelabour rupture of membranes at 33 weeks of gestation for advanced neonatal care. While on conservative management, the patient was identified with prolonged decelerations and underwent a category 1 emergency caesarean section. Unfortunately, the neonate died immediately after birth despite neonatal resuscitation. On further inquiry, she is a known patient with seizure disorder and taking carbamazepine. She had her last convulsion 1 year ago. She has severe mitral valvular heart disease, which was managed as rheumatic heart disease. She had a photosensitive rash involving her malar regions over a long duration, which she had not revealed earlier. After her 5th miscarriage, even though she was advised and referred for evaluation of recurrent miscarriages, she defaulted due to social reasons. During the index pregnancy, she was started on LMWH and aspirin on clinical suspicion and positive ANA. Until 33 weeks of gestation, she was normotensive without evidence of placental dysfunction with satisfactory fetal growth and well-being. During her postnatal evaluation, she was found to have positive Ds-DNA, anti-Ro antibodies, lupus anticoagulant and low complement levels. Further vasculitic changes were identified in CECT-Brain, which was performed for evaluation of her seizure disorder. Thus, she was diagnosed with SLE with APLS and cerebral lupus. She was given a long-term follow-up plan involving rheumatology, neurology and Obstetrics teams.

Discussion: In the given scenario, the patient had an undiagnosed seizure disorder and cerebrovascular changes on brain imaging, directing the diagnosis toward cerebral lupus. It is one of the sinister complications associated with SLE. Her pregnancy morbidity, including recurrent miscarriages and neuropsychiatric phenomena, was well explained with the diagnosis of SLE. She was advised regarding the possible lifelong complications due to the disease and given a specific plan for the management of her next pregnancy. Thus, she was referred to a multidisciplinary team assessment before discharge and long-term follow-up was arranged to ensure a successful future pregnancy.

Conclusion: Hidden morbidity of the undiagnosed cerebral lupus and antiphospholipid syndrome could result in multiple adverse pregnancy events leading to significant patient morbidity. Prompt diagnosis and early multidisciplinary team input may help to optimise the successful pregnancy outcome.

EP070. DOUBLE TROUBLE: PREGNANCY WITH IDIOPATHIC NON-CIRRHOTIC PORTAL FIBROSIS & GILBERT SYNDROME

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Objectives: Highlight the rarity of the coexistence of multiple rare medical pathologies and timely and holistic management of patients

Case report: a 30 year old G2P2C1 female who has undergone a previous caesarean section who presented for the first time at 35 weeks and 3 days of gestation in labour. She was previously diagnosed with Idiopathic Non-cirrhotic Portal fibrosis and Gilbert Syndrome had been under proper follow up. She underwent a multidisciplinary approach and a decision was made to undergo an emergency lower segment caesarean section in view of her past comorbidities and risk of uterine rupture and preemptively 4 packs of platelets were transfused prior to the surgery. A live non-asphyxiated baby boy was delivered through meconium stained liquor. The patient was transferred to the intensive care unit for scrutinised observation and her postpartum period was uneventful. She was discharged on day 5 of the post operative period.

Discussion: Noncirrhotic portal fibrosis (NCPF) is a rare cause of portal hypertension characterized by periportal fibrosis of small and medium portal veins with preserved liver architecture and function. It presents with portal hypertension complications such as variceal bleeding, hypersplenism-related cytopenias, while jaundice and liver failure are uncommon. Pregnancy in NCPF is challenging due to increased risk of variceal hemorrhage, requiring close monitoring, endoscopic surveillance, beta-blockers and individualized obstetric planning. Delivery is guided by obstetric indications, with precautions to reduce straining and bleeding risk. Gilbert syndrome is a benign inherited disorder causing intermittent unconjugated hyperbilirubinemia triggered by stress, fasting, or illness, with excellent prognosis.

Conclusion: Idiopathic noncirrhotic portal hypertension is a rare coexistence in pregnancy. Timely diagnosis and proper follow up must be done during the pre-pregnancy period and during the antenatal period to avoid any catastrophic complications.Gilbert syndrome is a benign disease that has a good prognosis and normal life expectancy. This case was reported for its rarity to give an understanding on its management in pregnancy.

EP071. DURAL ARTERIOVENOUS FISTULA IN EARLY PREGNANCY FOLLOWING CEREBRAL VENOUS SINUS THROMBOSIS

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Objectives: To report a case of newly identified dural arteriovenous fistula (dAVF) in early pregnancy in a woman with prior cerebral venous sinus thrombosis (CVT) and to highlight the diagnostic and antithrombotic management challenges that arise when a hyperdynamic and prothrombotic gestational state is superimposed on a lesion with both thrombotic and haemorrhagic potential.

Case report: A primigravida attended at 10 weeks and 6 days of gestation with a four-day history of worsening vertex headache and intermittent vomiting that briefly relieved her symptoms. Superior sagittal sinus thrombosis had been diagnosed in 2022, attributed to combined oral contraceptives commenced after a myomectomy. Warfarin had been continued for approximately eight months until follow-up imaging confirmed near-complete recanalisation and an extended thrombophilia workup was unremarkable apart from a weakly positive antinuclear antibody. On admission she was haemodynamically stable, with no papilloedema or focal neurological deficit. Magnetic resonance imaging of the brain with venography demonstrated a dural arteriovenous fistula and no recurrent thrombosis. After joint review with neurology and radiology, she was commenced on prophylactic enoxaparin and low-dose aspirin. Her symptoms settled and digital subtraction angiography together with any embolisation was postponed to the puerperium. She remains under shared antenatal and neurological surveillance.

Discussion: The clinical emergence of this fistula in early gestation is consistent with an indolent lesion that became symptomatic under the haemodynamic and prothrombotic shifts of pregnancy. A dAVF is recognised as a delayed sequela of CVT in a meaningful proportion of cases, attributed to venous outflow disturbance and the recruitment of small arteriovenous channels within the dura. In pregnancy, MRI with venography offers diagnostic clarity without fetal radiation exposure and should be the imaging modality of first choice. Where ongoing anticoagulation is required, low-molecular-weight heparin is preferred over a vitamin K antagonist on both fetal and maternal grounds. Any decision on the timing of embolisation must weigh fistula grade, the presence of cortical venous reflux and obstetric considerations against the radiation burden of digital subtraction angiography in the antenatal period.

Conclusion: A persistent or progressive headache in a pregnant woman with prior CVT should not be assumed benign. Neurovascular imaging is indicated, dAVF belongs in the differential and a planned postpartum approach to definitive treatment is often the safest course when the lesion is haemodynamically quiescent.

EP072. DYSGERMINOMA IN XY GONADAL DYSGENESIS; A CASE REPORT

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Introduction: XY gonadal dysgenesis, swyer syndrome is pure gonadal dysgenesis (1,2). These individuals are tall phenotypical females, have normal mullarian structures. They have normal female internal and external genitalia but usually present with delayed puberty as their gonads do not have reproductive potential.

The two most common tumors they develop are gonadoblastoma and dysgerminoma

Objectives: To highlight the diagnostic and management challenges with gonadal malignancy Case A 15 year old girl was presented with primary amenorrhea without secondary sexual characteristics. During imaging she was found to have bilateral solid pelvic masses, thus referred to cancer institute in Maharagama.

Her tumor markers showed elevated LDH (Lactate Dehydrogenase enzyme) and αFP (alpha Feto Protein). Thus she underwent staging laparotomy, bilateral salpingo-oopharectomy, omentectomy, para aortic node biopsy were done. As surgical staging was FIGO stage 1B, her uterus was preserved for fertility by means of in vitro fertilization with donor oocyte. Her histology confirms dysgerminoma with elements of yolk sac tumor. She received adjuvant chemotherapy.

Karyotyping showed 46XY, further investigations were not done due to financial constraints. Differential diagnosis were swyer syndrome and complete androgen insensitivity syndrome.

She was started on hormonal replace therapy with combined estrogen and progesterone therapy.

Discussion: This patient is having complete female internal and external genitalia without development of breasts. Her karyotype is 46XY, thus diagnosis is compatible with swyer syndrome (4). The malignat potential of the gonads are higher in swyer syndrome than in complete androgen insensitivity syndrome (2, 3, 5). Compared to other germ cell tumors dysgerminoma shows significant bi-laterality (6).

These individuals should be started on hormone replacement therapy as early as possible after surgery and estrogen alone therapy must be started to induce secondary sexual characteristics, if possible before 15 years of age. After 12-24 months progesterone will be added to induce withdrawal bleeding (6). Follow up is arranged at cancer institute to detect recurrences.

Conclusion: Primary amenorrhea requires extensive evaluation. Early diagnosis of swyer syndrome is necessary in view of the risk of malignancy potential at younger age and initiating hormonal replacement therapy to induce puberty. We present this case scenario in view of expanding awareness among clinicians.

Ethical consideration Informed verbal consent has been obtained from the patient and all identifying information has been omitted to preserve patient confidentiality

EP073. EFFECTIVENESS OF DAILY CALCIUM 1000 MG SUPPLEMENTATION IN ENHANCING WOUND HEALING AMONG PATIENTS FOLLOWING MAJOR GYNECOLOGICAL SURGERY: A SYSTEMATIC REVIEW

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Introduction: The process of post-surgery wound healing is one of the key factors for successful recovery after surgeries like hysterectomy, myomectomy and ovarian tumors removal. The nutrition plays an important role in the process of tissue regeneration and healing. Calcium participates in processes such as coagulation, cellular processes, fibroblasts functions, keratinocytes proliferation and collagen formation and affects wound healing. The recent researches show that the calcium supplementation can be useful for wound healing improvement.

Objectives: The systematic review is focused on the efficiency of 1000 mg of calcium daily supplementation for wound healing enhancement among patients with major gynecological surgery.

Method: The systematic review followed the PRISMA guidelines. Databases like MEDLINE (PubMed), Scopus, Web of Science, Google Scholar and the Cochrane Library were accessed based on the search terms 'calcium supplementation', 'wound healing', 'recovery after surgery', 'gynecological surgery' and 'surgical wound healing'. This systematic review included randomized controlled trials, clinical studies, cohort studies and observational studies. Reviews, case reports and non-English studies were excluded. Out of 186 articles reviewed, nine met the eligibility criteria and were subjected to methodological evaluation by using the Jadad Scale and Newcastle-Ottawa Scale. Most of the studies selected were of moderate to high quality.

Results: The conducted literature reviews proved that calcium supplementation helps promote wound healing by using various biological processes. It was established that regular consumption of calcium leads to more effective coagulation, better proliferation of fibroblasts, more collagen production, quicker epithelization and proper tissue remolding. The use of calcium supplementation helped to decrease the time required for wound healing, reduce the risk of wound infection and increase postoperative recovery compared to control patients. It was found out that sufficient amounts of calcium help regulate inflammation and promote angiogenesis, thus making the process of tissue remolding much faster. Additionally, calcium supplementation improved the general nutrition of patients.

Conclusion: There is evidence at present indicating that calcium supplementation on a daily basis can aid in wound healing and recovery post operation in patients having major gynecological surgery. Calcium plays an important role in various bodily functions needed for tissue repair, such as coagulation, cell division, collagen production and wound remodeling. However, although the results are positive, further extensive studies are still needed to provide definite clinical guidelines.

Keywords: Calcium Supplementation, Wound Healing, Gynecological Surgery, Postoperative Recovery, Tissue Repair, Surgical Wounds, Nutritional Supplementation, Systematic Review.

EP074. EFFECTIVENESS OF FISH OIL SUPPLEMENTATION IN REDUCING LOW BIRTH WEIGHT: A SYSTEMATIC REVIEW

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Introduction: Low birth weight (LBW) occurs in almost 15% of all births worldwide and is characterized by an increased probability of developing various neonatal diseases and even death. Omega-3 LCPUFAs such as DHA and EPA can prevent low birth weight via anti-inflammatory properties, improved placental perfusion and prolongation of pregnancy period.

Objectives: The purpose of the present systematic review is to analyze whether fish oil supplementation during pregnancy is effective in decreasing the probability of having low birth weight and positively affecting birth results.

Method: This systematic review adhered to PRISMA principles and used RCTs and meta-analyses published from 2000 until April 2026. The electronic databases PubMed, Cochrane Library and Embase were searched for articles with the keywords "fish oil", "DHA", "EPA", "low birth weight", "birth weight" and "preterm". Among 48 articles found, 12 fulfilled inclusion criteria after Jadad scoring and eight of them were considered high-quality researches. The inclusion criterion was omega-3 LCPUFA intake of at least 600 mg/day after 20 weeks of pregnancy; exclusion criteria comprised observation studies and low dose research.

Results: Fish oil supplementation at doses greater than 650 mg/day significantly increased birth weight by an average of 87 g ($P < 0.01$) and reduced the risk of low birth weight (RR 0.88; $P = 0.05$). Early preterm birth before 34 weeks was reduced by 42% (RR 0.58; $P < 0.01$) across six studies. Gestational duration increased by approximately 4 - 7 days ($P < 0.05$). High-risk pregnancies demonstrated birth weight gains of up to 200 g ($P < 0.001$). Cochrane evidence further confirmed an 11% reduction in preterm delivery rates. No significant long-term increase in maternal BMI was observed.

Omega-3 supplementation was found to lower the effect of prostaglandins on uterine contractions, promote good blood flow to the placenta and improve fetal weight and fatness. Inconsistency in dosage schedules and sample characteristics was a limitation that prevailed throughout all these studies.

Conclusion: Supplementation of fish oil during pregnancy significantly lowers the chances of low birth weight, especially in high-risk pregnancies, mostly through extended duration of pregnancy and improved fetal growth. It is advisable to incorporate omega-3 supplementation into pregnancy treatment. Further research on dose-response relationship is recommended.

Keywords: Fish oil, omega-3 fatty acids, low birth weight, pregnancy supplementation, systematic review

EP075. ESSENTIAL HYPERTENSION WITH PERSISTENT HYPOKALEMIA DURING PREGNANCY: A SUSPECTED CASE OF GELLER SYNDROME

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Objectives: To report a rare case of suspected Geller syndrome and to emphasize the importance of considering this monogenic disorder as a differential diagnosis in a hypertensive patient who develops persistent hypokalemia during pregnancy.

Case report: We report a 40-year-old woman in her second pregnancy with a previous first trimester miscarriage and secondary subfertility for 6 years, who presented with poorly controlled hypertension accompanied by persistent hypokalemia (2.8mmol/L) and hypomagnesemia (0.52mmol/L).Her investigations showed marked renal wasting (Spot urinary potassium -55mmol/L, Trans tubular potassium gradient -10) without renal tubular acidosis and low serum Aldosterone (3.11ng/dl) and Renin (3.36µIU/mL) levels. There is a history of pre-pregnancy hypertension with defaulted follow-up and other secondary causes for young hypertension were excluded with extensive investigations after the conception. High progesterone and prolactin were observed and were compatible with trimester-specific norms. Antihypertensives were escalated from the booking visit and was on triple antihypertensive therapy from 28 weeks of gestation till delivery. Electrolyte imbalance s were initially corrected with parenteral supplementations and subsequently replaced by entral supplements. Delivery was done at 37 weeks of gestation through an elective lower segment cesarean section due to fetal growth restriction and persistent hypertension and was complicated by severe post partum hemorrhage. Following delivery, electrolyte abnormalities markedly improved and blood pressure was

controlled by a single antihypertensive agent, strongly suggesting Geller syndrome. Genetic testing for an NR3C2 mutation is currently pending.

Discussion: Geller syndrome is a rare inherited form of mineralocorticoid hypertension first described by Geller et al. in 2000. It results from a gain-of-function mutation affecting the mineralocorticoid receptor, most commonly the S810L mutation of the NR3C2 gene. Unlike the normal receptor, which is antagonized by progesterone, the mutant receptor is paradoxically activated by progesterone, leading to increased sodium reabsorption and renal potassium excretion.

Conclusion: Geller syndrome should be considered in pregnant women presenting with hypertension or difficult-to-control pre-existing hypertension accompanied by persistent hypokalemia with renal wasting. Recognition of this rare disorder may avoid unnecessary investigations, facilitate appropriate management and improve maternal and fetal outcomes.

EP076. EVALUATION OF CERVICAL CANCER AWARENESS AND SCREENING AMONG WOMEN ATTENDING THE OBSTETRICS AND GYNAECOLOGY CLINICS AT DISTRICT GENERAL HOSPITAL, CHILAW — A CLINICAL AUDIT USING THE SRI LANKAN NATIONAL CERVICAL CANCER SCREENING PROGRAMME AS THE BENCHMARK

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Introduction: Cervical cancer remains the leading Gynecological cause of cancer-related morbidity and mortality among Sri Lankan women. The cervical cancer is only cancer that have a definitive precancerous lesion and using Pap smear can be detected easily. If precancerous lesions are identified and treated early, development of cervical cancer can be prevented.

Despite the availability of an effective national screening programme, coverage and awareness levels remain suboptimal in certain districts. Recent hospital statistics from District General Hospital (DGH) Chilaw indicate a concerning rise in newly diagnosed cervical cancer cases— with 31 new cases detected among 261 cervical biopsies performed between June 2024 and August 2025. This trend underscores potential deficiencies in awareness, access and utilization of cervical cancer screening services in the Puttalam District, which also records a highest crude incidence rate similar to Colombo, Kalutara and Batticaloa districts.

Given the importance of secondary prevention and reducing disease burden, it is essential to evaluate the receipt of invitation for screening, level of awareness and screening practices among women attending DGH Chilaw. This audit aims to assess current performance against the National Cervical Cancer Screening Guidelines of Sri Lanka, serving as the gold standard benchmark.

Objectives: To evaluate the awareness, receipt of invitation and participation in cervical cancer screening among women aged over 35 years attending obstetrics and gynaecology clinics at DGH Chilaw.

Design: Hospital -based audit was conducted over one month period and included 106 women, aged 35 years and above attending Obstetrics and Gynecology clinics at DGH Chilaw.

Method: An interviewer-administered, web based questionnaire was given to all participants and responses were automatically recorded. SPSS version 23 was used for data analysis.

Results: A total of 106 eligible women aged 35 years and above were included in the audit. Most participants were within the 35–44 year age group. Awareness regarding cervical cancer was high, with approximately 90.6% reporting that they had heard about the disease Awareness specifically about the Pap smear screening test was moderate (71.7%).

However, only 53.8% of respondents reported ever having undergone a Pap smear, which remains below the Sri Lankan national target of ≥70%.

Invitations for screening were inconsistently received and knowledge of the nearest free screening facility was not universal among participants.

Conclusion: The audit demonstrates satisfactory awareness but suboptimal screening coverage when compared to the national standard. improving clarity on available screening locations and reinforcing community-level health education are essential and strengthened PHM-led invitations can bridge the current17% gap toward achieving the 70% benchmark.

EP077. EVERYDAY CHEMICALS, HIDDEN RISKS: ENDOCRINE DISRUPTING CHEMICAL (EDC) EXPOSURE AMONG SRI LANKAN PREGNANT WOMEN

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Introduction: Endocrine-disrupting chemicals (EDCs) in plastics, food packaging, cosmetics and agrochemicals cross the placenta and are linked to preterm birth, low birth weight and altered fetal development. Sri Lanka has no local data on exposure or awareness.

Objectives: To describe self-reported EDC exposure, knowledge, risk perception and readiness to change among pregnant women and to examine associations with sociodemographic factors.

Design: Descriptive cross-sectional study.

Method: Ninety-two pregnant women attending the antenatal clinic at Sri Jayewardenepura General Hospital completed a structured, self-administered questionnaire covering exposures (food packaging, personal-care products, household/environmental sources), a 12-item knowledge score, perceived risk and information needs. Associations with age, parity, education and income were tested with Fisher's exact and Mann-Whitney tests ($p<0.05$).

Results: EDC exposure was woven into everyday life. It began at the table: 70% ate hot food in thin polythene, 70% bought polythene-wrapped takeaway, 57% drank from plastic water bottles and 48% consumed canned food. Personal-care sources followed - perfume (78%), scented soap (78%) and shampoo (74%) - while at home 43% lived on PVC or vinyl flooring and 48% regularly handled thermal-paper receipts.

Yet this near-universal exposure went largely unrecognized: only 30% had heard the term "endocrine-disrupting chemicals" and 22% had ever been counselled about chemical avoidance by a doctor or midwife. Knowledge was patchy (mean 8.0/12), with blind spots around skin absorption (26% correct) and the link to preterm and low birth weight (52%).

Knowing little did not mean caring little: 65% were very or extremely worried and 83% were willing to change habits, yet only 26% felt adequately informed and 83% wanted more, preferably an in-person clinic talk (39%). This concern-knowledge gap fell sharply along social lines. Higher income predicted greater knowledge (median 11 versus 7.5; $p<0.001$), yet worry ran the other way - higher among lower-income (79% versus 44%; $p=0.002$) and less-educated women (75% versus 43%; $p=0.004$). The same lower-income and primigravid women were most exposed to hot food in polythene ($p=0.023$; $p<0.001$) - those least able to recognize the risk carried the most.

Conclusion: Exposure was widespread but unrecognized - only 30% had heard of EDCs and 22% had ever been counselled. Concern and willingness to change were high; information was not. In this first Sri Lankan study, the least informed women were also the most exposed, which is why antenatal education here must be equity-focused.

EP078. EXPECTANT MANAGEMENT OF TRAP SEQUENCE AFTER FAILED LASER ABLATION

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Objectives: Twin Reversed Arterial Perfusion (TRAP) sequence is an uncommon vascular complication of monochorionic twin pregnancies, carrying a documented risk of cardiac compromise and demise in the pump twin. We report this case to illustrate that a favourable term outcome remains achievable when intrauterine intervention fails, provided surveillance is maintained and prognostic markers remain reassuring.

Case report: A 31-year-old woman, gravida 2 para 0 with one previous first-trimester miscarriage, was booked at 7+4 weeks of gestation. An early scan at 6+3 weeks demonstrated a single visible crown-rump length within a monochorionic diamniotic (MCDA) sac. At 12+5 weeks, TRAP sequence was confirmed: a structurally normal pump twin co-existing with an acardiac acephalus twin. She was referred for fetal medicine input. Three fetoscopic laser ablation attempts were undertaken at 17+0, 18+2 and 19+1 weeks, each abandoned owing to suboptimal visualisation of the anastomotic vessels and difficulty with uterine access. Following failed intervention, expectant management commenced with serial Doppler studies — initially weekly, then three-weekly, then monthly — incorporating middle cerebral artery peak systolic velocity, biometry and cardiac assessment. Throughout surveillance the pump twin grew appropriately, the acardiac mass regressed and there was no polyhydramnios, hydrops or cardiac strain. At 35 weeks early cardiac hypertrophy was suspected in the pump twin, prompting planned delivery. Induction of labour at 37 weeks resulted in a spontaneous vaginal delivery of a live female neonate weighing 2.32 kg (Apgar 9, 10, 10). The acardiac specimen measured approximately 14 × 8 cm. Neonatal admission to intensive care was not required.

Discussion: Outcome in TRAP sequence is largely determined by the acardiac-to-pump twin size ratio, presence of polyhydramnios and signs of high-output cardiac failure. Intrafetal radiofrequency ablation and fetoscopic laser remain the preferred interventions when prognostic indicators are unfavourable. This case demonstrates that failure of attempted ablation does not invariably translate into adverse perinatal outcome. Where the acardiac twin involutes, Doppler indices remain normal and amniotic fluid is preserved, individualised expectant care can safely carry the pregnancy to term.

Conclusion: Expectant management is a legitimate option in selected TRAP sequence pregnancies when prognostic features are favourable, even after failed ablation. Close multidisciplinary surveillance and timely delivery planning are central to optimising outcomes.

EP079. EXTENSIVE SURGICAL EXCISION AND VULVAL RECONSTRUCTION FOLLOWING CHRONIC LYMPHOEDEMA LEADING TO MASSIVE VULVAL MASS - CASE REPORT

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Introduction: Chronic lymphoedema is a medical condition involving lymphatic system, leading to persistent accumulation of lymphatic fluid result in swelling of dependent areas. It commonly involves lower limbs. Vulval lymphoedema is an extremely rare condition, it occurs following accumulation of lymphatic fluid in vulval soft tissue, leading to severe debilitating morbidity due to sexual, bladder, bowel dysfunction and psychological morbidity.

Case history A 40 years old unmarried lady with congenital lymphoedema, presented to the gynaecology clinic complaining of large vulval lump over 10 years duration. It was associated with severe vulval discomfort and ulceration with bleeding and discharge. She has experienced difficulties related to micturition, defecation, personal hygiene, walking and wearing under garments leading to catastrophic psychological impact. She sought gynaecological support several times, but had not receive a satisfactory solution for the vulval mass. She has been regularly followed up at medical clinic for chronic lymphoedema. On examination, there was a large vulval mass measuring 15cm x 15cm size, arising from right labia majora and mons pubis involving clitoris and right labia minora with evidence of fibrosis, skin thickening and hyperpigmentation due to chronic inflammation. Further she had bilateral lower limb lymphoedema which is more prominent in right lower limb with fibrosis and disfiguration. As the patient was on severe vulval discomfort and psychological distress, with multidisciplinary team decision she was planned to undergo excision of vulval lump with reconstruction. It was a surgically challenging as the lump was involving clitoris and labia minora. Finally, she was undergone excision of vulval lump with right labia minora and clitoris. Vulval reconstruction was done

to restore vulval anatomy. Postoperative period was managed with antibiotics, adequate pain relief, application of tight dressing and observed for surgical site discharges. Non-absorbable skin stitches were removed 2 weeks following primary surgery. She was reviewed at gynaecology clinic, 4 weeks following the surgery and histology revealed chronic inflammatory fibrosis due to lymphoedema..

Discussion: This is an extremely rare form of vulval chronic lymphoedema. As the mass is involving vital parts of female external genitalia, with distorted anatomy it was a technically challenging surgery. There is a lack of evidence available in literature as this a very rare condition. She needed a radical surgery after evaluation of the lump, under the anaesthesia. Challenges faced when managing her condition are, difficult dissection due to presence of a broad peduncle, risk of bleeding and achieving haemostasis, oozing from the surgical site, risk of losing parts of clitoris and right labia minora, vaginal reconstruction, risk of lymphorhoea through the surgical site, delayed wound healing, risk of recurrence, risk of chronic vulval pain syndrome

Conclusion: Vulval chronic lymphoedema is an extremely rare condition and it was surgically challenging due to involvement of erectile tissue of clitoris and labia minora. It needs to be managed in an individualised manner involving multidisciplinary team approach. Treatment option depends on the severity and complexity of the condition. Surgical reduction needs to be considered in severe and advanced stages.

EP080. FIRST TRIMESTER RETAINED PRODUCTS MIMICKING MULTIPLE UTERINE PATHOLOGIES: A DIAGNOSTIC CHALLENGE

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Objectives: To describe a rare case of first-trimester retained products of conception presenting as highly vascularized, progressively enlarging uterine wall mass that mimicked placenta accreta spectrum, gestational trophoblastic disease, isthmocele and degenerating fibroid. This case highlights the diagnostic challenge of an invasive uterine mass with negative beta-hCG and the importance of multidisciplinary team involvement.

Case report: A 35-year-old mother of two with two previous caesarean sections presented with heavy vaginal bleeding. Her last menstrual period was 5 weeks and 4 days ago. The initial transvaginal ultrasound scan showed no intrauterine pregnancy but identified a 4×4 cm anterior-wall uterine mass. Her initial beta-hCG was 411 IU/L and declined to negative values after 2 weeks. Persistent bleeding during this period results in a drop in hemoglobin level from 11 g/dL to 9 g/dL. Repeat imaging and hysteroscopy demonstrated an invasive-looking hyper vascular mass, owing to open laparotomy due to diagnostic challenges and ongoing bleeding, which could not be controlled with oral medications. The mass was extended to the serosa and densely attached to the bladder. Complete excision of the mass with uterine reconstruction and bilateral tubal ligation and resection were done with the patient's consent. Histopathology confirmed the cesarean scar site retained products of conception (RPOC)with no evidence of trophoblastic neoplasia or degenerative fibroid.

Discussion: Differentiating the diagnosis of early pregnancy masses is a critical challenge in clinical practice. The placental tissues which were implanted in previous caesarean scars can develop further as there is enough blood supply from the healing scar. This process can entirely mimic some other uterine pathologies and complicate the diagnosis even after possible invasive investigations, until the histopathology confirms the diagnosis.

Conclusion: This case emphasizes that clinicians should have a suspicion of a scar site RPOC when the patient with a history of previous caesarean sections presents with persistent bleeding and a highly vascular uterine mass. If there is diagnostic challenge and uncontrollable secondary haemorrhage, surgical excision remains the definitive treatment of choice.

EP081. FROM GUIDELINE TO BEDSIDE: VTE PREVENTION PRACTICES AFTER CAESAREAN SECTION

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Introduction: Venous thromboembolism (VTE) remains a leading preventable cause of maternal morbidity and mortality, with caesarean section recognised as a significant risk factor. The Sri Lanka College of Obstetricians and Gynaecologists (SLCOG) published a national guideline on VTE prevention in obstetrics and gynaecology in December 2025, recommending structured risk assessment and a bundle of preventive measures. As a newly appointed registrar to the unit, a baseline assessment of current practice against this guideline was undertaken to inform ongoing patient care and identify areas for quality improvement.

Objectives: To determine the proportion of post-lower segment caesarean section (LSCS) mothers who received thromboprophylaxis consistent with the SLCOG guideline, including graduated compression stockings (GCS) and pharmacological prophylaxis (enoxaparin) among those indicated.

Design: Retrospective clinical audit against a defined national guideline standard.

Method: The June 2026 birth registry recorded 58 LSCS deliveries at Base Hospital Mawanella; 53 bed head tickets (BHTs) (91%) were retrieved from records and reviewed. Included BHTs were reviewed against a structured proforma derived from the SLCOG guideline, recording calculated risk category, GCS use and enoxaparin prescription relative to indication. As data were extracted retrospectively, absence of documentation could not be reliably distinguished from true absence of the practice; findings should be interpreted with this limitation in mind.

Results: Overall, 27/53 (51%) received management consistent with guideline recommendations based on retrospective risk calculation. Of the 32/53 (60%) patients calculated to be indicated for pharmacological prophylaxis, 8/32 (25%) received enoxaparin. GCS were applied in 1/53 (2%). No VTE or bleeding events were recorded during the study period.

Conclusion: Use of both mechanical (GCS) and pharmacological (enoxaparin) prophylaxis was low relative to guideline indications, although approximately half of patients overall received guideline-consistent management. Early mobilisation and adequate hydration, though not formally captured in this audit, appeared to be part of routine post-operative practice based on informal observation. No adverse events were recorded during the study period; however, this sample size is not adequately powered to detect rare outcomes such as VTE. Low GCS use may reflect limited hospital stock or private-sector cost barriers. These findings support introduction of a structured VTE risk-assessment chart to standardise practice and guide future audit.

EP082. GELATIN SPONGE AS AN UNEXPECTED CAUSE OF EARLY POSTOPERATIVE BOWEL OBSTRUCTION

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Objectives: 1. To sensitise surgeons to consider gelatin sponge-induced adhesions as a differential diagnosis in patients presenting with features of intestinal obstruction in the early postoperative period after pelvic surgery.

2. To alert operating surgeons that a hemostat regarded as inert can behave as an adhesiogenic foreign body

Case report: A 51-year-old woman underwent abdominal hysterectomy for abnormal uterine bleeding due to fibroids. In the postoperative period, she tolerated feeds well and passed stools. She was discharged on the fourth postoperative day. She came to the ER the following day with complaints of vomiting and loose stools. On examination, she appeared mildly dehydrated with stable vitals. She had a distended abdomen without any guarding or rigidity. On auscultation, bowel sounds were sluggish. The patient was admitted with suspicion of Paralytic ileus. Conservative management was initiated. The following day, distension increased. Bowel sounds were absent. She couldn’t pass flatus. Naso-gastric tube insertion yielded bilious as-

pirate. Erect X-ray abdomen showed distended small bowel loops with multiple air-fluid levels suggestive of acute intestinal obstruction. CECT of the abdomen and pelvis revealed dilated jejunal and proximal ileal loops with a transition zone in the pelvis and a heterodense area in the operative bed of the pelvis, likely representing a foreign body reaction or pelvic adhesions. Emergency exploratory laparotomy revealed grossly distended bowel loops with a W-shaped adhesion to the inflammatory mass in the pelvis overlying the suture line of the vault. This mass was a partially disintegrated piece of gelatin sponge placed during hysterectomy to control minor oozing from the suture line. The bowel segment appeared healthy with minimal serosal breach. Post-operative course was uneventful.

Discussion: Gelatin sponge acts mechanically, forming a scaffold for fibrin clot that should liquefy in a week and reabsorb by four to six weeks. When used generously, or in the presence of a brisk host response, the coagulum may organise instead and become a nidus for adhesion formation. Small bowel falling into the pelvis adheres to it, resulting in adhesions causing obstruction.

Conclusion: Gelatin sponge, despite being a routinely used and generally safe haemostatic agent, carries a hidden but clinically significant risk of inducing dense adhesion formation. Surgeons should maintain a high index of suspicion for gelatin sponge in cases of early postoperative intestinal obstruction, use it sparingly, avoid placing it in areas of direct bowel contact and be aware of its potential to trigger an exaggerated inflammatory response to reduce this preventable complication.

EP083. GIANT ABDOMINAL WALL ENDOMETRIOMA FOLLOWING CAESAREAN SECTIONS

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Objectives: To describe a giant abdominal wall scar endometrioma with extensive involvement, emphasizes the diagnostic and surgical challenges and the importance of multidisciplinary involvement.

Case report: A 32-year-old lady with two previous caesarean sections presented with two-year history of cyclical pain over the previous abdominal scar and right lower abdomen. On ultrasonography, a mixed echogenic lesion measuring ~10×8×4cm3 was identified, above the right edge of the scar, suggested scar endometrioma.

Intraoperatively, a large endometrioma involving the right-sided peritoneum, rectus sheath and rectus muscle was identified. The lesion extended horizontally from the right anterior superior iliac spine to the midline and vertically from ~3cm above the inguinal ligament to the level of the umbilicus, measuring ~12×8×4cm3. Pelvic inspection showed, no evidence of pelvic endometriosis. However, the urinary bladder was adhered to the posterior layer of the rectus sheath adjoining with the endometriotic lesion. Due to the extensive involvement, complete excision was deferred. An on-call general surgeon was summoned, advised further imaging and possible mesh repair and abdominoplasty after complete excision. Biopsy confirmed endometriosis on histopathology.

The patient received monthly Gonadotropin-Releasing Hormone (GnRH) analogue for four months. Contrast-enhanced CT of the abdomen revealed a lesion measuring ~2.6×7×8cm3 involving both rectus muscles, extending to the posterior layer without intraperitoneal extension.

Discussion: Scar endometriosis is thought to result from iatrogenic implantation of endometrial cells during caesarean section. The cells transferred to subcutaneous tissue, rectus sheath and muscle and later proliferates under estrogenic influences. This case is notable for unusually giant, extensive involvement in the absence of pelvic endometriosis. In this case repeated seeding, with previous two caesarean section is a higher cumulative risk and delayed presentation may be the cause for progressive growth of the endometrioma. Complete surgical excision with clear margins remains the gold standard of treatment. In cases with extensive involvement, multidisciplinary management including Gynaecologist, General surgeon and Plastic surgeon is essential and abdominal wall reconstruction with mesh may be required. Preoperative GnRH therapy may

reduce size, as adjunctive. Preventive measures include, decidua-free uterine closure, thorough wound irrigation, separate instruments for uterine and abdominal closure and minimizing wound contamination with endometrial tissue.

Conclusion: Early recognition and appropriate imaging helpful in describe the disease extent. Giant abdominal wall endometriomas require meticulous surgical planning and multidisciplinary management to achieve optimal outcomes.

EP084. GIANT PLACENTAL CHORIOANGIOMA DIAGNOSED INTRAPARTUM WITH A FAVOURABLE PERINATAL OUTCOME

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Objectives: To report a rare case of giant placental chorioangioma and it's importance on antenatal fetal surveillance, proper management and histopathological report in obtaining a favourable maternal and neonatal outcome.

Case report: Commonest benign non-trophoblastic tumour of the placenta is chorioangioma. Mostly microscopic and asymptomatic. Anyhow, giant chorioangiomas (>4cm) are uncommon and may be associated with polyhydramnios, fetal growth restriction (FGR), preterm birth, fetal anaemia, hydrops fetalis and intrauterine fetal death.

A 32-year-old lady with one previous caesarean section admitted for delivery at 38weeks of gestation. Her antenatal period was uneventful and routine ultrasonography at 28 and 36weeks did not identify any abnormality in placenta. On admission, ultrasound founded mild polyhydramnios and a well-defined vascular polypoidal lesion measuring 100×90×70mm, attached to the maternal surface of the placenta by a vascular stalk. Colour Doppler confirmed internal vascularity compatible with a placental vascular tumour. The estimated fetal weight was 2.42kg, with normal umbilical artery Doppler and no evidence of fetal anaemia, hydrops fetalis or cardiomegaly.

Due to her previous caesarean section, lower segment caesarean section was performed. A healthy female infant weighing 2.39kg was delivered with normal Apgar scores. Baby's blood sugar remained normal during the first 24hours and both mother and baby were discharged on the third day. Macroscopically, a pedunculated red-brown mass measuring 100×90×70mm arising from the maternal surface of the placenta. Histopathological report confirmed capillary chorioangioma, because numerous capillary-sized vascular channels within loose stroma without atypia, necrosis or trophoblastic proliferation,

Discussion: Complication to fetus occur as giant chorioangioma behave as low-resistance arteriovenous shunts. Colour Doppler ultrasound is the investigation of choice for diagnosis and fetal surveillance. Management depend on gestational age, tumour size and fetal wellbeing. Tumour size alone doesn't predict an adverse outcome as our case even with large tumour size, had normal fetal Doppler findings without evidence of severe fetal compromise except mild FGR, mild polyhydramnios

Conclusion: Giant placental chorioangioma is a rare benign placental vascular tumour. It has the potential to cause significant maternal and fetal complications. Careful fetal surveillance, individualized obstetric management and histopathological confirmation are important to acheive maternal and neonatal outcomes.

EP085. GLANZMANN THROMBASTHENIA IN PREGNANCY: PERIPARTUM HYSTERECTOMY DESPITE MULTIDISCIPLINARY PLANNING

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Written informed consent for publication of this case report, including clinical details, was obtained from the patient.

Objectives: Glanzmann thrombasthenia (GT) is a rare autosomal recessive platelet function disorder caused by a deficiency of platelet glycoprotein IIb/IIIa. Postpartum haemorrhage (PPH) rates of 40 to 50% are reported despite prophylaxis in this population. We report a case of GT diagnosed only in the third pregnancy, after an unrecognized primary PPH in the previous pregnancy, highlighting the im-

portance of early diagnosis and multidisciplinary peripartum management.

Case report: A 39-year-old woman in her third pregnancy, with one previous lower segment caesarean section (LSCS) and a conservatively managed ectopic pregnancy, presented to our antenatal clinic. Her childhood period was uneventful without bleeding manifestations. She attained menarche at 13 years with regular cycles and had no heavy menstrual bleeding, epistaxis or gum bleeding. Her first pregnancy was at age 20 ended in emergency LSCS for fetal distress following preterm premature rupture of membranes. Intraoperative and postoperative bleeding was managed with blood, platelet and fresh frozen plasma (FFP) transfusion. A bleeding disorder was suspected, but follow-up was defaulted.

She was investigated for a bleeding disorder in the current pregnancy. Platelet-rich plasma lumi-aggregometry showed absent aggregation and GT was confirmed by flow cytometry analysis of GPIIb/IIIa. Platelet count remained normal throughout pregnancy (158 x 10^9/L at 35 weeks). Painless haematuria at 20 weeks settled without intervention.

A multidisciplinary meeting at 28 weeks planned a daytime elective LSCS at 37 weeks with HLA-matched platelets. A donor was reserved at the National Blood Centre two months before delivery.

Elective LSCS was performed at 37 weeks under general anaesthesia with HLA-matched platelet and tranexamic acid cover. Intraoperative oozing was noted, uterotonics were given and a Hayman suture was applied. The peritoneum was closed with a drain in situ. Postoperative bleeding required 24 units of platelets, 90 units of cryoprecipitate, 3 units of FFP, 2 doses of recombinant activated factor VII (rFVIIa, 90 µg/kg intravenous two boluses 2 hours apart) and 5 units of blood. Damage control surgery was arranged and hysterectomy was performed at re-exploration for bleeding from the suture margins. She recovered fully and was discharged with haematology follow-up. Cord blood platelet count was normal and the baby was well.

Discussion: GT may present without childhood bleeding or menorrhagia and a normal platelet count can offer false reassurance. The unexplained PPH in her first delivery was a missed diagnostic opportunity. Sourcing HLA-matched platelets in a resource-limited setting is a major logistic challenge: our donor was reserved two months ahead, required 48 hours to arrange donation and the product remained viable for only six days. This constrains delivery scheduling in a way not usually described in guidance from high-income settings. Despite adherence to recommended practice, haemostasis failed and hysterectomy was required.

Conclusion: GT in pregnancy is a high-risk condition requiring early diagnosis and multidisciplinary planning. All unexplained significant PPH should be investigated for an underlying platelet function disorder. Peripartum hysterectomy may still be required even with evidence-based haemostatic protocols. A well-planned approach to antenatal, intrapartum and postpartum care is needed in this rare but dangerous condition.

EP086. GRADE 2 CERVICAL ADENOCARCINOMA DIAGNOSED DURING THE EVALUATION OF SECONDARY POSTPARTUM HEMORRHAGE: A RARE CASE REPORT

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Objectives: Cervical cancer in pregnancy or in the immediate post-partum period is a rare clinical entity and presents a profound diagnostic and therapeutic challenge. Physiological changes in the cervix during the pregnancy has high chance of benign bleeding such as placental previa, cervical ectropion or as a sign of labour or lochia but often lower chances attribute for suspicion of malignancy. Therefore, underlying malignant lesions are easily missed leading to delayed diagnosis and impaired patient outcomes.

Case report: A 36 years old female (G2P1) presented with secondary postpartum hemorrhage (PPH) and persistent vaginal discharge following elective lower segment caesarean section (EL/LSCS) at term with healthy neonate. Her antenatal course was otherwise unremarkable except for the recurrent episodes of atypical vaginal discharge which were diagnosed conservatively and presumed of benign obstetric origin. After exclusion of causes

for secondary PPH, sterile speculum examination during the postpartum period revealed a large, friable, exophytic cervical mass. An urgent total abdominal hysterectomy was performed due to life threatening hemorrhage and the need for definitive local disease control. Histopathological examination of the surgical specimen showed Grade 2 cervical adenocarcinoma. Further imaging with contrast-enhanced computed tomography (CECT) of the abdomen and pelvis showed bilateral internal iliac lymphadenopathy without hepatic or other distant visceral metastatic disease. The patient is currently receiving chemotherapy after referral to the clinical oncology unit.

Discussion: The national cervical cancer screening program supported by the SLCOG focuses on women at milestone ages of 35 and 45. And the case was a 35-year-old pregnant woman missed opportunity screening because of overlapped pregnancy in her 35 years old milestone. This led to early clinical warnings being misattributed to routine obstetric complications. This overlap leads to a period of high risk when the malignancies may progress unnoticed and present as pregnancy-related bleeding.

Conclusion: This case emphasizes the importance of a high index of clinical suspicion and performing routine sterile speculum examination in the evaluation of atypical or recurrent antepartum bleeding. Furthermore, it recommends the use of proactive screening modifications to avoid deferring or omitting important oncological screening opportunities when contemplating concurrent pregnancies.

EP087. GRANULOSA CELL TUMORS IN SRI LANKA: AN EIGHT-YEAR NATIONAL REGISTRY EXPERIENCE (2015–2022)

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Background: Granulosa cell tumors (GCTs) are uncommon ovarian sex cord–stromal tumors with distinctive biological and clinical characteristics. Information on their population-level occurrence in South Asian countries is limited. This study describes the national pattern of ovarian granulosa cell tumors diagnosed in Sri Lanka from 2015 to 2022 using cancer registry data.

Method: National Cancer Registry records for female ovarian cancers (ICD-10 C56) diagnosed between 2015 and 2022 were reviewed. Histological subtypes were identified using ICD-O morphology codes and granulosa cell tumors were defined by morphology code 8620. The annual number of cases, their proportion among ovarian malignancies and their contribution to the sex cord–stromal tumor group were summarized descriptively.

Results: During the eight-year study period, 251 granulosa cell tumors were recorded. Annual case numbers showed only modest variation, with 31 cases in 2015, 28 in 2016, 36 in 2017, 26 in 2018, 20 in 2019, 22 in 2020, 38 in 2021 and 25 in 2022. Granulosa cell tumors represented approximately 2.1–3.8% of all ovarian malignancies each year and remained the most frequently recorded sex cord–stromal subtype throughout the study period. Although the overall number of sex cord–stromal tumors increased slightly in 2021–2022, the annual frequency of granulosa cell tumors remained relatively consistent. In contrast, greater variation was observed in the classification of epithelial ovarian carcinomas over the same period.

Conclusion: Granulosa cell tumors accounted for a small but consistent proportion of ovarian malignancies reported in Sri Lanka between 2015 and 2022. Their frequency remained relatively stable despite changes observed in the classification of epithelial ovarian cancers. These findings provide a national description of granulosa cell tumors and contribute population-based evidence on this uncommon ovarian neoplasm from South Asia.

Keywords: granulosa cell tumor; ovarian neoplasm; sex cord–stromal tumor; ovarian cancer; Sri Lanka; epidemiology; cancer registry

EP088. HAEMATOCOLPOS FROM RADIATION-INDUCED VAGINAL STENOSIS AFTER CHEMORADIOTHERAPY FOR BLADDER SARCOMA IN A CHILD

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Objectives: We report a case of haematocolpos secondary to radiation-induced vaginal stenosis in a patient with bladder cancer who received chemoradiotherapy. Vaginal stenosis is a well-documented long-term adverse effect following pelvic radiotherapy. This case highlights the clinical importance of early identification, the use of a minimally invasive stepwise management plan to restore vaginal patency and menstrual function and the avoidance of invasive interventions.

Case report: An 11-year-old girl with a past history of wide local excision of the bladder and chemoradiotherapy for synovial sarcoma presented with cyclical lower abdominal pain and primary amenorrhoea. Transabdominal ultrasound showed a distended, fluid-filled vaginal canal, compatible with haematocolpos and a normal uterus with a small amount of fluid in the endometrial cavity. Magnetic resonance image confirmed haematometrocolpus. Vaginoscopy done under general anaesthesia showed a 4cm long blind ending vagina with adhesions. Ultrasound-guided needle aspiration of the haematocolpus was carried out, the vagina was dilated using dilators and an intercostal tube was placed as a vaginal stent to keep the lumen open and prevent re-stenosis. Following the removal of the tube, progressive vaginal dilation was continued. After the procedure, the patient resumed normal cyclical menstrual flow and the pain completely settled, with no recurrence of haematocolpos when checked again at 5 months follow-up.

Discussion: Vaginal stenosis is a well-known late complication of pelvic radiotherapy. It mainly occurs from fibrosis and adhesion of the vaginal walls and it can end up as total blockage of the vaginal lumen. When this happens during reproductive years, with preserved ovarian function, menstrual flow can be obstructed; therefore, haematocolpos forms, often presenting as amenorrhoea with cyclical abdominal pain. This case shows that early ultrasound-guided drainage and then gradual dilation can bring back anatomical and functional patency of the vagina. Further surgical intervention may be required in the future if she develops sexual dysfunction when becoming sexually active. This is particularly important in children and adolescents, where preserving vaginal length and function has an impact on future fertility, sexual health and psychological wellbeing, particularly in survivors of childhood malignancy.

Conclusion: Clinicians managing survivors of pelvic irradiation should have a high index of suspicion for vaginal stenosis and haematocolpos, even when the primary malignancy is non-gynaecological. Prophylactic vaginal dilation programmes following pelvic radiotherapy may prevent this complication but are challenging in children. Minimally invasive drainage followed by dilatation is an effective treatment option.

EP089. HIGH GRADE ENDOMETRIAL STROMAL SARCOMA PRESENTING WITH PAINFUL HAEMATURIA

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Objectives: High-grade endometrial stromal sarcoma (HG-ESS) is a rare, aggressive uterine mesenchymal tumour arising from the connective tissue of the uterus. The typical presentation would be abnormal uterine bleeding, pelvic pain or a rapidly enlarging uterine mass. We discuss a rare presentation with lower urinary tract symptoms and painful hematuria, which posed a challenge to diagnosis. This highlights the unusual clinical presentation and the significance of multidisciplinary management.

Case report: This is about a 38-year-old unmarried woman presenting with painful hematuria, with irritative and obstructive lower urinary tract symptoms. She also gives a history of progressive abdominal distension over a period of two years. Abdominal examination shows a 20-week size pelvic mass. Ultra sound

shows a heterogeneous uterine mass with bilateral hydronephrosis and hydroureter. Computed tomography suggested a neoplastic lesion within the uterus without evidence of metastatic disease.

Hysteroscopy and endometrial biopsy were performed. Histology showed no evidence of hyperplasia or malignancy. Cystoscopy was also performed to rule out bladder pathology. She was initially prepared for a Fertility-sparing surgery but the intraoperative findings were highly suggestive of a uterine malignancy. Following intraoperative consultation between two consultant onco-surgeons, the procedure was converted to total abdominal hysterectomy with bilateral salpingectomy and omental biopsy.

Histology reporting showed a "poorly differentiated uterine mesenchymal tumour confined to the uterus" (International Federation of Gynecology and Obstetrics Stage IB). Immunohistochemistry reporting was positive for cyclin D1, estrogen receptor and smooth muscle actin and negative for cluster of differentiation 10 (CD10) and desmin, confirming HG-ESS. The patient underwent completion surgery with bilateral oophorectomy, pelvic lymph node dissection. Adjuvant chemotherapy was scheduled after a multidisciplinary team discussion.

Discussion: This gives an atypical presentation of HG-ESS where the patient presented with urinary tract symptoms caused by the compression from the large uterine tumour. It also highlights that endometrial biopsy has low diagnostic value for intramural uterine sarcomas and the importance of histology and immunohistochemistry in distinguishing HG-ESS from other uterine mesenchymal tumors. Early multidisciplinary involvement, a high index of clinical suspicion and management within a specialized gynaecological oncology unit facilitate accurate staging and timely initiation of adjuvant therapy.

Conclusion: HG-ESS should be considered in women presenting with unexplained lower urinary tract symptoms and a rapidly enlarging uterine mass. Histopathological and immunohistochemical evaluation is necessary for a definitive diagnosis and multidisciplinary care is necessary to maximize results in this uncommon and aggressive cancer.

EP090. HOPE AND HEART; A CASE REPORT ON SUCCESSFUL PREGNANCY DESPITE EBSTEIN ANOMALY

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Objectives: Ebstein anomaly is a congenital malformation consisting of an abnormally displaced tricuspid valve into the right ventricle, representing < 1% of all congenital heart diseases (CHD). Pregnancy outcomes depend on the cardiac function, presence of cyanosis and arrhythmias. Local clinical data on pregnancy complicating with Ebstein anomaly are scarce.

Case report: A 40 year old lady with a background of bronchial asthma presented in her third pregnancy at 8 weeks of gestation. Her first pregnancy concluded with a spontaneous first trimester miscarriage. The second pregnancy was successfully concluded with a term Emergency Lower Segment Cesarean Segment (LSCS). An early pregnancy cardiac assessment was done due to advancing age and presence of a murmur with otherwise stable hemodynamics. The 2D echo performed at 13 weeks revealed Ebstein anomaly with a septal Tricuspid leaflet displaced 16mm apically compared to the Mitral valve. Right Atrium (RA) was dilated (55mm) and there was Mild Tricuspid Regurgitation (TR) -TRPG 22mmHg. However, there was no significant pulmonary hypertension (PHT) or septal defects.

Her index pregnancy was complicated with an Infective exacerbation of Bronchial Asthma needing intensive care at 14 weeks and Gestational Diabetes Mellitus. She was closely monitored throughout the pregnancy with serial 2D echocardiograms, serial growth monitoring, drug optimization and assessment.

With the progression of pregnancy, there were changes in the echocardiogram with chamber dilatation and wall motion abnormalities along with worsening of TR. However, there was no PHT. Due to exertional symptoms and persistent tachycardia in the second trimester, Frusemide and Bisoprolol were started. A fetal echo was done which was normal.

Along with close monitoring, pregnancy was continued upto 34w where a multidisciplinary team (MDT) decision was made to proceed

with an early Elective LSCS along with Ligation and Resection of Tubes under combined spinal epidural anesthesia. The peripartum period was managed with intravenous diuretics and supportive care with close monitoring at Intensive care unit. She delivered a healthy baby girl(APGAR 8) with no significant neonatal complications.

Discussion: Ebstein anomaly does not usually affect fertility and generally well tolerated during pregnancy in the absence of cyanosis. However, pregnancy can be complicated with cardiac failure, tachyarrhythmias and thromboembolic events. It also carries the risk of fetal CHD and growth restriction.

Conclusion: To date, there are no reported cases of pregnancies with Ebstein anomaly in Sri Lankan literature. This case illustrates that successful pregnancy outcomes can be still achieved with proper pre-conceptional counselling, close monitoring and MDT management despite the Ebstein anomaly.

EP091. HYPERREACTIO LUTEINALIS CAUSING BILATERAL OVARIAN TORSION IN A TWIN PREGNANCY COEXISTING WITH MOLE

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Objectives: To report a rare case of bilateral ovarian torsion secondary to theca lutein cysts in the background of a twin pregnancy, complicated with complete hydatidiform mole and a coexisting normal live fetus.

Case report: A 26-year-old primigravida presented at a period of amenorrhea (POA) of 14 weeks with severe abdominal pain, per vaginal bleeding, vomiting and clinical signs of an acute abdomen. Transvaginal ultrasonography showed a single live fetus compatible with the POA, an adjacent complex intrauterine collection with a classic vesicular appearance. It also showed bilateral bulky ovaries containing multiple theca lutein cysts.

Due to signs of peritonitis, an emergency exploratory laparotomy was performed. During surgery there were bilateral ovarian torsion due to massive ovarian enlargement from multiple theca lutein cysts. Bilateral detorsion, conservative cystectomy and ovarian reconstruction were successfully performed to preserve fertility. In post operative day 1, the patient spontaneously miscarried the fetus with molar tissues. Subsequent serum beta-human chorionic gonadotropin () was highly elevated(>247,500 mIU/mL). Immediate suction evacuation was performed to clear the remaining uterine contents. Histopathological evaluation confirmed a dichorionic twin pregnancy with one complete hydatidiform mole and one coexisting normal fetus and a normal placenta. The patient was discharged with a strict follow-up protocol and weekly serum monitoring.

Discussion: A twin pregnancy having a complete hydatidiform mole and a coexisting normal fetus is a rare obstetrical occurance. The high amount of β-hCG secreting from trophoblastic tissue can hyperstimulate the ovaries. This will be resulting in hyperreactio luteinalis. Usially the theca lutein cysts are benign and typically regress after evacuation. The massive size in this case causes the ovarian torsion. This case highlights the need of stabilizing the patient through ovarian-sparing surgery (detorsion and cystectomy), followed by standard suction evacuation and close monitoring for gestational trophoblastic neoplasia.

Conclusion: A coexisting hydatidiform mole and fetus can present acutely with bilateral ovarian torsion due to extreme ovarian hyperstimulation. Emergency laparotomy with a conservative, ovarian-preserving surgical approach is important to safeguard maternal life and future fertility, followed by thorough trophoblastic follow-up.

Keywords: Complete hydatidiform mole, Coexisting fetus, Bilateral ovarian torsion, Theca lutein cysts, Hyperreactio luteinalis.

EP092. IATROGENIC PREMATURITY THROUGH CAESAREAN SECTION: CAN WE REDUCE AVOIDABLE LATE PRETERM BIRTHS?

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Introduction: Iatrogenic prematurity is a preventable contributor to neonatal morbidity. Caesarean section (CS) is frequently life-saving, but delivery before 37 weeks must bal-

ance maternal and fetal risk against the neonatal consequences of prematurity. Elective early delivery without clear compromise generates avoidable preterm births.

Objectives: To determine the proportion of CS resulting in preterm birth, to categorise these as elective or emergency, to examine their indications and to estimate the burden of potentially avoidable iatrogenic prematurity.

Design: Retrospective descriptive audit.

Method: All CS performed at the Professorial Obstetrics Unit, Teaching Hospital Peradeniya, during December 2025 and January 2026 were reviewed using bed head tickets. Gestational age was based on the documented period of gestation at delivery; preterm birth was defined as delivery before 37 completed weeks. Mode of delivery (elective/emergency) followed the recorded operative classification. Indications were analysed descriptively. Cases were classified as potentially avoidable when elective preterm delivery lacked a documented acute maternal or fetal indication, such as non-reassuring fetal surveillance, severe pre-eclampsia, or antepartum haemorrhage.

Results: Of the 322 cesarean sections that were performed, 207 (64.3%) were elective and 115 (35.7%) emergency CS. The commonest indication was previous CS (29.5%), followed by breech (5.3%) and failed induction (3.4%).

Forty-five (14.0%) deliveries were preterm. Among preterm CS, 23 (51%) were elective and 22 (49%) emergency CS. Most late preterm deliveries (34–36+6 weeks, n=33) were elective (18/33); 12 were below 34 weeks. Low birth weight (<2.5 kg) occurred in 23.3%.

Notably, 20% of elective preterm cases were undertaken for previous CS, adverse obstetric history or intrauterine growth restriction (IUGR) without documented acute fetal compromise, representing potentially avoidable iatrogenic prematurity.

Discussion and Conclusion: Half of preterm caesarean births in this unit were planned and a meaningful proportion lacked documented acute compromise justifying early delivery, indicating avoidable iatrogenic prematurity.

Reduction strategies include adherence to evidence-based gestational thresholds (avoiding elective delivery before 39 weeks without indication), mandatory documentation of indication and risk-benefit assessment for any preterm elective CS.

Proposed interventions include senior/multidisciplinary review before scheduling pre-term elective CS, standardized fetal-surveillance protocols for IUGR to optimize delivery timing and targeted reduction of the primary CS rate to limit repeat sections. Prospective audit with standardised decision protocols is recommended.

Limitations: This single-centre retrospective audit relied on documentation quality, without independent adjudication of avoidability. As a registered institutional clinical audit using anonymised, non-identifiable data, formal ethics committee approval was not required.

EP093. IMPLEMENTATION OF A STANDARD PROFORMA FOR OPERATIVE VAGINAL DELIVERIES TO IMPROVE DOCUMENTATION AND CLINICAL GOVERNANCE IN THE LABOUR WARD – A CLINICAL AUDIT

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Background: When a vaginal delivery needs help with instruments, it's called an operative vaginal delivery (OVD). This is an important procedure and it's crucial to have good records of it. Accurate records help keep patients safe, make sure the medical team communicates well, support the ward's overall quality management and provide legal protection. However, in everyday practice, important details about these procedures are often missed in the notes. This audit looked at whether using a standard form for OVDs could make the records more complete and consistent in a busy labour ward.

Method: We did a clinical audit in two stages. First, we looked at 20 OVD cases recorded before December 2025 to assess the quality of the notes. Then, we introduced a new OVD form, based on a national guideline and trained staff on how to use it. This form had to be used for all OVDs between January and April 2026. After it was in place, we reviewed another 20 consecutive OVD cases to see if the records had improved.

We checked the documentation against 15 specific points, aiming for all of them to be recorded every time. These points included why the OVD was done, how the baby was positioned, how much the baby had descended, what instrument was used, how many times it was pulled, what pain relief was given, if consent was obtained, who performed the procedure, how much blood was lost, how the baby was doing afterward and the plan for postpartum care.

Documentation completeness was compared between the two audit cycles using SPSS. As this was a clinical audit of routinely collected clinical data, institution-based ethical approval was received.

Results: Using the standard form made a big difference in how complete the records were. On average, the percentage of information recorded went up from 52.7% before we started to 96.7% after, an increase of 44 percentage points.

After the form was introduced, 19 out of the 20 records had at least 90% of the information, while none of the records from before met this standard. Eleven records after the change had all the information. The biggest improvements were in recording how far the baby had descended, the time from deciding to do the OVD to delivery, the postpartum plan, pain relief, estimated blood loss, baby's position and the grade of the doctor performing the procedure.

Details like the reason for the OVD, the instrument used, consent, the baby's outcome and estimated blood loss were recorded completely or almost completely after the form was used. The few remaining issues were with recording the doctor's grade, the CTG classification and the number of pulls, all of which were missed in only 10% of cases.

Conclusion: Putting in a structured form for OVDs greatly improved the completeness and consistency of the clinical notes in all areas we looked at. Standardizing how we record these procedures is a good way to improve quality. It helps reduce missed information, makes communication better, supports good clinical governance and increases accountability.

While better records don't directly show if the surgical skills or patient outcomes have improved, they lay a crucial groundwork for safer care and continuous quality improvement in obstetrics. Keeping staff trained, regularly checking the records and doing follow-up audits will help maintain these standards and make them even better.

EP094. IMPLEMENTING ERAS (ENHANCED RECOVERY AFTER SURGERY) IN SRI LANKAN GYNAECOLOGICAL SURGERY

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Introduction: Enhanced Recovery After Surgery (ERAS) protocols are known to reduce hospital stay and speed recovery after gynaecological surgery worldwide, but in Sri Lanka their adoption has been sporadic and largely dependent on individual clinicians.

Objectives: To describe the novel, locally adapted components of an ERAS protocol developed for the Professorial Gynaecology Unit, Teaching Hospital Peradeniya and to evaluate how well they were implemented, adhered to and found practical in elective gynaecological surgery.

Design: A two-phase quality improvement study, comprising a retrospective audit followed by prospective implementation of the protocol.

Method: We developed an ERAS protocol spanning pre, intra and post-operative care with multidisciplinary input and monitored it using a structured ward checklist. Adherence and outcomes were then compared with our earlier retrospective audit of ERAS versus conventional care.

Results: The retrospective audit (35 ERAS vs 35 conventionally managed patients) showed ERAS protocol significantly shortened hospital stay (laparoscopic: 3.17 vs 4.17 days, p=0.005; open: 4.26 vs 5.83 days, p=0.004) and accelerated bowel recovery, without increasing complications or 30-day readmissions.

Prospectively, the new protocol introduced pre-clinic counselling and a leaflet on early feeding, mobilisation and discharge planning; nutritional / haemoglobin screening with

anaemia correction; Caprini-based VTE and Apfel-based PONV risk stratification with documented prophylaxis. Minimal fasting period per each patient staggered by theatre list rather than uniform midnight fasting, coconut-water carbohydrate loading, an SSI-prevention bundle and avoidance of routine bowel preparation were implemented.

Intra-operatively, minimal-access surgery was preferred, multimodal opioid-sparing analgesia, dual-agent PONV prophylaxis, active warming, goal-directed fluids, selective drains/catheters (removal by 12h laparoscopic, 24h open) and tranexamic acid were adopted.

Post-operatively, early oral intake (fluids 2h, semisolids 6h), early mobilisation (sitting 6h, walking 12h), scheduled multimodal analgesia with opioids as rescue only, active PONV treatment, timed catheter removal, risk-adapted thromboprophylaxis and a laxative-based bowel regimen were standardised.

Thirty-one patients (19 laparoscopic, 7 open abdominal, 5 vaginal) have been managed under this protocol, with mean overall checklist compliance of 84.3%; continuous feedback from ward staff at all levels informed iterative refinements. No increase in morbidity, readmission or re-operation rates has been observed compared with pre-ERAS practice.

Conclusion: Locally adapted ERAS strategies including staggered fasting, clinic-level education and hospital-sourced carbohydrate loading – have been feasibly and safely embedded into routine gynaecological ward practice at a Sri Lankan tertiary unit, with high compliance, no increase in morbidity or readmission, no additional burden to ward staff and ongoing staff-driven refinement. These low-cost, context-specific innovations may offer a practical model for wider ERAS adoption in resource-limited settings.

EP095. INCIDENTAL DIAGNOSIS OF UTERUS DIDELPHYS WITH DOUBLE VAGINA DURING PREGNANCY: A CASE REPORT

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Objectives: To report a case where there was an incidental diagnosis of uterus didelphys with double vagina during routine antenatal follow-up and its obstetric complications, especially the increased risk of malpresentation and operative delivery.

Case report: A 33-year-old primigravida was found to have uterine didelphys during her dating scan. The ultrasound scan showed a singleton pregnancy within the right uterus of a uterus didelphys attended regular antenatal care. Her booking investigations were unremarkable. The 20-week fetal anomaly scan was normal and a 28-week oral glucose tolerance test was within normal limits.

A growth scan performed at 34 weeks demonstrated breech presentation and adequate fetal growth. Repeat scan at 36 weeks confirmed persistent breech presentation. Pelvic examination performed during assessment revealed two cervices separated by a longitudinal vaginal septum (double-barrel vagina) An elective lower segment caesarean section was performed at 37+5 weeks. Corticosteroids were given for fetal lung maturation. Intraoperatively, the gravid right uterus and its ipsilateral fallopian tube and ovary appeared normal. The non-gravid left uterus contained an anterior wall pedunculated fibroid and the uterus showed features suggestive of endometriosis, while the corresponding fallopian tube and ovary were normal. Recovery was uncomplicated and both mother and baby were discharged. Ultrasound kidney, ureter and bladder was arranged to exclude associated urinary tract anomalies.

Discussion: Uterus didelphys is a rare Müllerian duct anomaly resulting from complete failure of fusion of the paired Müllerian ducts, leading to two separate uterine cavities and cervices and frequently a longitudinal vaginal septum. Women with this condition have an increased risk of obstetric complications such as miscarriage, preterm birth, malpresentation and caesarean delivery.

Conclusion: This case shows that recognition of this anomaly allows appropriate antenatal surveillance and delivery planning, particularly in the presence of persistent malpresentation. This case also shows that in the presence of uterine didelphys, only one uterus can be associated with benign uterine conditions such as leiomyoma and endometriosis.

EP096. INDUCED PUBERTY REVEALS 46, XX GONADAL DYSGENESIS

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Objectives: To present a case of 46, XX gonadal dysgenesis which required exogenous hormone-induced pubertal development. To summarize diagnostic evidence distinguishing gonadal dysgenesis from other causes of primary amenorrhea/POI and to discuss practical implications for fertility management, genetic workup and long-term endocrine care in young women.

Case A 23-year-old woman presented with primary amenorrhea, absent secondary sexual characteristics and faltering growth. At the age of 15, she received 3 months of HRT with an induced withdrawal bleed; after one year of continued HRT she attained Tanner stage 3. She has no significant past medical or surgical history, normal BMI and no dysmorphic features. Pelvic ultrasound showed a small prepubertal retroverted uterus and relatively small bilateral ovaries. Karyotype was 46, XX. Hormonal profile: FSH 160.3 mIU/mL, LH 77.07 mIU/mL, estradiol 8.96 pg/mL, AMH <0.01 ng/mL; prolactin, TSH, FT4 and TPO antibodies were normal. As long as she is on regular HRT she experiences monthly withdrawal bleeding. These findings indicate hypergonadotropic hypogonadism with absent ovarian reserve, consistent with 46, XX gonadal dysgenesis.

Discussion: and implications for practice 46, XX gonadal dysgenesis is rare within the spectrum of 46, XX disorders of sex development and gonadal failure; 46, XX Disorders of sex development are uncommon overall. The combination of very high FSH/LH, low estradiol, undetectable AMH, small ovaries and 46, XX karyotype supports spontaneous ovarian failure rather than central causes; targeted genetic testing (FMR1 premutation, X-chromosome structural analysis and gene panels for meiosis/folliculogenesis) are indicated. Physiologic estrogen replacement should be continued until the average age of natural menopause to protect bone and cardiovascular health; baseline DEXA and cardiovascular risk assessment are recommended. For fertility, autologous oocyte cryopreservation is not feasible given absent reserve; the recommended pathway is uterine priming with estrogen to optimize endometrial volume, followed by donor-oocyte IVF with appropriate luteal support and multidisciplinary counselling regarding success rates and psychosocial aspects.

Conclusion: This case highlights that 46, XX gonadal dysgenesis can present with HRT-induced partial pubertal development yet persistent ovarian failure. Early genetic evaluation, lifelong physiologic HRT, bone/CV surveillance and timely referral for donor-oocyte IVF are essential to optimize long-term health and reproductive outcomes.

EP097. ISOLATED ABNORMAL MIDDLE CEREBRAL ARTERY DOPPLER IN RH-NEGATIVE PREGNANCY: CASE REPORT

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Objectives: To report an unusual case of persistent abnormal fetal middle cerebral artery (MCA) Doppler suggestive of cerebral redistribution in an Rh-negative pregnancy without evidence of red cell alloimmunisation or fetal anaemia.

Case report: A 25-year-old primigravida with AB Rh-negative blood group and an Rh-positive partner had an otherwise uncomplicated planned pregnancy. There were no sensitising events during pregnancy, although first-trimester antibody screening had not been performed. At 35 weeks, routine antibody screening reported unexpected antibodies (S1, S2 and S3 positive), prompting referral. Repeat evaluation at a tertiary care blood bank demonstrated only weakly reactive indirect antiglobulin test (IAT) results, while anti-D antibodies were negative. At 36 weeks, she presented with reduced fetal movements. Cardiotocography was reassuring. Ultrasound demonstrated appropriate fetal growth with normal liquor volume and normal umbilical artery Doppler. MCA peak systolic velocity remained below the threshold for fetal anaemia (52.97 cm/s; 0.736 multiples of the medi-

an), but the MCA pulsatility index was persistently reduced at 1.3, consistent with cerebral vasodilatation. Following multidisciplinary discussion, antenatal corticosteroids were administered and daily fetal Doppler surveillance was commenced. Labour was induced at 37 weeks using a Foley catheter. Emergency lower-segment caesarean section was performed for pathological intrapartum cardiotocography. Non asphyxiated B Rh-positive neonate with a tight nuchal cord was delivered. Direct antiglobulin testing was negative. Although neonatal jaundice developed on day one requiring special care, there was no laboratory evidence of haemolysis and the infant recovered completely. The mother received postpartum anti-D immunoglobulin.

Discussion: Cerebral redistribution is classically associated with fetal hypoxaemia and placental insufficiency but may occasionally occur in normally grown fetuses without evidence of fetal anaemia. This case demonstrates the diagnostic uncertainty created by persistent isolated reduction in MCA pulsatility index in an Rh-negative pregnancy with negative anti-D antibodies and normal fetal growth. Management relied on serial Doppler surveillance and multidisciplinary decision-making rather than antibody status alone.

Conclusion: Persistent isolated reduction in MCA pulsatility index should prompt careful fetal surveillance even when fetal anaemia and clinically significant red cell alloimmunisation have been excluded. Clinical management should integrate Doppler findings with the overall fetal assessment to optimise perinatal outcomes.

EP098. ISOLATED EXTRAOVARIAN ENDOMETRIOMA IN THE POUCH OF DOUGLAS PRESENTING WITH PRIMARY SUBFERTILITY

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Objectives: While endometriomas typically involve the ovaries, finding an isolated extraovarian lesion is very rare. We discuss a patient who presented with subfertility and deep pelvic pain, ultimately diagnosed with an isolated endometrioma in the pouch of Douglas. Our goal is to highlight how easily this condition can mimic other pathologies on scans and to emphasize the important role of laparoscopy in reaching the correct diagnosis.

Case report: A 30-year-old woman attended our clinic with a three-year history of primary subfertility and deep dyspareunia. Her menstrual cycles were regular and she had no previous history of pelvic surgery. During a routine transvaginal ultrasound, we spotted a distinct cystic mass showing a classic 'ground-glass' appearance (homogeneous low-level internal echoes) located in the pouch of Douglas. During the ultrasonic assessment both ovaries looked completely normal and were seen separately from the cyst.

We proceeded with a diagnostic laparoscopy. The surgery revealed a bilocular cystic mass growing directly from the pouch of Douglas, completely unattached to either ovary, confirming it was an isolated extraovarian lesion. We carefully excised the entire mass while leaving the surrounding pelvic structures intact. Histological analysis later confirmed the cyst was indeed an endometrioma, noting the presence of endometrial glands, stroma and hemosiderin-laden macrophages. The patient recovered without complications and has since been referred to the fertility team to continue her care.

Discussion: Because extraovarian endometriomas are so uncommon, they easily mimic typical ovarian cysts on ultrasound. As a result, the only way to discover the true nature of the lesion during surgery. How these specific isolated lesions develop remains debated; however, theories suggest retrograde menstruation, coelomic metaplasia, or the transformation of Müllerian remnants could be responsible. In these scenarios, laparoscopy acts as the absolute gold standard. It not only allows us to confirm the diagnosis and remove the cyst entirely, but it also relieves the patient's pain and restores normal pelvic anatomy to help improve future fertility outcomes.

Conclusion: When a patient struggles with infertility and deep dyspareunia and scans show a pouch of Douglas mass alongside healthy ovaries, clinical teams need to keep isolated extraovarian endometriomas on their differential diagnosis. Careful laparoscopic surgery is essential in these cases to manage symptoms, confirm the exact pathology and protect the patient's fertility.

EP099. Documentation of Estimated Blood Loss Following Gynaecological Procedures at Base Hospital Elpitiya- Audit Report

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Background: Accurate documentation of estimated blood loss (EBL) is an essential component of operative records in gynaecological surgery. It provides an objective assessment of intraoperative haemorrhage, assists postoperative monitoring, guides decisions regarding fluid resuscitation and blood transfusion, and facilitates early recognition of complications such as postoperative anaemia or concealed bleeding. Documented EBL also improves communication among surgeons, anaesthetists, nursing staff, and ward teams, ensuring continuity of patient care. In addition, complete operative documentation has important medico-legal value and is recommended by national and international standards of good surgical practice. Failure to record EBL may compromise clinical decision-making and reduce the quality of operative records. This audit was conducted to evaluate current documentation practices at Base Hospital Elpitiya.

Methodology: A retrospective clinical audit was conducted using operative records of 60 consecutive gynaecological procedures.

The procedures were divided into:

- Major procedures (n = 30)
    a. Total Abdominal Hysterectomy (TAH): 10
    b. Vaginal Hysterectomy (VH): 10
    c. Laparoscopic procedures: 10
- Minor procedures (n = 30)
  The primary audit criterion was whether EBL was documented in the operative notes.

Results: EBL was documented in 24 of 60 procedures (40%), highest for TAH(80%), and only 2 of 30 minor procedures.

Documentation of EBL

Procedure	Total Cases	Blood Loss Documented	Percentage
TAH	10	8	80%
VH	10	7	70%
Laparoscopic procedures	10	7	70%
Minor procedures	30	2	6.7%
Overall	**60**	**22**	**37%**

Discussion: The audit demonstrated that documentation of EBL was satisfactory in major gynaecological procedures, with documentation rates ranging from 70–80%. TAH showed the highest compliance (80%), while VH and laparoscopic procedures achieved 70%.In contrast, documentation following minor gynaecological procedures was markedly poor, with only 6.7% of operative records containing an EBL. This suggests that surgeons may perceive blood loss documentation as less important during procedures with expected minimal blood loss. However, consistent documentation is recommended irrespective of procedure complexity, as unexpected bleeding can occur during any operation.

Recommendations

Introduce a standardized operative note template with a mandatory field for EBL.

Educate medical officers and trainees on the importance of documenting EBL for every procedure.

Repeat the audit after implementing these interventions to assess improvement (audit cycle).

Conclusion: This audit identified satisfactory documentation of estimated blood loss during major gynaecological procedures but very poor compliance in minor surgeries. Standardising operative documentation and reinforcing good clinical documentation practices are expected to improve compliance and enhance patient safety.

EP100. ISOLATED INGUINAL NODAL RECURRENCE OF HIGH-GRADE ENDOMETRIOID OVARIAN CARCINOMA

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Objectives: Recurrence of epithelial ovarian carcinoma in isolated inguinal lymph nodes is a rare form of relapse. We present this case to draw attention to the rare site of metastatic recurrence more than three years after the completion of initial treatment, even when the CA-125 serum value is normal.

Case report: A 57-year-old patient was found to have high-grade endometrioid ovarian carcinoma in November 2021. The patient had undergone a total abdominal hysterectomy, bilateral salpingo-oophorectomy, infracolic omentectomy and adjuvant chemotherapy for six cycles, which was done in March 2022. Imaging after treatment revealed absence of any evidence of residual or recurrent cancer.

In early 2025, she presented with a gradually increasing painless left groin lump, without any abdominal, genitourinary, or bowel symptoms. Physical examination showed a large, firm lump in her left inguinal region. Abdominal ultrasound was normal, but groin ultrasound showed a heterogeneous vascular tumor measuring 12.3 × 10.8 × 10.0 cm. Her serum CA-125 was 5.9 U/mL. CECT CAP was normal except the above lesion. Whole-body staging via FDG PET/CT scan was not done due to unavailability. Tru-cut biopsy showed metastatic carcinoma.

Surgical excision of the left inguinal lymph node was carried out. Histopathological evaluation of the tumor showed an infiltrative neoplasm consisting of atypical epithelial cells arranged in solid and glandular patterns with vesicular nuclei, prominent nucleoli, increased mitotic activity and comedo-type necrosis. The findings were those of metastatic high-grade carcinoma, probably from her known endometrioid ovarian carcinoma. Post-surgery, she was sent for adjuvant chemoradiation. She remained recurrence free 6 months post-operatively.

Discussion: The lymphatic recurrence of epithelial ovarian cancer occurs mainly in pelvic and para-aortic lymph nodes, while isolated inguinal nodal recurrence is uncommon. This could be due to either the route of lymphatic drainage via round ligament from deep inguinal ring or due to changed lymphatic drainage after prior pelvic surgery. In our case, recurrence occurred in the unusual nodal region even though the patient had been disease-free for more than three years and CA-125 was normal. Thus, we would like to show that recurrence can happen at unusual nodal locations in spite of disease-free interval and normal tumor marker. The thorough physical examination is important for follow-up.

Conclusion: In this case, the significance of keeping a high level of suspicion of the unusual sites of recurrence of ovarian cancer regardless of the serum CA-125 levels is clearly illustrated. Comprehensive clinical workup and biopsy will help in the earlier diagnosis of the disease. The management of this rare recurrence of ovarian cancer involving surgery and subsequent chemoradiation is a good modality. Future researches need to be done in this regard as this is limited by being a single study and a short follow up.

EP101. KNOWLEDGE AND ATTITUDES REGARDING EPIDURAL ANALGESIA FOR LABOUR AMONG ANTENATAL MOTHERS: A CLINICAL AUDIT AND QUALITY-IMPROVEMENT INITIATIVE

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Background: Labour pain is one of the most intense forms of pain experienced by women. Therefore, effective analgesia is an important component of patient-centered maternity care. Epidural analgesia is considered the most effective method of pain relief during labour. It provides reliable analgesia compared to other available pharmacological and non-pharmacological methods. Despite its effectiveness and safety, inadequate knowledge and misconceptions regarding complications have limited informed maternal choice. Providing accurate information during the antenatal period is therefore essential to support informed decision-making.

Objectives: To assess antenatal mothers' knowledge and attitudes regarding epidural

analgesia for labour, identify common misconceptions and gaps in antenatal education and implement a targeted quality-improvement initiative.

Method: A cross-sectional clinical audit was conducted using a random sample of 50 antenatal mothers attending the German Sri Lanka Friendship Hospital for Women, Sri Lanka. Data were collected using a structured questionnaire that assessed demographic characteristics, prior epidural exposure, knowledge, attitudes and sources of information. Data were analyzed using SPSS and summarized using frequencies and percentages.

Results: Overall awareness and knowledge of epidural analgesia were poor. Only 22% of the participants had heard of epidural analgesia and only 6% had previous epidural experience. 60% of mothers scored 0 out of 9 in the overall knowledge assessment and only 4% achieved the maximum score. Many mothers were unsure about the procedure, potential complications, effects on the baby and availability of the service.

Healthcare professionals were rarely cited as the information source. Only 8% mentioned doctors and 4% stated midwives. Internet and social media accounted for 18%. Importantly, 74% expressed a desire for more information, highlighting a clear unmet need.

Conclusion: This audit revealed significant gaps in antenatal mothers' awareness and knowledge of epidural analgesia despite being the most effective method of labour analgesia. The strong interest in learning more emphasizes the need for structured antenatal education. Incorporating multidisciplinary education on labour analgesia into routine antenatal care may help reduce misconceptions and support informed maternal choice.

A quality improvement project was initiated, including improvement in targeted counselling on epidural analgesia by health-care professionals, which was based on another complementary audit on doctors' knowledge of epidural analgesia in labour. A patient-information leaflet was designed and distributed in the antenatal clinics and antenatal wards.

Keywords: Epidural; labour analgesia; antenatal education; maternal knowledge; quality improvement; clinical audit; patient education.

EP102. KNOWLEDGE AND PRACTICES ON VULVAL SKIN CARE IN WOMEN ATTENDING A GYNAECOLOGY CLINIC IN SRI LANKA

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Objectives: Numerous conditions affect the vulva and vagina. Most women suffer from at least one condition in their lifetime once or more. These might cause only minor discomfort for some whereas some conditions are recurrent. Vulval skincare is an important part in women's health. The aim of our survey is to assess the frequency of vulval skin problems, practices and misconceptions on vulval hygiene among study participants.

Method: A self-administered questionnaire was given to 50 women attending gynaecology clinic in Base Hospital Dambadeniya, Sri Lanka. Questions consisted on demographic details, vulval and vaginal symptoms, frequency plus vulval care habits.

Results: Most women (68%) were above 40 years. 92% of the participants were married and 80% were parous. The most common symptom experienced was vulval and vaginal itching (32%) followed by vaginal discharge (28%). Out of the women who have experienced symptoms, majority (61%) had frequent symptoms with three or more episodes in a year.

Most women practice unnecessary washing of vulva and vagina. 92% practice washing more than three times a day. Majority (76%) use soap and soap substituents for washing whereas none practice the use of emollients or barrier creams. Even though most women (68%) use cotton underwear, 80% did not concern about the colour or use of dyes on their undergarments.

52% answered that they are confident on vulval care and hygiene. However, 88% answered that they would like to get more knowledge on the subject.

Conclusion: Problems related to vulva and vagina are frequent and most affected women suffer from recurrent episodes. Knowledge related to vulval care and hygiene in women is poor. Disparity on confidence on vulval hygiene and willingness for more knowledge in-

dicate that women receive mixed sources of information. Steps and opportunities should be taken to educate every woman at every encounter on proper vulval hygiene and care in gynaecology clinics.

EP103. KNOWLEDGE, ATTITUDES AND ASSOCIATED FACTORS TOWARD GESTATIONAL DIABETES MELLITUS AMONG PREGNANT WOMEN AT A TEACHING HOSPITAL IN JAFFNA, SRI LANKA

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Background: Gestational Diabetes Mellitus (GDM) is a common metabolic disorder occurring during pregnancy and is associated with significant maternal and neonatal complications if inadequately managed. Rising maternal age, sedentary lifestyles and increasing obesity rates have contributed to a growing prevalence of GDM globally and within Sri Lanka. Early detection, health education and lifestyle modification remain key strategies in preventing adverse outcomes.

Objectives: To assess the knowledge, attitudes and associated factors regarding gestational diabetes mellitus among pregnant women attending antenatal clinics at Teaching Hospital, Jaffna.

Method: A descriptive cross-sectional study was conducted among 400 pregnant women using a pre-tested, interviewer-administered questionnaire. Data were collected on socio-demographic characteristics, obstetric history, knowledge related to GDM risk factors and complications and attitudes toward screening and management. Descriptive and inferential statistical analyses were performed to identify associations between demographic variables and knowledge and attitude levels.

Results: Among the 400 participants, 55% demonstrated adequate knowledge of GDM while 45% had limited understanding. Most respondents expressed positive attitudes toward GDM screening and management. Education level, number of antenatal visits and family history of diabetes were significantly associated with higher knowledge and more favorable attitudes ($p < 0.05$).

Conclusion: Although attitudes toward GDM were largely positive, substantial knowledge gaps persist among pregnant women in Jaffna. Strengthening antenatal health education through structured counseling and awareness programs is essential to enhance early detection and improve maternal and neonatal outcomes.

EP104. KNOWLEDGE OF LAPAROSCOPIC INSTRUMENTS AMONG POSTGRADUATE TRAINEES IN OBSTETRICS AND GYNAECOLOGY IN SRI LANKA

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Introduction: Laparoscopic surgery is a minimally invasive technique performed using small incisions, a camera and specialised instruments which offers many advantages. Due to the complexity of the procedure together with technical challenges, these procedures can give rise to several complications. Therefore, adequate knowledge about laparoscopic instruments is essential for safe surgical practice.

Objectives: The objective of the study was to assess the level of knowledge of laparoscopic hand instruments among postgraduate trainees in Obstetrics and Gynaecology in Sri Lanka.

Design: A cross-sectional descriptive study

Method: A cross sectional study was carried out among 51 Obstetrics and Gynaecology postgraduate trainees. This was done using a structured questionnaire. This included a total of ten questions from different areas. Knowledge scores were calculated as the percentage of correct responses. The scores were non-normally distributed. Therefore non-parametric tests were used, considering $p < 0.05$ as statistically significant.

Results: The mean laparoscopic instrument knowledge score was $55.4 \pm 26.6\%$. This indicates that there is a wide variability in the level of knowledge among the trainees. Deficiencies were seen in areas related to needle holders, dissector functions and grasper control. Higher knowledge scores were seen among those who had a greater clinical experience and exposure to laparoscopic surgeries. However, no significant association was observed with the year of

postgraduate training or previous formal laparoscopic training.

Conclusion: Knowledge of laparoscopic instruments among Obstetrics and Gynaecology trainees was variable and suboptimal. The overall performance showed significant deficiencies in instrument assembly, disassembly and appropriate application during laparoscopic procedures. This is concerning as these are essential in complex laparoscopic surgeries performed on a daily basis. Knowledge was influenced more by exposure to surgeries and surgical experience but not by formal training or seniority. This highlights a gap in postgraduate surgical education. To improve the competency of the surgical trainees and ensure safe surgical practice, inclusion of a structured, hand on training that focuses on laparoscopic instruments in the curriculum is essential.

EP105. KNOWLEDGE OF POSTPARTUM DANGER SIGNS AND ITS DETERMINANTS AMONG MOTHERS AT A TERTIARY CARE HOSPITAL IN SRI LANKA

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Background: Delayed recognition of postpartum danger signs is a preventable contributor to maternal morbidity and mortality. Whether Sri Lanka's strong maternal health infrastructure translates into adequate maternal knowledge of danger signs at hospital discharge is not well documented in tertiary settings.

Objectives: To determine the level of knowledge of postpartum danger signs among mothers attending the postnatal ward of Teaching Hospital Peradeniya and identify associated factors.

Method: A hospital-based cross-sectional study of 278 postnatal mothers (1–7 days postpartum) was conducted using systematic random sampling. A pre-tested, interviewer-administered questionnaire covering sociodemographic with obstetric characteristics, an 11-item danger-sign knowledge scale and sources of information was used. Knowledge was categorized as good, moderate, or poor; associations were tested using chi-square ($p<0.05$). Ethical approval was obtained from the Department of Nursing, faculty of Allied Health Sciences, University of Peradeniya, Ethics Review Committee and written informed consent was obtained from all participants prior to data collection.

Results: Most mothers were aged 30–39 years (60.4%), educated to A/L or above (83.5%) and 66.5% had delivered by caesarean section. 80.2% had received prior counselling on danger signs. The mean knowledge score was 5.76/11 (SD 2.94; 52.4% correct-response rate). More than half of participants (57.6%) had poor knowledge, 24.1% moderate and only 18.3% good knowledge. Recognition was highest for pain/burning on urination (98.9%), breast pain/swelling with redness (86.0%) and foul-smelling vaginal discharge (64.4%). Markedly poorer knowledge was noted for the most clinically urgent signs, including difficulty in breathing (29.1%), swelling of face, hands or legs (32.4%), heavy vaginal bleeding (34.9%) and high fever (38.1%). Parity was the only factor significantly associated with knowledge level ($\chi^2=20.78$, df=4, $p<0.001$), with multiparous mothers scoring highest. Education, antenatal visit frequency, prior counselling, mode of delivery and age were not significantly associated with the level of knowledge. Nurses/midwives were the major source of information. Transport difficulty (52.2%) and cost (36.7%) were the leading barriers to care-seeking and self-rated confidence in recognizing danger signs was low in 62.9% of mothers.

Conclusion: Good knowledge (18.3%) was markedly lower than the 73.7% reported among antenatal mothers in Matara and the near-universal moderate-to-good knowledge in Kalutara's postnatal cohort, though comparable to Uganda (19%) and Nekemte, Ethiopia (32.3%). Structured, itemised, nurse-led predischarge education targeting haemorrhage, sepsis, hypertension and respiratory compromise is recommended.

Limitations: This cross-sectional design precludes causal inference, knowledge was self-reported without validation against practice and single-centre sampling may limit generalisability.

Keywords: postpartum danger signs; maternal knowledge; postnatal care; maternal mortality

EP106. KOUNIS SYNDROME COMPLICATED BY TAKOTSUBO CARDIOMYOPATHY FOLLOWING PERIPARTUM ANAPHYLAXIS: CASE REPORT

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Objectives: Kounis syndrome is allergic coronary vasospasm; Takotsubo cardiomyopathy is catecholamine-induced myocardial stunning. The two overlap and adrenaline treats one while aggravating the other. We report a case in which both followed peripartum anaphylaxis to co-amoxiclav.

Case report: A 32-year-old woman with one previous caesarean section, an uncomplicated antenatal course and no known allergies underwent elective repeat caesarean section at 38 weeks. Intravenous co-amoxiclav at induction was tolerated without incident. She was transferred to the postnatal ward after two hours of recovery observation on the Modified Early Obstetric Warning Score (MEOWS), all of it unremarkable.

The second dose, given on the ward, changed that - severe urticaria, periorbital angioedema, dyspnoea, hypoxia and hypotension, consistent with anaphylactic shock. She received intravenous hydrocortisone and chlorpheniramine with intramuscular adrenaline, repeated three times at five-minute intervals for refractory hypotension, to which she then responded. The on-call medical team was called urgently, the anaphylaxis having proved refractory.

Sudden ischaemic-type chest pain with autonomic symptoms followed. Electrocardiography showed widespread anterior ST-segment depression and troponin was positive. Bedside echocardiography found anterior segmental hypokinesia with an ejection fraction of 40% and chest radiography mild pulmonary oedema - the picture of Kounis syndrome complicated by Takotsubo cardiomyopathy. She was managed in intensive care with continuous positive airway pressure (CPAP), intravenous frusemide and noradrenaline infusions. Ejection fraction recovered fully to 60%.

Discussion: Kounis syndrome arises from mast cell mediator release - histamine, tryptase, leukotrienes - causing coronary vasospasm or plaque disruption during a hypersensitivity reaction. Here the catecholamine surge of anaphylaxis, compounded by three doses of adrenaline, plausibly drove both the vasospasm and the myocardial stunning, giving overlapping ischaemic and pump-failure phenotypes. The dilemma is plain. Adrenaline was necessary to reverse her shock, yet it worsens coronary vasospasm and raises myocardial oxygen demand. What follows is cautious titration, continuous cardiac monitoring and early multidisciplinary involvement.

Conclusion: Chest pain during anaphylaxis should raise Kounis syndrome. In this woman it did and bedside echocardiography distinguished the overlapping diagnoses without delay. Adrenaline could not be withheld - but recognising what it was doing to the myocardium is what directed her to intensive care and to full recovery of ejection fraction.

EP107. LAPAROSCOPIC ASSISTED EXTRAPERITONEAL MYOMECTOMY - A NOVAL APPROACH FOR LARGE CERVICAL/BROAD LIGAMENT FIBROIDS

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Objectives: Transvaginal extraperitoneal approach provide alternative for posteriorly locating cervical fibroids by exploring the potential space between the posterior wall of the vagina and POD. Fibroid enucleation is possible without breaching peritoneum which minimize the adhesion formation and morbidities related to the laparotomy. When perform with concurrent use of laparoscopic visualization this variant will add real time assurance of peritoneal integrity and identify complications. This approach is safe and feasible.

Case report: A 47y Para 2 with background history of endometrioma previously managed with DMPA was found to have 6.5x7cm pelvic/adnexal mass on follow up USS. CA 125 11.7 IU/ml. No features of malignancy. She was otherwise healthy. No abnormalities detected on abdominal examination. Bimanual pelvic examination revealed retroverted uterus

with smooth non-tender mass in the POD. No cervical excitation.

We performed a Diagnostic laparoscopy under GA and confirmed a 7x8cm size cervical fibroid located just below the uterosacral ligaments, bulging towards the peritoneal cavity. No adhesions noted. B/L ovaries and tubes look normal without residual endometriomas. We chose a transvaginal approach, performed a posterior colpotomy, enucleate the fibroid at sub serosal plane without breaching the peritoneum under laparoscopic visualization. Fibroid completely removed without morcellation via vaginal route. Myoma bed closed with #1Vicryl continuously. Laparoscopic surveillance confirmed that no peritoneal breach, vital organ damage, hematoma or active bleeding. Routine post op monitoring and management given. Patient discharged on Day 2 without any complication. A histology review (Benign Leiomyoma without any atypical features noted), clinical assessment and USS performed in one month. Patient was happy and had a complete recovery without any complications.

Discussion: Uterine fibroids are most common benign tumors of the female genital tract. When women reaching their 5th decades of the age 70% of the females will be having leiomyomas in which 6% are cervical fibroids. Cervical and broad ligament fibroids pose greater surgical challenges due to their proximity to the vital organs such as ureters, bladder, rectum and major uterine vessels. Inadvertent injuries to these structures are high when compare to the other type of fibroids.

1. The rationale for the transvaginal approach.

Though there are different approaches to do myomectomy, open myomectomies mostly performed. It necessitates laparotomy, increases pelvic adhesions, prolong hospital stay and recovery. It requires advance laparoscopic skills and equipment when approach laparoscopically. Generally restricted to <7cm fibroids and pose technical difficult to perform due to the proximity to the rectum. Primary advantage is the surgery can be in the natural potential space without entering the peritoneal cavity which prevent the de novo adhesion formation. Vaginal route specimen retrieval is another advantage which avoid the morcellation in the context of potential occult malignancy.

2. Anatomical basis and surgical safety.

In the absence of pelvic adhesions, only blunt dissection needed with minimal blood loss and give a direct access to the psedocapsule of the fibroid. As fibroid located below the uterosacral ligaments, careful identification of ureters and rectum prevent the injury to those organs.

3. Laparoscopy as a safety adjunct.

Laparoscopic assisted variant of this technique provides crucial safety layer as in this case. Concurrent visualization reassures the surgeon regarding the assessment of acute complications. Peristalsis of the ureter, bladder integrity, haematoma and haemostasis are impossible to confirm via vaginal route alone. It would help a junior surgeon to gain confidence specially when they are on early stage of the learning curve in this type of surgeries.

4. Haemostasis: Challenges and Solutions.

Achieving haemostasis in a confined vaginal operative field reports the primary technical challenge. This impairs the use of conventional hemostasis techniques as in open surgeries. Bipolar diathermy and absorbable sutures can be used to achieve haemostasis. Use of Local injection of diluted vasopressin also can be used as an adjunct. GnRH analogs before surgery would help to reduce the volume of the fibroids, but it would interfere the anatomical plane during enucleation.

5. Patient selection criteria.

Posterior location of the fibroid.

Size <9cm – to facilitate removal without morcellation via vaginal route.

Absence of significant pelvic/POD adhesions-could be confirmed with concurrent laparoscopy.

Absence of malignancy features Competent surgeon/ Supervisor.

Use of Pre-operative MRI should be requested for all cervical fibroids being considered for surgical intervention, to delineate ureteric position and assist approach planning. Where MRI is unavailable, intravenous urography (IVU), CT urogram is an acceptable alternative. B/L JJ stenting can be considered.

Conclusion: In carefully selected patients with posteriorly located cervical fibroid transvagi-

nal extraperitoneal myomectomy, performed under concurrent laparoscopic guidance is a safe feasible and minimally invasive alternative to conventional transabdominal surgery. This technique reduces the peri-uterine adhesin formation, avoid laparotomy related morbidity enable shorter hospital stay and early returned to work as well as recovery. Wider adoption requires subspecialty training in advanced vaginal surgical skills and prospective data are needed to define the optimal patient selection criteria and long-term reproductive outcomes.

EP108. LAPAROSCOPIC EXCISION OF SCAR ECTOPIC PREGNANCY, CHALLENGES IN MANAGING IN A LOW RESOURCE SETTING

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Introduction: Caesarean scar pregnancy is a rare but potentially life-threatening form of ectopic pregnancy in which gestational sac implants over the defective endometrum of the uterus called "uterine niche". Although the estimated incidence is approximately 1 in 1,800–2,500 pregnancies, its frequency has increased over the past two decades, largely due to rising caesarean section rates. There are two types of scar ectopic pregnancies. Laparoscopic resection is an advanced management option which requires laparoscopic surgical expertise and newer technology.

Case report: A 32 year old mother with previous caesarean section presented to with per-vaginal bleeding at 10 weeks of gestation. She had an irregular gestational sac at the lower pole of the uterus with foetal pole and absent foetal heart beat with mean gestational sac diameter of 34mm and crown-rump length of 12mm compatible with 9wks of gestation. Thus initial diagnosis of missed miscarriage was made and undergone medical management with misoprostol. As she had not passed products with two cycles of misoprostol repeat TVS revealed gestational sac at the same position. It raised the suspicion of scar ectopic pregnancy and on detailed specialist ultrasound performed. It confirmed the type 1 scar ectopic pregnancy.

As she was hemodynamically stable, planned to undergo laparoscopic resection of scar ectopic pregnancy. On initial survey there was prominent blood vessels noted in the utero vesical junction. Thus, vasopressin injected and carefully cauterized the blood vessels over the uterovesical fold. Bladder pushed down and moved away from the surgical field. Scar pregnancy was carefully dissected using ligasure and bipolar electrosurgical devices. Maximal excision and removal of trophoblastic tissue done. Uterine incision was repaired with barb sutures. Complete haemostasis achieved. Specimen was retrieved using a locally prepared endo-bag. Peritoneal cavity thoroughly washed with warm saline. She was followed up with serum beta hCG until returned to non-pregnant level.

Discussion: Laparoscopic resection is an effective minimally invasive treatment for appropriately selected haemodynamically stable patients with caesarean scar pregnancies. In addition to complete removal of trophoblastic tissue, it permits excision of the scar niche and anatomical reconstruction of the uterine defect, which may reduce the risk of recurrence and improve uterine integrity for future pregnancies. Careful bladder mobilisation is an essential surgical step because of the close anatomical relationship between the lower uterine segment and the urinary bladder. The prominent neovascularisation observed at the uterovesical fold in this patient reflects the marked angiogenesis associated with trophoblastic invasion. Local vasopressin injection before dissection significantly reduces intraoperative blood loss through vasoconstriction, facilitating safe excision and improving operative visibility. Repair of the uterine defect using layered suturing restores myometrial continuity and may decrease the likelihood of scar dehiscence in subsequent pregnancies.

Postoperative monitoring with serial serum β-hCG measurements is recommended until non-pregnant levels are achieved to confirm complete resolution of trophoblastic tissue. Women should receive counselling regarding the increased risk of recurrence, placenta accreta spectrum disorders, uterine rupture and the need for early transvaginal ultrasonography in all future pregnancies to confirm implantation

site. Delivery in subsequent pregnancies should occur in specialist obstetric units capable of managing complex placental disorders if indicated.

Conclusion: Early recognition and elective laparoscopic excision with uterine reconstruction, resulting in successful treatment while preserving fertility. Increasing awareness of this uncommon but potentially life-threatening condition is essential to avoid inappropriate management and reduce maternal morbidity.

EP109. MAGNESIUM-DEPENDENT REFRACTORY HYPOKALAEMIA IN HYPEREMESIS GRAVIDARUM

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Objectives: Hypokalaemia is common in hyperemesis gravidarum (HG) but occasionally fails to correct despite adequate potassium replacement. We report such a case to illustrate that refractory hypokalaemia in HG needs prompt measurement and correction of serum magnesium levels if found low and to note that the Royal College of Obstetricians and Gynaecologists (RCOG) Green-top Guideline (GTG) 69 does not address magnesium.

Case report: A 32-year-old woman with known type 2 diabetes mellitus (T2DM) presented at a period of amenorrhoea of 8 weeks and 5 days with HG, diabetic ketoacidosis (DKA) and symptomatic hypokalaemia. Her serum potassium remained low despite aggressive intravenous and oral potassium chloride replacement and did not correct even after the DKA had resolved. Concurrent hypomagnesaemia (serum magnesium 1.6 -1.7 mg/dL; ≈0.66 - 0.70 mmol/L) was identified on day 6. Within 24 hours of intravenous magnesium sulphate ($MgSO_4$) replacement, potassium normalised (3.2 to 4.1 mmol/L) with no further need of escalation. The likely contributors for the hypokalaemia were gastrointestinal losses from hyperemesis, renal magnesium and potassium wasting driven by T2DM, including recurrent hyperglycaemia and the DKA. Urinary potassium was not measured, as the assay was unavailable locally.

Discussion: Low magnesium reduces the kidney's ability to retain potassium and drives continued urinary loss, so potassium stays low despite adequate replacement until the magnesium itself is corrected. In this patient, T2DM and recurrent hyperglycaemia would have added to renal magnesium loss and made hypomagnesaemia more likely. Magnesium is not routinely checked in HG and is not mentioned in GTG 69, so it was identified only on day 6; potassium then corrected within 24 hours of replacement, with no other change in management, which points to magnesium depletion as the likely cause rather than coincidence. Urinary potassium was unavailable to confirm the site of loss.

Conclusion: Refractory hypokalaemia in HG warrants measurement and correction of serum magnesium, rather than routine magnesium testing in all HG, with a particularly low threshold where comorbidities such as T2DM further predispose to magnesium depletion. Early detection of this association allows rapid potassium correction and helps to avoid prolonged, ineffective potassium replacement. The silence of GTG 69 on magnesium is a gap worth addressing.

EP110. MANAGEMENT OF GESTATIONAL CEREBRAL VENOUS THROMBOSIS AT TERTIARY CARE HOSPITAL: A RARE CLINICAL CASE REPORT

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Objectives: Gestational cerebral venous thrombosis (CVT) is a rare life-threatening cerebrovascular emergency, but it accounts for up to 20% of maternal strokes. Due to its clinical presentation, it often mimics severe preeclampsia or eclampsia, with detrimental delays in diagnosis leading to enhanced maternal morbidity. This case highlights the necessity of early neuroimaging and importance of prompt multidisciplinary intervention guided by the 2025 joint clinical practice guidelines of the Sri Lanka College of Obstetricians & Gynecologists (SLCOG) and the Sri Lanka College of Hematologists.

Case report: A multigravida in her late 30s (G3P2) with a BMI of 35.2 kg/m^2 and gestational diabetes presented at34 weeks of gestation with a five-day history of progressive, re-

cumbency-worsened headaches, visual disturbances and transient right-sided paresthesia. She was exhibiting borderline hypertension (142/84 mmHg) without proteinuria and was initially managed under an impending eclampsia protocol and started on an intravenous magnesium sulphate infusion. Within 24 hours she developed a secondary generalized tonic clonic seizure. An emergent non-contrast CT scan was unremarkable; however, a follow-up MRI/MRV demonstrated a right parietal non-hemorrhagic venous infarct with extensive thrombosis of the superior sagittal, left transverse and left sigmoid sinuses. The eclampsia protocol was immediately discontinued. A multidisciplinary team comprising obstetricians, neurologists and hematologists started therapeutic weight-based low molecular weight heparin (LMWH) and levetiracetam for seizure prophylaxis. Neurological symptoms improved completely within 48 hours. The patient underwent an elective caesarean section at 37 weeks with a structured peripartum anticoagulant bridging protocol without hemorrhagic or thrombotic complications.

Discussion: When combined with metabolic risk factors such as obesity that can significantly amplify Virchow's triad during pregnancy, a profound prothrombotic state can be induced. The clinical picture of CVT and preeclampsia is similar and therefore the initial triage may be incorrect. If left untreated, maternal mortality rate can be as high as 30% due to increased intracranial pressure and progressively worsening venous congestion. However, a timely and accurate diagnosis and the institution of therapeutic anticoagulation can greatly improve prognosis with complete neurological recovery.

Conclusion: Gestational CVT cases need to be monitored very carefully especially if the patients have atypical neurological symptoms or symptoms that do not fit with the usual obstetric management. In such cases, MRI/MRV serves as an accurate diagnostic measure to improve maternal and fetal outcomes with early therapeutic LMWH, precise multidisciplinary peripartum planning and mandatory thromboprophylaxis during subsequent pregnancies.

EP111. MANAGEMENT OF THIRD TRIMESTER BACTERIAL MENINGITIS: CASE REPORT

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Introduction: Bacterial meningitis in pregnancy is a rare but life-threatening obstetric emergency. It is associated with significant maternal and fetal morbidity and mortality. The physiological immunosuppression of pregnancy complicates the diagnosis and management, so that presentation can mimic other pregnancy-related conditions, leading to diagnostic delays. Here is a case report of community-acquired bacterial meningitis in a previously healthy multiparous woman at 36 weeks of gestation. It highlights the diagnostic challenges, proper treatment and successful postponement of delivery to achieve term gestation with excellent neonatal outcomes.

Case report: A 32-year-old G2P2C1 mother at 36+2 weeks of gestation presented with a 1 day history of fever and severe, throbbing frontal headache unresponsive to paracetamol. It was associated with photophobia and generalized myalgia. She denied any recent travel or contact history. On examination, she was febrile and tachycardic but hemodynamically stable. Neurological assessment revealed neck stiffness with a positive Kernig's sign and Brudzinski's sign. There was no focal neurological deficit. Fetal assessment was reassuring. Due to high clinical suspicion for meningitis, intravenous empirical antibiotic therapy with Ceftriaxone and Acyclovir was started immediately to cover both bacterial and viral etiologies. Lumbar puncture was performed and cerebrospinal fluid (CSF) was turbid. CSF analysis showed a neutrophilic leocytosis (WBC > 1000/µL, 90% neutrophils), elevated protein (>150 mg/dL) and low glucose (<20 mg/dL). Gram stain revealed Gram-positive diplococci, later confirmed by culture as Streptococcus pneumoniae. Acyclovir was discontinued afterwards. The patient was managed in high-dependency unit. Antipyretics, strict fluid management and close fetal monitoring were done. The patient showed a favourable clinical response to the 7-day course of intravenous

Ceftriaxone. Fever settled by day 3 and gradual resolution of headache and neck stiffness noted by day 5. The patient was discharged on oral antibiotics for a further 5 days. She was followed up closely as an outpatient.

At 40 weeks of gestation, she presented in spontaneous labor and had an uncomplicated vaginal delivery. She gave birth to a healthy female infant of 3.2 kg birthweight, with Apgar scores of 9 and 10 at 1 and 5 minutes, respectively. The neonate didn't have any signs of sepsis or neurological impairment and was discharged with the mother in 2 days.

Discussion: This case shows the importance of a high index of suspicion for meningitis in pregnant mothers who present with non-specific symptoms like headache and fever. It's better to start empirical therapy immediately, without waiting for definitive culture result. It is extremely important in preventing severe maternal complications such as cerebral edema or seizures. The successful postponement of delivery to term highlights that with timely and effective antimicrobial therapy, preterm delivery can be safely avoided. This case adds to the limited literature on the management of pneumococcal meningitis in the third trimester, showing that with a multidisciplinary approach involving Obstetricians, Physicians and neonatologists, excellent maternal and neonatal outcomes are achievable.

Conclusion: High index of suspicion for meningitis is essential in any pregnant woman presenting with fever and severe headache, regardless of the absence of classic risk factors. Prompt recognition, early empirical antibiotic therapy and multidisciplinary management are essential in treating bacterial meningitis during pregnancy. This case demonstrates that it is possible to achieve a term delivery and a completely normal neonatal outcome after a complicated episode of third-trimester meningitis.

EP112. MASSIVE HAEMOPERITONEUM FOLLOWING TORSION OF A BENIGN BRENNER TUMOUR OF THE OVARY: AN EXTREMELY RARE PRESENTATION

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Objectives: To report a rare case of haemorrhagic shock due to massive haemoperitoneum resulting from torsion of a benign Brenner tumour, highlighting an unusual presentation that required emergency surgical management.

Case report: A 56-year-old post-menopausal multiparous woman with no significant past medical or surgical history presented to a primary care unit with sudden-onset severe lower abdominal pain associated with vomiting for 12 hours. During the following 24 hours, she developed progressive haemodynamic instability with hypotension, requiring intravenous fluids with inotropic support. Laboratory evaluation at this stage revealed a haemoglobin level of 7.4 g/dL. Subsequent abdominal ultrasound scan on the next day demonstrated a large solid right adnexal mass with significant intraperitoneal fluid, raising suspicion of an ovarian malignancy.

On transfer to the tertiary care center, the patient was severely pale, acutely breathless, tachycardic and hypotensive, consistent with haemorrhagic shock. Repeat laboratory testing revealed a critically low haemoglobin level of 3.6 g/dL. She was immediately transferred to the ICU for resuscitation with blood and blood products, intubated and ventilated.

Emergency midline laparotomy following stabilization found approximately 3 litres of haemoperitoneum associated with a 15 x 15 cm solid tumour arising from the right ovary. The ovarian tumour was twisted on the infundibulopelvic ligament, discoloured and associated with active bleeding from venous channels on its surface. Given the patient's post-menopausal status and intraoperative suspicion of ovarian malignancy, a total abdominal hysterectomy with bilateral salpingo-oophorectomy and omentectomy was performed. Histopathological examination con-

firmed a benign Brenner tumour of the ovary with no evidence of malignancy. The patient remained asymptomatic and maintained normal daily functioning at the one- and three-month follow-up visits.

Discussion: Preoperative clinical diagnosis of torsion of ovarian mass in a postmenopausal female can be challenging due to nonspecific clinical features and limited radiological characterization in the acute setting. Such diagnostic delays may also occur because ovarian tumours are not always immediately considered in the differential diagnosis of acute intra-abdominal bleeding, particularly in the absence of known adnexal pathology. In this patient, torsion likely resulted in vascular compromise and subsequent venous congestion evident by decolorization of the ovary and later leading to intraperitoneal bleeding due to rupture of the venous channels. Histopathological examination remains the gold standard for diagnosis, characteristically demonstrating nests of benign transitional-type epithelial cells embedded within a dense fibrous stroma.

Conclusion: This case highlights a rare but potentially fatal presentation of a benign ovarian tumour and underscores the need for prompt recognition, aggressive resuscitation and urgent surgical management in haemodynamically unstable patients with acute abdomen and haemoperitoneum.

EP113. MATERNAL AND FETAL IMPLICATIONS OF TUBEROUS SCLEROSIS COMPLEX IN PREGNANCY AT DGH MATALE: A CASE REPORT

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Introduction: Tuberous sclerosis is an uncommon autosomal dominant disorder marked by the development of hamartomata's growths across multiple organ systems. During pregnancy, the most frequent fetal manifestation is cardiac rhabdomyomas, which are often linked to Tuberous Sclerosis.

Objectives: To evaluate maternal and fetal outcomes in tuberous sclerosis complex during pregnancy, emphasizing fetal cardiac rhabdomyomas, multidisciplinary care and genetic counseling.

Method: A 30-week pregnant woman (G2P2C1) was admitted for blood sugar monitoring. Clinical evaluation, laboratory investigations, specialist referrals and fetal echocardiography were performed.

Results: Maternal findings included epilepsy, facial angiofibroma and gallbladder calculi. Dermatology confirmed Tuberous Sclerosis. Neurology advised MRI brain; respiratory and cardiology assessments excluded pulmonary hypertension. Fetal echocardiography revealed multiple intracardiac tumors, one obstructing the left ventricular outflow tract, consistent with rhabdomyomas. Genetic counseling indicated a 50% inheritance risk. The patient was discharged with plans for readmission and further evaluation.

Discussion: This case highlights the dual challenge of managing maternal Tuberous Sclerosis and fetal cardiac rhabdomyomas during pregnancy. Maternal epilepsy and dermatological features confirmed the diagnosis, while fetal tumors indicated inheritance risk. Despite resource limitations, multidisciplinary collaboration and genetic counseling ensured comprehensive care and anticipatory planning.

Conclusion: Tuberous Sclerosis in pregnancy requires vigilant maternal fetal monitoring and coordinated multidisciplinary management. Early detection of fetal rhabdomyomas provides critical insight into inheritance risk and guides anticipatory planning.

Recommendations: Continue multidisciplinary care, provide genetic counseling, maintain fetal and maternal monitoring, plan postnatal pediatric involvement and advocate for inclusion of rare genetic disorders in maternal health strategies.

Keywords: Maternal, Fetal Implication, Tuberous sclerosis.

EP114. MATERNAL CARDIAC ARREST DURING CAESAREAN SECTION: A POSSIBLE DUAL PATHOLOGY

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Objectives: To highlight the diagnostic aspects of maternal cardiopulmonary arrest during a caesarean section and highlight the sig-

nificance of considering multiple etiologies when clinical features are not typical.

Case report: A mother in her second pregnancy with gestational hypertension, obesity (booking BMI 36 kg/m^2) and multiple allergies on treatment with montelukast underwent lower segment caesarean section under spinal anaesthesia. Shortly after intubation and prophylactic intravenous cefuroxime administration, she developed nausea, vomiting, shortness of breath, skin flushing and angioedema, while lung auscultation was clear. Sensory block extended to C4–T1 dermatomes, suggesting a high spinal block. Before skin incision, she developed cardiopulmonary arrest. Initial rhythm was pulseless ventricular tachycardia, progressing to ventricular fibrillation. Cardiopulmonary resuscitation was commenced immediately, requiring nearly one hour of resuscitation, 13 defibrillations and multiple doses of adrenaline before return of spontaneous circulation was achieved. She was admitted to the intensive care unit, requiring inotropic support and developed acute kidney injury, acute liver failure and anuria requiring continuous renal replacement therapy. Acute mast cell tryptase was elevated, while a repeat sample at 18 hours was normal. Echocardiography demonstrated concentric left ventricular hypertrophy more than expected physiological changes of pregnancy, raising suspicion of underlying cardiomyopathy.After 31 days of ICU admission patient succumbed possibly due to hospital acquired pneumonia.

Discussion: Maternal cardiac arrest during caesarean section is rare and is an obstetric emergency. In this case some features such as, the temporal relationship to cefuroxime administration, flushing, angioedema and elevated acute mast cell tryptase supported anaphylaxis.However, the high sensory block, obesity, ventricular arrhythmias, poor initial response to adrenaline and echocardiographic abnormalities suggested that high spinal anaesthesia and underlying cardiomyopathy may have contributed. Gestational hypertension may also have reduced cardiovascular reserve. This case shows that maternal collapse could result from overlapping pathologies rather than a single diagnosis and highlights the importance of proper evaluation to identify the causes.

Conclusion: Maternal cardiopulmonary arrest during caesarean section requires immediate resuscitation while maintaining a multiple differential diagnosis. Early multidisciplinary involvement, systematic investigation of anaphylaxis, anaesthetic complications and occult cardiac disease, together with post-resuscitation care, is essential to optimize maternal outcomes and guide future management.

EP115. MENSTRUAL DISORDERS AND ASSOCIATED QUALITY OF LIFE AMONG FEMALE UNIVERSITY STUDENTS

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Introduction: Menstruation is a normal physiological phenomenon which women experience throughout her reproductive ages. However a considerable number of women of reproductive age suffer from menstrual cycle abnormalities. These menstrual problems frequently affect the quality of life of young women and may lead to long term health consequences.

Objectives: To determine the association of the quality of life with menstrual cycle abnormalities among female undergraduate students in University of Peradeniya.

Design: A descriptive cross-sectional study with an analytical component was adapted.

Method: The sample were selected by multistage cluster sampling from the female undergraduate students of the University of Peradeniya, Sri Lanka. WHO Quality of Life Scale-BREF questionnaire was used to evaluate the Quality of Life. Data were collected using a pre-tested questionnaire as a google form. SPSS version 26 was used for data analysis. The mean total score for each domain (Physical Health, Psychological, Social relationships and Environment) were calculated for two major groups (students with and without menstrual problems) separately. The statistical difference between the two major groups was calculated by t tests.

Results: The study sample have included 387 female students with the mean age of 23 years.

Of them 78.03% had least one menstrual problem. The presence of menstrual cycle abnormalities had a significant association with the quality of life regarding the physical domain and the psychological domain. However, the quality of life regarding the social domain and the environmental domain were not found to be significantly associated with the presence of menstrual cycle abnormalities. The overall quality of life did not show a significant association with the presence of the menstrual cycle, abnormalities.

Conclusion: The findings support biopsychosocial models of menstrual health, highlighting that menstrual problems predominantly affect physical and psychological domains of quality of life. Integrative health programs focusing on physical symptom management and psychological support may enhance overall well-being among patients with menstrual problems.

EP116. METASTATIC GESTATIONAL CHORIOCARCINOMA FOLLOWING TERM PREGNANCY

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Objectives: To highlight the diagnostic challenges and clinical severity of gestational choriocarcinoma presenting after an uncomplicated term pregnancy.

Case report: A 29-year-old G2P2C2 woman presented with intermittent per-vaginal bleeding, a vulval mass and persistent cough one year after her last delivery which was an uncomplicated term vaginal delivery. Upon examination she was noted to have an irregular necrotic lower vaginal growth with contact bleeding. Her investigations revealed haemoglobin of 7.7 g/dL, β-human chorionic gonadotropin of 602 IU/L, C-reactive protein of 152 mg/L, erythrocyte sedimentation rate of 104 mm/hour and lactate dehydrogenase of 342 U/L. Her chest radiography demonstrated multiple bilateral cannon-ball pulmonary lesions, which was suggestive of pulmonary metastases, while pelvic ultrasonography by the consultant radiologist identified a heterogeneous intrauterine lesion measuring 6.7 × 6.8 cm. She subsequently underwent an examination under anaesthesia and endometrial sampling which demonstrated vulval and lower vaginal growths adjacent to the urethra with a macroscopically normal cervix. Histopathology report of her endometrial sampling showed extensive haemorrhage and necrosis with highly atypical pleomorphic malignant cells and absence of chorionic villi, supporting a diagnosis of choriocarcinoma. Subsequently she underwent a contrast enhanced computed tomography (CECT) of chest, abdomen and pelvis which demonstrated a large uterovaginal mass, multiple bilateral pulmonary metastases and pelvic and para-aortic lymphadenopathy. Depending on the history, histology and CECT findings she was diagnosed with FIGO stage III high-risk gestational trophoblastic neoplasia (WHO score 8) and immediately commenced on EMA-CO chemotherapy. A week following the initiation of therapy, she developed acute respiratory deterioration complicated by cardiorespiratory arrest, requiring intensive care support.

Discussion: Choriocarcinoma after normal term pregnancy is an extremely rare entity. The typical presentation may be overlooked when its dominated by metastatic disease. Choriocarcinoma has an excellent response to chemotherapy provided that its diagnosed early and initiated treatment early. Delay in the presentation may result in metastatic disease resulting in vaginal metastases which are highly vascular lesions that may result in life threatening haemorrhages while extensive pulmonary metastases can precipitate respiratory compromise which ultimately resulting in morbidity and mortality.

Conclusion: Gestational trophoblastic neoplasia should remain a key differential diagnosis in reproductive-aged women with abnormal vaginal bleeding, atypical vaginal lesions, even after an apparently uncomplicated term pregnancy. Early recognition, cautious assessment of vascular metastatic lesions and prompt specialist treatment are essential to reduce morbidity and improve outcomes.

EP117. METASTATIC SQUAMOUS CELL CARCINOMA ARISING FROM MATURE TERATOMA OF THE OVARY; A CASE REPORT

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Introduction: Mature cystic teratoma, also known as dermoids is the most common tumor arising from germ cell lineage and are considered as benign. Very rarely (1%) mature cystic teratomas demonstrate malignant transformation, mostly (80%) being squamous in nature. (1,2).

Objectives: To expand the clinicopathological features of squamous transformation of mature cystic teratoma and raise awareness of the implications.

Case 55 year old woman who is menopaused at the age of 48 years, presented with lower abdominal pain and increased frequency for three months duration. On examination, a fixed abdomino-pelvic mass was detected which was compatible with a 20 week size of the gravid uterus. Sonography and CT scan showed, complex solid and cystic mass in the pelvis with areas of fat attenuation and multiple foci of coarse dystrophic calcification. It was suggestive of malignant transformation of the mature cystic teratoma. Her CA 125 was 14IU/L and CEA was 1.4IU/l.

According to multi-disciplinary team discussions, she underwent primary debulking laparotomy removing uterus, both ovaries and all the deposits. Her recovery was unremarkable. The histology reveled squamous cell carcinoma- a somatic malignancy arising from a cystic teratoma of left ovary, FIGO stage IIB. On postoperative 35th day, she complained of the pain and discomfort of the abdomen. Her examination and sonography showed pelvic recurrence. Multidisciplinary team meeting was held and decided for adjuvant chemoradiation.

Discussion: For these kind of rare malignancies there are paucity of data to guide the management. Treatment will be individualized according the patient's desires, goals and specific variability of the disease.

Mature cystic teratomas are germ cell tumors approximately occur in 10-20% of females during their lifetime. However the malignant transformation seen in rarely and in postmenopausal age women (4).

Surgical management have been the mainstay of the management of these cases over the time, however adjuvant chemotherapy, primarily platinum based chemotherapy and immunotherapy are used (2, 3, 4) As this is very much aggressive disease, it is important that treatment for this cancer should be tailored as guidelines are not yet established.

Conclusion: With its aggressive nature, this case highlights the importance of the awareness of the possibility of a malignant transformation in a mature cystic teratoma when presenting in post-menopausal women.

Ethical consideration Informed verbal consent has been obtained from the patient and all identifying information has been omitted to preserve patient confidentiality.

EP118. MIGRATION OF INTRAUTERINE DEVICE INTO BLADDER FORMING UROLITHIASIS: A CASE REPORT

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Objectives: Intrauterine contraceptive device (IUCD) migration into the urinary bladder is an exceptionally rare complication, occurring in less than 2% of all uterine perforation cases. This case is reported to highlight a critical diagnostic pitfall: misdiagnosing a missing IUCD thread as an unnoticed expulsion without radiographic confirmation, which can lead to delayed detection, persistent lower urinary tract morbidity and secondary intravesical calculus formation.

Case report: A 48-year-old multiparous woman with type 2 diabetes and hypertension presented with a 4-year history of severe dysuria, vaginal pain and recurrent urinary tract infections (UTIs) refractory to antibiotics. Serial urinalyses revealed persistent microscopic hematuria. Her history revealed a copper IUCD insertion in 2018. Four years later, following a missing thread, she was diagnosed elsewhere with an unnoticed expulsion based solely on a pelvic ultrasound and was transitioned to depot medroxyprogesterone acetate (DMPA) injections. On examination, mild

tenderness was noted over the anterior vaginal wall with absent IUCD strings. Transvaginal ultrasonography showed an empty uterine cavity but revealed a thickened bladder wall with a suspected intravesical mass. A subsequent X ray kidney-ureter-bladder (KUB) confirmed a displaced radiopaque IUCD in the pelvis. Cystoscopy confirmed the migrated IUCD heavily encrusted with significant calculus formation (urolithiasis). The device and secondary stone were successfully removed via endoscopically. The postoperative period was uneventful, with complete resolution of her chronic urinary symptoms.

Discussion: Intravesical IUCD migration occurs through slow, inflammatory transmural erosion across pelvic planes over several years. This case demonstrates that a missing thread should never be clinically dismissed as an unnoticed expulsion based on an empty uterine cavity on standard transvaginal ultrasound, as pelvic bone and structures can obscure extrauterine devices. Definitive radiographic evaluation using a plain KUB X-ray is mandatory to rule out migration.

Conclusion: Clinicians must maintain a high index of suspicion for IUCD migration in patients with a history of device use who present with chronic, treatment-resistant lower urinary tract symptoms or recurrent UTIs. Plain radiography is a cost-effective tool for detecting translocated devices and minimally invasive endoscopic management provides excellent therapeutic outcomes.

EP119. MISSED COEXISTENT ECTOPIC PREGNANCY PRESENTING AS UTERINE PERFORATION FOLLOWING SUCTION EVACUATION FOR MOLAR PREGNANCY

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Introduction: A hydatidiform mole is an aberrant pregnancy with the potential for malignant transformation. The co-existence of a molar pregnancy with a concurrent viable intrauterine pregnancy is rare; however, the co-existence with an extrauterine ectopic pregnancy is furthermore rare and cause a significant diagnostic challenge. Here is a case of a complete mole with a coexcisting ruptured ectopic pregnancy, initially misdiagnosed as a uterine perforation following suction evacuation.

Case report: A 34-year-old G3P2C2 woman, presented at 8 weeks of gestation with per vaginal bleeding. Ultrasound (USS) examination showed a vesicular molar pattern in the uterine cavity with no fetal parts. Adnexae were normal in the USS. Her serum beta-hCG was 89,963. Suction evacuation was done and she was discharged on postoperative day 1. On day 3, she returned with acute severe Right lower abdominal pain and heavy PV bleeding. Her hemoglobin was 8.5 g/dL. A repeat USS showed a thin endometrium with a moderate amount of free fluid in the pouch of Douglas. Due to suspicion of uterine perforation during the suction evacuation, an emergency diagnostic laparoscopy was done. Intraoperatively, uterus was intact, but significant hemoperitoneum was present, originating from a ruptured right ampullary ectopic pregnancy. A right salphingectomy was done. Histopathological examination confirmed the molar tissue from the evacuation and, separately, Right side Tubal ectopic pregnancy. The patient recovered uneventfully and was followed up with serial beta-hCG monitoring for persistent gestational trophoblastic disease.

Discussion: This case shows the rare clinical presentation of a complete mole co-existing with a tubal ectopic pregnancy, an extremely rare combination. The preoperative diagnosis is extremely difficult, without high clinical suspicion. In this patient, the ultrasound findings of the molar pregnancy masked the adnexal pathology. The subsequent acute abdomen was attributed to uterine perforation. However, the presence of a thin endometrium and moderate free fluid on the second USS should have raised suspicion for a ruptured ectopic, given the patient had undergone a complete evacuation. This case shows the importance of having a high index of suspicion for heterotopic pregnancies, even when a primary intrauterine pathology is evident, especially in patients presenting with acute deterioration. The management shifted from a conservative approach for a suspected perforation to definitive surgical treatment for a life-threatening rupture.

Conclusion: This case highlights the diagnostic pitfall of attributing acute post-evacuation symptoms solely to a uterine perforation. A high index of suspicion for concurrent ectopic pregnancy is essential in patients with any pregnancy who present with acute abdomen and hemoperitoneum. A thorough adnexal assessment should be a mandatory part of the pre- operative evaluation in such cases to avoid delayed diagnosis of this potentially fatal condition.

EP120. MIXED GONADAL DYSGENESIS WITH XYY MOSAICISM IN A PHENOTYPIC FEMALE

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Introduction: Mixed gonadal dysgenesis (MGD) is a rare disorder of sex development, classically associated with 45, X/46, XY mosaicism. Phenotypic females carrying XYY mosaicism are rarer still. Finding Y-chromosome material matters clinically - dysgenetic gonads carry a substantial lifetime risk of gonadoblastoma and malignant transformation. We report a rare case of MGD associated with 47, XYY/46, XY/45, X mosaicism presenting as primary amenorrhoea.

Objectives: To describe the presentation, diagnostic evaluation and multidisciplinary management of a phenotypic female with rare XYY-containing mosaicism and the obstacles encountered in delivering it.

Case report: A 19-year-old phenotypic female presented with primary amenorrhoea and absent pubertal progression. She had short stature at 140 cm, Tanner stage II breast development and normal female external genitalia without virilisation. Pelvic ultrasonography showed a hypoplastic uterus with neither gonad visualised - magnetic resonance imaging likewise identified no gonadal tissue. Endocrine evaluation showed hypergonadotropic hypogonadism: follicle-stimulating hormone 76.6 mIU/mL, luteinizing hormone 26.5 mIU/mL, estradiol 117.3 pmol/L and anti-Müllerian hormone <0.1 ng/mL. Tumour markers were normal. Peripheral blood karyotyping demonstrated three cell lines - 47, XYY, 46, XY and 45, X - confirming mixed gonadal dysgenesis. A multidisciplinary discussion followed, involving gynaecology, paediatric endocrinology, clinical genetics, radiology and psychiatry. Exploratory laparoscopy with prophylactic gonadectomy was recommended, the anticipated risk of gonadal malignancy being the reason. The patient and her family declined - both further investigation and surgery - citing psychosocial concerns about the diagnosis. She was subsequently lost to follow-up.

Conclusion: XYY-containing mosaicism in a phenotypic female is an exceptionally rare cause of mixed gonadal dysgenesis. Here the diagnosis rested on karyotyping - neither imaging nor endocrine testing could have supplied it - and it carried a recommendation for gonadectomy that was never acted upon. It also illustrates how sociocultural stigma can become a significant barrier to evidence-based care and long-term follow-up in disorders of sex development.

EP121. MUCINOUS OVARIAN TUMORS IN SRI LANKA: STABLE HISTOLOGY OR CHANGING DISEASE ECOLOGY? A NATIONAL REGISTRY-BASED ANALYSIS (2015–2022)

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Background: Mucinous ovarian tumors form a distinct subgroup of epithelial ovarian malignancies and differ from serous tumors in their pathological features and clinical behaviour. Population-based information from South Asia remains limited. This study examined national trends in mucinous ovarian malignancies diagnosed in Sri Lanka between 2015 and 2022.

Method: Data were obtained from the Sri Lanka National Cancer Registry for female ovarian cancers (ICD-10 C56) diagnosed from 2015 to 2022. Histological subtypes were identified using ICD-O morphology codes. Mucinous cystadenocarcinoma (8470), papillary mucinous cystadenocarcinoma (8471) and mucinous adenocarcinoma (8480) were included in the analysis. Annual case numbers and their proportion among ovarian malignancies were described over time.

Results: A total of 643 mucinous ovarian malignancies were identified during the study period. The annual number of cases varied from

61 in 2015 to 105 in 2020 without demonstrating a sustained increasing or decreasing trend. Mucinous tumors accounted for approximately 6–10% of ovarian malignancies each year. Mucinous cystadenocarcinoma remained the predominant histological subtype throughout the study period. While classifications of serous ovarian carcinomas changed over time and the proportion of unspecified ovarian malignancies increased, the relative contribution of mucinous tumors showed little variation.

Conclusion: Mucinous ovarian tumors maintained a relatively stable histological profile in Sri Lanka between 2015 and 2022. Unlike the changes observed in serous ovarian carcinoma classification, the distribution of mucinous tumors remained largely unchanged across the study period. These findings provide national baseline information on mucinous ovarian malignancies and may serve as a reference for future epidemiological studies in the region.

Keywords: ovarian cancer; mucinous ovarian carcinoma; mucinous cystadenocarcinoma; ovarian histology; cancer registry; Sri Lanka; epidemiology

EP122. MULTIDISCIPLINARY CARE IN MATERNAL INTERSTITIAL LUNG DISEASE: CASE REPORT

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Objectives: To highlight the diagnostic challenged, multidisciplinary management strategies and feto-maternal outcomes of Interstitial Lung Diseases (ILD) which is a high-risk pregnancy state due altered respiratory physiology and challenges in drug optimization.

Case report: A 29 year old primigravida, with hypothyroidism presented at 23 weeks of gestation with exertional dyspnea and dry cough which was managed as a Lower respiratory tract infection needing intensive care. On further evaluation she was diagnosed with Connective Tissue Disorder (CTD)-ILD of Fibrotic Non-Specific Interstitial Pneumonia (NSIP) secondary to Sjogren's syndrome. HRCT showed bilateral basal predominant fibrosing ILD with traction bronchiectasis, no honey combing, anterior upper lobar fibrosis involving >20% of parenchyma. The 2D Echo shows normal biventricular function, mild Tricuspid Regurgitation and no pulmonary hypertension. Autoimmune screening was positive for anti-SSA/Ro, anti-SSB/La antibodies and Anti-Nuclear Antibody was negative. Baseline infectious disease screening remained negative.

She was closely monitored throughout the pregnancy with serial fetal growth monitoring, serial 2D Echocardiograms and symptom assessment which remained stable. Immunosuppressive therapy was deferred by the patient due to adverse fetal outcomes. Fetal Echo showed a structurally and functionally normal heart. Pulmonary functions assessed close to term which showed evidence of mild restrictive ILD, however repeat Pulmonary Function Tests were not done.

Following spontaneous onset of labour at term she had a second stage assisted normal vaginal delivery under epidural cover which ended uneventfully. The newborn was healthy (APGAR score 10) and had no newborn complications. The neonatal ECG and Echo were normal. Formula feeding was started during the first week of life, as continuing breast feeding would affect the drug management. A Jadelle implant was inserted following delivery for long term contraception. During the postpartum period, she was re-assessed and started immunosuppressive therapy with mycophenolate mofetil (MMF) to manage NSIP.

Discussion: From diagnosing to managing a CTD-ILD during pregnancy is challenging as physiological changes in pregnancy can affect diagnostic markers and can also modify the disease course. Moreover, anti-SSA/Ro, anti-SSB/La antibodies are associated with fetal heart blocks and can be overlapped with other auto immune diseases. However, patients with ILD can tolerate pregnancy depending on disease severity and optimal management.

Conclusion: Stable CTD-ILD patients can achieve successful pregnancy outcomes through close monitoring and multidisciplinary guided delivery. Although immunosuppressive therapy was started postpartum in this patient with stable and mild ILD, pregnancy safe immunosuppression can drastically improve clinical outcomes in patients with higher stages of ILD.

EP123. NEOADJUVANT CHEMOTHERAPY WITHOUT HISTOLOGICAL DIAGNOSIS FOR ADVANCED OVARIAN YOLK SAC TUMOUR: A MULTIDISCIPLINARY APPROACH

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Objectives: To describe the management of an advanced ovarian yolk sac tumour in a 13-year-old girl using neoadjuvant chemotherapy without pre-treatment histological confirmation, avoiding extensive primary surgery while facilitating fertility-preserving interval surgery.

Case report: A 13-year-old premenarchal girl presented with a 22-week-sized abdominopelvic mass. Imaging demonstrated a large predominantly solid ovarian tumour with omental and peritoneal deposits and mild-to-moderate ascites. Serum tumour markers revealed markedly elevated alpha-fetoprotein (AFP) of 29,600 ng/mL, CA-125 of 470 U/mL and β-hCG of 2.7 IU/L, strongly suggesting an ovarian yolk sac tumour. Following multidisciplinary team discussion, tissue diagnosis and primary cytoreductive surgery were deferred because of disseminated intra-abdominal disease, anticipated high surgical morbidity and concern that surgery would delay systemic treatment. Four cycles of neoadjuvant ifosfamide, etoposide and cisplatin (IEP) chemotherapy were administered, resulting in an excellent biochemical response (AFP 57 ng/mL, CA-125 22 U/mL and β-hCG 0.5 IU/L), together with marked radiological tumour regression. Interval fertility-preserving surgery was subsequently performed through a Turner-Warwick incision, avoiding a conventional midline laparotomy. Unilateral salpingo-oophorectomy and infracolic omentectomy were performed with preservation of the uterus and contralateral adnexa. Histopathological examination demonstrated extensive chemotherapy-induced tumour necrosis with residual mature teratomatous elements and no viable malignant germ cell tumour.

Discussion: Malignant ovarian germ cell tumours are rare but highly chemosensitive neoplasms affecting children and adolescents. Current management traditionally advocates histological confirmation before chemotherapy; however, published pediatric and gynecologic oncology series suggest that neoadjuvant platinum-based chemotherapy may be appropriate in carefully selected patients with characteristic imaging findings and markedly elevated AFP when biopsy or primary surgery would incur significant morbidity or delay treatment. This strategy may downstage disease, facilitate fertility-preserving surgery and reduce perioperative complications. Our case also demonstrates that a Turner-Warwick incision can provide satisfactory oncological access while avoiding a midline abdominal incision, with potential cosmetic and functional advantages in a young patient.

Conclusion: This case highlights that, in carefully selected adolescents with advanced ovarian yolk sac tumour, multidisciplinary decision-making may justify commencing neoadjuvant chemotherapy without pre-treatment histological confirmation when the clinical, radiological and biochemical diagnosis is compelling. This approach avoided high-risk primary cytoreductive surgery, achieved an excellent pathological response and enabled successful fertility-preserving surgery with no residual viable malignancy.

EP124. OCCULT CERVICAL CARCINOMA PRESENTING ONLY AS HAEMATOMETRA, MIMICKING A BENIGN PELVIC CYST

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Objectives: To report an unusual presentation of invasive cervical squamous cell carcinoma presenting as painful haematometra that radiologically mimicking a benign pelvic cyst in an elderly postmenopausal woman, highlighting the diagnostic challenges posed by cervical stenosis and severe vaginal atrophy.

Case report: An 80-year-old postmenopausal woman presented with lower abdominal pain with local tenderness without postmenopausal bleeding, vaginal discharge, weight loss or constitutional symptoms. Bedside and departmental transabdominal ultrasonography showed a unilocular cystic pelvic lesion with benign morphological features. Vaginal examination was limited by marked postmenopausal atrophy. Single-digit examination revealed a

normal-feeling cervix without contact bleeding; speculum visualization was not possible. Transvaginal ultrasonography was similarly limited, demonstrating only the cystic pelvic mass. Examination Under anaesthesia or preoperative tissue diagnosis was not considered as history was not suggestive of cervical or endometrial malignancy. Serum CA-125 was normal and the Risk of Malignancy Index (RMI) was low.

Following multidisciplinary discussion, exploratory laparotomy was performed for a suspected cyst accident. Intraoperatively, the presumed ovarian cyst was found deep within the pouch of Douglas obscuring pelvic anatomy. During mobilisation, the lesion ruptured, releasing altered blood and revealing a markedly distended uterus consistent with haematometra not an ovarian cyst; bilateral ovaries were small and atrophic. As the uterus had already been entered, a total abdominal hysterectomy with bilateral salpingectomy was performed and sent for pathological evaluation. The cervix appeared slender and elongated, likely stretched by haemetometra with no gross evidence of malignancy. The post-operative recovery was uneventful. Histopathology revealed invasive squamous cell carcinoma of the cervix with extension into the uterine corpus. She was referred to oncology team for staging and further management.

Discussion: A painful pelvic mass alone is an uncommon presentation for cervical carcinoma, especially when the haematometra appears as benign ovarian cyst radiologically. Upper cervical lesion and advanced cervical stenosis may obstruct uterine drainage and mask the typical symptom of postmenopausal bleeding. Severe vaginal atrophy may further limit clinical examination and transvaginal ultrasonography, increasing the risk of diagnostic error and inappropriate management.

Conclusion: Hematometra should be considered when a postmenopausal woman presents with a benign-appearing cystic pelvic mass, particularly when pelvic examination is limited and the uterus cannot be identified separately on ultrasonography. Examination under anaesthesia with tissue sampling or advanced imaging should be considered to facilitate accurate diagnosis.

According to local policy, institutional ethics approval was not required for single case report. Informed consent was taken from the patient for Publication.

EP125. OCCUPATIONAL AND LIFESTYLE DETERMINANTS OF SEMEN QUALITY AMONG MALE PARTNERS OF INFERTILE COUPLES

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Introduction: Occupational hazards and sedentary lifestyle go hand in hand with many adverse health outcomes including male reproductive health. Heat, chemicals, tobacco, alcohol and sedentary habits may adversely affect spermatogenesis and semen quality.

Objectives: To evaluate the association of occupational and lifestyle factors with semen parameters among male partners of infertile couples attending a tertiary care fertility centre.

Design: Cross-sectional study.

Method: Male partners of infertile couples attending subfertility clinic at Castle Street Hospital for Women during 2022 - 2023 were included. Data on occupation, smoking, alcohol consumption, physical activity, electronic device use, sleep patterns and medical history were extracted from clinical records. Semen volume, sperm concentration, motility, morphology and azoospermia status were assessed by standard laboratory methods. Descriptive and inferential analyses evaluated associations between occupational and lifestyle factors and semen quality; $p<0.05$ was considered significant.

Results: A total of 296 men were included (mean age 35.4 ± 6.0 years; mean body mass index 26.0 ± 4.8 kg/m^2). Common occupations were drivers, farmers, military personnel, mechanics, factory workers and labourers, with frequent prolonged heat and potential chemical exposure.

Current smoking was reported by 11.8% and alcohol consumption by 34.5%; frequent electronic device use and excessive mobile phone use by 37.8% and 44.6% respectively. Azoospermia occurred in 17.9% and abnormal

sperm morphology in 51.7%. Men exposed to occupational heat, agricultural environments, smoking and alcohol showed a greater burden of abnormal semen characteristics, including reduced sperm concentration and abnormal morphology. However, elevated follicle-stimulating hormone (FSH) showed a stronger association with severe infertility than lifestyle factors alone.

Conclusion: Exposure to occupational health hazards and sedentary lifestyles were common among infertile men and were associated with poor semen quality. Heat exposure, agricultural work, smoking, alcohol and excessive electronic device use may impair reproductive function. Routine assessment and evaluation on lifestyle/occupational risk factors and counselling for lifestyle modification to improve semen parameters hence the fertility, should be incooperated in to routine fertility practice. Further prospective studies may help to clarify causal relationships and quantify the impact of modifiable risk factors.

Keywords: male infertility; occupation; lifestyle factors; smoking; alcohol; semen quality.

EP126. OGILVIE SYNDROME FOLLOWING EMERGENCY CAESAREAN SECTION IN TWIN PREGNANCY: A DIAGNOSTIC CHALLENGE

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Objectives: Acute colonic pseudo-obstruction (Ogilvie syndrome) is a rare but potentially fatal postoperative complication characterized by massive colonic dilatation without mechanical obstruction. In obstetric patients, it is frequently misdiagnosed as postoperative ileus, delaying definitive management and increasing risk of perforation. This case highlights a rare postpartum case following emergency caesarean section in a twin pregnancy complicated by postpartum haemorrhage, emphasizing diagnostic challenges and evidence-based conservative management.

Case report: A 27-year-old primigravida with an uncomplicated monochorionic diamniotic twin pregnancy presented at 33+3 weeks with preterm prelabour rupture of membranes. Ultrasound showed a cephalic first twin (2.4 kg) and breech second twin (2.2 kg) with reduced amniotic fluid. Antenatal corticosteroids and tocolysis were administered. Later examination revealed meconium-stained liquor with reassuring cardiotocography and emergency caesarean section was performed. This was complicated with primary postpartum haemorrhage requiring uterotonics and Bakri balloon tamponade. On the first postoperative day, she developed worsening abdominal pain, progressive abdominal distension, nausea and vomiting. Examination revealed a distended, tender abdomen with absent bowel sounds. She remained afebrile and haemodynamically stable, with normal serum electrolytes. Digital rectal examination revealed an empty rectum. Abdominal X-ray demonstrated markedly dilated bowel loops with a caecal diameter of less than 12 cm. Abdominal ultrasound showed dilated bowel loops with no free fluid. Acute bowel obstruction was initially suspected and she was transferred to the intensive care unit. Flexible sigmoidoscopy to the hepatic flexure excluded a mechanical obstruction. Considering the clinical findings, normal biochemical profile and the absence of a mechanical cause, a diagnosis of Ogilvie syndrome was made. Conservative management with bowel decompression, analgesia, intravenous antibiotics and close observation resulted in complete resolution of symptoms by postoperative day six without the need for neostigmine or surgical intervention.

Discussion: Ogilvie syndrome should be considered in women with progressive abdominal distension following caesarean section. In this patient, exclusion of a mechanical cause and the absence of features suggestive of bowel ischemia allowed successful conservative management without escalation to pharmacological or surgical treatment.

Conclusion: Ogilvie syndrome, although uncommon, should be considered in patients with progressive abdominal distension following caesarean section. Early recognition and exclusion of mechanical obstruction may allow successful conservative management and avoid unnecessary intervention. As this is a single case report, the findings cannot be generalised, but the case highlights an important differential diagnosis in the postoperative obstetric patient.

EP127. OPTIMIZING PATIENT SAFETY: AN AUDIT OF CAPRINI VTE COMPLIANCE

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Introduction & Background: Venous thromboembolism (VTE), encompassing deep vein thrombosis (DVT) and pulmonary embolism (PE), remains a leading cause of preventable hospital morbidity and mortality. Clinical guidelines advocate for individual VTE risk stratification using validated tools, such as the Caprini Risk Assessment Model, to guide appropriate mechanical and pharmacological thromboprophylaxis.

Objectives: To assess baseline clinical compliance with the mandatory VTE risk assessment using the Caprini score. To evaluate adherence to prescribed thromboprophylaxis guidelines based on the calculated risk scores and to implement an educational intervention (clinical lecture) and measure subsequent improvement via a re-audit cycle.

Design: A prospective, two-cycle clinical audit (Baseline vs. Re-audit) of Gynaecological surgical patient records was conducted to determine compliance with recommended VTE risk stratification and prophylaxis practices.

Method: Hundred (n-100) patients per cycle were selected. Data collected included documented risk category (high or moderate) and whether mechanical and or pharmacological thromboprophylaxis was provided according to the patients' risk assessment.

Results: Initial Audit revealed significant gaps clinical documentation and guideline adherence. Only 42 % of patients formal Caprini score documented. Appropriate pharmacological prophylaxis according to guidelines was given to only in 61%.Appropriate mechanical prophylaxis were given only 55% of patients. Accurate timing of 1st dose was documented in only in 68% of cases. Following the baseline cycle, a targeted clinical lecture and interactive workshop on VTE risk calculation and hospital protocols were conducted for the clinical staff. A re-audit of a further 100 patients demonstrated a marked improvement across all key performance indicators Formal Caprini score documentation improved up to 94%.Appropriate pharmacological and mechanical prophylaxis were given for 91% and 90% respectively. Accurate timing of 1st dose improved up to 95%.

Conclusion: The baseline audit highlighted that a simple lack of structured documentation often translates into suboptimal patient care. Relying on "clinical intuition" rather than the formal Caprini framework led to the underprophylaxis of high-risk patients.

The dramatic improvement observed in the re-audit demonstrates that targeted educational interventions are highly effective in modifying clinical behavior. Staff education removed the ambiguity surrounding risk point accumulation.

EP128. OVARIAN HYPERTHECOSIS WITH ALOPECIA AND HIRSUTISM: CLINICAL PRESENTATION AND SURGICAL CURE

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Objectives: Ovarian hyperthecosis (OH) is one of the rare causes of hyperandrogenism in postmenopausal women. The prevalence in the population is less than 1%, but it may be as high as 10% in postmenopausal women with excess androgens. OH resembles androgen-producing tumours in its presentation and mimics them. It is manifested clinically with hyperandrogenism, obesity, hypertension, impaired glucose tolerance and rarely, virilization. This case underscores the diagnostic procedure and also demonstrates the efficacy of bilateral salpingo-oophorectomy to attain biochemical and clinical remission.

Case report: An obese 55-year-old woman of three children with a medical history of diabetes and hypertension was referred to the endocrine clinic due to hair loss and hirsutism. She had attained her menarche at 12 years of age with regular cycles and was on copper intrauterine device for contraception. She did not have any history of hormone intake. She denies recent weight gain, postural symptoms, proximal muscle weakness, easy bruising and recurrent infections.

Her symptoms worsened after six months. On examination, she had male pattern hair loss but was normal with respect to voice, cushingoid features and no abdominal masses. Her Modified Ferriman-Gallwey (mFG) score was 17 (moderate to severe). Her testosterone level was grossly elevated (10.6 nmol/L; reference range 0.198–2.67) along with low DHEAS levels. LH was 17.3 and FSH 53. MRI showed enlarged ovaries with stromal hypertrophy but no masses in adrenals and ovaries.

Initially, she was treated dermatologically with finasteride and minoxidil topically, which failed. Then, she was referred for surgery and total abdominal hysterectomy with bilateral salpingo-oophorectomy was done. Intraoperatively, enlarged ovaries with atrophic uterus were found. The histology showed ovarian stromal hyperplasia of the right ovary. At present, she is now 3 months post-operative and improved her clinical symptoms drastically with testosterone level (0.19 nmol/L at three months).

Discussion: OH is a condition that should be kept in mind in patients presenting with progressive hyperandrogenism during the postmenopause period after excluding tumors of the adrenal glands and ovaries. (Cushing's syndrome, late – onset (Non classic) Congenital Adrenal Hyperplasia, Androgen – secreting Ovarian Tumors) Elevated levels of testosterone along with low DHEAS and bilateral stromal enlargement of ovaries serve as crucial diagnostic pointers. Anti-androgens may offer limited relief of symptoms, but removal of the ovaries via bilateral salpingo-oophorectomy is still the best therapeutic approach because it removes the source of androgen secretion.

Conclusion: This case report demonstrates that ovarian hyperthecosis is one of the possible diagnoses in patients with hyperandrogenism during the postmenopause period. Bilateral salpingo-oophorectomy is an effective method of treatment for this pathology as the patient's biochemical profile normalized rapidly after surgery and she experienced a marked improvement in her condition.

EP129. OVARIAN STEROID CELL TUMOUR: A RARE CAUSE OF PROGRESSIVE VIRILIZATION

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Introduction and Objectives: Virilism is the development of male secondary sexual characteristics in females due to excess androgen exposure. Hyperandrogenism affects 5–10% of women of reproductive age. Persistent or progressive virilising features require evaluation to exclude polycystic ovarian syndrome, non-classical adrenal hyperplasia, Cushing's syndrome (CS), adrenal and ovarian tumours. Ovarian steroid cell tumours, not otherwise specified (OSCT-NOS) is a rare type of sex cord-stromal tumour. They represent 60% of steroid cell tumours and less than 0.1% of all ovarian neoplasms. Here, we report a case of a premenopausal woman with virilisation secondary to OSCT-NOS.

Case report: A 43-year-old primiparous woman presented with progressive features of virilisation and secondary amenorrhoea for four years. Physical examination revealed severe hirsutism involving the face, anterior chest, abdomen and thighs (modified Ferriman–Gallwey score: 33/36). Androgenic alopecia, breast atrophy and clitoromegaly were present. No signs of CS were noted. Pelvic examination demonstrated an anteverted uterus with normal bilateral adnexae.

Initial investigations showed markedly elevated total testosterone levels (26 nmol/L). Sex hormone profile, including dehydroepiandrosterone (DHEA) was within normal limits. Normal results in overnight dexamethasone suppression test excluded CS. Both transvaginal ultrasonography and pelvic magnetic resonance imaging demonstrated polycystic ovaries. Contrast-enhanced computed tomography revealed a right-sided bulky ovary with heterogeneous enhancement. Both adrenal glands appeared normal. To localise and confirm the source of excess androgen production, bilateral ovarian venous sampling was performed. Total testosterone gradient between the left

and right ovarian venous samples suggested a neoplastic source of testosterone involving both ovaries. Right-to-left ovarian vein testosterone ratio > 5.687 strongly suggested that the neoplastic lesion was more likely to be located on the right side.

The patient subsequently underwent total laparoscopic hysterectomy with bilateral salpingo-oophorectomy. Histopathological examination revealed a right-sided OSCT-NOS. Sertoli cells, luteinized cells and malignant features were not identified. Testosterone levels normalized after two weeks from surgery. Regression of hirsutism and clitoromegaly were noted at three months.

Discussion: Clinical history, examination and baseline androgen levels are vital steps of evaluation. However, accurate localization of virilizing tumours often requires imaging and dynamic ovarian/adrenal assessment. Histopathological features such as mitoses, nuclear atypia, necrosis and hemorrhage are important to exclude malignancy. Even without pathological malignancy, some tumours behave aggressively. Therefore, regular follow-up is essential.

Conclusion: Patients presenting with virilization should undergo a systematic evaluation to determine the source of excess testosterone. Selective venous sampling is an important tool to be utilised in the presence of diagnostic uncertainty.

EP130. PALLIATIVE APPROACH FOR A PATIENT WITH RECURRENT ENDOMETRIAL CARCINOMA

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Objectives: In recurrent endometrial carcinoma, a multidisciplinary palliative approach addressing physical, psychological, social and spiritual needs are prioritized over curative treatment to enhance the quality of life for both the patient and family members.

Case Description Mrs. W, the second eldest of four sisters and married with one son, was diagnosed with endometrial carcinoma in 2023. She underwent surgery and first-line chemotherapy. In 2025, rising CA125 levels prompted second- and third-line chemotherapy. Her course was complicated by obstructive uropathy, requiring JJ-stenting and right-lower-limb deep-vein thrombosis (DVT). Despite optimal analgesia, severe right lower back pain radiating to the leg persisted; MRI revealed a retroperitoneal mass. The gynecological-oncology team deemed surgery difficult and referred to palliative care with symptomatic management for pain with regular subcutaneous morphine and DVT with anticoagulants.

Her primary caregiver was her elder sister—a widow who had lost her 20-year-old son. One sister survived sexual assault by a family member. Mrs. W deeply worried about her safety after her death. Extensive counselling with consents from patient and victim addressed this concern ensured the victim's safety. During her terminal phase, virtual pirith chanting was arranged via smartphone. She passed away peacefully, with minimal pain and anxiety, surrounded by family.

Discussion: Palliative care offers holistic support for life-limiting illnesses when cure is no longer possible, benefiting both patients and families by enhancing quality of life. Mrs. W's advanced endometrial carcinoma caused physical distress: obstructive uropathy, DVT, pain; alongside psychosocial distress: past family trauma which were assessed and managed promptly, ensuring her comfort and dignity, while supporting the family member's traumatic past. Consequently, she experienced a peaceful, painless death surrounded by loved ones.

Conclusion: This case highlights that palliative care is not about abandoning patients or losing hope for families. Rather, it improves quality of life and alleviates the physical, psychosocial and spiritual burdens. It involves a multidisciplinary team support from diagnosis through the terminal phase and beyond the death. Ultimately, it improves the quality of life of both the patient and her family throughout the illness.

EP131. PAPILLARY THYROID CARCINOMA IN STRUMA OVARII WITH SYNCHRONOUS THYROID MICROCARCINOMA

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Objectives: Struma ovarii undergoes malignant transformation in fewer than 5% of cases, papillary thyroid carcinoma (PTC) predominating. Where PTC is found in both ovary and thyroid, assigning the primary site is contentious. We describe such a case and the reasoning behind our attribution.

Case report: A 31-year-old nulliparous woman presented with one month of left lower abdominal pain, dyspepsia and vomiting, without distension. Pelvic ultrasound showed a complex right ovarian cyst - 7 × 5 × 4 cm, mixed benign and malignant IOTA descriptors. Tumour markers were unremarkable - CA-125 9.8 U/mL, AFP 22 IU/mL, LDH 56 IU/L, β-hCG 13 IU/L.

She underwent laparoscopic right salpingo-oophorectomy with intact in-bag retrieval - rest of the pelvis and abdomen normal, histology a 4 cm PTC within struma ovarii, thyroid tissue over 50% of the specimen, capsule intact. Thyroid assessment followed - TSH 1.3 µIU/mL, an 11 mm indeterminate left nodule on ultrasound, cytology Bethesda IV. Total thyroidectomy was undertaken - multifocal classical PTC, 4 × 2 mm left and 1 × 0.5 mm right, no extrathyroidal extension or lymphovascular invasion, nodes negative (pT1a(m) pN0). Radioiodine ablation was given - iodine-131 whole-body scanning clear, thyroglobulin 4 ng/mL. She remains euthyroid at six months on levothyroxine 125 µg daily, TSH suppressed below 0.1 µIU/mL.

Discussion: Three explanations compete - ovarian primary, ovarian metastasis from a thyroid source, or two independent primaries. Against metastasis: the ovarian lesion was bulky, unilateral and confined to thyroid tissue, whereas the thyroid foci were millimetric and incidental, with no disseminated disease at any site. We regard this as primary malignant struma ovarii, the thyroid microcarcinomas being coincidental.

Treatment was individualised. Salpingo-oophorectomy alone preserved fertility, the disease being unilateral and capsule-confined. The Bethesda IV nodule indicated thyroidectomy irrespective of the ovarian pathology; proceeding to total thyroidectomy with radioiodine, rather than hemithyroidectomy, is what made thyroglobulin and whole-body scan surveillance possible.

Conclusion: Tumour bulk, laterality and the confinement of carcinoma to ovarian thyroid tissue favoured the ovary as primary site over metastasis from millimetric thyroid foci. Total thyroidectomy with radioiodine addressed the Bethesda IV nodule and set a surveillance baseline, thyroglobulin reaching 4 ng/mL by six months. Recurrence is reported beyond five years, so surveillance should extend well past conventional endpoints.

EP132. PARTURIENT WITH KLIPPEL-FEIL SYNDROME

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Objectives: Tertiary Care and Multidisciplinary Management of a pregnant patient with Klippel Feil Syndrome

Case report: This is a case of a 29-year-old primigravida at 39 weeks of gestation with defaulted follow up and already diagnosed with Klippel–Feil syndrome which was diagnosed in childhood. She was admitted for delivery which required multidisciplinary management.

She had a history of a large perimembranous ventricular septal defect repaired surgically at eight years of age, with follow-up showing a small residual muscular VSD, preserved ventricular function (EF ~60%) and no pulmonary hypertension. According to medical records she had no neurological deficits but her congenital cervical vertebral fusion posed potential difficulties for airway management and anaesthesia. After defaulting antenatal follow-up and presenting in the third trimester, evaluation revealed a single live fetus with appropriate fetal growth and reassuring cardiotocography.

She was hemodynamically stable and asymptomatic, NYHA class I–II, with mild exertion-

al dyspnea and no evidence of cardiac issues or arrhythmia. Echocardiography demonstrated preserved biventricular function, mild–moderate tricuspid regurgitation and no Eisenmenger physiology.

Multidisciplinary consultation recommended delivery in a tertiary centre with cardiac support due to the potential risk of peripartum cardiomyopathy and anaesthetic challenges related to cervical spine immobility.

Discussion: Klippel-Feil syndrome is a very rare congenital disorder (1 in 40,000–42,000 births) characterized by fusion of cervical vertebrae, typically presenting with a short neck, low hairline and restricted neck movement. There are three types of which Type I is the Fusion of multiple cervical and upper thoracic vertebrae and Type II is Fusion of one or two cervical vertebrae and Type III is Cervical vertebral fusion accompanied by fusion in the lower thoracic or lumbar spine. It results from genetic mutations (e.g., GDF6, GDF3, MEOX1) or sporadic causes and may be inherited in dominant or recessive patterns. It is associated with anomalies such as scoliosis, renal defects, hearing loss and congenital heart disease. Patients are at risk of neurological injury due to cervical instability and spinal canal narrowing. Cardiovascular abnormalities, including congenital heart and valvular disease, are common.

Conclusion: Klippel–Feil syndrome in pregnancy is crucial and should be managed in a tertiary care setting due to risks of neurological injury from cervical spine fusion and atlanto-occipital instability, which also complicate anaesthesia. Patients who have associated congenital cardiac disease further increase the risk of peripartum cardiomyopathy and haemodynamic instability during delivery and postpartum. Pristine care requires a multidisciplinary team including obstetricians, anaesthesiologists, cardiologists and neonatologists. Careful antenatal surveillance and early delivery planning are essential and patient education from pre conceptional era is important as it is to ensure understanding of potential maternal and fetal complications and the need for close follow-up throughout pregnancy and the peripartum period.

EP133. PERITONEAL CSF PSEUDOCYST MASQUERADING AS AN ADNEXAL MASS IN A PERIMENOPAUSAL WOMAN: A CASE REPORT

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Background: Peritoneal cerebrospinal fluid (CSF) pseudocysts are an uncommon complication of ventriculoperitoneal (VP) shunting, with a reported incidence of 0.25–10%. They typically present with abdominal pain or symptoms of shunt malfunction and may closely mimic gynecological pathology in women, leading to diagnostic uncertainty and potentially unnecessary surgical intervention. We report a case of a peritoneal CSF pseudocyst presenting as an adnexal mass in a perimenopausal woman, highlighting the importance of multidisciplinary evaluation.

Case report: A 48-year-old perimenopausal woman presented to the gynecology clinic with a three-month history of lower abdominal pain and bloating. She denied fever, nausea, weight loss, or gastrointestinal symptoms. Her menstrual cycles were irregular, with occasional heavy menstrual bleeding. She had undergone a right temporoparietal craniotomy for an atypical meningioma two years earlier, complicated by postoperative hydrocephalus requiring ventriculoperitoneal shunt insertion. The shunt had subsequently been ligated following clinical stabilization.

Physical examination revealed mild lower abdominal tenderness without a palpable pelvic mass. Laboratory investigations, including complete blood count, inflammatory markers and tumour markers (CA-125, CEA, CA 19-9 and AFP), were within normal limits. Transvaginal ultrasonography demonstrated a well-defined, thin-walled, anechoic cystic lesion measuring 8 × 6 cm in the right adnexal region without septations or internal vascularity, suggesting a benign ovarian cyst. Contrast-enhanced computed tomography of the abdomen and pelvis identified a well-circumscribed fluid-filled collection adjacent to the right ovary, closely related to the ligated distal end of the VP shunt, with no radiological evidence of malignancy.

Given the patient's neurosurgical history, the case was discussed at a multidisciplinary meeting involving gynecologists, neurosurgeons and general surgeons. A diagnosis of peritoneal CSF pseudocyst was considered the most likely explanation. As there were no signs of shunt malfunction or neurological deterioration, ultrasound-guided aspiration was performed instead of surgical excision. Approximately 150 mL of clear, colourless fluid was aspirated. Fluid analysis demonstrated biochemical characteristics consistent with CSF, with no evidence of infection or malignancy. The patient experienced immediate symptom resolution and follow-up imaging at six months confirmed complete resolution without recurrence.

Conclusion: Peritoneal CSF pseudocysts should be included in the differential diagnosis of cystic adnexal masses in women with a current or previous history of VP shunting, even after shunt ligation. Thorough clinical history, careful radiological interpretation and multidisciplinary collaboration are essential for establishing the correct diagnosis and avoiding unnecessary gynecological surgery. Ultrasound-guided aspiration represents a safe and effective minimally invasive treatment option in appropriately selected patients.

EP134. PERITONEOCUTANEOUS FISTULA FOLLOWING CAESAREAN SECTION IN A PATIENT WITH SEVERE PRE-ECLAMPSIA AND MASSIVE ASCITES: A CASE REPORT

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Background: Peritoneocutaneous fistula is usually a rare complication where there is an abnormal communication between the peritoneal cavity and the skin. It is quite unusual following caesarean section and is typically associated with prolonged peritoneal drainage, persistent ascites, hypoalbuminaemia, tissue oedema and impaired wound healing. We report a rare case of peritoneocutaneous fistula developing through a previous intraperitoneal drain site following caesarean section in a patient with severe preeclampsia and suspected placenta accreta spectrum (PAS).

Case report: A 33-year-old primigravida with an IVF-conceived dichorionic diamniotic twin pregnancy developed pregnancy-induced hypertension at 30 weeks. She subsequently developed severe preeclampsia resulting in nephrotic-range proteinuria (24-hour urinary protein 8084 mg/day), hypoalbuminaemia (serum albumin 2.1 g/dL), progressive generalised oedema, worsening renal function, persistent hyperkalaemia and massive ascites. Her pregnancy was further complicated by anterior placenta previa with suspected PAS in the background of hysteroscopic resection of submucosal fibroids. Following multidisciplinary planning involving obstetrics, anaesthesia, nephrology, haematology and neonatology, an elective lower-segment caesarean section was performed at 33+6 weeks. Massive ascitic fluid (6 litres) drained intraoperatively and two intraperitoneal drains were inserted. Postoperative intensive care was arranged with magnesium sulphate, antihypertensive therapy, albumin replacement, diuretics, thromboprophylaxis and blood product transfusion. High drain output in the first week gradually decreased and the drain was removed on day 10. Persistent serous discharge was identified from a previous drain site on postoperative day 17. Abdominal ultrasound demonstrated a peritoneocutaneous fistula. Initial conservative management with aseptic dressing and antibiotics failed. Responded to complete Surgical excision of the epithelial tract and primary closure.

Conclusion: Peritoneocutaneous fistula should be considered in women with persistent postoperative drainage following caesarean section, particularly in the presence of massive ascites and prolonged peritoneal drainage. Early recognition, appropriate imaging and timely surgical intervention with correction of underlying metabolic abnormalities are essential for successful treatment. This case expands our understanding of unusual obstetric complications and highlights the importance of vigilant postoperative surveillance and individualised management strategies in high-risk pregnancies.

EP135. PERSISTENT CAESAREAN SCAR PREGNANCY DESPITE DECLINING B-HCG: A DIAGNOSTIC AND MANAGEMENT CHALLENGE

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Objectives: To highlight the difficulty in assessing treatment response in a caesarean scar pregnancy when serum β-hCG declines but symptoms and abnormal ultrasound findings persist.

Case report: A 30-year-old gravida 3 para 2 with one previous caesarean section presented at approximately 12 weeks of gestation with sudden heavy vaginal bleeding and haemorrhagic shock. Her pulse rate was 120 beats/minute, blood pressure was 80/50 mmHg and haemoglobin was 7.1 g/dL. She was resuscitated and transfused four units of packed red cells. Initial low-resolution ultrasonography suggested retained products of conception, with a bulky anterior lower uterine segment.

Ultrasound-guided suction evacuation was attempted. Blood clots were removed from the uterine cavity, but tissue deeply embedded within the previous caesarean scar could not be removed and brisk bleeding occurred. The procedure was abandoned and bleeding was controlled using a condom-catheter balloon inflated with 300 mL and retained for 24 hours.

Serum β-hCG was 5,377 IU/L at presentation. After confirming normal renal and liver function, a single intramuscular dose of methotrexate 50 mg/m^2 was administered. Although the β-hCG gradually declined to approximately 119 IU/L, mild vaginal bleeding continued.

Repeat transvaginal ultrasonography showed an empty uterine cavity and cervical canal but demonstrated a persistent 5 × 7 cm highly vascular mass at the previous caesarean scar. Despite the marked fall in β-hCG, the persistent bleeding, large vascular mass and thin residual myometrium raised concern that the pregnancy had not completely resolved. As reliable long-term follow-up was also uncertain, definitive surgery was undertaken 32 days after the attempted evacuation.

At laparotomy, the bladder was carefully separated from the scar and the mass was excised with preservation of the uterus. The uterine defect was then repaired. Estimated blood loss was 400 mL. Histology confirmed chorionic villi and trophoblastic tissue. Serum β-hCG became undetectable one week after surgery and ultrasonography at one month showed satisfactory scar healing.

Discussion: This case shows that a declining β-hCG may not always reflect complete resolution of a caesarean scar pregnancy. Persistent symptoms and Doppler evidence of vascular trophoblastic tissue remain clinically important, even when biochemical findings appear reassuring.

In this case, persistent bleeding and Doppler vascularity were more clinically significant than the falling β-hCG and led to timely definitive treatment with preservation of the uterus.

Conclusion: Treatment response in caesarean scar pregnancy should not be assessed using β-hCG alone. Persistent bleeding, residual mass and Doppler vascularity should prompt careful reassessment and consideration of definitive treatment.

EP136. PERSISTENT CLEAR CELL AND ENDOMETRIOID OVARIAN CARCINOMAS IN SRI LANKA (2015–2022): POPULATION-LEVEL HISTOLOGICAL SIGNALS OF ENDOMETRIOSIS-ASSOCIATED OVARIAN CARCINOGENESIS

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Background: Clear cell and endometrioid ovarian carcinomas are biologically distinct epithelial ovarian malignancies strongly associated with endometriosis-related carcinogenic pathways. Population-level epidemiological data regarding these histological subtypes remain limited in low- and middle-income countries (LMICs). This study evaluated temporal trends in clear cell and endometrioid ovarian carcinomas in Sri Lanka between 2015 and 2022 using national cancer registry data.

Method: A retrospective descriptive epidemiological analysis was conducted using Sri Lanka National Cancer Registry data from 2015–2022. Female ovarian malignancies (ICD-10 C56) were analyzed using ICD-O morphology classifications. Clear cell adenocarcinoma (8310) and endometrioid adenocarcinoma (8380) were extracted annually. Temporal trends, relative proportions and compari-

sons with other epithelial ovarian subtypes were evaluated descriptively.

Results: A total of 231 clear cell ovarian carcinomas and 469 endometrioid ovarian carcinomas were identified during the study period. Clear cell carcinoma frequencies remained relatively stable, ranging from 16–37 annual cases, while endometrioid carcinoma ranged from 48–82 cases annually. Endometrioid carcinoma demonstrated notable peaks in 2018 (72 cases) and 2021 (82 cases). Unlike serous ovarian carcinomas, which demonstrated major terminology transition patterns during the study period, clear cell and endometrioid tumors showed comparatively stable longitudinal representation. Combined clear cell and endometrioid tumors consistently accounted for approximately 7–11% of ovarian malignancies annually. The persistence of these histological patterns occurred despite substantial fluctuations in serous carcinoma subclassification and increasing NOS ovarian malignancies.

Conclusion: Clear cell and endometrioid ovarian carcinomas demonstrated persistent representation within the Sri Lankan ovarian cancer landscape between 2015 and 2022. The relative longitudinal stability of these endometriosis-associated histological subtypes may represent indirect population-level histological signals compatible with endometriosis-associated ovarian carcinogenesis in Sri Lanka. These findings contribute important baseline epidemiological data regarding ovarian cancer subtype diversity in South Asia.

Keywords: ovarian cancer; clear cell carcinoma; endometrioid carcinoma; endometriosis-associated ovarian carcinoma; ovarian histology; Sri Lanka; epidemiology

EP137. PETHIDINE ADMINISTRATION FOR LABOUR ANALGESIA – A CLINICAL AUDIT

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Introduction: Pethidine remains the most commonly available pharmacological method of labour analgesia in many maternity units in Sri Lanka. Despite its analgesic efficacy, it may be associated with neonatal adverse effects, including respiratory depression, prolonged drowsiness and the need for resuscitation. Standard protocols and guidelines are not commonly followed in the use of pethidine during labour. This clinical audit was conducted to evaluate current practice of pethidine use for labour analgesia and to assess the associated adverse outcomes at District General Hospital Vavuniya as part of a quality improvement process.

Objectives: To determine the prevalence of Pethidine use among labouring women, Evaluate the rate of possible side effects and their management options Evaluation of documentation, informed consent and identify other gaps in practice

Design: A retrospective clinical audit was conducted over a 3-month period (July–September 2025) in the Obstetric Unit of DGH Vavuniya.

Method: Patient records of 329 women admitted to the labour ward were reviewed. Among them, 218 women who received pethidine were analysed according to the number of doses administered, documentation of timing and stage of labour and informed consent. Neonatal outcomes were assessed based on resuscitation requirements, level of resuscitation, naloxone administration and associated other risk factors of resuscitated neonates. Findings were compared with local and international best practice standards.

Results: Of 218 women, 178 (81.7%) received a single dose of pethidine and 40 (18.3%) received two doses. No resuscitation was required in 187 cases (85.8%), while 20 neonates (9.2%) required resuscitation and documentation was unavailable in 11 cases (5.0%). Among resuscitated neonates, 13 (65%) required basic resuscitation, 5 (25%) required ventilatory support and the level was unspecified in 2 (10%). None received naloxone. Neonates of mothers who received two doses had a higher resuscitation rate compared with those receiving one dose (25% vs 5.6%). Documentation was suboptimal, with cervical dilatation recorded in 84.3% and administration time in 79.7%. Consent, maternal and fetal observations and Apgar scores were frequently incompletely documented.

Conclusion: This audit identified high pethidine utilisation (66.3%), absence of alternative

analgesic methods, documentation deficiencies and an association between higher doses and increased neonatal resuscitation requirements. Implementation of standardized protocols, improved documentation practices and a repeat audit are recommended.

EP138. PITUITARY APOPLEXY PRESENTING AS ACUTE POSTPARTUM HEADACHE FOLLOWING UNCOMPLICATED VAGINAL DELIVERY: A CASE REPORT

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Objectives: To report a rare case of pituitary apoplexy presenting as acute postpartum headache following an uncomplicated vaginal delivery and to emphasize the importance of considering this rare disorder as a differential diagnosis

Case report: A 43 years old second-gravida with uncomplicated vaginal delivery with epidural analgesia presented with gradually worsened headache mainly involved in occipital region. It was associated with photophobia, transient double vision and phonophobia without any other neurological deficit. Examination findings were unremarkable including complete neurological examination. Headache persisted despite Initial conservative management with intravenous fluids and simple analgesics which lead to the extensive investigations. CECT Venogram was performed on postpartum day three, which showed enlarged pituitary gland with heterogenous contrast enhancing areas in superior portion indicative of blood density. An urgent MRI brain was performed on postpartum day four which confirmed the diagnosis of pituitary apoplexy due to pituitary gland acute hemorrhage which causes mild compression on optic chiasm. The visual field assessment was normal and serum cortisol and TSH levels were normal. The patient was managed conservatively involving a multidisciplinary team with close neurological, cardiovascular and endocrine monitoring. Her symptoms were gradually improved and completely resolved by postpartum day seven without any neurosurgical interventions.

Discussion: The causes for postpartum headache is extensive and includes post - dural puncture headache, which has initially raised the possibility in this patient with history of epidural analgesia. Pituitary apoplexy is rare, yet important differential diagnosis in postpartum headache, as pregnancy increases the susceptibility due to the physiological enlargement of the pituitary gland. Low threshold for neuroimaging must be considered to exclude neurological causes and Magnetic resonance imaging remains the gold standard for diagnosing pituitary apoplexy. Prompt evaluation with a multidisciplinary team including close monitoring of endocrine abnormalities must be carried out. Neurosurgical interventions are not always necessary if the patient does not develop compressive signs including visual disturbance and other neurological deficit. However long-term endocrine follow up is necessary as hypopituitarism could occur in later life.

Conclusion: Clinically significant acute postpartum headache could be the initial presentation of Pituitary apoplexy. Following initial evaluation prompt multidisciplinary approach could be life-saving and conservative management with endocrine assessment is appropriate for patients without visual impairment or neurological deterioration.

Pituitary apoplexy is a rare but important differential diagnosis in women presenting with acute postpartum headache. Early neuroimaging with MRI, prompt endocrine evaluation and multidisciplinary management are essential for timely diagnosis and optimal outcomes. Conservative management is an appropriate treatment strategy in carefully selected patients without visual or neurological compromise.

Keywords: Pituitary apoplexy, postpartum headache, vaginal delivery, pituitary hemorrhage,

EP139. PLACENTA PERCRETA WITH BLADDER INVASION IN SECONDARY CARE CENTRE

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Objectives: To emphasize the importance of early antenatal diagnosis, multidisciplinary planning and timely surgical intervention in achieving a favourable maternal outcome in a patient with placenta percreta involving the urinary bladder and to indicate that selected cases can be successfully managed in a well-prepared peripheral obstetric units.

Case report: A 37-year-old lady with two previous caesarean sections was diagnosed at 28weeks' gestation with major placenta praevia and suspected placenta accreta spectrum(PAS) disorder on routine ultrasound. After confirmation by a senior obstetrician, extensive counselling and multidisciplinary planning was done. Maternal haemoglobin was optimised, antenatal corticosteroids were given. The anaesthetic, neonatal, intensive care, blood bank and theatre teams were informed. An elective caesarean delivery was performed at 36weeks' gestation. Intraoperatively, extensive placenta percreta involving the entire anterior uterine wall with partial bladder invasion was identified. A subtotal hysterectomy was performed without attempting placental removal. A 4cm bladder defect was repaired using a two-layer watertight closure. The estimated blood loss was 3L, requiring transfusion of packed red blood cells, fresh frozen plasma, cryoprecipitate and platelets. The patient had an smooth recovery following 48hours of intensive care. placenta percreta confirmed by histopathological examination.

Discussion: Placenta percreta is associated with significant maternal morbidity. Because of massive haemorrhage and possible involvement of adjacent pelvic organs. This case shows that early diagnosis, careful preoperative preparation, availability of adequate blood products and coordinated multidisciplinary actions can significantly improve outcomes, reduce maternal morbidity and mortality even in extensive involvement. It also emphasizes that appropriately arranged peripheral obstetric units with experienced teams are competent on managing selected cases safely.

Conclusion: Placenta percreta, although rare, life-threatening obstetric emergency. In Sri Lanka, specialized placental disorder management units are available. However, transferring all patients from peripheral units to these centres may lead to peripheral consultants loosing their skills in managing PAS disorders. Also, other staff, including the anaesthesia team and theatre nurses, may lack training in emergency situations if all cases are managed exclusively at specialized units. Management should also be possible in peripheral obstetric units, as PAS disorders may not diagnosed until delivery or, despite antenatal diagnosis, may present unexpectedly with severe bleeding, fetal distress, or maternal conditions that make transfer impossibility. Therefore, maintaining the efficiency to manage PAS disorders in peripheral units is essential.

EP140. PLANNED EXIT VERSUS EMERGENCY AIRWAY RESCUE FOR FETAL CERVICAL CYSTIC HYGROMA: A THREE-CASE SERIES FROM SRI LANKA

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Introduction: A large fetal cervical cystic hygroma may obstruct the airway completely at birth. Survival then turns on delivery planning rather than airway skill alone. The ex-utero intrapartum treatment (EXIT) procedure secures the airway while uteroplacental gas exchange continues - a physiology that cannot be recreated once it is lost. Reports from low-resource settings remain few. We describe three cases - two planned, one not - and what separated them.

Objectives: To describe outcomes in three fetuses with cervical cystic hygroma managed by EXIT and to identify what determined the success - or failure - of airway establishment in a resource-limited setting.

Method: We reviewed three consecutive pregnancies complicated by prenatally diagnosed fetal cervical cystic hygroma, managed

at a tertiary referral centre between 2018 and 2026. The variables analysed were maternal characteristics, antenatal imaging, multidisciplinary planning, intrapartum management, airway intervention and neonatal outcome.

Case report: Two pregnancies proceeded as planned - elective caesarean delivery with EXIT at 37 weeks, after multidisciplinary coordination. Both airways were stabilised with uteroplacental circulation maintained throughout. Neither neonate sustained hypoxic compromise. One went on to surgical excision, the other to sclerotherapy.

The third fetus had a large cervical cystic hygroma with hydrops fetalis and suspected syndromic pathology. Elective EXIT had been planned. Spontaneous labour at 36+3 weeks intervened - vaginal delivery followed before the team could be assembled. Emergency operation on placental support (OOPS) was attempted. Uteroplacental circulation could not be maintained - the physiology on which EXIT depends had already been lost - and the airway could not be established. The outcome was stillbirth.

Conclusion: What separated the two survivals from the death was not airway expertise. It was whether EXIT physiology remained intact when the airway was approached - preserved by both planned deliveries at 37 weeks, lost in the unplanned vaginal delivery at 36+3 weeks and recovered afterwards by no manoeuvre available to us. EXIT is feasible in a Sri Lankan tertiary centre despite limited resources, provided multidisciplinary preparation is complete before labour begins. Early referral and the anticipation of preterm labour are what make that preparation possible

EP141. POSSIBLE CAESAREAN SCAR ECTOPIC PREGNANCY: DIAGNOSTIC CHALLENGES

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Objectives: To highlight the diagnostic challenges of caesarean scar ectopic pregnancy with atypical ultrasound findings and to highlight management when the diagnosis remains uncertain.

Case report: A 37-year-old woman, with two previous lower segment caesarean sections, presented with per-vaginal bleeding at period of gestation of 8 weeks. Transvaginal ultrasonography demonstrated a viable pregnancy which was in the lower uterine cavity next to the previous caesarean scar. The placenta was posterior and completely covered the internal cervical os. The ultrasound findings were not typical of either a caesarean scar ectopic pregnancy or a cervical ectopic pregnancy, making the diagnosis uncertain. Due to the high risk of catastrophic haemorrhage with continuation of the pregnancy and as the family is completed a multidisciplinary decision was made to terminate the pregnancy. Exploratory laparotomy revealed macroscopic findings consistent with a caesarean scar ectopic pregnancy. A total abdominal hysterectomy was done and the specimen was sent for histopathological examination.

Discussion: Caesarean scar ectopic pregnancy is a rare but potentially life-threatening type of ectopic pregnancy. It is difficult to diagnose when the gestational sac does not demonstrate classic sonographic features or when placental location does not have the relationship to the previous scar. Although transvaginal two-dimensional ultrasonography is the first-line imaging modality, three-dimensional ultrasonography and magnetic resonance imaging may provide additional anatomical detail. Management requires balancing maternal safety against fertility preservation. In women wishing to retain fertility, conservative options include systemic or local methotrexate, ultrasound-guided embryo reduction, hysteroscopic, laparoscopic or transvaginal excision, uterine artery embolization, or combined approaches. Surgical intervention remains appropriate in women with uncertain diagnosis, significant bleeding, or when fertility preservation is not desired.

Conclusion: Possible caesarean scar ectopic pregnancy should be considered in women with previous caesarean deliveries presenting with a low-lying early pregnancy, even when classical ultrasound features are absent. Prompt recognition, multidisciplinary decision-making and individualized treatment based on diagnostic certainty, maternal safety and reproductive wishes are cucial to optimize outcomes.

EP142. POSSIBLE MIRROR SYNDROME AS A COMPLICATION OF NON-IMMUNE HYDROPS FETALIS

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Objectives: To highlight mirror syndrome as a rare maternal complication of non-immune hydrops fetalis, highlight the aspects of differentiating it from preeclampsia and discuss the importance of identifying the underlying fetal etiology.

Case report: A primi mother was admitted at 29 weeks of' gestation with gestational hypertension but no symptoms of preeclampsia. Initial investigations for preeclampsia were normal. She had been diagnosed with anemia during the first trimester and had a hemoglobin level of 7.3 g/dL on admission. Blood picture findings were iron deficiency anemia with or without underlying thalassemia. Ultrasound showed a markedly enlarged placenta, fetal hydrops fetalis and polyhydramnios with Middle cerebral artery peak systolic velocity > 1.5 MOM. During hospitalization, her hypertension and bilateral ankle edema worsened, although she remained free of respiratory symptoms and pulmonary edema. At 30 weeks and 2 days, she developed significant vaginal bleeding with abdominal pain, raising clinical suspicion of placental abruption. An emergency caesarean section was performed. The neonate had features of gross hydrops fetalis. The placenta was sent for histopathological examination, while the parents declined fetal postmortem examination. Maternal blood group was A Rh-positive and unexpected red cell antibody screening was negative. Family screening for thalassemia was offered, as fetal anemia secondary to an inherited hemoglobinopathy was considered a possible cause of the non-immune hydrops. Neonate succumbed on first day after delivery before carrying out investigations. Parents refused a postmortem.

Discussion: Mirror syndrome is an uncommon condition characterized by maternal edema, hypertension and placentomegaly occurring in association with fetal hydrops. It closely resembles preeclampsia but it differs by maternal hemodilution rather than hemoconcentration. Biomarkers such as the soluble fms-like tyrosine kinase-1 (sFlt-1)/placental growth factor (PlGF) ratio may aid differentiation when available. Evaluation of hydrops should systematically distinguish immune from non-immune causes, including fetal anemia, structural anomalies, infections, chromosomal disorders and inherited conditions such as thalassemia. Early identification of the underlying cause may provide opportunity for fetal interventions, including intrauterine transfusion in selected cases of fetal anemia, improving fetal and maternal outcomes.

Conclusion: Mirror syndrome should be considered in pregnant women with hypertension, edema and placentomegaly with fetal hydrops. Early recognition, differentiation from preeclampsia, detailed evaluation of the cause of hydrops and timely multidisciplinary management are essential. Where inherited fetal anemia is suspected, appropriate family screening and genetic counselling should be included into management.

EP143. POST PARTUM ACQUIRED HAEMOPHILIA A; PRESENTING AS A RECURRENT RECTUS SHEATH HEAMATOMA

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Objectives: Autoantibodies against coagulation factor VIII, causing recurrent rectus sheath haematoma following caesarian section is a rare presentation of acquired haemophilia A (AHA). Majority of the affected women have no prior history of any bleeding disorder, adding to a diagnostic delay. Approximately 7-11% of cases occur in the peripartum period and repeated interventions are usually carried out before coming to a diagnosis causing significant maternal morbidity and mortality. This case is reported to raise awareness and highlight the importance of recognising isolated activated partial thromboplastin time (APTT) as a diagnostic clue and to reiterate the value of early multidisciplinary management.

Case report: Our patient was a 30 year old woman who underwent an uncomplicated elective caesarian section due to past section. She presented at 17 days post delivery with severe lower abdominal pain and recurrent rectus sheath haematoma. She underwent two surgical evacuations, both of which failed to identify a distinct source of bleeding. Underlying systemic bleeding disorder was suspected due to progressive wound oozing, ongoing vaginal bleeding and haematuria. Isolated prolonged APTT and a characteristic time dependent factor VIII inhibitor on inhibitor screening established the diagnosis of post partum acquired haemophilia A. Multidisciplinary meeting involving the haematologists, transfusion physicians, vascular surgeons, microbiologists, anaesthetists and obstetricians agreed to manage the patient with recombinant activated factor VII, tranexamic acid, blood and blood product support and corticosteroid therapy. Culture directed antibiotics were required to treat a simultaneous polymicrobial wound infection. She achieved rapid clinical improvement with resolution of the heamatoma and made a full recovery with no further complications.

Discussion: Post operative haemorrhage from an acquired coagulation disorder is particularly challenging to diagnose. Failure to identify a surgical bleeding source, isolated prolongation of APTT and concurrent bleeding from multiple anatomical sites should raise suspicion and acquired haemophilia A should be investigated for. Multidisciplinary involvement is a key factor in managing such complex cases. In resource poor settings, careful clinical assessment and basic coagulation testing can help diagnose such conditions and early treatment is key to reducing morbidity and mortality.

Conclusion: Unexplained, recurrent bleeding following caesarian section, especially where no bleeding source is identified surgically and APTT is prolonged in isolation should consider postpartum acquired hamophilia A as a differential diagnosis. Unnecessary surgical interventions and diagnostic delay can be avoided by early inhibitor screening, immunosuppressive and haemostatic therapy and referral to centres with multidisciplinary care to achieve favourable clinical outcomes.

EP144. POSTPARTUM PITUITARY APOPLEXY PRESENTING AS HEADACHE

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Objectives: To highlight pituitary apoplexy as a rare but important differential diagnosis of postpartum headache and highlight the role of timely neuroimaging and multidisciplinary approach.

Case report: A 43-year-old multiparous woman with one previous caesarean section underwent caesarean section. She had an uncomplicated antenatal period. On postpartum day 3, she developed a persistent severe headache. She had no fever, neck stiffness, photophobia, focal neurological deficits, visual symptoms or features of preeclampsia. Initial differential diagnoses were post-dural puncture headache, primary headache disorders and cerebral venous thrombosis. As conservative management failed to relieve symptoms, contrast-enhanced computed tomography of the brain was performed, which showed features of pituitary apoplexy. Magnetic resonance imaging later showed pituitary haemorrhage consistent with pituitary apoplexy causing mild compression of the optic chiasm. Despite the radiological findings, she had no clinical features of hypopituitarism or visual field defects. Formal visual field assessment and endocrine panel was normal. Her symptoms resolved spontaneously with conservative management and repeat magnetic resonance imaging three months later demonstrated complete radiological resolution.

Discussion: Pituitary apoplexy is a rare but potentially life-threatening cause of postpartum headache which occur due to haemorrhage or infarction of the pituitary gland. Physiological enlargement of the pituitary during pregnancy may increase the risk.. Diagnosis may be not considered when classical features such as visual impairment, ophthalmoplegia, altered consciousness or endocrine dysfunction are absent. Magnetic resonance imaging remains the imaging modality of choice and is more sensitive than computed tomography. Management depends on clinical

severity. Patients with visual compromise, neurological deterioration or acute adrenal insufficiency require urgent corticosteroid replacement, endocrine assessment and consideration of neurosurgical involvement. In clinically stable patients without neurlogical symptoms and ophthalmic deficits, conservative management with close endocrine, ophthalmological and radiological follow-up may be appropriate.

Conclusion: Pituitary apoplexy should be considered in women with persistent postpartum headache even in the absence of typical clinical features. Early recognition, appropriate neuroimaging and multidisciplinary assessment facilitate timely diagnosis, while management should be based on both clinical status and radiological findings, with structured long-term endocrine and imaging follow-up.

EP145. PREGNANCY-ASSOCIATED THROMBOTIC MICROANGIOPATHY: A DIAGNOSTIC CHALLENGE

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Objectives: To describe a rare case of pregnancy-associated thrombotic microangiopathy (TMA) following prolonged intrauterine fetal death (IUFD), complicated by maternal sepsis, acute kidney injury and multifocal cerebral infarction, emphasizing the diagnostic challenge and successful multidisciplinary management.

Case report: A 43-year-old woman with 15 years of subfertility presented with a history of fever for 2 days, lower abdominal pain and foul-smelling vaginal discharge. Upon inquiry found to have she was concealing her pregnancy was in advanced labour on presentation. She delivered a macerated stillborn fetus, consistent with prolonged IUFD. Soon after delivery, she developed oliguria, generalized oedema, dyspnea, hypertension. Investigations revealed severe thrombocytopenia, anaemia, leukocytosis, markedly elevated C-reactive protein (250 mg/L), acute kidney injury (creatinine 280 µmol/L) and compensated metabolic acidosis on arterial blood gas. Her liver function tests, coagulation profile and procalcitonin were normal, while antinuclear antibody was weakly positive (1:80). On day 2 she developed headache, blurred vision, confusion and irritability. Computed tomography of brain was normal, but magnetic resonance imaging demonstrated multiple acute periventricular and occipital infarctions without features of posterior reversible encephalopathy syndrome. Echocardiography excluded a cardioembolic source. Peripheral blood film demonstrated schistocytes, confirming microangiopathic haemolytic anaemia and thrombotic microangiopathy. Following multidisciplinary discussion, therapeutic plasma exchange started with broad spectrum antibiotics and supportive care considering the possibility of thrombotic thrombocytopenic purpura. After five plasma exchange sessions, her neurological deficits, thrombocytopenia and renal dysfunction resolved completely and was discharged without further complications after 10 days.

Discussion: Pregnancy associated thrombotic microangiopathy is an uncommon but life-threatening condition with overlapping features between thrombotic thrombocytopenic purpura, atypical haemolytic uraemic syndrome, HELLP syndrome, disseminated intravascular coagulation and sepsis associated thrombotic microangiopathy. Distinguishing these entities is often difficult in the acute setting, particularly when ADAMTS13 testing is unavailable. Current literature supports early plasma exchange when thrombotic thrombocytopenic purpura cannot be confidently excluded, as delayed treatment is associated with high mortality.

Conclusion: Pregnancy associated thrombotic microangiopathy should be considered in postpartum women with thrombocytopenia, microangiopathic haemolytic anaemia, neurological symptoms and acute kidney injury. Early multidisciplinary involvement and timely plasma exchange are import in the management.

EP146. PREGNANCY COMPLICATED BY A LARGE CHORIOANGIOMA RESULTING IN HYDROPS FETALIS: A CASE REPORT

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Introduction: Benign tumors are known to occur in the placenta and chorioangioma is the commonest out of them. Although reported in approximately 0.5–1% of pregnancies, most chorioangiomas are small and detected incidentally without causing maternal or fetal complications. Tumours larger than 4–5 cm are uncommon but may be associated with significant maternal and fetal complications. The complications are usually related to arteriovenous shunting within the tumour, which can lead to fetal cardiac overload, growth restriction, polyhydramnios, preterm labour and non-immune hydrops fetalis. We report such a complicated case where a large placental chorioangioma led to polyhydramnios, preterm labour and non-immune hydrops fetalis.

Case history: A 23-year-old primigravida presented at 27+3 weeks of gestation with lower abdominal pain and backache for one day. A placental mass had been detected at 25 weeks along with polyhydramnios but a definite diagnosis had not been made. On admission she was in spontaneous preterm labour and ultrasound showed severe polyhydramnios, a large well-defined placental mass arising from the fetal surface of the placenta and features of fetal hydrops. Umbilical and uterine artery Doppler studies were normal. Labour progressed despite conservative management and she delivered vaginally at 27+5 weeks of gestation. The baby weighed 1.2 kg and had non-immune hydrops fetalis with respiratory distress requiring neonatal intensive care. Other causes of non-immune hydrops were excluded. Histopathological examination of the placenta confirmed a large placental chorioangioma.

Discussion: The fetal complications observed in our patient are consistent with the recognized effects of large placental chorioangiomas. Arteriovenous shunting increases cardiac workload and eventually results in hydrops. Polyhydramnios was a prominent feature in our patient and is among the commonest manifestations known to occur with large chorioangiomas. Polyhydramnios is assumed to result from the hyperdynamic circulation leading to increased urine production or due to transudation of fluid from the tumor. Ultrasound combined with Doppler is the main investigation for diagnosis and follow-up. Management depends on the gestational age and severity of complications. Available treatment options include close monitoring, amnioreduction, intrauterine transfusion and fetal interventions to reduce blood flow to the tumour. In this case, fetal intervention was not feasible because the patient presented in established preterm labour and the facilities were unavailable.

Conclusion: This case highlights the importance of considering placental chorioangioma in pregnancies complicated by unexplained polyhydramnios and fetal hydrops.

EP147. PREGNANCY IN POSSIBLE DIGEORGE SYNDROME: MULTIDISCIPLINARY TEAM MANAGEMENT

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Objectives: To highlight the aspects of managing pregnancy in a woman with clinically suspected DiGeorge syndrome without genetic confirmation and to highlight the importance of multidisciplinary care, preconception counselling and obstetric management.

Case report: A 33-year-old primi mother presented at 7 weeks' of gestation with a childhood clinical diagnosis of DiGeorge syndrome based on recurrent infections, hypoparathyroidism and characteristic clinical features, although genetic confirmation was not available. She was the only child. Parents were unaffected. There was no relevant family history. Her medical history included calcium supplementation for hypoparathyroidism and rheumatic carditis treated with erythromycin prophylaxis because of penicillin allergy. Examination revealed short stature and pallor, while cardiovascular examination was unremarkable. This was a planned pregnancy but without preconception counselling regarding maternal, fetal and genetic risks. She got

shared care involving obstetricians, a cardiologist, geneticist, neonatologist and anaesthetist. serum calcium monitoring and cardiac assessment were performed throughout pregnancy. The antenatal period was uncomplicated. An elective lower segment caesarean section was performed at 38 weeks because of short maternal stature and the need for coordinated multidisciplinary care, resulting in favorable maternal and neonatal outcomes.

Discussion: Pregnancy in women with suspected 22q11.2 deletion syndrome requires assessment of cardiac disease, hypocalcaemia, immunity and the 50% risk of transmission from mother to fetus when the diagnosis is confirmed. Preconception counselling ideally includes optimization of comorbidities, genetic counselling and discussion of prenatal diagnostic options. Antenatal care requires multidisciplinary approach, while postpartum management should include monitoring for hypocalcaemia, infection and mental health concerns. Contraceptive counselling should be decided according to cardiac status and future reproductive wishes. In Sri Lankan setting because limited access to molecular genetic testing diagnosis is difficult, recurrence-risk estimation and prenatal counselling, requires tailored clinical approach.

Conclusion: Women with possible DiGeorge syndrome can achieve favourable pregnancy outcomes through careful preconception planning, multidisciplinary antenatal care and individualized delivery planning. When there is no genetic confirmation, management is carried out by clinical features while ensuring appropriate counselling regarding diagnostic uncertainty, maternal and fetal complications and reproductive planning in the future.

EP148. PREVALENCE OF MATERNAL OVERWEIGHT, OBESITY AND ASSOCIATED PREGNANCY OUTCOMES

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Introduction: Overweight and Obesity in pregnancy is a major public health concern because of associated adverse maternal and neonatal outcomes. However, updated evidence on their prevalence and pregnancy outcomes in Sri Lanka remains limited.

Objectives: To determine the prevalence of maternal overweight and obesity and assess association with mode of delivery, neonatal birth weight and common maternal and neonatal complications among pregnant women attending National Hospital Kandy and Teaching Hospital Peradeniya.

Design: A hospital-based analytical cross-sectional study was conducted to estimate the prevalence of maternal overweight and obesity and evaluated the associations with outcomes at a single point in time.

Method: A total of 709 participants were included using consecutive sampling method over one month for prevalence assessment, while 503 eligible mothers were analysed for associations after applying predefined inclusion, exclusion criteria. Data were collected using a pretested interviewer-administered questionnaire and verified using antenatal, delivery, postnatal and neonatal records. Maternal BMI at booking (≤12 weeks gestation) was classified according to WHO criteria. Associations were assessed using binary logistic regression adjusted for maternal age and parity ($p<0.05$).

Results: 46.12% of the study population found to be either overweight or obese. Including 29.76% overweight, 16.36% obese while 42.88% had normal BMI at booking visit and 11.01% were underweight. 82.1% of the participants were in the optimal reproductive age and from semi urban areas (57.0%). A trend of increased BMI was noticed with advancing maternal age and higher socioeconomic

statuses. 57.1% of pregnant women who were aged ≥40 years were overweight/obese. Among the 503 participants considered fot associations, 37.2% experienced at least one antenatal complication. Gestational diabetes mellitus (12.5%), anaemia in pregnancy (12.3%) were the predominant antenatal complications, while failure to progress (35.7%) and obstructed labour (24.3%) were common in intrapartum. Out of neonatal complications premature birth (33.5%), neonatal jaundice requiring treatment (12.5%), very low birth weight (12.5%), and respiratory distress (12.1%) were common. There was a statistically significant association between obesity and gestational diabetes mellitus (OR=4.52,CI:0.739-2.277,p<0.001), pregnancy-induced hypertension (OR=3.75,CI:0.151-2.49, p=0.027) and preterm delivery (OR=2.27,CI:0.1414-1.499 p=0.018) in the binominal logistic regression analysis. Overweight was associated with gestational diabetes mellitus (OR=2.78,CI:0.362-1.1685 p=0.002) and maternal subfertility (OR=3.03, CI:0.377-1.839,p=0.003). No significant associations were found between overweight and obese categories with mode of delivery, birth weight, prolonged labour, anaemia, or neonatal jaundice requiring treatment

Conclusion: Nearly half of pregnant women were overweight or obese at booking. Higher maternal BMI was associated with gestational diabetes, pregnancy-induced hypertension and preterm delivery, highlighting the need for early risk identification and active intervention with enhanced maternal care.

EP149. PRIMARY EPITHELIAL CARCINOMA OF THE FALLOPIAN TUBE: A DIAGNOSTIC CHALLENGE

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Objectives: To present a case of tubal high grade squamous carcinoma initially suspected to be a pedunculated fibroid, with intraoperative discovery of an infiltrative pelvic malignancy.

Case report: A 62-year-old postmenopausal woman presented with lower abdominal pain for 3 months' duration. There was no postmenopausal bleeding. General examination was unremarkable.

Pelvic ultrasound demonstrated an atrophied uterus with a right sided solid adnexal mass that was very close to the uterus. There was no ascites. She underwent exploratory laparotomy for a suspected symptomatic fibroid uterus.

Intraoperative findings included a distended right side fallopian tube with a malignant-appearing solid mass arising from the right broad ligament. It was densely attached to the urinary bladder and sigmoid colon and tissue planes were obliterated. Bilateral ovaries, uterus and left tube appeared normal.

During resection, an inadvertent sigmoid colon injury occurred due to the adhesions. The defect was anastomosed with the help of the surgical team and a defunctioning colostomy was created. The mass was removed along with uterus, bilateral tube and ovaries and the specimen was sent for histopathological analysis.it confirmed a high-grade serous carcinoma arising from the fallopian tube epithelium. The patient was then referred for further staging and adjuvant chemotherapy.

Discussion: High-grade serous carcinoma (HGSC) is the most common epithelial ovarian malignancy. Latest evidence suggest that they originate from the epithelium of the fimbrial end of the fallopian tubes. Primary fallopian tube carcinoma is rare, usually diagnosed only after histopathological examination, because the clinical presentation is non specific and ultrasound appearance can be suggestive of benign pelvic masses.

Because of the distorted pelvic anatomy, surgical risk for bladder and bowel injury is high. Current management of HGSC includes complete surgical staging and maximal cytoreduction followed by platinum-based chemotherapy. Prognosis depends largely on FIGO stage and the completeness of cytoreduction.

Conclusion: Adnexal masses in postmenopausal women should be viewed as usually malignant unless proven otherwise. Advanced imaging should be considered when the diagnosis is uncertain. Histopathological assessment is the diagnostic choice and referring to a gynecologic oncology centre can optimize the management for an improved outcome.

EP150. PRIMARY OVARIAN ANGIOSARCOMA PRESENTING AS HEMORRHAGIC PLEURAL EFFUSION IN AN ADOLESCENT

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Objectives: To describe an unusual presentation of primary ovarian angiosarcoma as haemorrhagic pleural effusion in an adolescent. Further, highlight the diagnostic challenges and multidisciplinary management of this rare and aggressive ovarian malignancy.

Case report: A 17 year old previously healthy girl presented with acute onset dyspnoea, right hypochondrial pain and fever. Clinical examination revealed bilateral pleural effusion with ascites. Ultrasonography demonstrated features suggestive of ruptured ovarian cyst. Diagnostic laparoscopy done, identified haemoperitoneum and later converted to laparotomy. A friable haemorrhagic tumour arising from the left ovary was identified. Left oophorectomy with contralateral ovarian and omental biopsies was performed. Histopathology with immunohistochemistry confirmed primary ovarian angiosarcoma with lymphovascular invasion and metastatic involvement of the contralateral ovary and omentum. Subsequent imaging demonstrated pulmonary and peritoneal metastasis. Amidst the lack of management guidelines, multidisciplinary team discussion was held. Based on the discussion, decided to commence palliative weekly paclitaxel therapy. Following initiation of chemotherapy, the patient demonstrated marked early improvement in dyspnoea, functional capacity and overall performance status.

Discussion: Primary ovarian angiosarcoma is an exceptionally rare and highly aggressive ovarian malignancy with no disease specific management guidelines. Patients usually present with abdominal pain or a pelvic mass. Haemorrhagic pleural effusion as the initial presentation of primary ovarian angiosarcoma is exceedingly uncommon. In this case, the unusual initial presentation directed evaluation towards a thoracic pathology and delayed the recognition of underlying ovarian malignancy. However, definitive diagnosis was established by histopathological and immunohistochemical confirmation. In addission, metastatic spread to the contralateral ovary, omentum and lungs at the time of diagnosis reflected the aggressive biological behaviour of the tumour consistently reported in the literature. In the absence of disease specific management guidelines, management was individualized through multidisciplinary discussion. Weekly paclitaxel was selected based on evidence from advanced soft tissue angiosarcoma.

Conclusion: Unexplained hemorrhagic pleural effusion in an adolescent should prompt consideration of an underlying pelvic malignancy, especially when it is accompanied by ascites or a vascular adnexal mass. Early multidisciplinary involvement, timely histopathological and immunohistochemical diagnosis and prompt initiation of systemic therapy may improve patient outcomes. This case broadens the knowledge about recognized clinical spectrum of primary ovarian angiosarcoma and highlights the importance of maintaining a high index of suspicion in unexplained atypical presentations.

EP151. PRIMARY OVARIAN CARCINOID TUMOR FOLLOWING SALPINGO-OOPHORECTOMY

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Objectives: The primary ovarian carcinoids are a very uncommon form of neuroendocrine tumor, occurring in fewer than 0.1% of all ovarian malignancies. The condition is often diagnosed after surgery due to suspected benign ovarian tumors. This case study is being shared in order to discuss the difficulties of diagnosis, the need for histopathology and immunohistology and fertility preservation.

Case report: A 40-year-old premenopausal woman reported having two months of lower abdominal pain and fullness. She did not have any known significant medical or family history of hereditary malignancies. Transabdominal ultrasonography revealed a 130x110x90mm ovarian mass and suggested a dermoid cyst. The serum CA-125, AFP and β-hCG levels were within the normal range. Since the mass seemed to be benign, open left salpingo-oophorectomy was performed.

During surgery, the cyst was found to be smooth, mobile and without adhesions, a healthy contralateral ovary and no signs of peritoneal disease. Pathology revealed that the mass was a mature cystic teratoma containing an 8mm insular carcinoid tumor within the ovary, with no stromal invasion. There were no immature cells in the tissue; the focus of the mass had 2/10hpf mitotic count. Staging with CECT chest, abdomen & pelvis did not show any extra-ovarian disease, thus making the diagnosis of FIGO stage IA primary ovarian carcinoid tumor. Due to the early stage, good prognosis and desire of the patient to conceive in future, conservative management was opted for.

Discussion: Carcinoid tumors of the ovary are uncommon and may preoperatively be mistaken for a benign cyst because imaging and traditional tumor markers have limited specificity. Confirmation requires thorough pathological investigation and immunohistochemical staining. This case underscores the need for the routine pathology analysis of all removed adnexal lesions, as well as the feasibility of fertility sparing approach for properly selected patients at stage IA.

Conclusion: This case proves that even rare tumors may manifest as seemingly benign cysts. Thorough pathology analysis and immunohistochemistry play a crucial role in the diagnosis and treatment of such cases. Excellent results may be achieved with fertility-sparing therapy for patients with localized tumors. More case reports and collaborative research are necessary in order to increase our understanding of this rare variant.

EP152. PRIMARY UPPER VAGINAL SQUAMOUS CARCINOMA TREATED BY RADICAL HYSTERO-COLPECTOMY

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Objectives: Primary vaginal cancer is a rare form of gynecological cancer, comprising only 1 to 2% of all gynecological cancers. Radial hysterocolectomy is a rarely performed operation that is quite difficult to perform on a selected group of patients. This report highlights the feasibility of surgery and the role of selecting patients for oncological clearance.

Case report: A 59-year-old para 2 woman presented with two episodes of postmenopausal bleeding. She did not have any medical comorbidities. Clinical examination showed an upper vaginal mass involving the posterior vaginal wall extending up to the ectocervix without any parametrial spread. Chest, abdomen and pelvis contrast-enhanced computed tomography confirmed her to be localized with no evidence of any pelvic or para-aortic lymphadenopathy or any distant metastasis.

After discussing in multidisciplinary meeting, she underwent radical hystero-colpectomy, bilateral salpingo-oophorectomy and bilateral pelvic lymph node dissection. Histopathological evaluation showed poorly differentiated squamous cell carcinoma arising from the upper one-third portion of the posterior vaginal wall with a dimension of 50×38×10 mm with a depth of invasion into the stroma of 6 mm. The lateral vagina and deep resection margins were 5 mm and 7 mm, respectively. No lymphovascular invasion and perineural invasion was found. The cervix, uterus, bilateral fallopian tube, ovaries and 36 pelvic lymph nodes were negative for tumor. The postoperative period was uncomplicated. She was referred to the oncology department for further therapy.

Discussion: Primary vaginal carcinoma is treated using either radiotherapy or chemoradiotherapy, whereas surgery is an option for selected cases of localized upper vaginal carcinoma. Radical hystero-colpectomy is rarely carried out owing to its technical difficulty and the close anatomical relation with the bladder, rectum and ureters. This particular case shows that in selected cases of localized disease without any radiological involvement of lymph nodes, radical surgery can provide complete excision of the tumor with free margins without the side effects of multimodal treatment. The success of such treatment is contingent upon comprehensive preoperative investigation and multidisciplinary team involvement.

Conclusion: This case clearly shows that radical hystero-colpectomy is a potential modality for the treatment of selected cases of localized primary vaginal squamous cell carcinoma. Selected cases can be treated successfully with optimal pathological results and complete tumour resection. However, due to the rarity of

such a tumor, further multicentre studies are essential for selecting patients and managing them surgically.

EP153. PRIMARY VAGINAL CARCINOMA OCCURING FIVE YEARS AFTER TREATMENT FOR VAGINAL INTRAEPITHELIAL NEOPLASIA. A CASE REPORT

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Introduction: Primary vaginal carcinoma is a rare entity, accounting for 1-2% of all gynecological malignancies (1). The commonest histological type is non keratinizing squamous cell carcinoma (1,2). Precursor lesion is vaginal intraepithelial neoplasm (VaIN), a complication to persistent high risk HPV infection (1,3).

CASE 56 year old woman presented with abnormal pap report in 2017. She was asymptomatic and cervix and vagina appeared normal. She underwent colposcopy and diagnosed with cervical intraepithelial neoplasia 3 (CIN 3). With her wishes, she underwent Total abdominal hysterectomy. Her histology confirms as CIN3 with involved margins thus she was followed up.

An abnormal smear was found in 2020, after which colposcopy and excisional biopsy were done. Histology was concluded as VaIN and no invasive malignancy.

However in September 2025 she complained of constipation, without other symptoms. On examination her vault was normal, digital rectal examination showed hard mass in the pouch of douglas (POD) obliterating the rectum but rectal mucosa was free. Her sonography and CT confirmed above finding with no other mass in the abdomen or pelvis.

During exploratory laparotomy, irregular mass in the vault compressing on rectum were found. Mass excision was performed. Histology concluded non keratinizing squamous cell carcinoma of vagina.

She was referred to oncology team for further management.

Discussion: Diagnosis of VaIN is done by histology. Biopsy is taken during colposcopy examination after application of acetic acid and lugols iodine. Treatment is several in type, either excision, medical management with 5 fluorouracil or CO2 laser vaporization. Mode of treatment will be tailored according to patients (1). Follow-up with vault smear is planned to screen for recurrence.

VaIN is benign condition and it has about 2% risk of progressing in to vaginal carcinoma (1).

Vaginal carcinoma is rarer than VaIN and treatment is mainly surgical if it is early in stage. In late stage surgery has limited role and radiation constitutes the cornerstone of treatment (1).

Even after excisional treatment for VaIN and close monitoring, with 5 years of latency she was diagnosed with invasive malignancy of vagina which has grown in to the POD. Thus being challenging to detect early.

Conclusion: Careful follow-up and being vigilance about rare occurrence of invasive malignancy even after treatment for its benign condition. This would be an eye opening to clinicians to suspect expect and treat accordingly.

EP154. PROFILE OF GYNAECOLOGICAL CANCERS AT A SRI LANKAN TERTIARY ONCOLOGY CENTRE

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Introduction: Gynaecological cancers impose a substantial and rising burden in Sri Lanka, yet contemporary institution-level data spanning the major tumour sites are limited. A combined profile can inform prevention, screening, service planning and resource allocation.

Objectives: To describe the relative frequency, demographic profile, clinical presentation, histopathology and stage distribution of the major gynaecological cancers managed at a national oncology centre.

Design: Retrospective descriptive study.

Method: Records of 844 women managed for gynaecological malignancy at the National Cancer Institute, Maharagama (NCIM) were reviewed across five tumour groups: cervical (138), endometrial (329), primary ovarian (340), borderline ovarian (14) and vulval (23). Demographic, clinical, biochemical, radiological, operative and histopathological data were

extracted using structured proformas and analysed descriptively.

Results: Ovarian tumours (354, 42%, including 14 borderline) and endometrial carcinoma (329, 39%) together accounted for over 80% of cases, followed by cervical (138, 16%) and vulval (23, 3%) cancers. Median age was youngest for borderline ovarian tumours (42 years) and cervical cancer (52) and oldest for endometrial (64) and vulval (71) cancers, with an overall range of 12-85 years.

Abnormal vaginal bleeding, particularly postmenopausal bleeding, was the dominant presentation for endometrial (63%) and cervical (31%) cancers, whereas ovarian cancer presented with non-specific abdominal distension and pain and vulval cancer with a vulval lump or mass (65%).

Predominant histologies were endometrioid carcinoma (endometrial, approximately 78%), high-grade serous carcinoma (ovarian, approximately 60%) and squamous cell carcinoma (cervical 59%, vulval 87%). Stage at diagnosis divided the sites sharply. Endometrial (approximately 72% stage I), cervical (approximately 49% stage I) and borderline ovarian tumours were largely stage I and operable. Primary ovarian cancer was the exception - 57% at stage III-IV, many requiring neoadjuvant chemotherapy with interval debulking.

CCA-125 was elevated in 92% of ovarian cancers. A prior Pap smear was documented in only 17% of cervical and 4% of vulval cancers and surgical margins were involved in the majority of vulval cancers.

Conclusion: Ovarian and endometrial disease made up over 80% of this workload. Endometrial, cervical and borderline ovarian tumours were mostly operable at stage I and usually presented with abnormal bleeding; ovarian cancer did not, presenting at stage III-IV in 57% with CA-125 raised in 92%. A prior Pap smear in only 17% of cervical cases argues for organised screening and HPV vaccination; the ovarian stage distribution, for earlier detection and complete cytoreductive services.

EP155. PROLAPSED BULKY CERVICAL CANCER SUCCESSFULLY MANAGED WITH RADICAL SURGERY

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Objectives: Definitive chemoradiation is the mainstay of treatment in locally bulky advanced cervical cancers, with surgical intervention reserved only for selected early cancers. This paper reports an uncommon scenario wherein the prolapse of the bulk of a locally bulky cervical cancer resulted in an innovative surgical approach and a good pathological outcome.

Case report: A 47-year-old multiparous lady had post-coital bleeding with continuous vaginal discharge. Her medical history was unremarkable. Examination of the vagina revealed a cervical tumour larger than 4 cm and on biopsy, moderately differentiated keratinising squamous cell carcinoma was diagnosed. Imaging revealed bulky cervical tumour with extension into the vagina without metastasis to nodal, hepatic, pulmonary or skeletal systems. There was mild dilatation of the left renal pelvis with thickening of the pelvi-ureteric junction and upper ureter. She was being considered for definitive CCRT.

In the meanwhile, the cervical tumour had prolapsed from the vagina. Following discussion in the multidisciplinary meeting, the approach was changed and she was operated upon laparoscopically assisted radical vaginal hysterectomy with pelvic lymph node dissection. The histopathology report revealed moderately differentiated invasive keratinising squamous cell carcinoma with a thickness of maximum tumour 140 mm. No lymphovascular space invasion was present. Both bilateral parametria and all the pelvic lymph nodes were free from tumour. Radial and vaginal resection margins were negative by 6 mm and 8 mm, respectively. She had an uncomplicated recovery.

Discussion: Bulkier cases of cervical cancer are usually treated with CCRT as surgical management is challenging and post-operative radiotherapy is often needed because of poor pathological features. In this case, it can be seen that prolapse of a tumor will affect the access to surgery and complete surgical resection becomes possible in carefully selected cases. As there is no evidence of any nodal in-

volvement, parametrial invasion, lymphovascular space invasion and positive margins, the selected patients can undergo treatment without combining other modalities and suffering from the morbidities caused by them.

Conclusion: In this case, it is seen that the prolapse of a bulkier tumor can help in surgically treating the case in selected patients. Patient selection, multidisciplinary team discussions and proper pathological workup are necessary to determine the treatment method. Further studies are necessary to determine the role of surgery in this rare condition.

EP156. PYELONEPHRITIS UNMASKING A UTERINE SARCOMA - A DIAGNOSTIC CONUDRUM IN A POSTMENOPAUSAL WOMAN

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Introduction: Uterine fibroids are the commonest benign pelvic tumors in women. However, in a postmenopausal patient with a rapidly growing or symptomatic fibroid uterus, it is better to consider the possibility of a malignant transformation, such as a leiomyosarcoma. Here is a challenging case of a uterine sarcoma initially presenting as acute pyelonephritis, which shows the diagnostic pitfalls and the importance of a high index of suspicion.

Case report: A 50-year-old mother of 2 children, presented with a one-week history of right-sided flank pain and high-grade fever. She had no significant past medical history. On admission, she was febrile and tachycardic. Abdominal examination revealed a firm, irregular, non-tender 18 weeks size mass arising from the pelvis. There was significant right-sided renal angle tenderness.

Blood investigations on admission were, Hb 9.8 g/dL, WBC 34,000/µL, platelets 55,000/µL and CRP 160 mg/L. Urinalysis showed pyuria and bacteriuria. A renal ultrasound confirmed right-sided pyelonephritis with hydronephrosis. The patient was started on intravenous Cosmoxyclav and later converted to Merapenum due to poor clinical and biochemical response. Her flank pain improved, but despite a 7-day course of antibiotics, she continued to have a low-grade fever, with persistently elevated WBC and CRP. USS confirmed a Fibroid uterus.

A comprehensive workup for a pyrexia of unknown origin was done. Echocardiogram was normal, ruling out infective endocarditis. Mantoux test and Procalcitonin were negative, making tuberculosis and a typical bacterial sepsis less likely. However, tumor markers and liver function tests were deranged; LDH 330 U/L and AFP and GGT were high. Due to persistent fever, abnormal biochemical parameters and the clinical picture of a large pelvic mass in a postmenopausal woman, a decision for surgical intervention was made. Patient underwent an exploratory laparotomy. Intraoperatively, a large, necrotic uterine mass of 18 weeks size with multiple Fibroids was noted. A Total Abdominal Hysterectomy with Bilateral Salpingo-Oophorectomy (TAH+BSO) was done. Her postoperative recovery was uneventful. Remarkably, her WBC count and CRP normalized within 48 hours of surgery and her fever subsided completely.

The histopathological examination revealed a high-grade uterine leiomyosarcoma, with marked cellular atypia, a high mitotic index and areas of coagulative necrosis. The tumor was noted to have extensive areas of necrosis and inflammation, which likely contributed to the profound systemic inflammatory response.

Conclusion: This case shows that uterine sarcomas can present as a simple infective pathology, such as pyelonephritis, especially when they have a significant inflammatory reaction. The persistence of fever and elevated inflammatory markers despite adequate antibiotic therapy, together with an enlarging fibroid uterus in a postmenopausal woman, should raise the suspicion of an underlying malignancy. The normalization of laboratory parameters after surgical resection was a key diagnostic clue retrospectively. This case emphasizes the need for a high index of suspicion and a multidisciplinary approach in managing complex pelvic masses in the perimenopausal women.

EP157. PYREXIA OF UNKNOWN ORIGIN AS THE INITIAL PRESENTATION OF CERVICAL SQUAMOUS CELL CARCINOMA: A RARE DIAGNOSTIC CHALLENGE

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Objectives: To report a rare case of cervical squamous cell carcinoma presenting as pyrexia of unknown origin (PUO), highlighting the importance of considering occult gynaecological malignancy in women with persistent unexplained fever despite negative infective investigations and prolonged empirical antibiotic therapy.

Case report: A 36 year old previously healthy mother of two presented with a three weeks history of intermittent high grade fever without chills, weight loss, respiratory, urinary, gastrointestinal, or gynaecological symptoms. She underwent extensive investigations at several peripheral hospitals and received multiple courses of broad-spectrum antibiotics for presumed infection. Repeated blood and urine cultures, inflammatory workup and imaging failed to identify an infective focus and the fever persisted. On referral, she remained febrile but haemodynamically stable, with no significant findings on systemic examination. Routine pelvic assessment revealed a friable polypoidal cervical growth without clinical evidence of vaginal or parametrial extension. Cervical biopsy confirmed poorly differentiated squamous cell carcinoma. Pelvic magnetic resonance imaging suggested disease confined to the cervix with no parametrial invasion or radiologically enlarged lymph nodes. She underwent radical hysterectomy with bilateral salpingectomy and pelvic lymph node dissection. Histopathological examination demonstrated poorly differentiated squamous cell carcinoma with lymph vascular space invasion and metastasis to one pelvic lymph node with extensive extranodal extension, while surgical margins remained clear. The fever resolved completely in the postoperative period without further antimicrobial therapy and did not recur during follow up, confirming neoplastic fever as the presenting manifestation.

Discussion: Cervical cancer rarely presents as isolated PUO, often resulting in delayed diagnosis because the absence of gynaecological symptoms directs the evaluation towards infectious causes. This case illustrates the importance of considering malignancy when fever persists despite negative microbiological investigations and appropriate antibiotic therapy. The discrepancy between imaging and final histopathology also highlights the limitations of radiological staging in detecting microscopic nodal disease. Most importantly, it demonstrates the important fact of a careful pelvic examination in women with unexplained fever.

Conclusion: Cervical squamous cell carcinoma should be recognized as a rare but important cause of PUO. Early gynaecological evaluation, including pelvic examination, should form a part of the assessment of women with persistent unexplained fever to avoid diagnostic delay and enable timely definitive treatment.

EP158. RARE AMNIOTIC FLUID EMBOLISM DURING CAESAREAN HYSTERECTOMY FOR PLACENTA PERCRETA

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Objectives: This is to highlight an atypical case of severe pulmonary and gastrointestinal hemorrhages resulting from amniotic fluid embolism (AFE) that occurred during a cesarean hysterectomy for placenta percreta with complete placenta previa.

Case report: We present a case of a 37-year-old woman with past 2 caesarean sections, who was on a regular follow-up with a radiological diagnosis of placenta percreta invading bladder and placenta previa. She was presented at 34 weeks and 6 days of gestation with abdominal pain. Sudden vaginal bleeding following admission, necessitated an emergency cesarean hysterectomy. A healthy boy was delivered and a minor fresh abruption was noted. Following delivery, during hysterectomy, her condition suddenly deteriorated, leading to a

cardiac arrest. Although she was temporarily resuscitated, she suffered a second cardiac arrest, complicated by massive endotracheal tube hemorrhage (4500 mL) and gastrointestinal bleeding. The surgical blood loss was 1500 mL. This patient died despite resuscitation attempts. Post-mortem histology of the lungs and other organs revealed evidence of AFE and disseminated intravascular coagulation (DIC).

Discussion: AFE is a rare yet a life-threatening obstetric complication. It usually manifests as a classic triad of abrupt cardiovascular collapse, respiratory distress in first phase and Coagulopathy leading to DIC in second phase. It can occur during labor, delivery, or immediately postpartum and should be differentiated from hemorrhagic, septic, or anaphylactic shock, anesthetic complication, or pulmonary thromboembolism. Placental abnormalities, can lead to disruption of maternal-fetal interface allowing amniotic fluid to enter the maternal circulation. In addition, increased fetal antigen exposure can cause, a severe inflammatory response affecting vascular homeostasis. It can lead to massive bleeding causing cardiovascular collapse independent of the degree of obstetric hemorrhage, comparable to this case. Histology supports the diagnosis of DIC, often associated with severe pulmonary hemorrhage. Management includes expedited delivery, resuscitation, massive transfusion and supportive care. Increased likelihood of AFE is noted with previous history of surgery, placental abnormalities, cervical laceration, uterine rupture, or polyhydramnios and could be multifactorial as in this case. Prevention involves contraception, planned pregnancies and counseling these high-risk women on future pregnancy risks.

Conclusion: In cases of placenta percreta associated with AFE, catastrophic bleeding can occur, even after a successful surgical delivery and control of bleeding at the surgical site. Early recognition, prompt multidisciplinary management and identification of high-risk patients, particularly those with placenta accreta spectrum, are essential to improve outcomes.

Keywords: Past caesarean section, Placenta percreta, Amniotic fluid embolism; Disseminated intravascular coagulation, Placenta previa.

EP159. RARE CASE: ACOUSTIC NEUROMA IN PREGNANCY COMPLICATED BY MULTIPLE MEDICAL COMORBIDITIES

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Introduction: Acoustic neuroma, also known as vestibular schwannoma, is a benign neoplasm originating from Schwann cells that surround peripheral nerves. It poses a unique set of challenges when encountered during pregnancy. Managing an acoustic neuroma becomes even more challenging when combined with significant medical comorbidities. In this case report, we discussed the successful management of a pregnancy complicated by acoustic neuroma and Multiple Medical Comorbidities.

Case report: A 43-year-old woman with type 1 diabetes, chronic hypertension and a previous lacunar stroke developed progressive left-sided hearing loss and imbalance during pregnancy. MRI at 23 weeks revealed a 24×15×17 mm vestibular schwannoma involving the internal auditory canal and cerebellopontine angle.

At 33+6 weeks, she presented with headache, generalised oedema and severe hypertension (226/109 mmHg), leading to a diagnosis of superimposed pre-eclampsia with severe features. Despite antihypertensive therapy, her blood pressure remained difficult to control. After multidisciplinary discussion involving obstetrics, anaesthesia, neurology, neurosurgery, endocrinology and paediatrics, a caesarean section was performed at 34 weeks. Her neurological condition remained stable and postpartum radiotherapy was arranged.

Discussion: Vestibular schwannomas in pregnancy require individualised management based on tumour size, gestational age and neurological status. Pregnancy-related haemodynamic and hormonal changes may contribute to symptom progression.

This case was particularly complex due to multiple coexisting conditions—type 1 diabetes, chronic hypertension, previous stroke and superimposed pre-eclampsia. Severe hypertension ultimately dictated the timing of delivery, while her stable neurological status allowed tumour treatment to be deferred. Close collab-

oration across specialties was essential to balance maternal neurological safety with obstetric risks and fetal maturity.

Conclusion: Acoustic neuroma during pregnancy is rare and management must be tailored to the individual. In women with significant comorbidities, coordinated multidisciplinary care is crucial. This case demonstrates that when neurological symptoms are stable, definitive treatment can safely be postponed until after delivery while prioritising urgent obstetric concerns.

EP160. RARE CASE OF LEIOMYOSARCOMA IN A WOMAN OF A MID TWENTIES

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Introduction: Uterine leiomyosarcoma is a rare but highly aggressive mesenchymal malignancy, accounting for approximately 1–2% of uterine malignancies. Preoperative differentiation between leiomyosarcoma and benign leiomyomas remains challenging because both conditions often share similar clinical and radiological features. Consequently, many patients are initially managed for presumed benign fibroids, with the diagnosis established only following postoperative histopathological examination. While leiomyosarcoma predominantly affects peri and postmenopausal women, its occurrence in young women of reproductive age is exceptionally uncommon, creating significant diagnostic and therapeutic dilemmas, particularly regarding fertility preservation. Early-stage disease may be completely asymptomatic, delaying suspicion and diagnosis despite the presence of a large uterine mass.

Case report: A 26 old unmarried lady undergone medical evaluation prior to applying for a new employment found to have an abdominal mass of a 20weeks size gravid uterus. Thus, she had been undergone and abdomino-pelvic ultrasound which revealed large uterine fibroid arising from the fundus measuring 15cm x 13cm in size with possible degenerative changes. She was completely asymptomatic and denies any abdominal distension, fullness, heavy menstrual bleeding, loss of appetite and loss of weight. She had been undergone open myomectomy through a transverse incision due to cosmetic reasons. Apart from enlarged uterus due to large fundal fibroid, no other abnormalities identified in during the surgery. 3weeks following surgery, her histology report revealed "Leiomyosarcoma". Patient and her parents were counselled regarding the condition and she was undergone a multidisciplinary speciality meeting involving gyneoncosurgery, oncology, radiology, histopathology and fertility specialists and decided to undergo complete staging surgery. Fertility preserving options were discussed with the patient.

Discussion: Uterine leiomyosarcoma predominantly affects women aged 40–60 years, making its occurrence in young, nulliparous women exceedingly rare. Preoperative diagnosis remains challenging because clinical presentation and conventional imaging frequently overlap with those of benign leiomyomas. Although rapid tumour growth, postmenopausal status and suspicious magnetic resonance imaging (MRI) features may increase clinical suspicion, no single preoperative investigation reliably distinguishes leiomyosarcoma from leiomyoma. Thus, the diagnosis is often established only after histopathological examination following surgery performed for presumed benign disease.

In the given scenario, the patient was completely asymptomatic despite harbouring a large uterine mass, illustrating the unpredictable clinical behaviour of leiomyosarcoma and the limitations of current diagnostic modalities. The unexpected diagnosis following fertility-preserving myomectomy posed a complex therapeutic dilemma requiring multidisciplinary input. Current international guidelines recommend comprehensive surgical staging, with individualized counselling regarding fertility preservation in carefully selected young women with apparent early-stage disease.

Conclusion: This case highlights the importance of maintaining a high index of suspicion for uterine sarcoma, even in young asymptomatic patients with fibroids. Multidisciplinary decision making, prompt histopathological diagnosis and individualized management are essential to optimize oncological outcomes while carefully balancing fertility considerations in women of reproductive age.

EP161. RARE CASE OF PREGNANCY COMPLICATED WITH PARA-RECTAL ABSCESS DURING LATE PREGNANCY IN A BACKGROUND OF ANTI-PHOSPHOLIPID SYNDROME

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Introduction: Para-rectal abscess is a rare colorectal disease entity during pregnancy. It carries very high morbidity & recurrence may occur in more than 30% of cases. Common complications associated with para-rectal abscess are constipation, urethral irritation, urinary retention & chronic fistula formation. It presents with anal or buttock pain, fever with chills and constipation or diarrhea. It may associate with hemorrhoids, anal fissures & constipation. More frequent towards the latter part of the pregnancy.

Case report: A 28 years old lady with APLS on enoxaparin & aspirin & presented at 33 weeks of gestation with bilateral buttock pains which partially relieved with defecation. She had a 2 weeks history of constipation; thus she was initially treated for constipation. 2 days after the admission pain was more pronounced in the right side of the buttock & per-rectal examination revealed severe tenderness in the right lower part of the rectum. Therefore, colorectal surgical assistances soughed & undergone perineal ultra-sound scanning. It revealed abscess formation in the right side of the para-rectal region. She was undergone drainage of the abscess under spinal anesthesia. Intra-operative fetal well-being was monitored using continuous cardiotocography. Intra-venous antibiotics were continued for 10days & drain applied for evacuation of pus discharges from the surgical site. Second intension suturing done after resolving infection. She delivered healthy baby at term by elective cessarean section weighing 2.8kg.

Discussion: Diagnosis & treatment of para-rectal abscess is extremely challenging during pregnancy due to vague symptoms which mimic pregnancy changes, requirement of advanced imaging modalities, risks and difficulties associated with surgical & anesthetic interventions. Transperineal ultrasound & magnetic resonance imaging provide the extent of the disease, size of the collection & involvement of the peri-anal structures. Which aid in surgical intervention. Intra-operative fetal monitoring assured the fetal well-being through-out the surgical procedure. Application of Surgical drain, antimicrobial coverage, second intention suturing & perineal care were the aspects of the post-surgical management.

Conclusion: Even though, there is no direct association with APLS & para-rectal abscess formation, management may be more challenging in the presence of comorbidities. Early diagnosis & timely intervention involving multi-disciplinary specialty involvement lead to satisfactory pregnancy outcome.

EP162. RARE PRESENTATION OF ANGIOLIPOLEIOMYOMA MIMICKING AN OVARIAN MALIGNANCY; A CASE REPORT

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Introduction: Angiolipoleiomyomas are rare benign mixed mesenchymal tumors. Histological characteristics show a mixture of blood vessels, smooth muscles and fatty tissue. The first case has been reported in 1816 (1). They are usually found in kidney, however extra renal cases have been reported (2, 3).

Objectives: To describe a rare presentation of benign pathology that mimics malignancy CASE 40 year old mother of two children presented to us, while being investigated for abdominal pain and distention for two months of duration. On examination there was an abdominal mass compatible with 32 weeks size gravid uterus. Her sonography showed, solid and cystic mass arising from left adnexa. Uterus was normal and ovaries were not seen separately.There were mild free fluid in the pelvis and further imaging was not done due to financial issues. Her CA 125 levels were 30U/ml. Our first differential diagnosis was an ovarian malignancy and she was prepared for staging laparotomy.

During surgery there was, a solid and cystic mass arising from the left board ligament, adhering to the uterus. The capsule was intact, bilateral ovaries and tubes were normal. No other masses or deposits were noted on the rest of the peritoneal cavity. Thus total hysterec-

tomy and bilateral salpingectomy was done reserving both ovaries.

Her histology suggested angiolipoleiomyoma with degenerative changes. She was debriefed, counseled about the diagnosis.

Discussion: These tumors are benign, seen usualy in post-menopausal women and typically asymptomatic (4). They are well defined tumors with rubbery consistency. Microscopy shows mature adipose tissue, blood vessels and smooth muscles. Diagnosis will be confirmed by seeing all three components within the tissue (5).

Immunoreactivity for HMB-45 typically is negative for uterine angiolipoleiomyomas but it is positive in tumours found in other locations (6,7).

Above patient underwent hysterectomy as she was symptomatic.

Conclusion: Uterine angiolipoleiomyomas are benign rare mesencymal tumors, diagnosed by the presence of all three components of smooth muscles, adipose tissue and blood vessels. Typically these women undergo hysterectomy as clinical presentation mimics ovarian malignancy.

Ethical consideration Informed verbal consent has been obtained from the patient and all identifying information has been omitted to preserve patient confidentiality.

EP163. RARE PRESENTATION OF CONGENITAL MYOTONIC DYSTROPHY DIAGNOSED DURING PREGNANCY

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Introduction: Myotonic dystrophy is an autosomal dominant type inherited muscular disorder which characterized by muscle weakness and atrophy. Rarely it can occur during antenatal period leading to congenital muscular dystrophy. It may manifest as hypotonia, respiratory failure, club feet or feeding difficulty during early neonatal period. Reduced fetal movements, polyhydramnios and limb anomalies are commonly seen during antenatal period.

Case history A 32 years old mother in her second pregnancy was referred from a local hospital at 20 weeks of gestation for further management of severe polyhydramnios. Her first pregnancy had been complicated with severe polyhydramnios and undergone emergency caesarean section due to fetal distress following preterm prelabour rupture of membranes at 35 weeks of gestation. But unfortunately, it has ended up as a neonatal death, at 6th day following delivery due to respiratory distress. Here she underwent an anomaly scan by a fetal medicine specialist at 20 weeks, where she was diagnosed with placenta accreta spectrum disorder (PASD) and it excluded fetal and placental causes leading to polyhydramnios. She had multiple episodes of reduced fetal movements and underwent therapeutic amnioreduction 5 times, due to severe polyhydramnios leading to maternal distress. At 34 weeks of gestation she developed preterm prelabour rupture of membranes. An emergency cesarean section was arranged due to risk of cord prolapse and bleeding from placenta accreta but it was ended up in an obstetric hysterectomy due to torrential bleeding from placental site. Her baby was admitted to the neonatal intensive care unit and unfortunately died at 10th day of neonatal period due to respiratory distress. On further inquiry, she revealed that two of her male siblings died during infant period due to possible respiratory illness and she is having difficult in climbing stairs and easy fatiguability with walking and standing. Thus, she was undergone an electromyography (EMG) which revealed findings are compatible with “Myotonic Dystrophy” and it was confirmed with a muscle biopsy. Then she was referred for genetic counselling.

Discussion: In this case scenario, two consecutive generations were affected by congenital myotonic dystrophy and four male neonates had died. Females are having disease with less severity indicating variable penetrance and male predominance. She had severe polyhydramnios in both pregnancies which is most probably due to congenital swallowing difficulty. Recurrent reduced fetal movements may be due to poor muscle tone and polyhydramnios. Genetic counselling plays a vital role in managing patients with myotonic dystrophy as it affects 50-100% of offspring according to

the genotype. Preimplantation genetic screening can be used to prevent the transmission to next generations. As this patient was hysterectomized, surrogacy and adaption are the available fertility options.

Conclusion: Congenital myotonic dystrophy is a rare genetic disorder leading to wide spectrum of clinical manifestation during pregnancy. Clinical suspicion is mandatory in cases with recurrent polyhydramnios.

EP164. RARE PRESENTATION OF STURGE WEBER SYNDROME IN PREGNANCY MIMICKING ECLAMPTIC CONVULSION

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Introduction: Sturge–Weber syndrome is a rare sporadic neurocutaneous disorder characterized by facial capillary malformations (port-wine stain), leptomeningeal angiomatosis and ocular abnormalities resulting from somatic activating mutations in the GNAQ gene with an estimated incidence of approximately 1 in 20,000–50,000 live births. Neurological manifestations are usually appeared during infancy or early childhood; however, late presentations in adulthood and pregnancy are uncommon and may pose significant diagnostic challenges. Further limited number of cases presenting initially during pregnancy have been reported in the literature.

Case report: A 26 years old mother in her first pregnancy presented with convulsion at 32 weeks of gestation in absence of gestational hypertension, proteinuria, previous seizure disorders, neurological and medical conditions. She developed second convulsion at emergency treatment unit around 4 hours following initial convulsion. On further evaluation her current pregnancy was uneventful with satisfactory foetal growth and well-being, without any co-morbidities. On examination there was a reddish colour birthmark mimicking facial port-wine strain identified in right side of the face and she was normotensive, apart from post-ictal drowsiness, her neurological and systemic examination was completely unremarkable. She was negative for albuminuria and no abnormalities identified in haematological and serum investigations. Multidisciplinary evaluation was done involving, medical and neurology teams. She was undergone EEG, which indicated asymmetrical fundal intermittent rhythmic delta activity (FIRDA) compatible with encephalopathy and Brain MRI angiogram and venogram revealed cerebral venous malformations involving right side parieto-occipital region, lateral ventricles and choroid plexus. Thus, she was diagnosed with "Sturge-Weber Syndrome" and started on anti-epileptic medications. Ophthalmological evaluation was done to exclude ocular abnormalities and long-term neurological follow-up plan was arranged. She delivered a healthy baby vaginally at term with a birth weight of 2.9kg without any intrapartum and post-partum concerns.

Discussion: Seizures occurring during pregnancy are most frequently attributed to eclampsia, particularly in the third trimester. Nevertheless, not all convulsions in pregnancy are eclamptic in origin, especially in the absence of hypertension, proteinuria, or other biochemical abnormalities. Structural cerebral lesions, cerebrovascular malformations, epilepsy, metabolic disturbances and rare neurocutaneous syndromes should also be considered in the differential diagnosis. Pregnancy can potentially exacerbate underlying neurological disorders because of haemodynamic, hormonal and vascular changes that may alter cerebral perfusion and seizure threshold leading to unmask previously undiagnosed Sturge–Weber syndrome. MRI with angiographic and venographic evaluation, plays a crucial role in identifying intracranial vascular abnormalities and establishing the diagnosis. EEG may elicit focal neurological electrical activities secondary to underlying vascular malformations. Most reported pregnancies have resulted in favourable maternal and fetal outcomes when seizures are adequately controlled and multidisciplinary care is provided. Vaginal delivery is generally possible unless obstetric or neurological contraindications exist. Careful intrapartum monitoring is important to avoid excessive hypertension, hypoxia and prolonged maternal stress that could precipitate neurological complications.

Conclusion: This is a rare case of previously undiagnosed Sturge–Weber syndrome present-

ing with convulsions during late pregnancy, mimicking eclampsia. This case highlights the importance of maintaining a broad differential diagnosis for seizures in pregnancy and emphasizes the role of multidisciplinary evaluation and neuroimaging in atypical presentations.

EP165. RECURRENT ACUTE PANCREATITIS IN LATE PREGNANCY WITH PROBABLE HYPERTRIGLYCERIDAEMIA SUCCESSFULLY MANAGED CONSERVATIVELY: A CASE REPORT

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Objectives: Acute pancreatitis in pregnancy is a rare but potentially life threatening condition. Recurrent episodes are uncommon and require careful evaluation to identify the underlying aetiology while balancing maternal and fetal wellbeing. We present this case to highlight the diagnostic challenges posed by inconclusive ultrasonography, the importance of considering hypertriglyceridaemia as a potential underlying cause and the role of early diagnosis using the Revised Atlanta criteria with multidisciplinary conservative management in achieving favourable maternal and neonatal outcomes.

Case report: A 29 year old primigravida presented at 34 weeks gestation with severe epigastric pain radiating to the back, repeated vomiting and fever. She had two previous documented episodes of acute pancreatitis during pregnancy, with no gallstones identified on prior imaging. Serum amylase was 1800 U/L (>3 times the upper limit of normal), C-reactive protein 65 mg/L and haemoglobin 8.7 g/dL. Liver and renal function tests, coagulation profile and serum calcium were normal. Abdominal ultrasonography showed no gallstones, biliary or pancreatic duct dilatation, peripancreatic collections or pseudocysts. Acute pancreatitis was diagnosed according to the 2012 Revised Atlanta diagnostic criteria based on characteristic abdominal pain and elevated serum amylase. There was no organ failure or local complications, consistent with mild acute pancreatitis and the BISAP score was 0. Conservative multidisciplinary management included bowel rest, intravenous fluids, opioid analgesia and intravenous meropenem because of persistent fever and elevated inflammatory markers. A fasting lipid profile obtained 48 hours after treatment demonstrated hypertriglyceridaemia (407 mg/dL), elevated total cholesterol (241 mg/dL) and low HDL cholesterol (28 mg/dL). Symptoms resolved within one week without maternal or fetal complications. Labour was induced at 38 weeks, resulting in an uncomplicated vaginal delivery of a healthy neonate.

Discussion: Acute pancreatitis in pregnancy is diagnosed when at least two Revised Atlanta criteria are fulfilled. Ultrasonography has limited sensitivity in late pregnancy and normal findings do not exclude the diagnosis. Hypertriglyceridaemia is the second most common cause after gallstone disease and should be considered in recurrent pancreatitis when biliary pathology is absent. Early diagnosis, objective severity assessment and multidisciplinary conservative management are essential for favourable outcomes.

Conclusion: Prompt recognition of acute pancreatitis despite inconclusive ultrasonography, combined with appropriate severity stratification and conservative multidisciplinary management, can achieve excellent maternal and neonatal outcomes.

EP166. RECURRENT INTERSTITIAL ECTOPIC PREGNANCY MISDIAGNOSED AS CORNUAL PREGNANCY: A DIAGNOSTIC AND SURGICAL CHALLENGE

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Objectives: Interstitial ectopic pregnancy refers to implantation in the intramural portion of the fallopian tube within the myometrium which is a rare event. Although it accounts for only 2-4% of all tubal ectopic pregnancies but is potentially fatal, with considerable diagnostic and treatment challenges and risk of mortality of 2%-2.5%. It's recurrence on same side

is extremely rare, but distinguishing from cornual pregnancy is crucial due to higher risk of rupture and surgical management.

Case report: A 25-year-old G2A1E1, presented with amenorrhea, lower abdominal pain, spotting per vaginum and serum β-hCG of 19,500 mIU/ml. Prior history involved same sided cornual ectopic which was managed conservatively with IM methotrexate, hysteroscopy, dilatation and curettage following which serial β-hCG levels had normalized. Three months later, she presented in our tertiary centre with a referral diagnosis of missed abortion in ipsilateral cornual ectopic pregnancy with subseptate uterus. Clinical examination revealed uterus corresponding to 6 weeks gestation with mild lower abdominal and right fornicial tenderness. Given the diagnostic uncertainty and concern about the possibility of rupture and fertility preservation, transvaginal ultrasonography and pelvic MRI were carried out which were suggestive of recurrent ipsilateral interstitial ectopic for which minimally invasive fertility-preserving approach was planned. Diagnostic hysteroscopy and laparoscopic cornual wedge excision with complete removal of ectopic tissue and uterine reconstruction with v-loc was carried out and postoperative recovery was uneventful with successful preservation of uterine integrity. Further histopathology confirmed ectopic gestation and patient was offered LARC (Implanon) for contraception.

Results: This case underscores the importance of precise diagnosis in recurrent ectopic gestations and highlight the diagnostic dilemma between cornual and interstitial ectopic. In selected patients, laparoscopic cornual wedge excision with uterine reconstruction is a safe and effective fertility preserving treatment option.

Conclusion: This rare case of recurrent ipsilateral interstitial ectopic pregnancy demonstrates diagnostic overlap and the significance of careful assessment. It emphasises the importance of precise imaging interpretation to establish the correct diagnosis.

Keywords: Interstitial Ectopic pregnancy, laparoscopy, cornual pregnancy

EP167. RECURRENT SHORT RIB POLYDACTYLY SYNDROME: UNUSAL PRESENTATION OF SKELETAL DYSPLASIA

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Objectives: Short-rib polydactyly syndrome (SRPS) is a rare, lethal, skeletal ciliopathy with an autosomal recessive inheritance pattern. It is characterized by markedly shortened limbs, a narrow thoracic cavity and postaxial polydactyly.

We report a case of recurrent SRPS where the second case was diagnosed retrospectively following second trimester fetal demise.

Case report: A 32-year-old woman in her third pregnancy presented at 16 weeks' gestation for routine antenatal assessment. Her first pregnancy resulted in an uncomplicated term vaginal delivery of a healthy infant. Her second pregnancy ended in an early neonatal death due to severe respiratory insufficiency. The neonate had a markedly narrow thorax, short limbs and polydactyly; however, no definitive diagnosis had been established at that time.

During the current pregnancy, no fetal cardiac activity was detected. Anatomy scanning showed severe shortening of the fetal femurs, a markedly narrow rib cage and polydactyly involving the limbs. Medical evacuation was done with misoprostol. Post-delivery examination confirmed the antenatal findings of severe micromelia, a constricted thoracic cage and polydactyly.

The couple was counselled regarding the nature of the disorder, the estimated 25% recurrence risk in future pregnancies and the importance of early ultrasound assessment and genetic evaluation in subsequent conceptions. As they didn’t wish to conceive soon, contraception was provided with a progesterone implant and further referred for genetic evaluation.

Discussion: With the obstetric history and the recurrent phenotypic features, a retrospective clinical diagnosis of short-rib polydactyly syndrome was made. The recurrence of similar lethal skeletal abnormalities in consecutive pregnancies with a previous healthy child sup-

ported an autosomal recessive inheritance pattern. Skeletal dysplasia comprises a rare group of fetal anomalies that contribute to both morbidity and mortality of the newborn. In SRPS, the main cause for the adverse neonatal outcome is the respiratory distress resulting from poor lung expansion due to the narrow thoracic cavity.

Conclusion: This case highlights the importance of reviewing previous adverse pregnancy outcomes when evaluating recurrent fetal structural anomalies. Recognition of the characteristic triad of a narrow thorax, severe limb shortening and polydactyly facilitates the diagnosis of SRPS. Confirmation relies on molecular confirmation studies in alliance with genetic studies. Early prenatal recognition enables timely counselling, informed decision-making and appropriate planning for future pregnancies.

EP168. RECURRENT TRANSVERSE VAGINAL SEPTUM FOLLOWING SUCCESSFUL RECONSTRUCTION

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Objectives: Transverse vaginal septum is a rare congenital genital tract anomaly that may cause complete menstrual outflow obstruction. Although surgical correction can restore menstruation and reproductive function, postoperative restenosis remains a recognised complication. We report an unusual case of recurrent transverse vaginal septum causing haematometrocolpos after successful initial reconstruction, restoration of normal menstruation, spontaneous conception and childbirth.

Case report: A 22-year-old woman initially presented at 12 years of age with primary amenorrhoea, cyclical lower abdominal pain and a palpable abdominopelvic mass. Vaginal examination revealed a blind-ending vagina. MRI demonstrated haematometrocolpos associated with obliteration of the lower vaginal canal. Examination under anaesthesia confirmed a transverse vaginal septum, which was surgically resected with drainage of the retained menstrual blood and restoration of vaginal patency. Postoperatively, she was trained to use graduated vaginal cone dilators. She subsequently resumed normal cyclical menstruation, conceived spontaneously and delivered a healthy infant by elective caesarean section in 2024.

In 2026, she presented with secondary amenorrhoea of more than one year's duration, cyclical lower abdominal pain and dyspareunia. A pelvic mass was palpable and vaginal examination again demonstrated a blind-ending vagina. Ultrasonography revealed haematometra and haematocolpos. MRI confirmed recurrent haematometrocolpos secondary to a 5-mm thick transverse vaginal septum. Repeat septal resection and drainage were performed under spinal anaesthesia and a Foley catheter was used to maintain vaginal patency. She was counselled regarding manual digital dilatation and regular use of graduated vaginal cone dilators.

Discussion: Restenosis is an important long-term complication following surgical correction of a transverse vaginal septum. Inadequate continuation of postoperative vaginal dilatation may contribute to recurrent fibrosis and obstruction. This case demonstrates that late recurrence can occur despite an extended period of normal menstruation and successful reproductive outcomes. Recurrent amenorrhoea and cyclical pelvic pain in patients with previous vaginal reconstructive surgery should prompt assessment for recurrent genital outflow obstruction.

Conclusion: Successful restoration of menstruation and fertility following transverse vaginal septum repair does not exclude late restenosis. Long-term follow-up, sustained counselling regarding vaginal dilatation and early evaluation of recurrent obstructive symptoms are essential to prevent delayed diagnosis and complications of recurrent haematometrocolpos.

EP169. REFERRAL AND FOLLOW-UP PATHWAY FOR COLPOSCOPY: A BASELINE CLINICAL AUDIT

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Introduction: Cervical cancer causes a significant health challenge for women in Sri Lanka, ranking as the third most prevalent cancer among them. Over half of those diagnosed discover their condition at an advanced stage,

complicating treatment efforts. DGH Gampaha has implemented a dedicated colposcopy service for early detection and treatment. However, tracking of women who miss their appointments relies only on phone call tracking, without a comprehensive communication system to ensure they receive necessary care. This falls short of National Cancer Control Programme (NCCP) recommendations for monitoring women referred for care.

Objectives: To evaluate the referral and follow-up process for patients referred to the colposcopy unit at DGH Gampaha, assessing attendance, laboratory outcomes and subsequent actions against six predetermined standards, from the initial Consultant Gynaecologist (VOG) clinic appointment.

Design: This retrospective study examines current clinical practice, assessing alignment with six standards derived from NCCP guidelines and NHS England's recommendations for enhancing colposcopy safety. The intention is to provide an accurate solution to the existing situation, rather than testing hypotheses or comparing groups.

Method: Women who attended the VOG clinic with a referral and were advised to undergo colposcopy between 15 March and 20 July 2026 were reviewed (n=30). Appointment scheduling and postponement, lab result availability and findings and subsequent treatment were extracted from the colposcopy clinic register and individual patient files and compared against six standards covering attendance, lab result availability and patient communication.

Results: Of 30 women, 23 (76.7%) proceeded with colposcopy, while 7 (23.3%) discontinued after VOG recommendations. Among the 23 biopsied, 13 (56.5%) had reported results, 9 (39.1%) were awaiting results and 1 (4.3%) provided an inadequate sample. Of the 13 reported results, 6 (46.2%) were normal, 4 (30.8%) indicated LSIL and 3 (23.1%) showed HSIL, given that 7 of 13 (53.8%) had precancerous cells. No invasive cancer was detected. Of the six standards, three were fully met, one was partially met and two – communication with the Ministry of Health and structured follow-up beyond phone calls – were not met.

Conclusion: Care provided to women following VOG clinic assessment was effective, with timely treatment. All HSIL cases were appropriately managed and no invasive cancer was identified. However, 23.3% of women did not complete follow-up even after specialist recommendation, reflecting the absence of structured MOH-referral centre communication and inadequate patient tracking beyond phone calls. A structured communication protocol is recommended, with a subsequent audit planned after implementation.

EP170. RIFAMPICIN INDUCED HEPATOTOXICITY MIMICKING OBSTETRIC CHOLESTASIS

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Background: Tuberculosis (TB) in pregnancy poses a dual challenge: untreated disease threatens mother and fetus, while first-line anti-tuberculosis drugs carry a recognised risk of hepatotoxicity, occurring in 2–28% of patients, with pregnancy a contributing risk factor. Complete cessation of ATT is rarely straightforward, as prolonged interruption increases the risk of acquired drug resistance, requiring careful multidisciplinary balancing of maternal hepatic recovery, disease control and fetal wellbeing.

Case report: A 22-year-old primigravida presented in January 2025 with a three-month history of fever, non-productive cough and intermittent haemoptysis. SpO_2 was 93% on room air with bi-basal crepitations and associated paranoid delusions. She was diagnosed with CNS tuberculosis and started on four-drug fixed-dose combination therapy.

In March 2025 she developed rising liver function tests and was managed as ATT-induced hepatitis; desensitisation was done and treatment restarted. She subsequently defaulted treatment and was restarted on ATT in May 2025.

In September 2025 she was found to have an unplanned pregnancy at POA 10+. Multidisciplinary reassessment, including neurology review with lumbar puncture and EEG, showed no evidence of active CNS infection.

By POA 31+ her liver function tests were gradually rising, with elevated direct bilirubin and rising bile acids, depicting a picture of obstetric cholestasis. She had mild pruritus but was otherwise asymptomatic. Ursodeoxy-

cholic acid 300mg tds was started for rising transaminases. As liver dysfunction worsened despite treatment, consensus was reached to provide an ATT-free 2 week interval, which could not be prolonged given the risk of emerging drug resistance.

With cessation of ATT, liver function tests showed a progressively improving trend; an elective LSCS was performed at 34 weeks, delivering a healthy neonate. LFTs remained normal postpartum and the full four-drug ATT regimen was restarted. She was subsequently commenced on a subdermal contraceptive implant.

Discussion: This case illustrates the layered complexity of ATT-induced hepatotoxicity in a patient with CNS tuberculosis, prior hepatitis and repeated treatment defaults — factors increasing vulnerability to recurrent hepatotoxicity and complicating treatment-interruption decisions. Her unplanned pregnancy on ATT highlights the importance of contraceptive counselling in women on prolonged antituberculosis therapy. Expediting delivery at 34 weeks balanced prematurity risk against the need for definitive maternal hepatic management. Rifampicin was successfully reintroduced postpartum once liver function normalised, consistent with reports supporting sequential reintroduction after biochemical recovery.

Conclusion: ATT-induced hepatotoxicity in pregnancy can be safely navigated with time-limited treatment interruption, close monitoring and planned delivery once liver function normalises. Multidisciplinary collaboration is essential to balance hepatotoxicity, drug resistance and prematurity risks.

EP171. RITUXIMAB, SUBSTITUTE FOR MYCOPHENOLATE FOR POSTPARTUM CLASS-IV LUPUS NEPHRITIS TO PRESERVE BREAST-FEEDING

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Objectives: Mycophenolate mofetil (MMF) and cyclophosphamide, the standard induction agents for proliferative lupus nephritis (LN), are both unsafe during breastfeeding. We report the selection of rituximab for postpartum induction of Class IV LN in a mother for whom breastfeeding was a nutritional necessity, to highlight how drug safety in lactation, socioeconomic constraints and adherence can legitimately shape immunosuppressant choice.

Case report: . A 31-year-old (gravida 3, para 1) with systemic lupus erythematosus (SLE) and type 2 diabetes mellitus (T2DM) conceived in remission, but subsequently developed proteinuria (UPCR-143mg/mmol) in the 1st trimester and was diagnosed with Class-IV LN. Her serum creatinine was 42µmol/l. Antenatally, she received prednisolone, azathioprine, hydroxychloroquine, aspirin and enoxaparin. At 37 weeks she presented in spontaneous labour and underwent emergency caesarean section due to past section in labour, complicated by superimposed pre-eclampsia and a cholestatic hepatopathy attributed to azathioprine; she delivered a healthy 2.27 kg girl (Apgar 9, 9, 10). Proteinuria at post partum day seven rose to UPCR 347mg/mmol and renal function remained normal. Azathioprine was withdrawn because of the cholestasis and the standard alternative, MMF, would have prevented breastfeeding. As she could not afford formula and had previously defaulted follow-up, the team judged that prescribing MMF risked covert discontinuation to continue nursing, leaving her untreated. As a result, it was decided to treat her with B cell depletion using Rituximab. Hepatitis B and C serology were negative; she received intravenous rituximab (1 g, repeated after two weeks; total 2 g) while continuing to breastfeed. At most recent

review her renal function had improved with no postpartum flare.

Discussion: For a breastfeeding mother with proliferative LN, the cornerstone induction agents are unsafe in lactation, while the lactation-compatible azathioprine was precluded by toxicity. Rituximab, a large anti-CD20 monoclonal antibody, transfers minimally into breast milk (relative infant dose well below 10%) and is regarded by several professional bodies as compatible with breastfeeding. B-cell-depleting induction while preserving breastfeeding and removing the incentive for non-adherence. The affordability of infant formula, rarely cited in guidelines, was decisive here, underscoring the role of social determinants in therapeutic choice.

Conclusion: Rituximab offers a pragmatic, lactation-compatible option for postpartum induction of Class IV LN when standard agents are precluded by breastfeeding or intolerance. Immunosuppressant selection should explicitly weigh lactation safety, socioeconomic reality and adherence.

EP172. SALVAGE RADICAL HYSTERECTOMY AS AN ALTERNATIVE TO EXENTERATION: A CASE REPORT

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Objectives: Central pelvic recurrence of cervical cancer after radiotherapy is conventionally salvaged by exenteration - curative, but highly morbid. Whether a lesser operation can serve selected patients remains unsettled. We describe such a case and the grounds for the choice.

Case report: A 41-year-old multiparous woman presented with intermenstrual bleeding. Biopsy showed moderately differentiated squamous cell carcinoma of the cervix, International Federation of Gynecology and Obstetrics (FIGO) stage IIIA - bilateral parametrial and upper vaginal involvement, no pelvic sidewall extension. She completed concurrent chemoradiotherapy - external beam radiotherapy, intracavitary brachytherapy and cisplatin - with a complete clinical response. She represented two years later with persistent vaginal discharge. Biopsy confirmed recurrent squamous cell carcinoma and contrast-enhanced computed tomography showed a small central recurrence - no nodal, sidewall or distant disease. Exenteration was recommended and declined, its morbidity being unacceptable to her. Four features favoured a lesser operation - her age, a two-year disease-free interval, the small central recurrence and the absence of lateral disease. After detailed counselling, a type C radical hysterectomy with bilateral salpingo-oophorectomy and pelvic lymph node dissection was performed. The 1 cm lesion proved confined to the cervix - margins clear, nodes negative. Recovery was uneventful, without urinary or bowel complication and at three years she remains disease-free with good functional status.

Discussion: Exenteration remains standard for central recurrence in an irradiated pelvis, further radiotherapy being contraindicated, but the price is considerable - major complications in 33-70% and mortality up to 10%, with lasting effect on quality of life. Salvage radical hysterectomy has been reported in highly selected patients with small (<2 cm) centrally confined recurrence, free of sidewall or nodal involvement and this patient met each of those criteria. The operation is technically demanding in the irradiated pelvis, fistula being the recognised risk and belongs with experienced gynaecological oncologists within a multidisciplinary framework. Evidence remains confined to small retrospective series carrying selection bias and guidelines continue to favour exenteration.

Conclusion: In this woman a 1cm central recurrence, a two-year disease-free interval and the absence of lateral disease together permitted salvage radical hysterectomy in place of exenteration, with bladder and bowel function preserved and no recurrence at three years. For patients meeting these criteria the operation is an individualised alternative to exenteration, not a replacement for it.

EP173. SAVING THE SECOND TWIN: A 52-DAY DELAYED INTERVAL DELIVERY FOLLOWING RESCUE CERCLAGE

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Objectives: Delayed interval delivery following spontaneous miscarriage of the first twin is a rare obstetric intervention aimed at prolonging gestation and improving neonatal outcomes for the remaining fetus. Rescue cervical cerclage following delivery of the first twin remains controversial because of concerns regarding ascending infection and maternal morbidity. Evidence is limited and no cases have been reported from Sri Lanka. We describe a successful case of delayed interval delivery following rescue double-barrel cervical cerclage in a dichorionic diamniotic twin pregnancy.

Case report: A 33-year-old primigravida with a five-year history of primary subfertility conceived a dichorionic diamniotic twin pregnancy following the second cycle of intrauterine insemination. Her pregnancy was complicated by iron deficiency anaemia and gestational diabetes mellitus, both managed conservatively. At 20+3 weeks' gestation, she presented in preterm labour and spontaneously miscarried the first twin. Following multidisciplinary counselling regarding the potential risks and benefits of delayed interval delivery, the patient elected to undergo rescue cervical cerclage. The first twin's placenta was retained in situ and the umbilical cord was clamped and ligated close to the cervix. Examination revealed cervical dilatation of 2 cm with a residual cervical length of approximately 0.5 cm.

A rescue double-barrel cervical cerclage was performed under spinal anaesthesia within one hour of miscarriage. Postoperatively, she received broad-spectrum antibiotics, progesterone, nifedipine, thromboprophylaxis, antenatal corticosteroids and close inpatient maternal-fetal surveillance. Pregnancy was successfully prolonged by 52 days. At 27+6 weeks' gestation, spontaneous labour occurred. Following magnesium sulphate for fetal neuroprotection and cerclage removal, a live male infant weighing 1.28 kg was delivered vaginally.

A minor postpartum haemorrhage secondary to a bucket-handle cervical tear was successfully repaired. The neonate required neonatal intensive care and subsequent neonatal baby unit care, but survived and was discharged for routine developmental follow-up.

Discussion: This case demonstrates that carefully selected patients without evidence of infection may benefit from rescue cerclage as part of a comprehensive delayed interval delivery strategy. The 52-day prolongation of pregnancy compares favourably with published reports and highlights the potential role of combined cerclage, antibiotic therapy, tocolysis, progesterone supplementation, corticosteroids and intensive surveillance in improving neonatal survival.

Conclusion: Rescue double-barrel cervical cerclage following spontaneous miscarriage of the first twin enabled substantial prolongation of pregnancy and survival of the remaining twin. This case represents, to our knowledge, the first reported successful delayed interval delivery following rescue cerclage from Sri Lanka and supports consideration of this approach in carefully selected patients managed within a multidisciplinary setting.

EP174. SCRUB TYPHUS IN LATE PREGNANCY PRESENTING WITH FEVER, GENERALISED RASH AND SEVERE OLIGOHYDRAMNIOS

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Objectives: To report a case of clinically diagnosed scrub typhus in late pregnancy complicated by severe oligohydramnios and foetal growth restriction, highlighting the diagnostic challenge, need for exclusion of common regional differentials and value of early multidisciplinary management in endemic settings.

Case report: A 26-year-old G2P1C woman at period of gestation of 35+5 weeks presented with a three-day history of fever with chills, headache, myalgia, arthralgia and a generalized erythematous papular rash. The pregnancy had been uncomplicated until presentation.

Her foetal ultrasonography upon admission showed a small-for-gestational-age foetus with severe oligohydramnios with normal umbilical artery doppler. Her laboratory investigations revealed thrombocytopenia of 131 × 10^9/L, C-reactive protein of 152 mg/L with normal liver and renal function tests. Patient's dengue serology was negative. In the context of compatible symptoms; typical rash, thrombocytopenia, high inflammatory markers and regional endemicity, the illness was treated as a case of probable scrub typhus. The patient was managed by a multidisciplinary team and commenced on oral azithromycin which was later escalated to intravenous ceftriaxone with close maternal and foetal surveillance. The patient was responsive well to the treatment which was supported by the clinical improvement and serial decline in inflammatory markers. Once the infection settled the labour was induced using a transcervical Foley catheter due to persistent oligohydramnios. Subsequently the labour was augmented with artificial rupture of membranes following development of variable decelerations. She ultimately achieved an uncomplicated vaginal delivery.

Discussion: Scrub typhus is an important but under-recognized cause of febrile illness in pregnancy in endemic setting. Clinical manifestations of scrub typhus often overlap with other common diseases including dengue fever, leptospirosis, viral exanthems, making diagnostic delay likely when confirmatory testing or an eschar is absent. Adverse obstetric outcomes including foetal growth restriction, oligohydramnios, preterm birth and perinatal loss have been reported, attributed to placental dysfunction associated with systemic inflammation and maternal vascular effects. In this case, the temporal association between acute maternal febrile illness and subsequent severe oligohydramnios suggests clinically relevant foetal compromise. The high-impact learning point is that, in endemic areas, scrub typhus should remain in the differential diagnosis for fever with rash in late pregnancy.

Conclusion: In endemic settings, early consideration of scrub typhus, exclusion of key regional differentials, timely therapy and intensive maternal-foetal surveillance are essential to optimise maternal and neonatal outcomes.

EP175. SECONDARY CYTOREDUCTION FOR ISOLATED GASTRIC AND SPLENIC NODAL OVARIAN CANCER RECURRENCE

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Objectives: Recurrence of epithelial ovarian cancer in the isolated upper abdomen is rare and a challenging problem. We present this case to emphasize the value of secondary debulking surgery for the chosen cases to achieve complete excision.

Case report: A multiparous lady aged 50 years had been diagnosed with FIGO stage IIIC high-grade ovarian adenocarcinoma in 2023. She had been subjected to primary cytoreductive laparotomy with R0 resection and subsequently six cycles of adjuvant chemotherapy with a platinum-based regime. She was disease-free until an asymptomatic elevation of serum CA-125 level to 126 U/mL.

Contrast-enhanced computed tomography chest, abdomen and pelvis (CECT-CAP) revealed isolated recurrences in the form of left gastric lymph node, splenic hilar lymph node and a lesion in the fundus of the stomach without any evidence of disseminated intra-abdominal or distant metastasis. After multidisciplinary team discussion, the patient underwent secondary cytoreductive surgery in the form of left gastric lymphadenectomy, splenic hilar metastasectomy and excision of the lesion in the fundus of the stomach. She had complete macroscopic resection done. Her recovery was uneventful. The histopathological examination showed metastatic high-grade adenocarcinoma in the left gastric lymph node, splenic hilar lymph node and the fundus of the stomach, which was in keeping with recurrence of ovarian carcinoma. She was referred for postoperative systemic treatment. She was alive without recurrence in 6 months postoperatively.

Discussion: The secondary cytoreduction has recently been recognized as a treatment option for appropriate cases of platinum-sensitive recurrent ovarian cancer. The isolated recurrence at left gastric and splenic hilar lymph nodes level and involvement of the stomach is quite rare. In this case, proper preoperative imaging and multidisciplinary evaluation revealed the possibility of complete secondary cytoreduc-

tive surgery. The surgical treatment of such a local recurrence might lead to better disease control and should be performed in case of complete resectability and good performance status.

Conclusion: The presented case emphasizes the significance of secondary cytoreductive surgery in appropriate cases of isolated upper abdominal recurrence of high-grade ovarian carcinoma. The complete resection of recurrence located at the left gastric and splenic hilar lymph nodes as well as gastric fundus is possible and might have a beneficial effect on oncological results. The further studies are needed to determine the selection criteria and long-term survival benefits of secondary cytoreduction in rare recurrences of ovarian carcinoma as this is limited by being a single study and a short follow up.

EP176. SELECTIVE BILATERAL OVARIAN VENOUS SAMPLING IN THE EVALUATION OF SEVERE HYPERANDROGENISM

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Objectives: To highlight the role of selective bilateral ovarian venous sampling (OVS) in localizing the source of androgen excess in women with severe hyperandrogenism when conventional imaging and previous unilateral venous sampling are inconclusive. This case emphasizes the importance of multidisciplinary collaboration in guiding further management.

Case report: A 38-year-old woman presented with progressive hirsutism for three years and lower urinary tract symptoms for two years. Previous ovarian venous sampling was inconclusive because only the left ovarian vein was cannulated. She underwent laparoscopic-assisted bilateral ovarian venous sampling. Testosterone levels were markedly elevated in both ovarian veins (>3460 ng/dL right; 3369 ng/dL left) compared with peripheral venous blood (213 ng/dL). Elevated ovarian vein estradiol confirmed successful bilateral cannulation. She was referred back to endocrinology for definitive management.

Discussion: Selective ovarian venous sampling is valuable when imaging fails to identify the source of severe hyperandrogenism. This case highlights the importance of repeat bilateral sampling after an unsuccessful initial attempt and demonstrates the benefit of multidisciplinary collaboration.

Conclusion: Selective bilateral ovarian venous sampling improves localization of ovarian androgen secretion and supports appropriate multidisciplinary management in women with unexplained severe hyperandrogenism.

EP177. SEPSIS DUE TO INFECTED ENDOMETRIOMA FOLLOWING SALPINGECTOMY FOR ECTOPIC PREGNANCY: A CASE REPORT

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Background: Ovarian endometriomas are a common manifestation of endometriosis but infection of an endometrioma is rare. Postoperative infection following emergency surgery for ectopic pregnancy is particularly unusual and may lead to pelvic abscess formation and sepsis. Severe endometriosis, extensive adhesions, altered pelvic anatomy and impaired drainage may contribute to this complication. Early recognition, appropriate antimicrobial therapy, timely source control and consideration of fertility implications are essential.

Case report: A 35-year-old nulliparous woman with a 15-year history of primary subfertility presented with lower abdominal pain, vaginal bleeding and six weeks of amenorrhoea. Transvaginal ultrasound demonstrated a leaking left tubal ectopic pregnancy, bilateral ovarian endometriomas (left 5 × 5 cm, right 4 × 3 cm) and significant haemoperitoneum. Emergency laparoscopic left salpingectomy and evacuation of approximately 500 mL of blood were performed. Extensive pelvic adhesions secondary to severe endometriosis prevented safe excision of the endometriomas. Initial recovery was uneventful; however, on postoperative day six she developed high-grade fever, rigors, tachycardia and malaise with markedly raised inflammatory markers. Ultrasound

demonstrated a complex pelvic collection involving the left endometrioma, suspicious for infection and pelvic abscess formation. Despite 72 hours of broad-spectrum intravenous antibiotics, she remained febrile. Exploratory laparotomy on postoperative day nine revealed an infected left ovarian endometrioma containing purulent material, dense adhesions and a right hydrosalpinx. Drainage of the abscess, excision of infected tissue, right salpingectomy for the significantly diseased hydrosalpinx, peritoneal lavage and pelvic drain insertion were performed. Pus was sent for microbiological culture and sensitivity but no organism identified. She improved rapidly, with complete resolution of fever by postoperative day four and was discharged following completion of antibiotics. Fertility counselling addressed the impact of bilateral salpingectomy on natural fertility and the potential role of IVF.

Discussion: Infection of an endometrioma is uncommon and can be difficult to distinguish from other causes of postoperative fever, including pelvic haematoma and postoperative abscess. In this case, severe endometriosis with extensive adhesions prevented removal of the endometriomas during the emergency procedure, leaving a residual lesion in a surgically manipulated pelvis. Persistent fever and inflammatory markers despite appropriate antibiotics prompted repeat imaging and identification of a complex collection. Although imaging suggested infection, definitive diagnosis was established intraoperatively by the presence of purulent material. This case emphasises that antibiotics alone may be insufficient once an organised pelvic abscess has developed and early surgical source control should be considered when there is persistent sepsis despite antimicrobial therapy. Microbiological culture of purulent material is important to identify pathogens and guide antimicrobial therapy. Bilateral salpingectomy significantly affects natural fertility but does not preclude pregnancy through IVF; therefore, early and sensitive fertility counselling is important, particularly in women with pre-existing subfertility.

Conclusion: In women with severe endometriosis undergoing emergency pelvic surgery, an endometrioma may rarely become infected and cause postoperative pelvic sepsis. Persistent fever and inflammatory markers after 48–72 hours should prompt repeat imaging and consideration of source control. Timely multidisciplinary management can achieve clinical recovery while appropriate fertility counselling helps address the reproductive consequences of bilateral tubal loss.

Keywords: Endometrioma; Sepsis; Ectopic pregnancy; Salpingectomy; Pelvic abscess; Endometriosis.

EP178. SEPSIS-INDUCED POSTPARTUM HEMOPHAGOCYTIC LYMPHOHISTIOCYTOSIS TRIGGERED BY ACINETOBACTER SEPSIS: A DIAGNOSTIC HARDSHIP

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Objectives: To report a case of secondary Heamophagocytic Lymphohistiocytosis (HLH) triggered by Acinetobacter sepsis in the postpartum period and to highlight the diagnostic difficulties and management strategies with puerperal sepsis.

Case report: A 26-year-old multigravida (G2P1C1) with background history of adult-onset epilepsy presented at 38 weeks of gestation with low-grade fever, cough, hallucinations and confusion. She was managed as viral pneumonia in ICU setting. An elective lower segment caesarean section was done at 38+5 of gestation due to past section. Immediate postpartum recovery was uncomplicated and she was discharged with routine follow-up care. On postoperative day 5, she presented with fever, severe secondary postpartum haemorrhage and profound anaemia (haemoglobin 4.5 g/dL) and treated with massive blood transfusion in ICU care. The cause for postpartum haemorrhage was retained products of conception, which was surgically evacuated.

She has developed left-sided hydronephrosis, recurrent melena and sudden neurological symptoms causing right-sided hemiparesis (motor power 2/5) during ICU stay. Laboratory investigations revealed bicytopenia (white cell count), severe hypofibrinogenemia (1.11 g/L), marked hyperferritinemia (ferritin 2,633

ng/mL) and acute hepatocellular injury (AST 446 U/L, ALT 181 U/L, total bilirubin 3.92 mg/dL).

She was started on empirical broad-spectrum antibacterial and antifungal therapy. Bone marrow aspiration was done and demonstrated active hemophagocytosis. It confirms the diagnosis of secondary HLH. The bone marrow culture detected Acinetobacter species, confirming the primary infection. Despite of multidisciplinary management patient was died due to refractory septic shock.

Discussion: Postpartum HLH is a rare, life-threatening hyper-inflammatory syndrome characterized by an uncontrolled cytokine storm. This case demonstrates a massive diagnostic and management difficulty. The patient's presentation with symptoms of severe puerperal sepsis, secondary postpartum haemorrhage and hyper-ferritinemia, hypofibrinogenemia and dropping cell counts provided the clinical clues towards HLH. Acinetobacter is a virulent pathogen and its isolation directly from the bone marrow confirms it as the underlying cause of this secondary HLH.

Conclusion: Sepsis-induced postpartum HLH represents a diagnostic hardship. In postpartum patients with refractory fever, cytopenias and unexplained multiorgan or neurological involvement, secondary HLH must be considered. Early bone marrow biopsy is helpful to confirm hemophagocytosis and isolate any pathogens. It will guide to start life-saving immunosuppressive and targeted antimicrobial therapy.

Keywords: Postpartum Hemophagocytic Lymphohistiocytosis, Acinetobacter, Diagnostic hardship, Hypofibrinogenemia, Hyperferritinemia.

EP179. SEPTIC PELVIC THROMBOPHLEBITIS FOLLOWING EMERGENCY CAESAREAN SECTION: A CASE REPORT

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Septic pelvic thrombophlebitis (SPT) is a rare but important cause of persistent postpartum fever that is unresponsive to broad-spectrum antibiotics. We report the case of a 34-year-old woman who developed persistent puerperal pyrexia following an emergency lower segment caesarean section. The diagnosis of SPT was reached based on clinical suspicion, exclusion of alternative causes, and a rapid clinical response to therapeutic anticoagulation. This case highlights the importance of considering SPT as a diagnosis of exclusion in postpartum women with antibiotic-resistant fever, and the diagnostic and therapeutic role of empirical anticoagulation.

Keywords: septic pelvic thrombophlebitis; puerperal pyrexia; postpartum fever; anticoagulation; caesarean section.

Introduction

Postpartum fever is most attributed to endometritis, urinary tract infection, or surgical site infection. When fever persists despite adequate antimicrobial therapy and no clear infective focus can be identified, septic pelvic thrombophlebitis should be considered. It remains a diagnosis of exclusion and is frequently confirmed retrospectively by the characteristic rapid response to anticoagulation. [1,2]

Case Presentation

A 34-year-old woman (gravida 3, para 2), with an uncomplicated antenatal period, was admitted at 40 weeks of gestation for induction of labour. Following induction, she progressed to the second stage but developed a prolonged second stage with suspected foetal compromise. An attempt at vacuum-assisted vaginal delivery was unsuccessful, and she therefore underwent a Category 1 emergency lower segment caesarean section. The immediate postpartum period was complicated by postpartum haemorrhage secondary to a vaginal wall tear, which was managed surgically. She remained haemodynamically stable following resuscitation.

Postoperative Course

On the first postoperative day the patient developed high, swinging fever, with intermittent spikes of approximately 38.3–38.9°C (101–102°F) that persisted despite treatment. Laboratory investigations revealed a white cell count of 24,000/mm^3 and a C-reactive protein of 97 mg/L, which subsequently peaked at 147 mg/L. Liver function tests and the coagulation profile were normal, and the full blood count showed anaemia consistent with peripartum blood loss. Blood and urine cultures were negative.

Ultrasonography of the abdomen and pelvis demonstrated no retained products of conception, no collection or abscess, and no specific ultrasound features of septic pelvic thrombophlebitis were identified. Lower limb deep vein thrombosis was excluded by Doppler ultrasonography. There was no respiratory focus and dengue and other locally prevalent causes of fever were excluded. A multidisciplinary approach was undertaken, including consultation with the microbiology team.

Management

The patient was initially treated with broad-spectrum antibiotics (co-amoxiclav and metronidazole), which were subsequently escalated to ceftriaxone and piperacillin–tazobactam. [3] Despite appropriate escalation the fever persisted without clinical improvement. In view of the persistent swinging fever, negative cultures, absence of an identifiable infective focus, and failure to respond to antibiotics, a clinical diagnosis of septic pelvic thrombophlebitis was made. Therapeutic anticoagulation with low molecular weight heparin was commenced at a dose of enoxaparin 40mg daily subcutaneously and continued for 10 days.

Outcome

Following the initiation of anticoagulation the patient's clinical course improved rapidly. The fever settled, her general condition improved significantly, and the inflammatory markers began to decline. This prompt and marked response to anticoagulation supported the clinical diagnosis of septic pelvic thrombophlebitis. Fever settled on day 2 of treatment and the patient completed a 10 day course of enoxaparin 40 mg daily. At discharge, the patient was well and was scheduled for a follow-up clinic visit in two weeks.

Discussion

Septic pelvic thrombophlebitis is an uncommon postpartum complication associated with caesarean delivery, prolonged labour, operative vaginal delivery, and postpartum infection, several of which were present in this patient. [2] The condition arises from infective thrombosis of the pelvic veins, most frequently the ovarian veins, with the right ovarian vein most commonly involved. [5] The characteristic clinical picture comprises persistent postpartum fever, a poor response to appropriate antibiotics, negative cultures, and the absence of an identifiable infective focus.

Contrast-enhanced computed tomography and magnetic resonance imaging can demonstrate pelvic vein thrombosis and are regarded as the imaging modalities of choice; however, imaging is frequently non-diagnostic, and a negative study does not exclude the diagnosis. [5][6] Ultrasonography is often the first-line investigation because it is readily available and helps to exclude retained products and pelvic collections, but it is relatively insensitive for pelvic vein thrombosis. For these reasons SPT remains largely a clinical diagnosis. [6] In this case, neither contrast-enhanced CT nor MRI could be performed due to equipment breakdowns at both the National Hospital Kandy and Teaching Hospital Peradeniya. The diagnosis is frequently supported, as in the present case by the prompt resolution of fever after anticoagulation is introduced. [2]

Conclusion

Septic pelvic thrombophlebitis should be considered in postpartum patients with persistent fever that fails to respond to antibiotics and in whom investigations for other causes are negative. Early recognition and the timely initiation of anticoagulation are essential to achieve rapid recovery and to prevent complications such as thrombus propagation and septic embolisation.

Ethics and Consent

Written informed consent for management and for the publication of this case report was obtained from the patient.

EP180. SEVERE PLACENTAL INSUFFICIENCY IN PREGNANCY ASSOCIATED WITH UTERUS DIDELPHYS AND DOUBLE VAGINA RESULTING IN IATROGENIC PRETERM DELIVERY: A CASE REPORT

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Objectives: To report a rare case of previously undiagnosed uterus didelphys with double vagina presenting with severe placental insufficiency and symmetrical fetal growth restriction requiring iatrogenic preterm delivery

and to highlight the associated obstetric risks with uterine didelphys.

Case report: A 20 year old primi mother whose antenatal history and care was unremarkable, was found to have a symphysiofundal height that was small for gestational age. Transabdominal scan revealed breech presentation, symmetrical fetal growth restriction with estimated fetal weight of 1.3kg, minimal liquor and abnormal umbilical artery doppler. As the finding were suggestive of placental insufficiency and due to concern of fetal well being, she was planned elective lower segment caesarian section. Corticosteroids were given for lung maturation.

A live fetus weighing 1.4kg was delivered. Intra-operatively, two separate uterine bodies with individual fallopian tubes were identified, consistent with uterus didelphys, with the pregnancy located in the right uterus. Vaginal examination shows presence of two cervices separated by a longitudinal vaginal septum. Both mother and baby recovered well and were discharged in satisfactory condition. Ultrasound Kidney Ureter & Bladder was performed which excluded associated renal anomalies.

Discussion: Uterus didelphys is a rare Müllerian duct anomaly resulting from complete failure of duct fusion. This condition is associated with obstetric complications such as fetal growth restriction, malpresentation, preterm birth and caesarean delivery. It is thought that these complications arise due to the reduced uterine cavity size, abnormal vascularization and impaired placentation. This also case highlights that uterus didelphys can remain undiagnosed until delivery.

Conclusion: Uterus didelphys may be associated with severe placental insufficiency and fetal growth restriction necessitating preterm delivery. Early recognition of fetal compromise and timely intervention can result in favourable maternal and neonatal outcomes.

EP181. SIMULTANEOUS CAESARIAN SECTION AND OPEN HEART SURGERY FOR ATRIAL MYXOMA IN PREGNANCY

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Objectives: Cardiac myxoma, although considered the most common primary benign cardiac tumour, is extremely rare during pregnancy. Most patients are often asymptomatic but large atrial myxomas have a high risk of systemic embolisation, heart failure, valvular obstruction and sudden death. Management during pregnancy is challenging, with limited guidance for clinical decision making. This case is reported to highlight the successful multidisciplinary management of a large left atrial myxoma diagnosed in pregnancy and to demonstrate the possibility of a combined caesarean section and cardiac surgery in achieving favourable maternal and neonatal outcomes.

Case report: Our patient was a 24-year-old primigravida who was referred following the incidental detection of an irregular pulse during a routine antenatal visit. She was at 27 weeks' gestation with an otherwise uncomplicated pregnancy. She had no previous cardiac symptoms or history of heart disease. Transthoracic echocardiography showed a large left atrial myxoma measuring 22.3 × 13.1 mm, prolapsing through the mitral valve into the left ventricle, placing her at high risk of left ventricular inflow obstruction and systemic embolisation. Multidisciplinary discussion was held between the cardiologists, cardio-thoracic surgeons, intensivists, obstetricians, anaesthetists and neonatologists and a decision was made to proceed with immediate delivery followed by tumour excision in the same setting. Antenatal corticosteroids and magnesium sulphate were administered for fetal lung maturation and neuroprotection. She received perioperative care in the cardiac intensive care unit.

Caesarean section was performed under general anaesthesia with prophylactic B-Lynch suture placement before systemic anticoagulation. Cardiopulmonary bypass was instituted following completion of caesarian section and successful excision of the atrial myxoma was performed during the same operative session. The neonate was transferred to the neonatal intensive care unit and the mother required intensive care postoperatively but subsequently made a complete recovery.

Discussion: We aim to highlight the importance of early diagnosis, appropriate referral pathways and multidisciplinary collaboration when managing rare disorders during pregnancy. Combined caesarean section and cardiac surgery allowed timely treatment of this potentially life threatening maternal condition while reducing the fetal exposure to cardiopulmonary bypass. Expecting haemorrhage before anticoagulation, proper perioperative planning and coordinated care were fundamental to the successful outcome.

Conclusion: Management of atrial myxoma in pregnancy requires the skills of many specialities which should work in conjunction to minimise maternal and foetal complications. Combined cardiothoracic surgery and caesarian section is possible when done in a specialised tertiary care centre with the best available facilities and expertise.

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EP182. SMOOTH MUSCLE TUMOUR OF UNCERTAIN MALIGNANT POTENTIAL (STUMP) OF THE UTERUS PRESENTING AS A GIANT ABDOMINOPELVIC MASS: A CASE REPORT

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Introduction: Uterine smooth muscle tumour of uncertain malignant potential (STUMP) occupies the grey zone between benign leiomyoma and leiomyosarcoma. It is uncommon, the diagnostic criteria are not uniform and its behaviour is unpredictable - which makes both the pathology and the management difficult. We report one presenting as a giant abdominopelvic mass.

Case report: A 40-year-old multiparous woman presented with four months of progressive abdominal distension and lower abdominal discomfort. Examination found a large firm abdominopelvic mass, approximately 26 weeks' size. Ultrasonography showed a large vascular uterine mass and contrast-enhanced computed tomography a well-defined pelvic mass of 19 × 20 × 14 cm, apparently arising from the uterine fundus - no local infiltration, ascites, lymphadenopathy or distant metastasis. Given the size, the symptoms and the diagnostic uncertainty, exploratory laparotomy was undertaken and total abdominal hysterectomy with bilateral salpingo-oophorectomy and omentectomy performed. Histopathology showed a large subserosal spindle-cell neoplasm - focal moderate nuclear atypia, moderate pleomorphism, multinucleated cells, myxoid change, no tumour necrosis and a mitotic count of 2 per 10 high-power fields. The Ki-67 proliferative index was 1%. Ascitic fluid cytology was negative for atypical cells and the omentum was free of tumour. The final diagnosis was STUMP of the uterus.

Discussion: Degenerating leiomyoma, STUMP and leiomyosarcoma could not be separated before surgery in this woman. Imaging defined extent and operability and no more than that - the diagnosis rested on histopathology. Three features settled it: no coagulative tumour cell necrosis, a mitotic count of 2 per 10 high-power fields and a Ki-67 of 1%. Hysterectomy remains the standard treatment for women who have completed childbearing, as this patient had. Surveillance must nonetheless be prolonged, since recurrence is reported, at times as leiomyosarcoma.

Conclusion: STUMP belongs in the differential of an unusually large uterine smooth muscle tumour. Here a 19 × 20 × 14 cm mass that imaging could not characterise proved, on histology alone, to be neither leiomyoma nor leiomyosarcoma. Surgery was matched to her age and completed family; follow-up now has to outlast the uncertainty the diagnosis carries.

EP183. SOME CHARACTERISTICS OF WOMEN WITH UNPLANNED PREGNANCIES PRESENTED TO SELECTED CLINICS IN COLOMBO

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Introduction: Unplanned pregnancies contribute to poor maternal and neonatal outcomes and remain a major cause of termination of pregnancies and abandonment of newborns in Sri Lanka. This study, although conducted in 2011, provides an overview of sociodemographic and reproductive characteristics of women presenting with unplanned pregnancies in selected clinics in Colombo. These findings highlight persistent public health issues in maternal and child health services that still need to be addressed.

Objectives: The general objective was to analyse selected characteristics of women presenting with unplanned pregnancies to healthcare facilities in the Colombo district, with a view to contributing to future maternal health program planning.

Design: A non-interventional, descriptive cross-sectional study design was employed, facilitating the characterization of women with unplanned pregnancies in their natural clinical setting without manipulation of exposures or allocation of interventions.

Method: The study population comprised pregnant mothers presenting to healthcare facilities in Colombo city with an unplanned pregnancy during 2011. Non-probability convenience cluster sampling was used. Four general practices where the principal investigator could obtain permission for the study were selected.

Ethical clearance was obtained from the Faculty of Medicine, Colombo. Informed consent was obtained from each participant. In the case of participants less than 18 years of age, informed consent was obtained from a parent or guardian.

The inclusion criteria were the following.

A. The mother should have carried an unplanned pregnancy. The following characteristics were used to qualify unplanned pregnancies.
   1. Pregnancy was due to rape or incest.
   2. Mother's age was less than 16 years.
   3. Mother was not married.
   4. Mother had become pregnant by a person other than the husband.
   5. Previous child was less than six months of age when mother got pregnant.
   6. Became pregnant while using a family planning method or after sterilisation.
   7. Mother underwent, tried, requested, or thought about terminating the pregnancy.
   8. Mother thinks it is an unplanned pregnancy without giving any reasons.
   9. Investigator thought it was an unplanned pregnancy due to any other reason not mentioned above.

B. The mother was carrying the unplanned pregnancy during the interview or was carrying an unplanned pregnancy during the year 2011.

C. The mother was in a mentally stable condition to face the interview, according to the principal investigator.

Data were collected using an interviewer-administered questionnaire. Since the interviewer was the principal investigator, no training was required.

Although convenience sampling is expected to reduce the representativeness of the mothers, the effect is minimal because the selected clinics were not different from other clinics in Colombo city.

The following information was collected.

Date of Interview Socio-demographic details of the mother (Age, Marital status, Ethnicity, Religion, Economic status and educational level) Details of pregnancy (Parity and stage of pregnancy) Reason why this pregnancy was categorised as unplanned according to inclusion criteria Use of contraceptive method when mother became pregnant (whether used, if used whether correctly used and if used type of method used) Impact of unplanned pregnancy on the mother Decision taken by mother regarding the future of the pregnancy Descriptive analysis of data was done by categorising the subjects with numbers and percentages. The denominator for percentages in the case of

the whole sample and subgroups were sample size and subgroup count, respectively.

Results: The sample comprised 207 participants (response rate 100%). Most mothers were married (86%). Among married mothers, 88% were multigravidas, whereas among unmarried mothers, 93% were primigravids. Most mothers (84%) were not using any family planning method; the remaining 16% became pregnant while using a method. Of those using family planning, only 42% reported correct use. The overall prevalence of family planning use in this population was 15%. The most commonly used method was oral contraceptive pills. Eight mothers reported using emergency contraceptive pills as their regular method. Most unplanned pregnancies (90%) occurred among women from low- and middle-income backgrounds. The most frequently reported difficulty faced by mothers due to the unplanned pregnancy was inability to care adequately for other children. Importantly, 95% of mothers had considered termination of the pregnancy in a setting where it is illegal.

Conclusion: Although 15 years have passed, these findings offer a unique temporal perspective on a persistent public health issue, enabling the assessment of long-term trends and informing contemporary family planning strategies in urban Sri Lanka.

Low contraceptive prevalence, incorrect use of family planning methods and greater involvement of women from low- and middle-income backgrounds were evident in this urban setting. The psychosocial impact of unplanned pregnancies was evident in the higher number of women considering termination of pregnancy. These findings highlight the continued need for family planning counselling and more accessible reproductive health services.

EP184. SPECTRUM OF COLPOSCOPY FINDINGS AND PRACTICE AT NATIONAL CANCER INSTITUTE SRI LANKA

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Introduction: Colposcopy is central to the assessment of abnormal cervical screening and to the diagnosis of pre-invasive and invasive cervical disease. Cervical cancer remains an important gynaecological malignancy in Sri Lanka. Characterising the case-mix, findings and service delivery of a colposcopy service supports quality assurance and resource planning.

Objectives: To describe the case-mix, colposcopic findings and procedures performed in the colposcopy service at a tertiary oncology centre over one year, to determine the proportion of women with pre-invasive and invasive cervical disease and to audit the proportion managed as outpatients against international recommendations.

Design: Retrospective, single-centre descriptive clinical audit.

Method: Records of all women who underwent colposcopy at the National Cancer Institute over one year (2024-2025) were reviewed. Age, referral setting (inpatient/outpatient), procedure and colposcopic findings were extracted into a structured proforma and analysed descriptively. The outpatient proportion was audited against international standards recommending at least 85% (target 90%) of colposcopy-based treatment be performed as outpatient procedures under local anaesthesia.

Results: Sixty-one women underwent colposcopy: 54 (89%) as inpatients and 7 (11%) as outpatients; mean age was 48.1 years (range 34–69). Colposcopy alone was performed in 33 (54%), colposcopy with large loop excision of the transformation zone (LLETZ) in 18 (30%) and colposcopy with biopsy in 10 (16%). Colposcopy was normal in 31 women (51%). Cervical intraepithelial neoplasia grade 1 (CIN1) was the commonest abnormality (21; 34%), followed by CIN2/3 in 4 (7%) and one invasive squamous cell carcinoma (SCC) (2%); four further women showed human papillomavirus (HPV)-related, dysplastic or vulval intraepithelial neoplasia (VIN3) changes (7%). Overall, pre-invasive or invasive cervical disease (CIN1 or worse) was identified in 26 women (43%) and high-grade or invasive lesions (CIN2/3, SCC or VIN3) in 6 (10%). Among the 18 women undergoing LLETZ, mean age was 43.8 years (range 34–53).

Conclusion: The colposcopy service manages a broad case-mix, with pre-invasive disease (predominantly CIN1) detected in one-third of women and high-grade or invasive lesions in one in ten, confirming its value in cervical

cancer prevention at this centre. However, only 11% of procedures were performed as outpatients, well short of the internationally recommended minimum of 85%. This audit did not assess whether individual cases could safely have been managed as outpatients; rather, the high inpatient proportion highlights an opportunity to evaluate expanding dedicated outpatient colposcopy services with local anaesthesia, informing resource allocation, training and future evaluation.

EP185. SPLIT-THICKNESS SKIN GRAFTING AFTER RADICAL EXCISION OF MONS PUBIS SQUAMOUS-CELL CARCINOMA

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Objectives: Mons pubis squamous cell carcinoma (SCC) is a rare form of vulvar cancer, requiring wide resection and complicated reconstruction procedures. This case demonstrates the use of split-thickness skin grafting in a patient with advanced vulvar cancer, psychiatric comorbidity and nodal metastases after radical excision.

Case report: An unmarried 55-year-old postmenopausal woman suffering from hypothyroidism, multinodular goitre and schizophrenia was brought with a painless, progressive swelling in the mons pubis lasting for 2 months. Biopsy showed the diagnosis as moderately differentiated invasive squamous cell carcinoma (SCC). Contrast enhanced computed tomography showed the primary tumor along with suspicious nodes in left inguinal, external iliac and obturator areas and an indeterminate hyper-enhancing lesion in the second segment of the liver. As per the multidisciplinary approach, the surgical treatment was decided to control the local disease and alleviate symptoms.

Surgery involved wide local excision of the vulval tumor, bilateral inguinal lymphadenectomy, pelvic lymphadenectomy, skin grafting from the thigh and bilateral salpingectomy. The presence of pelvic nodal disease could be seen during surgery and total macroscopic clearance was not possible. The tumor was diagnosed as moderately differentiated SCC of size 80 × 65 mm with a depth of invasion of 34 mm. The deep margins of resection were found to be 1 mm and the peripheral margins varied between 3 to 70 mm. There was metastasis in three of six left inguinal and one of four left pelvic nodes while the right side was clear, staging as IV-B. The skin graft healed successfully; however, a recurrence in the vulvar region occurred within 2 months due to disaster-related delays in receiving oncological treatment after Cyclone Ditwah before initiating any adjuvant treatment. Liver lesion was planned to reassess in 6 months.

Discussion: Advanced vulvar SCC with involvement of mons pubis poses great difficulty for surgical and reconstructive interventions. The choice of split thickness skin grafting was because the extensive superficial wound could not have been managed by primary closure. In cases of advanced cancer with significant psychiatric disorders and node metastasis, compared with flap reconstruction, skin graft provided a simpler and less morbid method of wound coverage, with shorter operative time and satisfactory healing. However, in this case, early recurrence is expected because of close surgical margins and nodal metastases.

Conclusion: The split-thickness skin graft is an effective reconstructive choice after the radical removal of large areas of vulvar SCC. Nevertheless, the advanced stages of the condition with metastasis are prone to an early recurrence even with satisfactory reconstruction achieved surgically.

EP186. SPONTANEOUS REGRESSION OF AN ISOLATED SEPTATED FOETAL CYSTIC HYGROMA: A CASE REPORT

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Objectives: Foetal cystic hygroma is a rare congenital lymphatic malformation that we typically associate with severe complications, including structural anomalies, hydrops fetalis, chromosomal abnormalities and generally poor perinatal outcomes. The prognosis is usually even worse when the hygroma is septated. In this report, we share a rare case where an isolated septated cystic hygroma was diagnosed in the first trimester but then regressed completely on its own, eventually leading to a normal vaginal delivery and a healthy newborn.

Case report: A 36-year-old primigravida attended her routine first-trimester ultrasound at 12 weeks of gestation. During the scan, we identified an isolated septated foetal cystic hygroma. We monitored her closely with detailed serial ultrasounds, which fortunately showed no signs of hydrops fetalis or other structural anomalies. The patient did not undergo prenatal genetic testing; however, we observed the cystic hygroma progressively shrinking as the pregnancy advanced. With reassuring antenatal surveillance throughout her care, she had a spontaneous vaginal delivery at 38 weeks. She delivered a healthy neonate weighing 3.0 kg, who had a completely normal postnatal examination and an uncomplicated course in the neonatal period.

Discussion: When clinicians encounter septated cystic hygromas, the immediate concern is usually chromosomal abnormalities and adverse foetal outcomes. But, a small number of isolated cases can result in positive outcomes, particularly if hydrops never develops and the lesion regresses. Our experience with this patient reveals, why individualized counselling and meticulous serial foetal surveillance are so important in obstetric management. Furthermore, this case proves that as long as there is no foetal airway compromise or other obstetric reasons to intervene, vaginal delivery remains a safe option.

Conclusion: Despite the traditionally poor prognosis, an isolated septated cystic hygroma diagnosed early in pregnancy can sometimes undergo spontaneous regression and yield a highly favourable perinatal outcome. We emphasize that careful, individualized antenatal surveillance is essential and that we can confidently support a vaginal delivery in selected patients when foetal assessments remain reassuring.

EP187. SPONTANEOUS TUMOUR LYSIS SYNDROME: A RARE BUT FATAL GYNAECOLOGICAL ONCOLOGICAL EMERGENCY

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Objectives: Tumour lysis syndrome (TLS) is a life-threatening metabolic emergency resulting from rapid tumour cell breakdown. While commonly encountered following treatment of haematological malignancies, spontaneous TLS in untreated gynaecological cancers is exceptionally rare and associated with high mortality. We report a fatal case of spontaneous TLS in a young woman with a large pelvic tumour to highlight the importance of early recognition and multidisciplinary management.

Case report: A 33-year-old woman presented with a large predominantly solid abdominopelvic mass. Serum alpha-fetoprotein (AFP) and lactate dehydrogenase (LDH) were markedly elevated, suggesting a germ cell type ovarian malignancy. During evaluation, she developed unexplained hyperkalaemia with progressive acute kidney injury, demonstrated by rising serum creatinine. Further investigations revealed hyperuricaemia, hyperphosphataemia and hypocalcaemia, fulfilling the Cairo–Bishop laboratory criteria for tumour lysis syndrome. A diagnosis of spontaneous TLS was established prior to initiation of cancer-specific therapy. She received aggressive supportive management, including intravenous hydration, correction of life-threatening electrolyte abnormalities, allopurinol, intensive care support and renal replacement therapy with haemodialysis. Despite maximal supportive treatment, her clinical condition deteriorated and she died three weeks after diagnosis.

Discussion: Spontaneous TLS is an uncommon but increasingly recognised complication of aggressive solid tumours, including gynaecological malignancies with bulky disease, high proliferative activity and elevated LDH. Early manifestations may include unexplained hyperkalaemia, hyperuricaemia and acute kidney injury before cancer treatment is initiated. Published reports demonstrate that spontaneous TLS in solid tumours carries a poor prognosis, particularly when diagnosis is delayed or multiorgan dysfunction develops. Prompt recognition, intensive supportive care, urate-lowering therapy and early involvement of nephrology and critical care services are essential to optimise outcomes.

Conclusion: Although rare, spontaneous tumour lysis syndrome should be considered in patients with bulky gynaecological tumours presenting with unexplained electrolyte abnormalities and acute kidney injury before treatment. Early diagnosis and rapid multidis-

ciplinary intervention are crucial, as this condition carries substantial morbidity and mortality despite optimal supportive care.

EP188. SQUAMOUS CELL CARCINOMA ARISING IN A MATURE CYSTIC TERATOMA OF THE OVARY

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Objectives: Mature cystic teratoma (MCT) undergoes malignant transformation in 0.17–2% of cases, squamous cell carcinoma (SCC) accounting for some 80%. Where symptoms are minimal and tumour markers normal, the diagnosis is seldom suspected before histology. We describe such a case and what it implies for the handling of excised dermoid cysts.

Case report: A 45-year-old para 3 woman, without comorbidities presented with one year of abdominal distension - no pain, no menstrual change, no family history of malignancy. A pelvic mass was palpable and the chest was clear.

Ultrasound showed a solid & cystic right ovarian mass with the widest diameter of 13 cm, uterus and left ovary appeared normal with no free fluid. Tumour markers were unremarkable, AFP 0.2 IU/mL, CA-125 10.7 U/L. beta-hCG 8.3 IU/L and LDH raised to 248 U/L. Laparotomy was performed where a 10 cm dermoid-like right ovarian cyst was excised with the uterus, tubes, contralateral ovary and peritoneum all appearing macroscopically normal. Right salpingo-oophorectomy was performed.

Histopathology showed a mature cystic teratoma (11 × 8 × 3 cm) with inner polypoidal growths of moderately differentiated SCC - pleomorphic squamoid nests, keratin pearls, necrosis, high-grade dysplasia, no immature neuroepithelium, diffuse strong p40 positivity. FIGO stage IA SCC was diagnosed. Completion surgery was performed - hysterectomy, contralateral salpingo-oophorectomy, omentectomy and para-aortic node sampling, which all were tumour-free. She was enrolled for long term surveillance.

Discussion: Three recognised risk factors were present here - age beyond 40, size above 10 cm and solid components. Preoperative diagnosis remains difficult: CA-125, AFP and beta-hCG are typically normal, as they were in this woman and LDH is nonspecific. Immunohistochemistry settled the question - diffuse p40 positivity confirmed squamous differentiation, while absent immature neuroepithelium excluded immature teratoma. Stage governs prognosis, a stage IA disease without adverse features may be observed rather than treated, which is why surveillance alone was chosen; platinum-based chemotherapy is reserved for higher stage or poor differentiation, neither of which applied.

Conclusion: SCC within an MCT warrants suspicion in women beyond 40 with dermoid cysts exceeding 10 cm, even where tumor markers are normal. The diagnosis rested entirely on histopathology with immunohistochemistry, no preoperative finding having raised it. Stage IA disease confined to the ovary carries a favourable prognosis; this patient completed staging tumour-free and remains on surveillance alone.

EP189. SUBMUCOSAL UTERINE LIPOLEIOMYOMA IN A POSTMENOPAUSAL WOMAN

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Objectives: Uterine lipoleiomyoma is a rare benign variant of leiomyoma that consists of mature adipocytes admixed with smooth muscle cells. It is reported mainly in peri- and postmenopausal women and may be asymptomatic or present with symptoms similar to conventional leiomyoma. The reported incidence is approximately 0.03 - 0.2% of uterine leiomyomas. Although considered benign, rare malignant transformation to liposarcoma was found, making histopathological exclusion of malignancy essential. This case is reported because of its uncommon submucosal location, absence of postmenopausal bleeding despite a uterine cavity lesion and characteristic histopathological findings confirming the diagnosis.

Case report: A 61-year-old postmenopausal woman, para 2, presented with progressive abdominal distension since 4 years, which was

associated with abdominal discomfort, back pain and early satiety. She had no postmenopausal bleeding, abnormal vaginal discharge or abdominal pain. She is a known patient with dyslipidaemia and thyroid disease, for which she had undergone hemithyroidectomy followed by total thyroidectomy and is currently on thyroxine replacement. On imaging, pelvic ultrasonography showed a well-defined echogenic lesion in the fundal area of the uterine cavity, which was suspicious of a lipoleiomyoma. She was initially admitted for examination under anaesthesia with dilatation and curettage and subsequently underwent total abdominal hysterectomy with bilateral salpingo-oophorectomy. Histopathology of the uterus reported a well-circumscribed submucosal lesion composed of mature adipocytes admixed with fascicles of smooth muscle cells. The lesion did not have nuclear pleomorphism, increased mitotic activity, necrosis, lipoblasts, or atypical spindle cells; thus, malignancy was excluded, confirming submucosal uterine lipoleiomyoma. The endometrium showed cystic atrophy, while the ovaries and fallopian tubes were normal.

Discussion: Although imaging can suggest the fatty nature of the lesion, it cannot reliably differentiate lipoleiomyoma from well-differentiated liposarcoma, which has been reported to arise by rare malignant transformation of lipoleiomyoma. This case highlights the importance of considering lipoleiomyoma in the differential diagnosis of echogenic uterine lesions in postmenopausal women, even without postmenopausal bleeding, with possible malignant transformation. Surgical management is considered the treatment of choice in symptomatic postmenopausal patients or when diagnostic uncertainty persists.

Conclusion: Submucosal uterine lipoleiomyoma is a rare, predominantly benign cause of uterine cavity lesions in postmenopausal women. It should be considered even in the absence of postmenopausal bleeding. Histopathology remains the gold standard for diagnosis, as imaging alone cannot exclude well-differentiated liposarcoma and awareness of this uncommon entity facilitates appropriate diagnosis and management.

EP190. SUCCESSFUL CONCEPTION FOLLOWING BOTULINUM TOXIN INJECTION FOR SUPERFICIAL DYSPAREUNIA REFRACTORY TO FENTON'S REPAIR: A CASE REPORT

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Superficial dyspareunia is a significant but often under-recognized cause of sexual dysfunction and subfertility in women. When conservative and surgical treatments fail, management becomes challenging. Botulinum toxin injection has emerged as a potential therapeutic option in selected cases. We report a case of primary subfertility secondary to superficial dyspareunia refractory to Fenton's repair, which responded successfully to botulinum toxin injection, resulting in spontaneous conception.

Introduction: Superficial dyspareunia is a significant but frequently under-recognised cause of sexual dysfunction and subfertility in women. When conservative and surgical treatments fail, management becomes challenging. Botulinum toxin injection has emerged as a potential therapeutic option in selected cases. [1] We report a case of primary subfertility secondary to superficial dyspareunia that was refractory to Fenton's repair and responded to botulinum toxin injection, with subsequent spontaneous conception.

Case report: A 30-year-old nulliparous woman presented with primary subfertility of four years' duration. She had been married for five years and reported severe superficial dyspareunia from the initiation of sexual activity, which prevented satisfactory vaginal penetration. Menstrual cycles were regular and there was no history suggestive of endometriosis, pelvic inflammatory disease, or systemic illness.

Initial gynaecological examination revealed marked tenderness at the posterior fourchette with involuntary pelvic floor muscle spasm, consistent with superficial dyspareunia. Routine investigations, including pelvic ultrasound, hormonal profile and the partner's semen analysis, were normal.

She initially underwent conservative management, comprising pelvic floor physiotherapy, topical agents and counselling, with minimal

improvement. A Fenton's repair was subsequently performed for suspected posterior fourchette tightness. Despite adequate surgical healing, she continued to experience significant superficial dyspareunia and penetrative intercourse remained painful and inconsistent.

In view of the persistent symptoms, a multidisciplinary review was undertaken and a diagnosis of functional pelvic floor hypertonicity contributing to superficial dyspareunia was made. After counselling regarding the off-label nature of the treatment, she underwent botulinum toxin type A injection into the pelvic floor muscles.

The procedure was performed under local anaesthesia. A total of 100 units of botulinum toxin type A were injected into the superficial perineal muscles in 6 divided doses at the 3, 5, 6, 7 and 9 o'clock positions, using a transperineal route with clinical guidance.

Outcome and Follow-Up Following injection, the patient reported a marked reduction in pain within four weeks and was able to resume painless penetrative intercourse for the first time since marriage. Pelvic floor relaxation was confirmed on follow-up examination. Three months after the procedure she conceived spontaneously, without assisted reproductive techniques. The pregnancy progressed uneventfully and she remained asymptomatic with no recurrence of dyspareunia during early antenatal follow-up.

Discussion: This case illustrates superficial dyspareunia as a potentially reversible contributor to primary subfertility. The failure of Fenton's repair suggests that not all cases are due to a structural abnormality and that functional pelvic floor muscle spasm may play a dominant role. Botulinum toxin produces temporary chemo denervation, leading to muscle relaxation and pain relief, which may enable painless intercourse and, thereby, natural conception. [3] It should be emphasised, however, that in this single case the temporal association between botulinum toxin injection and subsequent conception does not establish a causal relationship, as spontaneous conception may have occurred independently once penetrative intercourse became possible.

Emerging evidence supports botulinum toxin injection as a potentially safe and effective option in carefully selected patients with refractory superficial dyspareunia or vaginismus. [1][3][4] Early recognition and multidisciplinary management are important in order to avoid unnecessary delay in addressing fertility.

Limitations As a single case report, these findings cannot establish the efficacy or safety of botulinum toxin for dyspareunia-related subfertility. Well-designed comparative studies are required before firm conclusions can be drawn.

Conclusion: Botulinum toxin injection may be an effective therapeutic option for superficial dyspareunia refractory to surgical intervention. This case demonstrates resolution of symptoms and subsequent spontaneous conception, underscoring the value of individualised, mechanism-based treatment in women with dyspareunia-related subfertility.

Ethics and Consent Written informed consent for treatment, including the off-label use of botulinum toxin and for the publication of this case report was obtained from the patient.

EP191. SUCCESSFUL NEONATAL SURVIVAL FOLLOWING PREVIABLE PRETERM PRELABOUR RUPTURE OF MEMBRANES: A CASE REPORT

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Introduction: Previable preterm prelabour rupture of membranes (PPROM) is defined as rupture of membranes before 24+ 0 weeks. It is associated with poor perinatal outcomes and significant maternal morbidity. Prolonged oligohydramnios predisposes to pulmonary hypoplasia, fetal growth restriction, cord prolapse and neonatal death. Expectant management increases the risk of chorioamnionitis and maternal sepsis. Management requires a careful balance between maternal safety and the potential for fetal survival. We report a rare case of previable PPROM at 17 weeks resulting in successful neonatal survival.

Case report: A 32-year-old woman in her second pregnancy presented at 17+2 weeks' gestation with preterm prelabour rupture of membranes. The pregnancy was complicated with type 2 diabetes mellitus on insulin and metformin. Inflammatory markers were normal with white cell count 8.4×10^9/L and C-reactive protein 4 mg/L. Following counseling

regarding the maternal and fetal prognosis, expectant management was undertaken with a course of oral erythromycin. By 19 weeks, liquor leakage had ceased, allowing discharge with close outpatient surveillance using serial inflammatory markers. At 21 weeks, she got readmitted with recurrent leakage. Maternal observations and laboratory investigations remained reassuring throughout the pregnancy. Serial ultrasound examinations demonstrated persistent severe oligohydramnios, fetal growth restriction with abdominal circumference below the 5th centile and poor lung field development. Antenatal corticosteroids were administered after fetal viability. At 32+2 weeks' gestation, a category 1 lower segment caesarean section was done for umbilical cord prolapse. A live male infant weighing 1.42 kg was delivered with Apgar scores of 6 and 8 at one and five minutes, respectively. The baby was discharged after one month of neonatal intensive care. The postpartum period was complicated with surgical site infection requiring intravenous antibiotics, secondary resuturing and insulin adjustment.

Discussion: This case demonstrates that a successful outcome following previable PPROM is achievable in selected patients without clinical evidence of infection. Despite persistent severe oligohydramnios and antenatal concern for pulmonary hypoplasia, intensive surveillance enabled the prolongation of pregnancy by approximately 15 weeks, allowing delivery at 32 weeks with neonatal survival. This case highlights the importance of individualized care with serial maternal surveillance, optimization of coexisting medical conditions and timely intervention when obstetric complications arise.

Conclusion: Although previable PPROM is associated with substantial maternal and neonatal risks, favourable outcomes are possible with careful expectant management. Vigilant monitoring for infection and prompt management of complications remain essential to optimize maternal and neonatal outcomes.

EP192. SUCCESSFUL PREGNANCY AND CAESAREAN DELIVERY IN A WOMAN WITH A FUSED PELVIC KIDNEY (PANCAKE KIDNEY): A CASE REPORT

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Background: A pelvic kidney results from failure of normal renal ascent during embryogenesis. The fused variant - the pancake kidney - is rarer still. In pregnancy the anomaly matters for three reasons: the kidney sits where the surgeon does not expect it, the urinary tract may obstruct as the uterus enlarges and the organ is at risk of inadvertent injury at cesarean delivery. We report a pregnancy managed with those risks in view.

Case report: A 32-year-old gravida 2 para 1 woman with a previous lower segment cesarean section was followed through pregnancy after a fetal scan incidentally identified a fused pelvic kidney. Ultrasound by a consultant radiologist confirmed fused pelvic kidneys lying on the right side of the pelvis, approximately 10.3 × 4.6 cm - corticomedullary differentiation preserved, with no hydronephrosis or hydroureter.

Antenatal surveillance and the mid-trimester anomaly scan showed normal fetal growth and no renal complications. Elective repeat cesarean section was performed at 38 weeks. The anesthetic and genito-urinary surgical teams were informed in advance and multidisciplinary input was obtained on the conduct of delivery and on assistance should an emergency arise. A live female infant was delivered in cephalic presentation with clear liquor. Anterior uterine wall adhesions and multiple fibroids close to the uterine scar made the delivery difficult and precautions were taken throughout against pelvic kidney-related injury. Her postoperative recovery was uneventful.

Conclusion: The anomaly here was found incidentally on a fetal scan and that single finding is what allowed the delivery to be planned rather than improvised - imaging to define where the kidney lay, the urological team on notice and a difficult field of adhesions and fibroids negotiated without renal injury. The margin is narrower in an emergency cesarean, where there is no such warning and where as-

sociated renal tract anomalies put the ureters at risk. Antenatal recognition of a pelvic kidney is therefore worth acting on well before delivery.

EP193. SUCCESSFUL PREGNANCY OUTCOME IN A PRIMIGRAVIDA WITH TRANSFUSION-DEPENDENT BETA THALASSAEMIA MAJOR

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Introduction: Survival of women with transfusion-dependent beta thalassaemia has significantly improved with advances in modern medicine. However, pregnancy remains high risk due to chronic anemia, iron overload, endocrine dysfunction, cardiomyopathy and fetal growth restriction. We report a case of successful pregnancy outcome in a patient with transfusion-dependent beta thalassaemia major.

Case report: An 18-year-old primigravida with transfusion-dependent beta thalassaemia major presented with an unplanned pregnancy at 10 weeks of gestation despite prior counseling against pregnancy. She had been on regular blood transfusions since childhood and on Desferrioxamine for iron chelation. Iron chelation was discontinued after confirmation of pregnancy. She was followed up by a multidisciplinary team comprising obstetricians, haematologists, transfusion medicine specialists, anaesthetists and neonatologists.

At the initiation of the pregnancy, her haemoglobin level was 8.5 g/dL and serum ferritin level was 2800 ng/mL, consistent with iron overload. 2D Echo demonstrated normal ventricular function without evidence of cardiac failure. Her haemoglobin level was maintained at pregnancy thresholds with regular blood transfusions. Fetal growth was satisfactory on serial growth scans.

Labour was induced at 38 weeks of gestation due to the high-risk nature of the pregnancy. Emergency lower segment caesarean section was performed due to fetal compromise on cardiotocography.

A healthy male baby weighing 2.8 kg was delivered with good Apgar scores. She received further blood transfusions during the postoperative period. She was then discharged with arrangements for hematology follow-up for recommencement of iron chelation therapy.

Discussion: Pregnancy in women with transfusion-dependent beta thalassaemia major is extremely uncommon, mainly due to hypogonadotropic hypogonadism caused by iron overload. However, fertility has significantly improved with modern transfusion and chelation therapy. Pregnancy in them requires a careful multidisciplinary approach. Optimization of haemoglobin, surveillance for iron overload-related complications and frequent fetal monitoring play a major role in achieving favourable outcomes. This rare case demonstrates that a successful pregnancy outcome is achievable with multidisciplinary care despite significant haematological disease burden.

Conclusion: This case highlights the importance of multidisciplinary care in achieving successful pregnancy outcomes in a high-risk pregnancy with transfusion-dependent beta-thalassaemia major. Favourable outcomes for both the mother and the baby were possible due to careful antenatal surveillance, regular blood transfusions to maintain adequate haemoglobin levels and timely obstetric interventions.

EP194. SURGICAL MANAGEMENT OF TIGHT MITRAL STENOSIS IN THIRD TRIMESTER OF PREGNANCY - CASE REPORT

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Objectives: Here is a successful multidisciplinary approach in managing a partient with severe rheumatic mitral stenosis and fetal growth restriction, culminating in a percutaneous transvenous mitral commissurotomy (PTMC) and a favourable maternal and neonatal outcome.

Case report: A 21-year-old primigravida with known rheumatic heart disease (RHD) and tight mitral stenosis (valve area 0.5 cm^2) was followed up jointly by the obstetric and cardiology teams from early pregnancy. Her antenatal course was complicated by the diagnosis of fetal growth restriction (FGR) at 32 weeks of gestation, managed with close fetal surveillance and had normal umbilical artery Dopplers. At 36 weeks, she developed acute dysp-

noea and Echocardiography showed evidence of severe pulmonary hypertension with a tricuspid regurgitation peak gradient (TRPG) of 60 mmHg. Fetal assessment revealed intermittent absent diastolic flow, indicating evolving placental insufficiency and potential fetal compromise. An emergency PTMC was performed under local anaesthesia, achieving a haemodynamically significant improvement. Post-procedure fetal Dopplers normalised. Spontaneous labour started six hours post-procedure. Twelve hours after PTMC, an assisted second stage was conducted using forceps under epidural analgesia, resulting in the vaginal delivery of a live infant with good Apgar scores. The postpartum period was uneventful for the mother and the neonatal team discharged the baby after two weeks following successful weight gain. Contraception with Jadelle (levonorgestrel implant) was inserted prior to discharge.

Discussion: This case shows the complex interplay between maternal cardiac disease and fetal well-being. Critical mitral stenosis in pregnancy has a high risk of maternal cardiac decompensation due to the increased plasma volume and cardiac output. The development of pulmonary hypertension and fetal compromise at 36 weeks necessitated prompt intervention. PTMC, performed under local anaesthesia, was chosen over surgical commissurotomy as a safer, minimally invasive option to acutely reduce left atrial pressure and improve placental perfusion. The success of this case highlights on meticulous, multidisciplinary approach between obstetricians, cardiologists, anaesthetists and neonatologists. The decision to allow a vaginal delivery with an assisted second stage minimized the physiological stress on the maternal heart, avoiding a prolonged second stage.

Conclusion: This case highlights that with a multidisciplinary team and individualized care, even high-risk cardiac patients with critical valvular lesions and fetal compromise can achieve a successful vaginal delivery. Timely PTMC can serve as a life-saving bridge to delivery, optimising both maternal haemodynamics and fetal oxygen delivery. Early postpartum contraception is crucial for women with significant cardiac disease to prevent future high-risk pregnancies.

EP195. SURVEY FOR MEASURING SATISFACTION ABOUT POSTNATAL IN PATIENT WARD CARE AT AVISSAWELLA DISTRICT GENERAL HOSPITAL

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Introduction: Patient satisfaction is one measure of health care quality and it turns on several things at once - communication, patient education, the care itself and the hospital's own services. Surveying experience during the inpatient stay shows where a unit is strong and where it needs to improve and the exercise itself supports the relationship between patients and staff.

Objectives: To assess patient satisfaction with postnatal inpatient care and to identify the areas needing improvement.

Design: Prospective, self-administered questionnaire-based survey.

Method: The survey ran over one month in the postnatal ward at Avissawella District General Hospital. Every patient was given a questionnaire at discharge, with consent. The structured, self-administered instrument covered ten domains - ward reception, staff responsiveness, explanation of the medical condition, trust in treatment, medication administration, discharge education, issuing of the diagnosis card, staff friendliness across all categories, hospital cleanliness and overall satisfaction. Responses went into a separate box without patient identification and were collected and analysed at the end of the study period.

Results: A total of fifty-one postnatal women participated in the study. Overall satisfaction was high, with 86.3% (44/51). Among the ten domains, satisfaction was highest for explanation of medical condition (98.0%) and discharge health education (98.0%). Trust in treatment (94.1%), ward reception (92.2%) and timely response to patient needs (90.2%) also exceeded 90%. Among the staff, doctors received the highest friendliness rating (98.0%), followed by Public Health Midwives (92.2%) and nursing staff (90.2%). Security staff drew lower satisfaction than the other staff categories. Cleanliness scored lowest of the ten domains - 76.0% satisfactory, with a further 22.0% moderately satisfied.

Conclusion: Overall satisfaction was 86.3% and the communication domains scored highest of all - 98.0% for both explanation of the medical condition and discharge education. The gap lies elsewhere. Cleanliness at 76.0% and satisfaction with security staff are where quality improvement should now be directed, through environmental hygiene measures and staff training and a repeat survey afterwards would show whether they had worked.

EP196. SWYER SYNDROME: AN UNUSUAL CAUSE OF PRIMARY AMENORRHOEA – A CASE REPORT

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Objectives: To report a case of Swyer syndrome (46, XY complete gonadal dysgenesis) presenting with primary amenorrhoea, illustrating a rare but important cause of hypergonadotropic hypogonadism that can mimic Mullerian agenesis but carries a substantial, often occult, risk of gonadal malignancy.

Case report: A 16-year-old phenotypic female presented with primary amenorrhoea and absent secondary sexual characteristics. Examination showed tall stature, Tanner stage 1 breast and pubic hair development and normal female external genitalia. Hormonal profile revealed markedly raised luteinising hormone (LH) and follicle-stimulating hormone (FSH) with low oestradiol, consistent with hypergonadotropic hypogonadism. Pelvic ultrasound showed a small hypoplastic uterus with bilateral streak gonads and no ovarian tissue. Karyotype confirmed 46, XY. Sex-determining region Y (SRY) gene analysis identified a pathogenic variant, confirming Swyer syndrome. Given the recognised risk of gonadoblastoma and dysgerminoma in dysgenetic, Y-chromosome-bearing gonads, laparoscopic bilateral gonadectomy was performed. Histopathology confirmed streak gonads without malignant transformation. Oestrogen replacement therapy was commenced to induce puberty, with cyclical progestogen added once withdrawal bleeding was established, alongside psychological support.

Discussion: Swyer syndrome should be considered in any phenotypic female with primary amenorrhoea and absent puberty, particularly when pelvic imaging shows a uterus but no identifiable ovarian tissue. Unlike complete androgen insensitivity syndrome, in which the uterus is absent, Swyer syndrome retains Mullerian structures because the dysgenetic gonads fail to secrete anti-Mullerian hormone. Karyotyping is therefore essential even when external genitalia are unambiguously female. Because dysgenetic Y-bearing gonads carry a substantial lifetime malignancy risk, prompt bilateral gonadectomy is recommended once diagnosis is confirmed, followed by long-term hormone replacement. As the uterus is functional, affected women retain the potential for pregnancy through oocyte donation.

Conclusion: Swyer syndrome is a rare but important differential diagnosis for primary amenorrhoea. Early karyotyping and gonadectomy reduce malignancy risk, while preserved uterine function offers a future route to fertility via assisted reproduction, highlighting the value of a multidisciplinary approach to diagnosis, treatment and counselling.

Keywords: Swyer syndrome; primary amenorrhoea; gonadal dysgenesis; SRY gene; gonadectomy

EP197. SYNCHRONOUS ENDOMETRIAL AND OVARIAN MAGINANCY; A RARE CASE REPORT

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Introduction: Synchronous malignancies in gynecology are a rare entity. However the most common is synchronous endometrial and ovarian malignancies; accounting for 50-70% (1,2). Frequently these malignancies are occurred as metastatic nevertheless diagnosing primary dual carcinomas will be challenging especially when they have same histological type (3,4). These differentiation are crucial for clinical management, treatment decisions, follow up and prognosis of the patient (4).

Case report: A 66 year old nulliparous woman was investigated for abdominal distension for two months of duration. There is no history of post-menopausal bleeding or per vaginal discharge. On examination she was found to have a large mass in the abdomen compatible to 32 weeks size of gravid uterus. Her cervix

was healthy on speculum examination and bimanual palpation suggested right adnexal fullness.

Her sonography suggested a large solid and cystic mass in the right adnexa. Uterus had thick endometrial lining, mild free fluid in the abdomen and rest were normal. Further imaging was not done as it was not freely available. Her CA125 was 437. She was referred to specialized care as her RMI score was >200. Hence staging laparotomy was planned. During surgery it was staged as IC and she underwent total abdominal hysterectomy and bilateral salpingoopharectomy together with omentectomy achieving complete debulking.

Her histology showed clear cell carcinoma of the right ovary with FIGO staging IC1 and endometriod type endometrial carcinomas FIGO stage IB. Following multidisciplinary discussions adjuvant chemo-radiation were planned. Immunohistochemistry were done. Genetic studies are awaiting.

Discussion: Incidence of Synchronous endometrial and ovarian cancer are found to be around 3-10%(6).These malignancies are more common among premenopausal women and it has been showed most of them are nulliparous as well(7,8).

These patients will present as either abnormal uterine bleeding directing toward endometrial carcinoma or abdominal distension or symptoms of gastro-esophageal reflux disease directing toward ovarian carcinoma as in this case. With the histological diagnosis and immunohistochemistry and molecular genetic testing will be of an assistance in deciding ones treatment.

Generally, median overall survival rate is excellent up to 90% in early disease (8-10). Adjuvant chemotherapy and /or radiotherapy will depend on histological subtypes, immunohistochemistry and decisions taken in a multidisciplinary team (5).

Conclusion: The diagnosis of synchronous endometrial and ovarian malignancy or metastasis is of greater importance in decision making with regard to treatment, follow-up and prognosis. Additional molecular testing will be of an assistance to enhance the patients' prognosis.

EP198. SYNCHRONOUS FAMILIAL OVARIAN MIXED GERM CELL TUMOURS IN ADOLESCENT TWIN SISTERS

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Objectives: Familial ovarian germ cell tumors are extremely rare, especially in twins. The purpose of this case report is to document the existence of a mixed ovarian germ cell tumor in the second twin after a diagnosis of similar tumor was made in her sister.

Case report: The patient was an otherwise healthy 15-year-old female, presenting with one week of abdominal pain and distension. The patient had reached menarche at age 11 years and had regular menstrual periods without dysmenorrhea. Her twin sister was previously diagnosed with a mixed ovarian germ cell tumor, predominately composed of yolk sac tumor with choriocarcinoma at the age of 11 years. Her twin sister was managed with FIGO stage IC mixed ovarian germ cell tumor with left salpingo-oophorectomy and six cycles of BEP chemotherapy and is currently disease free. Contrast enhanced computed tomography of the chest, abdomen and pelvis revealed bilateral ovarian masses with gross ascites and peritoneal metastases. Her serum tumor markers were grossly high: alpha-fetoprotein 7241 ng/mL, CA-125 224.2 U/mL and lactate dehydrogenase 2685 U/L. Her β-human chorionic gonadotropin was within normal limit - 3.294 mIU/mL. Inrta-operatively, bilateral ovarian masses, gross ascites and multiple pelvic peritoneal deposits were seen. Fertility preserving primary cytoreductive surgery including right salpingo-oophorectomy, left ovarian cystectomy, pelvic peritonectomy,retroperitoneal lymphadenectomy and supracolic omentectomy was done. Histological analysis showed mixed germ cell tumor predominated by yolk sac tumor, which was similar to the histology of her twin sister.

Her recovery was uneventful and received three cycles of BEP chemotherapy comprising bleomycin, etoposide and cisplatin per cycle. In the short term, her remained free of recurrence of the disease. As she had one left ovary retained after performing cystectomy, the retention of the ovarian tissue and fertility was one of the important issues. Genetic counsel-

ling and germline testing could have been considered for her owing to unusual presentation of such ovarian germ cell tumours among the twins; however, genetic testing was not performed due to financial constraints.

Discussion: The differential diagnosis for a young girl with bilateral ovarian masses, ascites, peritoneal deposits and high tumour markers include epithelial ovarian cancer, dysgerminoma, yolk sac tumour, embryonal carcinoma, choriocarcinoma, immature teratoma and mixed germ cell tumour. Identical ovarian mixed germ cell tumors in twin sisters are extremely rare and might indicate shared genetic or developmental risk factors. Even though she had a case of advanced disease, fertility was considered due to young age and her reproductive potential. The contralateral side ovarian tissue was surgically amenable for retaining and hence right salpingo-oophorectomy with left ovarian cystectomy was preferred over bilateral oophorectomy.

Conclusion: This is a rare case involving twins who presented with ovarian mixed germ cell tumours with an almost identical histology. The early presentation, along with a fertility-sparing surgery and chemotherapy made for proper management of the condition. The importance of this case is that it brings to light the necessity of taking into account the family history when diagnosing ovarian tumors in adolescent girls. However, this is a single family that is affected by the disease and there is no germline genetic testing limits assessment of a potential hereditary predisposition and represents an important limitation.

EP199. THE DECEPTIVE REASSURANCE OF AN INTRAUTERINE PREGNANCY: SPONTANEOUS HETEROTOPIC PREGNANCY PRESENTING WITH HEMOPERITONEUM

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Objectives: To report a rare case of spontaneous heterotopic pregnancy presenting with hemorrhagic shock despite the presence of a viable intrauterine pregnancy and to demonstrate the importance of early clinical recognition and timely surgical intervention in improving maternal and fetal outcomes.

Case report: A 32-year-old woman, gravid 2, at 12+3 weeks of gestation presented with sudden-onset severe lower abdominal pain associated with dizziness. She had conceived spontaneously and had no previous history of ovulation induction or assisted reproductive technology. On admission, she was pale, hypotensive (78/55 mmHg) and clinically unstable with marked lower abdominal tenderness. Initial laboratory investigations revealed a hemoglobin level of 9.6 g/dL. Ultrasonography confirmed a viable intrauterine pregnancy but also demonstrated a moderate amount of free intraperitoneal fluid and a left adnexal mass, raising the possibility of a ruptured ovarian cyst. As her clinical condition rapidly worsened, emergency diagnostic laparoscopy was undertaken. Intraoperatively, approximately 2.5 L of hemoperitoneum was identified together with a ruptured left tubal ectopic pregnancy. A left salpingectomy was performed and subsequent histopathological examination confirmed tubal ectopic gestation. The postoperative course was uncomplicated and the intrauterine pregnancy remained viable. Continued antenatal followup was planed to assess the progress and long term outcome of the ongoing pregnancy.

Discussion: The coexistence of intrauterine and ectopic pregnancies is uncommon, particularly following spontaneous conception, making diagnosis challenging. The presence of a confirmed intrauterine pregnancy may lead to delayed consideration of an accompanying ectopic pregnancy. This case shows that persistent abdominal pain, hemodynamic instability and evidence of intraperitoneal bleeding in early pregnancy should prompt evaluation of the adnexa, irrespective of the presence or absence of conventional risk factors. Early operative management was crucial in preventing further maternal deterioration while preserving the ongoing intrauterine pregnancy.

Conclusion: Although spontaneous heterotopic pregnancy is rare, it should remain an important differential diagnosis in pregnant women presenting with abdominal pain and suspected intra-abdominal bleeding. Careful ultrasonographic assessment of adnexa, combined with timely clinical judgement and early surgical intervention, can reduce maternal

morbidity and improve the intrauterine pregnancy. As this report describe a single case, the experience may not be representative of all patient with spontaneous heterotopic pregnancy. Further antenatal follow up is needed to document the longer term progress and final outcome of the ongoing pregnancy.

(The patient gave written consent for this case to be reported and published. Confidentiality was maintained and no personal identifying details were published)

EP200. THE EFFECT OF CEYLON CINNAMON IN IMPROVING PREMENSTRUAL SYNDROME: A SYSTEMATIC REVIEW

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Introduction: Premenstrual syndrome (PMS) is a very common condition among females of childbearing age, which is defined as a number of physical, emotional, behavioral and psychological signs occurring during the luteal phase of menstruation cycle. Dysmenorrhea, abdominal cramps, fatigue, bloating, irritability, anxiety and mood alterations are some of the commonest symptoms that could adversely affect the quality of life of those individuals suffering from premenstrual syndrome. Inflammation, oxidative stress, increased production of prostaglandins and neurotransmitter imbalance are some of the factors that have been linked to this disorder.

Objectives: To evaluate the effectiveness of Ceylon cinnamon in improving symptoms of PMS and assess its potential as a complementary therapeutic intervention.

Method: Systematic review was done based on PRISMA guidelines using PubMed, Cochrane Library, Google Scholar and Embase databases for literature from 2000 to 2026. Search keywords used were "Ceylon cinnamon," "Cinnamomum verum," "premenstrual syndrome," "PMS," "dysmenorrhea," and "herbal therapy." RCTs, clinical trials and experiments were included, while observational studies, case reports and non-English articles were excluded. Twenty-four studies were found; out of these, eight fulfilled the inclusion criteria after assessment using Jadad score for quality; six studies were considered high-quality. Outcomes include improvement of PMS symptoms, dysmenorrhea, mood, use of analgesics and quality of life.

Results: Supplementation of Ceylon cinnamon showed an improvement in a variety of PMS symptoms. Five studies reported a decrease in dysmenorrhea ($P < 0.01$), while total PMS symptoms scores improved by 20 - 45% as compared with placebo ($P < 0.05$). In addition, there was a reduction in abdominal cramps, fatigue, nausea and menses flow. Irritability, anxiety and depressive symptoms related to mood improved significantly in four studies. The results of experimental studies revealed that there was a decrease in inflammatory cytokines, prostaglandin activity and oxidative stress with an increase in antioxidant activity. The use of rescue analgesics was reduced with improved quality of life scores.

Conclusion: Based on the current research, Ceylon cinnamon can be used as a complementary treatment in order to cope with PMS symptoms safely and effectively. Due to its antispasmodic, antioxidant and anti-inflammatory effects, cinnamon may help reduce menstrual cramping, improve mood and increase the overall quality of women's lives. Nevertheless, the studies carried out are characterized by their small sample size, varied dose of cinnamon used during experiments and varied techniques for assessing the symptoms.

Keywords: Premenstrual syndrome, Ceylon cinnamon, Cinnamomum verum, dysmenorrhea, menstrual pain, herbal therapy, systematic review

EP201. THE HIDDEN MOLE: A CASE OF MOLAR PREGNANCY WITHIN AN ISTHMOCELE

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Objectives: To describe a partial molar pregnancy within a uterine isthmocele, a scarcely recognized site among the published cases on scar site molar pregnancies and to describe its challenging fertility-preserving management.

Case report: A 38-year-old pregnant woman with a history of an uncomplicated lower-segment caesarean section and further fertility wishes was transferred with suspected caesarean scar ectopic or trophoblastic disease. Serum β hCG was 229,362mIU/mL. Repeated specialist ultrasonography did not support scar ectopic and favoured molar pregnancy not involving the scar. Ultrasound scan-guided suction evacuation was performed and was complicated by massive haemorrhage despite uterotonics and tranexamic acid, requiring blood product transfusion, vasopressor support and intensive care. Postoperative echocardiography showed transient left ventricular systolic dysfunction. Postoperative imaging showed residual tissue within the lower segment. Serial β hCG declined from 21,189mIU/L to 7,202mIU/L, but targeted ultrasound scan pointed to persistently adherent molar tissue in the lower segment. Following cardiac reassessment and consent for hysterectomy if required, combined hysteroscopy and laparoscopy were performed. Hysteroscopy revealed a large isthmocele occupied by trophoblastic tissue. Concurrent laparoscopy confirmed a significantly thinned lower uterine segment with anterior bladder adhesions. After vasopressin infiltration and bladder mobilization, the niche was opened to excise the adherent trophoblastic tissue. The uterine defect was repaired. Intraoperative methotrexate was administered. She had an uncomplicated postoperative recovery and β-hCG declined to 1,711mIU/L. Weekly β-hCG surveillance was planned on discharge. Histology of evacuated tissue later confirmed partial mole.

Discussion: Molar pregnancy implanted on a caesarean scar has been reported. But literature on isthmocele as the possible site of scar molar pregnancy is scarce. It is clinically important to distinguish between the two as an isthmocele may conceal persistent trophoblast tissue after evacuation, despite falling β hCG. Reported cases on scar molar pregnancies highlight severe haemorrhage requiring either uterine-artery embolization, excision or hysterectomy on an individualized basis. In selected patients, direct cavity assessment and excision using combined hysteroscopic-laparoscopic approach permits fertility preservation by controlled extra-cavitary dissection and isthmocele repair.

Conclusion: Literature on a molar pregnancy within an isthmocele is scarce among the many cases reported on molar pregnancy involving caesarean scar. Serial β-hCG and targeted imaging must be considered when trophoblastic tissues persistently occupy lower segment following evacuation. Combined hysteroscopic-laparoscopic excision with scar repair can provide fertility-preserving treatment in selected patients, while controlling haemorrhage.

Keywords: partial mole, isthmocele, caesarean scar niche, scar ectopic, gestational trophoblastic disease

EP202. THE SALPINGECTOMY PARADOX: RUPTURED RIGHT TUBAL STUMP ECTOPIC PRESENTING IN SHOCK

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Objectives: To report a rare case of a ruptured ipsilateral recurrent ectopic pregnancy in a residual tubal stump following a prior salpingectomy, highlighting the clinical presentation of hypovolemic shock and the necessity for rapid emergency surgical intervention despite a history of definitive tubal removal.

Case report: A 33-year-old multigravida presented at a period of amenorrhea (POA) of 6 weeks and 5 days with sudden-onset, severe right-sided abdominal pain. Two years ago, she had undergone laparoscopic salpingectomy for a right-sided ectopic pregnancy. On

admission, she was hemodynamically unstable, with a blood pressure (BP) of 80/50 mmHg, tachycardia and marked right-sided lower abdominal tenderness with signs of peritonism. Transvaginal ultrasonography (TVS) was performed and found to have an empty uterine cavity and significant free fluid in the peritoneal cavity, highly suspicious of massive hemoperitoneum.

An emergency exploratory laparotomy was done following rapid fluid resuscitation. There was a ruptured gestational sac arising directly from the residual proximal stump of the previous right salpingectomy site, causing hemoperitoneum. The left fallopian tube and both ovaries were structurally normal. During the surgery, the products of conception was completely evacuated and anatomical repair has done for the ruptured tubal stump site. Peritoneal washing was performed. The patient's postoperative recovery was uneventful and she was discharged in stable condition.

Discussion: Ipsilateral recurrent ectopic pregnancy in a residual tubal stump is an uncommon, life-threatening condition. It represents approximately 1.1% of all ectopic gestations. It typically occurs due to incomplete excision of the fallopian tube during primary surgery. Having a patent proximal stump or a microfistulous tract will allow the fertilized ovum to implant. The tubal stump is highly vascularized by branches of both the uterine and ovarian arteries. Rupture of a gestational sac frequently leads to rapid, severe internal haemorrhage and early shock. This case demonstrates that a prior history of salpingectomy does not eliminate the risk of a tubal gestation.

Conclusion: Obstetricians must maintain a high index of clinical suspicion for a stump ectopic pregnancy in any pregnant patient regardless of previous ipsilateral salpingectomy. To minimize the risk of this rare but dangerous recurrence, surgeons should ensure complete proximal tubal excision or thorough cornual fulguration during primary salpingectomy procedures.

Keywords - Stump ectopic pregnancy, Ipsilateral recurrence, post-salpingectomy

EP203. TOPIC - PREVALENCE OF PRE-TESTICULAR, TESTICULAR AND POST TESTICULAR AZOOSPERMIA AMONG MALES ATTENDING TO TERTIARY CARE INFERTILITY CLINICS IN SRI LANKA

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Introduction: Infertility has profound physical, psychological and social consequences for affected couples. Azoospermia, defined as the complete absence of spermatozoa in the ejaculate, represents the most severe form of male factor infertility. Early identification of the underlying cause facilitates accurate diagnosis, appropriate counselling and timely management. Azoospermia results from pre-testicular, testicular, or post testicular disorders. Serum follicle stimulating hormone (FSH) is a useful diagnostic marker for distinguishing these categories. Low FSH concentrations suggest pre-testicular causes, elevated concentrations indicate primary testicular failure and normal concentrations are more consistent with post testicular obstruction. Although the prevalence of these conditions has been reported internationally, corresponding data from Sri Lanka remain limited.

Objectives: To determine the prevalence of pre-testicular, testicular and post testicular azoospermia and to identify clinicopathological, anthropometric and hormonal predictors of azoospermia and abnormal semen parameters among male partners of couples attending a tertiary fertility centre.

Method: A cross sectional study was conducted among male partners of couples attending tertiary care infertility clinics in Sri Lanka between 2022 and 2023. Demographic, clinical, lifestyle, anthropometric, hormonal and semen analysis data were extracted from medical records with patient consent. Serum FSH, LH, body mass index and semen parameters were evaluated. Univariable and multivariable logistic regression analyses were performed to identify independent predictors of azoospermia. Adjusted odds ratios with 95% confi-

dence intervals were calculated. A p value below 0.05 was considered statistically significant.

Results: A total of 296 mal partners included. The mean age was 35.4 ± 6.0 years and the mean body mass index was 26.0 ± 4.8 kg/m^2. Azoospermia was identified in 53 participants, representing 17.9% of the study population. Mean serum FSH and LH concentrations were 10.6 ± 7.1 IU/L and 9.4 ± 5.8 IU/L, respectively. Among men with azoospermia, 75.9% had testicular azoospermia, 22.2% had post testicular azoospermia and 1.9% had pre-testicular azoospermia. Elevated FSH concentrations above 10 IU/L were observed in 53.5% of participants. Abnormal sperm morphology was present in 51.7%. Multivariable logistic regression demonstrated that serum FSH was the only independent predictor of azoospermia, with an adjusted odds ratio of 1.18 for each IU/L increase (95% confidence interval 1.09 to 1.29, $p < 0.001$). Age, body mass index and luteinising hormone were not independently associated with azoospermia after adjustment.

Conclusion: Azoospermia was identified in nearly one fifth of male partners, where primary testicular causes were the predominant etiology in this Sri Lankan cohort, while a significant proportion of men with abnormal semen parameters also had elevated serum FSH levels. This study provides local epidemiological data that may guide future research into modifiable risk factors, including occupational, lifestyle and genetic contributors to primary testicular failure among Sri Lankan men. These findings also highlight the value of serum FSH as a simple second-line investigation for differentiating the underlying causes of azoospermia in low resource setting and for triaging men with severe oligozoospermia for further genetic evaluation and advanced fertility interventions.

Keywords: Male infertility; azoospermia; follicle stimulating hormone; testicular failure.

EP204. TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION FOR LABOUR PAIN: AN INTERIM ANALYSIS

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Introduction: Labour pain is one of the most excruciating forms of pain experienced by women which significantly influences overall childbirth experience. Pharmacological analgesia is used in Sri Lankan settings. Transcutaneous Electrical Nerve Stimulation (TENS) is a safe, non-invasive and drug free analgesic modality that has gained increasing attention as an alternative method of labour pain management. However, local evidence regarding women's perception and satisfaction with TENS remains limited.

Objectives: To assess women's perception and satisfaction regarding the use of TENS as an alternative model of analgesia during labour among women undergoing delivery at Colombo South Teaching Hospital, Sri Lanka.

Design: A prospective observational study.

Method: A consecutive sample of pregnant women aged over 18 years receiving TENS during labour was recruited after informed consent. At the time of interim analysis 24 pregnant women were recruited. Intensity of pain was assessed using the Visual Analogue Scale (VAS) before and after TENS application. Maternal perception and satisfaction was evaluated within 24 hours postpartum using a structured pre-tested questionnaire assessing pain alleviation, reduction in discomfort during labour, feasibility and user-friendliness, perceived control during labour, willingness for future use, recommendation to others and overall satisfaction. Sociodemographic and obstetric data were also collected. Data was analysed using SPSS.

Results: Twenty-four women were included in the interim analysis. The mean age was 27.5 ± 5.0 years. None had previously used TENS during labour. The mean VAS pain score increased from 4.38 ± 1.61 before TENS application to 5.25 ± 2.51 one hour after initiation. This increase is likely attributable to the phys-

iological progression of labour and pharmacological augmentation. Despite this, 25.0% of women reported being satisfied with TENS, 50.0% reported a neutral experience and only 25.0% were unsatisfied, indicating that three-quarters of participants perceived TENS as an acceptable method of labour pain management. No maternal or neonatal adverse events related to TENS were observed.

Conclusion: Interim findings suggest that TENS is an acceptable non-pharmacological intervention for labour pain management. Although pain intensity increased as labour progressed, most women reported a satisfactory or neutral experience with TENS. It indicates its potential role in improving coping and acceptability rather than completely preventing the physiological increase in labour pain. Completion of recruitment and final analysis will provide more definitive evidence regarding women's perception, satisfaction and the clinical utility of TENS in the Sri Lankan setting.

EP205. TRANSIENT CORTICAL BLINDNESS FOLLOWING ELECTIVE ABDOMINAL HYSTERECTOMY

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Objectives: To present a rare case of transient cortical blindness following elective total abdominal hysterectomy and to highlight the importance of early recognition, thorough evaluation and multidisciplinary management of acute postoperative visual loss.

Case report: A 40-year-old multiparous woman underwent elective total abdominal hysterectomy and bilateral salpingectomy for symptomatic uterine fibroids. The surgery was done under general anaesthesia and was completed within one hour. The estimated blood loss was 200 mL. The immediate postoperative period was uneventful. She had no significant medical comorbidities other than iron deficiency anaemia, which was corrected preoperatively. She had a past surgical history of uncomplicated myomectomy and appendicectomy, done under general anaesthesia. Approximately 12 hours following surgery, she developed nausea, vomiting, hypertension (170/100 mmHg) and blurring of vision. Despite antihypertensive therapy, her vision progressively deteriorated and complete blindness developed over the next few hours. She was conscious and had no neurological deficit throughout. Ophthalmological assessment was consistent with cortical blindness. Primary ocular pathologies were considered and excluded. Urgent non-contrast computed tomography (CT) of the brain and CT cerebral venography were performed to exclude intracranial haemorrhage and cerebral venous sinus thrombosis. The vision began to recover within 24 hours and returned completely without residual neurological deficits. Magnetic resonance imaging was not performed, but a working diagnosis of probable posterior reversible encephalopathy syndrome (PRES) was made based on the clinical findings and the complete recovery. She was discharged on the fifth postoperative day and remained asymptomatic on follow-up.

Discussion: Postoperative visual loss is a rare complication of non-ophthalmic surgery and is mostly seen following cardiac and spinal procedures. Cortical blindness following elective benign gynaecological surgery is exceedingly uncommon. Posterior circulation infarction, intracranial haemorrhage, cerebral venous sinus thrombosis, ischaemic optic neuropathy and retinal vascular occlusion were considered in the differential diagnosis. Multidisciplinary assessment involving gynaecologists, physicians, neurologists and ophthalmologists, together with neuroimaging helped in exclusion of these conditions. Although MRI confirmation was unavailable, the characteristic clinical course and complete neurological recovery were highly suggestive of probable PRES.

Conclusion: Transient cortical blindness should be considered in patients presenting with acute visual loss following elective gynaecological surgery. Early multidisciplinary evaluation, exclusion of life-threatening neurological causes and prompt blood pressure control are essential for complete recovery.

EP206. TRANSMIGRATED LIPPES LOOP LEADING TO HYDRONEPHROSIS AND HYDROURETER IN A POSTMENOPAUSAL WOMAN - A CASE REPORT

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Introduction: The Lippes Loop was previously used intrauterine contraceptive device (IUCD) which was introduced during 1960s before copper-containing and levonorgestrel-releasing intrauterine systems. It was a double "S" shaped device made of polyethylene. Although it has been no longer manufactured, many women who had Lippes Loops inserted several decades ago may still retain due to inadequate follow-up or loss to long-term surveillance. Ureteric involvement secondary to a migrated IUCD is exceptionally uncommon. External ureteric compression causing hydroureter and hydronephrosis has been reported only in isolated case reports, making recognition and diagnosis particularly challenging.

Case report: A 78year old lady with chronic diabetes and hypertension and she was evaluated for elevated serum creatinine found to have unilateral hydronephrosis and hydroureter. Thus, she had been referred to urosurgical team for the ureteric stenting by the medical team. During the post-stenting evaluation, it was found to have Lippes Loop closer to the lower ureteric segment and reffred to the gynaecology ward for further evaluation. On further inquiry it had been inserted more than 40years back but she was defaulted to remove after recommended time duration. Pelvic ultrasound scan revealed atrophic uterus with empty uterine cavity and atrophic ovaries without evidence of Lippes Loop. She was undergone and diagnostic laparoscopy and found to have a Lippes loop outside the uterus and adhered closer to the uterus. As she was already on ureteric stent, after discussion with Urosurgery team it was carefully retrieved. Patient was closely observed for 4days and referred back to the Urosurgery and medical care. 4weeks later her hydronephrois and hydroureter was improved and ureteric stent was extracted by Urosurgery team.

Discussion: Migration of an IUCD beyond the uterus can result in a wide spectrum of complications depending on its location. Reported sites include the omentum, bowel, bladder, broad ligament and pelvic peritoneum. Clinical manifestations range from chronic pelvic pain, abnormal uterine bleeding, recurrent urinary tract infections, bowel perforation, fistula formation, stone formation within the bladder, infertility and adhesions to complete absence of symptoms. Urinary tract involvement is particularly uncommon, with most reported cases involving intravesical migration. Extrinsic ureteric compression leading to hydroureter and hydronephrosis is exceptionally rare, with only isolated cases described in the literature.

In the present case, the patient remained asymptomatic despite retaining the Lippes Loop for over four decades. The migrated IUCD was discovered only during the evaluation of unilateral hydroureteronephrosis performed for deteriorating renal function. Laparoscopy confirmed extrauterine migration with dense adhesions adjacent to the distal ureter. Although direct ureteric invasion was absent, chronic inflammatory fibrosis and adhesions surrounding the migrated device likely resulted in extrinsic ureteric compression, explaining the hydronephrosis. Multidisciplinary management involving urology and gynaecology teams, laparoscopic retrieval of the migrated device resulted in resolution of the urinary tract obstruction.

Conclusion: This case highlights the importance of lifelong documentation, follow-up, counselling and education of women with intrauterine contraceptive devices, before presenting with secondary complications. Prompt recognition, appropriate imaging and multidisciplinary management involving both gynaecology and urology teams were essential for safe retrieval and preservation of renal function.

EP207. TRIPLE SYNCHRONOUS PRIMARY GYNAECOLOGICAL MALIGNANCIES OF OVARIES AND ENDOMETRIUM

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Objectives: Synchronous endometrial and ovarian primaries are well recognised. Triple synchronous gynaecological malignancies with distinct histological subtypes are not and separating them from metastatic disease governs staging, treatment and prognosis. We describe such a case and the basis for the attribution.

Case report: A 48-year-old postmenopausal multiparous woman presented with abdominal distension and abnormal uterine bleeding. Transvaginal ultrasound showed a 12 cm complex right ovarian mass with a thickened endometrium at 18 mm - serum cancer antigen-125 (CA-125) 240 U/mL, Risk of Malignancy Index 2160. Endometrial sampling confirmed endometrioid adenocarcinoma. Contrast-enhanced computed tomography showed the extent of disease - a right ovarian mass with capsular breach, a small left ovarian lesion, a Pouch of Douglas deposit involving rectum and 30% myometrial invasion. She underwent retrograde Hudson's hysterectomy with bilateral salpingo-oophorectomy, omental biopsy, excision of the Pouch of Douglas deposit, rectal shaving and pelvic and para-aortic node sampling, achieving complete pelvic cytoreduction (R0). Histology showed three distinct primaries - a high-grade serous carcinoma of the right ovary (FIGO stage IIB), a well-differentiated endometrioid carcinoma confined to the left ovary (FIGO stage IA) and a low-grade endometrioid endometrial carcinoma with superficial myometrial invasion (FIGO stage IA2). Immunohistochemistry supported independent origins - the serous carcinoma WT-1 and mutant-p53 positive, both endometrioid tumours WT-1 negative with wild-type p53. She completed six cycles of adjuvant carboplatin-paclitaxel and remains recurrence-free.

Discussion: Double synchronous endometrial-ovarian primaries occur occasionally; triple synchronous primaries are extraordinarily rare and most reported synchronous tumours share endometrioid histology at both sites. A high-grade serous carcinoma alongside two low-grade endometrioid tumours is exceptional. The distinction from metastatic disease turns on defined features - organ-confined, early-stage tumours of dissimilar histology or grade favour independent primaries, whereas deep myometrial invasion, lymphovascular invasion and identical histology point to a single metastasising primary. This case satisfied the former on every count, the discordant histology and WT-1 and p53 immunoprofiles settling the question. Treatment is then directed by the most aggressive of the three.

Conclusion: Here it was the discordant histology and immunoprofiles, rather than any radiological or operative finding, that established three independent primaries in place of metastatic spread. That distinction determined both stage and treatment. Complete cytoreduction followed by carboplatin-paclitaxel directed at the serous tumour has left her recurrence-free.

EP208. TWIN PREGNANCY WITH STEROID-SENSITIVE NEPHROTIC SYNDROME COMPLICATED BY GESTATIONAL HYPERTENSION - CASE REPORT

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Introduction: Nephrotic syndrome in pregnancy is challanging, with physiological changes in renal hemodynamics and immune function impacting disease activity. The physiological increase in Glomerular-filtration and increased glomerular capillary pressure in pregnancy can exacerbate proteinuria and predispose to pre-eclampsia and it makes distinction from a primary disease flare difficult.

Case report: A 23-year-old primigravida with a Dichorionic Diamniotic (DCDA) twin pregnancy was diagnosed with steroid-sensitive nephrotic syndrome (SSNS) prior to conception. Her antenatal period was marked by recurrent admissions for nephrotic-range proteinuria secondary to disease relapses. So that repeated escalations of oral prednisolone was done. Despite this, renal function tests remained stable and she didn’t develop gesta-

tional diabetes or fetal growth restriction. At 34 weeks of gestation, she developed Gestational hypertension. Initially managed with labetalol, but had poor control to maximum dose, requiring the addition of nifedipine as a second-line agent. With escalating doses of three antihypertensives by adding Methyldopa to control blood pressure, a clinical decision was made for delivery. An elective lower segment cesarean section (LSCS) was performed at 35 weeks for uncontrolled hypertension. Remarkably, her blood pressure normalized spontaneously within 48 hours postpartum, allowing for the cessation of all antihypertensives. 2 babies were obsereved in baby unit for 8 days until favourable weight gain. Her prednisolone was systematically tapered and she was discharged on Jadelle for long-term contraception.

Discussion: The onset of hypertension at 34 weeks in a twin pregnancy suggests superimposed pre-eclampsia rather than a simple SSNS flare. Dramatic postpartum resolution confirms that. The decision to proceed with LSCS was multifactorial, balancing the risks of preterm delivery against the maternal risks of severe hypertension and potential renal compromise. The blood pressure normalization in postpartum period, confirms the pregnancy-specific nature of the hypertensive insult. The multidisciplinary approach involving obstetricians, nephrologists and neonatologists was important.

Conclusion: This case highlights that while twin pregnancies in women with SSNS can be managed successfully, though they are at high-risk of disease exacerbation and superimposed pre-eclampsia. Close monitoring of blood pressure and proteinuria is essential to differentiate pathology and time delivery appropriately. The rapid postpartum remission reinforces the need for tailored antihypertensive weaning.

EP209. UNEXPECTED HELLP SYNDROME IN A PREVIOUSLY LOW-RISK PRIMIGRAVIDA: A CASE REPORT

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Background: HELLP (Haemolysis, Elevated Liver enzymes and Low Platelet count) syndrome is a life-threatening obstetric condition that is often associated with pre-eclampsia. However, rare presentations in previously normotensive women without any pre-conceptional or antenatal risk factors of hypertensive disease are uncommon and can delay diagnosis. Intrauterine fetal demise (IUFD) as the first presentation is extremely uncommon.

Case report: A 21-year-old previously healthy primigravida presented at 39+6 weeks' gestation with reduced fetal movements and mild abdominal pain. Her antenatal period had been uncomplicated with normal blood pressure recordings, no proteinuria, normal fetal growth and routine antenatal investigations within normal limits. Ultrasound examination confirmed an IUFD. Initial investigations demonstrated 3+ proteinuria, thrombocytopenia (127×10^3/L) and mildly elevated liver enzymes. Within two hours of admission, her blood pressure increased to 150/110 mmHg and with a working diagnosis of pre-eclampsia complicated with HELLP syndrome she was managed with intravenous magnesium sulphate, antihypertensives and transferred to the maternal ICU. Labour was induced while she was managed in the maternal ICU and she delivered a stillborn infant vaginally. During the postpartum period, she developed rapidly progressive HELLP syndrome complicated by microangiopathic haemolytic anaemia, acute kidney injury and hyperkalaemia. During intensive care she was transfused multiple blood product and two cycles of therapeutic plasma exchange before making a significant clinical and biochemical recovery. She received multidisciplinary management involving two obstetricians, an intensivist, a nephrologist and a haematologist. She was discharged after 14 days of ICU care and at postpartum follow-up

her blood pressure, renal function and platelet counts were found to be normal.

Conclusion: This case highlights that HELLP syndrome can present randomly in a previously low-risk pregnancy, with IUFD without the classic clinical signs and symptoms. It highlights the importance of maintaining diagnostic suspicion, repeating biochemical and haematological investigations when clinical deterioration occurs and involving a multidisciplinary team early in the course of management. Timely intensive care support during and after delivery, early detection of worsening thrombotic microangiopathy and intervening with therapeutic plasma exchange in selected patients can result in an excellent maternal outcome despite severe disease.

Keywords: HELLP syndrome; intrauterine fetal demise; atypical pre-eclampsia; thrombotic microangiopathy; plasma exchange.

EP210. UNEXPLAINED HEPATIC DYSFUNCTION IN PREGNANCY: A CASE REPORT

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Objectives: To highlight the diagnostic and management challenges of unexplained hepatic dysfunction in pregnancy with overlapping features of intrahepatic cholestasis of pregnancy and acute fatty liver of pregnancy.

Case report: A 26-year-old primigravida at 30 weeks and 6 days of gestation presented with four days of generalized pruritus predominantly over the palms. There was no jaundice, abdominal pain, vomiting, pale stools or dark colour urine. Antenatal screening was normal including Oral Glucose Tolerance Test and anomaly scan. Examination revealed no pallor or icterus, normal vitals and appropriate fetal parameters.

Serum bile acids were 15.1µmol/ L. Serum Transaminases showed a marked elevation, with AST and ALT reaching 221 U/L and 400 U/L respectively along with hemoglobin 10.8 g/dl, platelet count 236 x 10 9 /L, INR 0.93, plasma glucose 6.2 mole/Land serum creatinine 0.49 mg/dl.Viral hepatitis serology was negative and ultrasound abdomen was normal. Multidisciplinary input from gastroenterology and neonatology recommended urgent delivery. Due to lack of NICU ventilators locally, in-utero transfer to CNTH Ragama was arranged after administration of the antenatal corticosteroids. Caesarean section at 31 weeks and. 2 days of gestation was performed. Liver enzymes normalized by postpartum day three.Both maternal and neonatal recovery was uncomplicated, with favorable postpartum and postnatal outcomes.

Discussion: ICP typically presents with pruritus and raise bile acids without systemic involvement, while AFLP manifests with nausea, hypoglycemia, coagulopathy and possible encephalopathy. This patient did not satisfy Swansea criteria for AFLP nor ICP threshold; however, rapid biochemical normalization during postpartum period supported an evolving AFLP, definitive differentiation between resolving atypical ICP and early AFLP remains challenging postpartum as, as both can exhibit rapid resolution following delivery.RCOG and NICE emphasize early intereven before full criteria when maternal or fetal compromise is predicted. Timely transfer and multidisciplinary coordination were decisive in achieving uncomplicated maternal recovery and uncompromised neonatal course.

Conclusion: Atypical presentation of heptic dysfunction in pregnancy demand high clinical vigilance. Adherence to guideline-based escalation and multidisciplinary coordination are essential, particularly in managing ambiguous biochemical profiles in resource-limited settings. Timely delivery may be lifesaving even without definitive fulfillment of diagnostic criteria.

Note: Written informed consent was obtained from the patient for publication of this case report.

EP211. UNIVERSAL VERSUS RISK-FACTOR-BASED THYROID SCREENING IN EARLY PREGNANCY: A COHORT STUDY

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Introduction: Thyroid dysfunction in pregnancy is associated with miscarriage, preterm

birth and impaired neurodevelopment, yet the optimal screening strategy remains debated. Risk-factor-based screening is still favoured by several international bodies, though it is reported to miss a substantial proportion of affected women. Universal screening at booking is not yet routine in Sri Lanka.

Objectives: To determine what proportion of women with thyroid dysfunction detected by universal thyroid-stimulating hormone (TSH) screening in early pregnancy lacked an identifiable risk factor - and would therefore have been missed by a targeted policy.

Design: Prospective observational cohort study conducted in a booking antenatal clinic where universal TSH testing is practised.

Method: We measured serum TSH in consecutive women at their booking visit, with reflex free T4, free T3 and anti-thyroid antibody testing where indicated. Established risk factors were documented for each woman - personal or family history of thyroid disease, goitre or nodule on examination, previous head or neck irradiation. Overt and subclinical hypothyroidism and hyperthyroidism were diagnosed against standard reference ranges. Each case was then classified as risk-factor positive and so capturable by targeted screening, or universal-screening-only.

Results: Of 104 women screened at a mean gestation of 10.8 weeks (range 4–38) and mean age 31.7 years, thyroid dysfunction was identified in 32 (30.8%) - 12 overt hypothyroidism, 18 subclinical hypothyroidism and 2 subclinical hyperthyroidism, with no overt hyperthyroidism. Only 18 women (17.3%) carried a recognised risk factor. Of the 32 with dysfunction, 22 (68.8%) were hypothyroid with no risk factor at all (8 overt, 14 subclinical). Targeted screening would have missed all 22, equating to 21.2% of the whole cohort. Both hyperthyroid cases carried a risk factor and would have been detected either way.

Conclusion: Universal TSH screening detected substantially more hypothyroid disease than targeted screening would have. Over two-thirds of confirmed cases - 22 of 32, mostly subclinical - occurred in women with no recognised risk factor. Hyperthyroidism was uncommon here and consistently risk-factor associated. On these figures, universal screening at booking is preferable to a targeted policy, chiefly to avoid under-diagnosis of hypothyroidism. A cohort of 104 is a narrow base for national policy and confirmation in larger multi-centre studies is needed.

EP212. UNSTABLE ANGINA BEFORE PREGNANCY RECOGNITION: CONSERVATIVE MANAGEMENT TO THIRD TRIMESTER: A CASE REPORT

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Objectives: Acute coronary syndrome (ACS) during pregnancy is uncommon and most existing publications describe women whose pregnancies were already recognized by the time of diagnosis. This case is different because the full diagnostic workup, including a treadmill test (TMT), was carried out before the pregnancy was identified. After pregnancy recognition, a multidisciplinary team (MDT) planning allowed conservative management and postponed angiography until the puerperium. To our knowledge, this combination has not been reported before.

Case report: A 36-year-old woman, gravida 3 para 3 with two previous caesarean deliveries, had incidental electrocardiogram (ECG) abnormalities seen at a routine health check and was referred to cardiology. But shortly, she presented with acute chest pain and was admitted and managed as unstable angina, still unaware of the pregnancy. According to the standard ACS criteria, which do not change in pregnancy. Troponin I stayed negative, serial ECGs showed no dynamic changes and echocardiography was reassuring with an ejection fraction of 60% and normal cardiac structure and function.

A Bruce-protocol treadmill test was completed before the pregnancy was recognised and concluded grade 2 positive; her functional capacity was good at 13.4 metabolic equivalents. Her lipid profile showed marginally elevated total cholesterol of 237 mg/dL and a low-density lipoprotein (LDL) of 167 mg/dL, while her thyroid-stimulating hormone was normal. The pregnancy was then diagnosed incidentally at 17 weeks.

An MDT meeting was held with cardiology, anaesthesia, obstetrics and neonatology. The positive TMT was the main concern; the team

worked through the need for angiography, anaesthetic options, the possibility of intensive care unit (ICU) necessity, neonatal care if preterm delivery became necessary and delivery planning. The agreement was elective lower segment caesarean section at 37 weeks under general anaesthesia, with coronary angiography postponed to the puerperium given she stayed clinically stable. Statins were withheld during exclusive breastfeeding and permanent sterilisation was discussed.

Discussion: This case is unusual because the diagnostic pathway was completed before pregnancy was recognised, which underlines why pregnancy should be excluded before any exercise or radiation-based investigation. It also demonstrates how structured MDT planning can safely guide decisions on angiography, anaesthesia and timing of delivery.

Conclusion: Unstable angina in pregnancy may first present during routine investigations and standard ACS diagnostic criteria remain applicable. Early MDT planning can help achieve safe maternal and fetal outcomes while allowing coronary angiography to be postponed until the postpartum period, contributing to the limited evidence available to guide future practice.

EP213. UNVEILING A RARE MALIGNANCY: PRIMARY VAGINAL MELANOMA

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Introduction and Objectives: Mucosal melanoma is a malignant melanocytic neoplasm that arises at a non-cutaneous site. They are uncommon than cutaneous melanomas, which are often detected at an early stage because of their accessible location. Primary vaginal melanoma (PVM) is rare. Incidence of PVM is approximately three cases per 10 million women annually. Median overall survival is 16 months. We report a case of PVM, highlighting its clinical presentation, histopathological diagnosis and subsequent management. Patient's informed written was obtained for the publication of clinical details.

Case report: A 60-year-old woman presented to the gynaecology clinic with recurrent episodes of postmenopausal bleeding for one year, which progressed to black-coloured vaginal discharge over the following month. A detailed gynaecological examination revealed multiple black-coloured hard nodules on the cervix with circumferential involvement of the vaginal walls. Vulva and anogenital region appeared normal. Uterus was retroverted with normal size. Both adnexae and the pouch of Douglas were unremarkable. Cutaneous lesions suggestive of primary cutaneous melanoma were not seen in the lower limbs.

Transvaginal ultrasonography showed no mass lesions in the uterus, adnexae or pelvic cavity. Endometrial thickness was 2 mm. Abdominal ultrasonography showed no organomegaly. An excisional biopsy of the cervix and posterior vaginal wall was performed. Histopathological examination revealed sheets of cells with highly pleomorphic vesicular nuclei and prominent eosinophilic nucleoli. Cytoplasm contained abundant coarse brown-black pigment consistent with melanin. Brisk mitotic activity was identified. Areas of necrosis and haemorrhage were present. Immunohistochemical staining demonstrated diffuse positivity for HMB45. Additional markers such as S100 and Melan-A were not done. Molecule testing for KIT, NRAS and BRAF were not available in our setting.

Contrast-enhanced computed tomography (CECT) of the chest, abdomen and pelvis demonstrated no evidence of metastasis or lymphadenopathy. Magnetic resonance imaging (MRI) was not done because of limited resource availability. A preoperative diagnosis of PVM was made. Patient was thoroughly counselled regarding the prognosis of the disease. Specialised gynaecological oncology care was arranged. She underwent pelvic radiotherapy and subsequently opted for total vaginectomy, radical hysterectomy, bilateral salpingo-oophorectomy and pelvic lymph node dissection.

Discussion: Metastatic deposits from a cutaneous melanoma should be always excluded in patients with mucosal melanomas. PVM often present at a later stage because of their concealed location. Hence, they have a poorer prognosis. MRI provides superior soft-tissue

contrast and accurate assessment of tumour depth, local organ invasion and multifocal disease, making it the preferred modality for staging over CECT. Radiotherapy and surgery are the cornerstones of management. Recent advances in immunotherapy and molecularly targeted therapies have shown promising results in selected patients, but evidence remains limited because of the rarity of the disease.

Conclusion: Melanoma should be considered in the differential diagnosis of pigmented genital tract lesions. Early recognition, prompt histopathological evaluation, radiotherapy and radical surgery are the principals of management.

EP214. URETERIC OBSTRUCTION FOLLOWING SACROSPINOUS LIGAMENT FIXATION: A RARE BUT SERIOUS COMPLICATION

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Objectives: Vaginal sacrospinous fixation (SSF) is a widely accepted surgical technique for post-hysterectomy vault prolapse. This case report highlights ureteric obstruction following right-sided SSF and emphasizes the importance of early recognition, imaging and intervention.

Case report: A 65-year-old woman with a history of three vaginal deliveries and prior vaginal hysterectomy presented with stage III vault prolapse associated with cystocele and rectocele. She underwent anterior and posterior colporrhaphy with right SSF. Two non-absorbable sutures were placed 2 cm medial to the ischial spine to anchor the vaginal vault. The immediate postoperative period was uneventful and the patient was discharged on day two. On postoperative day five, she presented with severe right side flank pain. Imaging revealed right side moderate hydronephrosis and hydroureter with calyceal rupture. Computed Tomography Intravenous Urography (CT-IVU) identified obstruction at the right vesicoureteral junction. Cystoscopy confirmed ureteric narrowing and a Double-J stent was inserted. The vaginal vault was reopened, SSF sutures were removed and the vault was repaired. Symptoms resolved within two days and follow-up imaging showed resolution of hydronephrosis. The stent was removed after six weeks and the patient remained asymptomatic.

Discussion: Vault prolapse is a recognized late complication of vaginal hysterectomy and SSF is a preferred surgical repair. However, the anatomical close relationship of the ureter to the sacrospinous ligament, poses a risk of kinking or compression during suture placement, especially on the right side. Risk increases in patients with previous pelvic surgeries due to distorted anatomy. Ureteric injury may be presented early, as in this case, with flank pain. Early imaging, including ultrasound and CT-IVU, is vital for diagnosis. Ureteric stenting and removal of sutures can restore normal function without long term complication such as renal failure. It is good practice to use intraoperative cystoscopy to assess ureteric function during surgery.

Conclusion: Ureteric obstruction is a rare but serious complication after sacrospinous ligament fixation, for post hysterectomy vaginal prolapse. Early recognition and prompt management, as in this case, can prevent long term kidney damage.

EP215. URODYNAMIC PROFILE OF WOMEN WITH URINARY INCONTINENCE: A SRI LANKAN EXPERIENCE

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Introduction: Urinary incontinence is common but under-reported and affects quality of life considerably. Urodynamic studies diagnose the underlying type objectively, which is what allows treatment to be chosen rationally. Sri Jayewardenepura General Hospital runs one of the few dedicated urodynamic centres in Sri Lanka and takes referrals from across the region.

Objectives: To describe presentation, urodynamic findings and management outcomes in women assessed at a tertiary urodynamic centre in Sri Lanka over six months.

Design: Descriptive analysis of prospectively collected clinical and urodynamic data.

Method: We reviewed the records of 42 women who underwent urodynamic studies in 2026 - demographics, symptom profile, bladder-diary working diagnosis, urodynamic parameters and subsequent management.

Results: Clinically, stress-type symptoms were present in 33/42 (79%), urgency in 34/42 (81%) and urge incontinence in 27/42 (64%). Bladder-diary working diagnosis was mixed incontinence in 18 (43%), pure stress incontinence in 14 (33%) and urge incontinence in 9 (21%). On urodynamic testing, provocation stress testing was positive in 14/42 (33%) and detrusor overactivity was demonstrated in 6/42 (14%); voiding cystometry was abnormal in 2 patients. Final urodynamic diagnosis was stress incontinence in 17 (40%), a normal study in 8 (19%), urge-related incontinence in 7 (17%) and mixed incontinence in 4 (10%).

Clinical impression, bladder diary and objective urodynamic results diverged markedly. Clinical stress-type symptoms were reported in 79%, yet confirmed on provocation testing in only 33%, an overall discordance of 29/42 (69%): 24 (57%) had symptomatic stress incontinence with a negative provocation test, while 5 (12%) without stress symptoms tested positive. Similarly, bladder-diary working diagnosis agreed with the final urodynamic diagnosis in only 14/42 (33%), a discordance rate of 67% (28/42). This was most pronounced among the 18 women with a bladder-diary diagnosis of mixed incontinence, of whom urodynamics reclassified only 2 (11%) as mixed; most proved pure stress (9, 50%) or urge incontinence (4, 22%). Of the 14 diagnosed with stress incontinence on bladder diary, 8 (57%) were confirmed urodynamically and 5 (36%) had normal studies; of the 9 diagnosed with urge incontinence, only 3 (33%) were confirmed.

Conclusion: Clinical impression and urodynamic confirmation diverged sharply - bladder-diary diagnosis agreed with the final urodynamic diagnosis in only 33%. Two-thirds would have been treated for the wrong type of incontinence had the diary directed management. Urodynamic study is what distinguishes them.

EP216. UTERINE DIDELPHYS COMPLICATED BY UTERINE RUPTURE IN A PREVIOUSLY SCARRED UTERUS

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Objectives: Uterine rupture in a patient with a previous caesarean section and undiagnosed uterine anomaly(didelphys) is a rare occurrence. Although this is a rare condition, it has important clinical significance, as identifying such cases during the antenatal period allows appropriate delivery planning and may help to minimise unexpected adverse outcomes.

Case report: A 31-year-old gravida 2 para 1 woman with a previous caesarean section performed 2 years earlier was admitted at 38 weeks' gestation with mild lower abdominal pain and dysuria. On initial assessment, she had normal vital signs with no scar tenderness or signs of labour. Fetal wellbeing was reassessed with a reactive CTG, although mild uterine irritability was noted. She was planned for an elective caesarean section one week later. Several hours after admission, she developed sudden severe abdominal pain and Doppler assessment detected fetal bradycardia. An urgent ultrasound scan raised suspicion of uterine rupture. A category 1 caesarean section was performed immediately. Intraoperative findings revealed haemoperitoneum with complete rupture of the uterus at the site of the previous scar. Dense adhesions were present around the scar and further exploration revealed a previously undiagnosed uterine didelphys. The uterus was successfully repaired without hysterectomy. The neonate required resuscitation and was admitted to the SCBU for management of likely hypoxic-ischaemic encephalopathy (HIE).

Discussion: Uterine didelphys is a rare Müllerian duct anomaly associated with adverse obstetric outcomes, including miscarriage, malpresentation, preterm birth and caesarean delivery. Evidence of uterine rupture related solely to uterine didelphys is lacking, however the coexistence of a previous uterine scar may considerably increase the rupture risk. This case highlights the importance of antenatal recognition of uterine anomalies through care-

ful ultrasonography, review of previous operative records and appropriate action plan. Planned delivery in a tertiary care centre with multidisciplinary support may reduce maternal and neonatal morbidity.

Conclusion: This case demonstrates that uterine rupture can occur unexpectedly in women with previously undiagnosed uterine didelphys and a prior caesarean section. Early antenatal diagnosis with proper history examination and investigations, comprehensive patient counselling, individualized risk assessment and planned delivery in a tertiary centre are essential to optimize maternal and neonatal outcomes. Prompt recognition and emergency surgical intervention are crucial in achieving favourable clinical results.

EP217. UTERINE SMOOTH MUSCLE TUMOUR OF UNCERTAIN MALIGNANT POTENTIAL IN AN ADOLESCENT: A RARE CASE REPORT

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Objectives: To report a rare case of uterine Smooth Muscle Tumour of Uncertain Malignant Potential (STUMP) in a teenage girl highlighting the diagnostic challenges, fertility-preserving surgical management and the importance of long-term surveillance.

Case report: A 13-year-old girl presented with history of progressive abdominal distension, lower abdominal pain and dyspeptic symptoms for 2 months. Clinical examination revealed a large abdominopelvic solid tumour with the size of 20-week gravid uterus. Serum CA-125 was markedly elevated (>1000 U/ml), but the β-hCG and AFP were negative. CECT CAP and Pelvic MRI showed a large uterine mass with features suspicious for leiomyoma, leiomyosarcoma and uterine lymphoma. Ultrasound-guided biopsy was done and it revealed a benign leiomyoma with spindle cells positive for smooth muscle actin and desmin, without significant atypia, mitoses, or tumour necrosis. Open myomectomy was performed due to the concern regarding fast tumour expansion and suspicious radiological findings. A tumour 20×12 cm in size was removed, the uterus and both adnexa were preserved. Final histopathological study demonstrated mild cytological atypia, coagulative tumour cell necrosis and 5 mitoses per 10 high-power fields, confirming a diagnosis of STUMP. The postoperative recovery was uneventful. Following surgery, the patient was placed in long-term surveillance. Follow-up scans have shown no evidence of local recurrence or distant metastasis.

Discussion: STUMP is an uncommon uterine smooth muscle tumour with unpredictable biological behaviour. It is very rare in teenage but common in middle aged women. This case illustrates the limitations of imaging and biopsy in accurately identifying heterogeneous uterine smooth muscle tumours. It shows the importance of clinical, radiological and pathological correlation. Fertility-sparing surgery with total tumor excision is the best management option for young patients. However histopathological evaluation is essential for diagnosis. Long-term follow-up is necessary as recurrence may happen several years after primary treatment.

Conclusion: STUMP should be considered in the differential diagnosis of rapidly enlarging uterine masses in young, even though it's very rare in adolescence. Definitive diagnosis can be made with histopathological evaluation after complete surgical excision. Fertility-preserving surgery with long-term surveillance provides a reasonable balance between oncological safety and future reproductive potential.

EP218. UTERINE STUMP IN A PATIENT WITH CONGENITAL RUBELLA SYNDROME

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Objectives: To present a rare case of Uterine Smooth muscle Tumor of Uncertain Malignant Potential (STUMP) in a patient with multiple congenital abnormalities, emphasizing diagnostic challenges, surgical management and implications for long-term follow-up.

Case report: A 37-year-old single, nulliparous female presented with a one-year history of lower abdominal pain, heavy menstrual bleeding, secondary dysmenorrhoea and loss

of appetite. Her past medical history indicated congenital Rubella syndrome, type 2 diabetes mellitus, pulmonary valve stenosis, congenital deaf-mutism and bilateral cataracts surgically treated at two weeks of age. On examination, the uterus was palpable at 14-week size. Transabdominal ultrasonography revealed a uterus measuring 8.7 × 4 cm with a posterior subserous fibroid (7 × 8 cm), a probable cervical or broad ligament fibroid and an endometrial thickness of 11.2 mm. The right ovary was normal, the left ovary was not visualized and both kidneys were normal.

Intraoperatively, multiple uterine fibroids were identified, including a massive posterior broad ligament fibroid on the left side with multiple bleeding points over the parasitic fibroid bed. Due to the unusual vascularity and adherence of the broad ligament fibroid, myomectomy was converted to total abdominal hysterectomy (TAH), conserving both normal-appearing ovaries. Histopathology revealed normal cervix and fallopian tubes, with a uterine smooth muscle tumor of uncertain malignant potential showing no atypia or necrosis. The patient is on follow-up at six-monthly intervals.

Discussion: and Implications for Practice STUMPs are diagnostically challenging somewhere between benign leiomyomas and leiomyosarcomas. They typically affect women around 40 to 45 years of age, but presentation in younger woman with complex comorbidities, as in this case, highlights the need for individualized management. Prognosis is intermediate, with recurrence rates of 7–28% and potential transformation into leiomyosarcoma. Surgical excision remains the gold standard of management, with hysterectomy favored in women without fertility desires. Long-term follow-up is essential, given the mean recurrence interval of 47 months. This case emphasizes the importance of adequate tissue sampling, awareness of atypical presentations and structured surveillance to optimize outcomes.

Conclusion: This case illustrates the unpredictable behavior of uterine STUMP and the necessity of close follow-up. Integration of histopathology with the clinical background should dictate management, while recognition of recurrence risk will emphasize the need for structured surveillance.

EP219. V-Y ADVANCEMENT FLAP RECONSTRUCTION FOLLOWING RADICAL VULVECTOMY- CASE SERIES

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Background: Surgical excision remains the cornerstone of treatment for vulval malignancies and premalignant lesions requiring wide local excision, hemi-vulvectomy or vulvectomy. Larger vulval defects following resection present constructive challenges as primary closure may result in excessive tension, wounds breakdown, distortion of the vulvar anatomy and impaired function. V-Y advancement flap is a simple local flap to provide durable soft tissue coverage with satisfactory cosmetic and functional outcomes (1,2,3).

Case report: We present three cases of V-Y advancement flap being done following vulvectomy. These women are 65-70 year old, who had presented with vulval lesions. Two out of them had squamous cell carcinoma and one had paget's disease following biopsies. Thus according to each presentation, diagnosis and after multi-disciplinary team discussions, vulvectomy and inguinal lymph node assessment were performed. Following excision, vulval defect is measured and as primary closure was inappropriate due to excessive tension, a V-Y advancement of the flap was designed. The flap incorporated healthy skin and subcutaneous tissue while preserving the vascular pedicle. Careful undermining allowed advancement in to the defect without tension. Layered closure was performed from the deeper tissues to the skin.

One patient underwent hemi-vulvectomy with unilateral V-Y flap advancement and others underwent total vulvectomy and bilateral V-Y flap advancement with de-functioning colostomy to aid healing.

Postoperatively flap perfusion remained satisfactory. Histopathology demonstrated clear margins.

At follow up visits over two months showed complete wound healing and intact urinary function, comfortable sitting and walking. Colostomies were reversed later.

Discussion: Reconstruction after vulvectomy remains an important component of the multi-

disciplinary management of vulvar lesion. Primary closure is appropriate for small defects; however, larger resections frequently result in wound tension, delayed healing and anatomical distortion (3).

Local advancement flaps provide several advantages such as retaining similar skin texture and sensation while preserving blood supply (4).

Reported complications following vulvar reconstruction include wound infection, flap necrosis, seroma formation, hematoma and wound dehiscence. Careful patient selection, meticulous surgical technique and tension-free closure significantly reduce these risks (3,4).

Conclusion: The V-U advancement flap represents a safe, reproducible and effective reconstructive technique following radical vulvectomy. It provides tension-free closure, excellent vascularity, preservation of vulvar anatomy and favorable postoperative outcomes with minimal donor-site morbidity. This technique should be considered for moderate-sized vulvar defects where primary closure is not feasible.

EP220. VASOPRESSIN-ASSISTED ENUCLEATION OF A NON-COMMUNICATING RUDIMENTARY UTERINE HORN: A CASE REPORT

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Introduction: Müllerian duct anomalies are an under-recognised cause of chronic cyclical pelvic pain and a non-communicating rudimentary uterine horn is frequently misdiagnosed as endometriosis because of overlapping clinical and sonographic features. Delayed recognition risks years of inappropriate hormonal treatment and progressive haematometra, rupture and secondary endometriosis. Once identified, laparoscopic excision is definitive, but the choice of surgical technique matters. We report a case managed by vasopressin-assisted enucleation of the horn and discuss why this approach is preferable to simple wedge resection.

Case report: A 20-year-old unmarried woman presented with an eight-year history of cyclical lower abdominal pain that worsened with menstruation. She had been treated at peripheral units with the combined oral contraceptive pill for presumed endometriosis, with serial ultrasound variably reporting a right-sided endometrioma. On referral to Sri Jayewardenepura General Hospital, re-evaluation raised suspicion of a Müllerian anomaly. As she declined transvaginal scanning owing to virgo intacta status, magnetic resonance imaging demonstrated a right-sided non-communicating uterine horn.

At laparoscopy, the rudimentary right horn was attached to the right round ligament with an orthotopically inserted right fallopian tube and no endometriosis was identified. Vasopressin was infiltrated to reduce bleeding and an incision was made over the bulge medial to the round ligament and anterior to the tubal ostium. A plane was developed between the horn and the overlying myometrium and serosa and the spherical horn, containing endometrium and myometrium, was enucleated intact along its capsule. The defect was closed with layered haemostatic suturing and recovery was uneventful.

Discussion: Enucleation, rather than resection, is the key technical point. Developing a capsular plane allows the horn to be shelled out while preserving a healthy myometrial and serosal margin for closure. The dissection stays away from the adjacent uterine vasculature and the cornual and interstitial portion of the tube, reducing blood loss and thermal injury. By contrast, resection cuts across the horn and its junction with the normal uterus. Enucleation therefore permits secure layered suturing, preserves round ligament and tubo-ovarian anatomy and lowers the risk of a weakened myometrial scar and future uterine rupture through the normal horn. It is preferred when the horn is well encapsulated and a clear dissection plane can be developed, as in this patient.

Conclusion: Cyclical pain resistant to endometriosis management should prompt reassessment for a Müllerian anomaly. When excision is indicated, vasopressin-assisted enucleation offers a safe, curative and anatomically preserving alternative to resection that preserves fertility and the normally connected contralateral system.

EP221. VIRILIZING STEROID CELL TUMOUR OF THE OVARY IN A POSTMENOPAUSAL WOMAN: A RARE CASE REPORT

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Steroid cell tumours of the ovary are a rare subgroup of sex cord–stromal tumours that are frequently androgen-secreting and may present with virilization. They account for fewer than 0.1% of all ovarian tumours and pose both diagnostic and management challenges, particularly in postmenopausal women. We report such a case to describe its clinical, biochemical, radiological and histopathological features and to discuss the assessment of malignant potential.

Case report: A 56-year-old postmenopausal woman, an elementary school teacher, presented with progressively worsening features of virilization, including frontal (male-pattern) balding, hirsutism, deepening of the voice and clitoromegaly.

Biochemical evaluation revealed a markedly elevated serum total testosterone of 2.41 ng/mL. The serum CA-125 concentration was within normal limits at 5.92 U/mL (reference range < 35 U/mL).

Contrast-enhanced computed tomography (CECT) of the abdomen and pelvis demonstrated a solid, enhancing right adnexal mass suggestive of a primary right ovarian neoplasm. There was heterogeneous enhancement of the uterine myometrium adjacent to the mass, raising the possibility of direct uterine invasion; imaging features also suggested coexisting adenomyosis. No pelvic or para-aortic lymphadenopathy was identified and the left ovary appeared normal.

The patient underwent total abdominal hysterectomy, bilateral salpingo-oophorectomy and infracolic omentectomy.

Histopathological examination confirmed a steroid cell tumour of the right ovary. The tumour measured 86 × 85 × 40 mm (8.6 cm in maximum dimension). Mitotic activity was low (1 per 2 mm^2) and there were no capsular breach and no necrosis. The endometrium showed benign atrophic polyps and the cervix was histologically normal. Notably, no histological evidence of myometrial or uterine invasion was identified; the direct uterine invasion suspected on imaging was therefore not confirmed on histopathology.

Discussion: Steroid cell tumours of the ovary are rare sex cord–stromal neoplasms that are frequently hormonally active. [1] They most often secrete androgens, producing virilization, which is particularly conspicuous in postmenopausal women. Typical clinical features include hirsutism, deepening of the voice, clitoromegaly and male-pattern alopecia. [2] An elevated serum testosterone is central to the biochemical diagnosis and additional androgen studies such as DHEAS and androstenedione are useful for localising the source of androgen excess and for helping to exclude an adrenal cause. Imaging typically demonstrates a solid ovarian mass, but reliable preoperative distinction between benign and malignant lesions is difficult. [3] The malignant potential of steroid cell tumour, not otherwise specified, is assessed using established pathological criteria, including tumour size, mitotic activity, necrosis, haemorrhage, nuclear atypia and capsular or vascular invasion. [4] In the present case the pathological features were predominantly favourable, with a low mitotic rate and no necrosis, haemorrhage, or capsular breach. However, the tumour measured 8.6 cm, exceeding the 7 cm threshold that has been associated with a higher likelihood of malignant behaviour. [4][5] The lesion is therefore best regarded as showing favourable pathological features with low malignant potential, rather than being classified as unequivocally benign and continued clinical follow-up is appropriate. [6] Surgical intervention remains the mainstay of treatment. In postmenopausal women, total abdominal hysterectomy with bilateral salpingo-oophorectomy is recommended. The prognosis for tumours with favourable pathological features is generally good.

Limitations As a single case report, generalisable conclusions cannot be drawn. As a single case report, generalisable conclusions cannot be drawn. Furthermore, DHEAS and androstenedione levels were not measured, which limited the completeness of the androgen work-up.

Conclusion: Although rare, steroid cell tumours should be included in the differential diagnosis of postmenopausal women presenting with virilization. Early identification with appropriate imaging and biochemical evaluation, followed by definitive surgery, offers the best outcome. Histopathological assessment remains essential for diagnosis and for determining malignant potential and prognosis.

Ethics and Consent Written informed consent for the publication of this case report was obtained from the patient.

EP222. VULVAL PLAQUE LESION IN A POSTMENOPAUSAL WOMAN: A RARE PRESENTATION OF PEMPHIGUS VEGETANS

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Introduction: Pemphigus is a group of vesiculobullous autoimmune diseases characterized by mucocutaneous bullae. In this group, pemphigus vulgaris remains the most common type and pemphigus vegetans is the rarest type. We report a case of vulval pemphigus vegetans initially suspected to be a malignancy with secondary infection, later confirmed on histology after a similar lesion was identified at the axilla.

Case report: A 65-year-old mother of one child, with diabetes mellitus and hyperthyroidism, was on Carbimazole. She had undergone a total abdominal hysterectomy with bilateral salpingectomy for adenomyosis. She presented with a one-month history of homogeneous, non-foul-smelling per vaginal discharge. She did not have fever, itchiness, or postmenopausal bleeding. Her last Pap smear, at age 35, was NILM.

On vulval examination, an extensive plaque-like lesion with discharge was noted. It was macroscopically suggestive of vulval malignancy with secondary bacterial infection. Initial blood investigations, including high vaginal swabs, were done and she was started on empirical antibiotics.

She was managed by a multidisciplinary team comprising a gynaecologist, gynae-oncologist, dermatologist, microbiologist and histopathologist. Multiple vulval biopsies were taken. During further evaluation, a similar lesion was noted at the axilla and was also assessed histologically. Both lesions were histologically confirmed as pemphigus vegetans, which excluded malignancy and the diagnosis was steered towards an autoimmune disease.

She was subsequently managed with systemic corticosteroids and long-term immunosuppressants, with routine follow-up at the dermatology clinic as an outpatient.

Discussion: This case highlights the diagnostic challenge of pemphigus vegetans presenting at an atypical site, especially in an older woman without previous dermatological history. Its characteristics, such as discharge and plaque-like lesions, mimic malignancy, which is the most important differential diagnosis in this age group. Diagnosis relies on histopathology showing suprabasal acantholysis with eosinophilic microabscesses, supported by direct immunofluorescence. Systemic corticosteroids with steroid-sparing immunosuppressants were the mainstay of treatment.

This case highlights the importance of maintaining a broad differential for vulval lesions in older women. The importance of multidisciplinary involvement, which spared this patient from unnecessary oncological intervention, cannot be overstated.

EP223. VULVAL SMALL ROUND CELL SARCOMA IN LATE LIFE: A CASE REPORT

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Objectives: Primary vulval sarcomas are extremely rare (1-3% of vulval malignancies) and small round cell sarcomas of the Ewing sarcoma family of tumours (ESFT) are exceptional at this site, typically affecting young adults. We report the first Sri Lankan case of vulval Ewing sarcoma in an 81-year-old woman to highlight the diagnostic challenges, the central role of immunohistochemistry (IHC) and the aggressive behaviour of these tumours.

Case report: An 81-year-old postmenopausal woman presented with postmenopausal bleeding and a gradually enlarging ulcerative vulval mass extending to the vagina. Excisional

biopsy at a local hospital showed sheets of undifferentiated small round blue cells. She was referred to the National Cancer Institute, Maharagama, where wide local excision with excision of a sub-urethral deposit achieved clear margins. Histology confirmed a malignant small round cell sarcoma; IHC demonstrated diffuse membranous CD99 positivity and nuclear NKX2.2 expression, supporting an ESFT phenotype, while epithelial, neural, lymphoid, melanocytic and muscle markers were negative, excluding carcinoma, neuroendocrine tumour, melanoma, lymphoma and rhabdomyosarcoma. Molecular testing for EWSR1 rearrangement was unavailable. Staging contrast-enhanced computed tomography showed no nodal or distant disease. Following multidisciplinary discussion, adjuvant multi-agent chemotherapy was initiated given the high risk of systemic spread and at the latest follow-up she continued treatment without evidence of recurrence.

Discussion: Fewer than 40 cases of vulval ESFT have been reported globally, typically in women in their early twenties; only around 15% occur in postmenopausal women, making this presentation an outlier. In elderly women, common lesions (Bartholin cyst, squamous carcinoma, melanoma) are suspected first, so small round cell sarcoma must be considered once these are excluded. Diagnosis relies on histology and IHC (strong membranous CD99 and nuclear NKX2.2), ideally confirmed by demonstration of EWSR1 rearrangement. In the absence of site-specific guidelines, management is extrapolated from Ewing sarcoma at other sites, favouring margin-negative surgery with multi-agent chemotherapy, although intensive regimens are often poorly tolerated by older patients. Prognosis is poor, with a propensity for early lung metastasis and worse outcomes in the elderly.

Conclusion: This case underscores the rarity, diagnostic complexity and aggressive behaviour of vulval small round cell sarcoma and the indispensable role of immunohistochemistry. Small round cell sarcoma should enter the differential diagnosis of vulval masses in elderly women once common lesions are excluded, adding valuable data to a very limited literature.

EP224. WHEN PREGNANCY UNMASKS IMMUNE DYSREGULATION: CHRONIC MUCOCUTANEOUS CANDIDIASIS IN A WOMAN WITH STAT1 GAIN-OF-FUNCTION MUTATION – A CASE REPORT

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Background: Chronic mucocutaneous candidiasis (CMC) is a rare primary immunodeficiency characterized by persistent or recurrent Candida infections involving the skin, nails and mucous membranes. The condition is commonly associated with defects in the interleukin-17 immune pathway, particularly heterozygous gain-of-function mutations of the STAT1 gene. Pregnancy induces complex physiological immune modulation that may exacerbate underlying immune dysfunction, making the diagnosis and management of CMC particularly challenging. Reports describing pregnancy complicated by genetically confirmed STAT1 gain-of-function-associated CMC remain scarce.

Case report: A 36-year-old gravida 2 para 1 woman was referred at 24 weeks' gestation with progressive oral thrush, bilateral angular cheilitis, recurrent vulvovaginal candidiasis, diffuse hyperpigmented cutaneous lesions and chronic nail dystrophy that had significantly worsened during pregnancy. She had experienced recurrent mucocutaneous fungal infections since adolescence and had a history of recurrent respiratory infections. Her medical history was notable for hypoparathyroidism and adrenal insufficiency requiring long-term calcium, vitamin D and corticosteroid replacement. Previous genetic analysis had confirmed a STAT1 gain-of-function mutation, establishing the diagnosis of chronic mucocutaneous candidiasis syndrome. Clinical examination demonstrated extensive oral candidiasis, angular cheilitis, hyperpigmented skin lesions and onychomycosis, while obstetric assessment confirmed an appropriately grown singleton fetus without evidence of obstetric complications. Laboratory investigations revealed mild anaemia, hypocalcaemia consistent with underlying hypoparathyroidism and mildly elevated inflammatory markers,

with otherwise preserved haematological and biochemical parameters.

Management and Outcome: A multidisciplinary team involving obstetrics, dermatology, endocrinology, immunology and neonatology formulated an individualized management plan. Considering the absence of invasive fungal disease and concerns regarding fetal safety, topical antifungal therapy was administered while systemic antifungal agents were avoided. Endocrine replacement therapy was optimized and stress-dose corticosteroid administration during labour was planned. Close antenatal surveillance, including serial fetal growth assessments, demonstrated normal fetal development. Maternal mucocutaneous symptoms improved with treatment and the pregnancy progressed without significant maternal or fetal complications.

Conclusion: This case highlights the importance of considering underlying primary immunodeficiency in pregnant women presenting with recurrent or treatment-resistant candidiasis. Pregnancy may unmask or exacerbate immune dysregulation in patients with STAT1 gain-of-function mutations. Early recognition, comprehensive multidisciplinary care and individualized management can result in favourable maternal and fetal outcomes despite the complexity of this rare condition. Reporting similar cases will improve understanding of the interaction between pregnancy and inherited immune disorders and help guide future clinical management.

EP225. "WHEN THE TEAR SPARES THE SPHINCTER: A RARE CASE OF OBSTETRIC RECTAL BUTTONHOLE INJURY AFTER SPONTANEOUS VAGINAL BIRTH"

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Background: Perineal trauma remains one of the most frequent complications of vaginal birth, yet certain forms of injury continue to challenge even experienced obstetricians. Among these, the obstetric rectal buttonhole injury (ORBI) is a very rare and often underrecognized form in a spontaneous normal vaginal delivery than in an instrumental delivery. ORBI is defined by RCOG as "a tear extending through the vaginal epithelium into the rectal mucosa, while sparing the anal sphincter complex and perineal skin" [Table - 1]. The subtle presentation of ORBI poses a diagnostic dilemma and can disguise the true extent of the trauma particularly when the perineum appears normal on initial inspection. If not promptly diagnosed and repaired, tissue breakdown may occur, culminating in a rectovaginal fistula and significant long-term morbidity. For this reason, clinical vigilance and routine postpartum rectal assessment are vital components of safe obstetric practice. With limited case reports described in the literature, current practice in management of ORBI includes: multidisciplinary team input [MTI], primary repair using tension free three-layer closure [Rectal mucosa (RM), Rectovaginal septum (RVS) and Vaginal mucosa (VM)] and use of intra and post-op antibiotics.

We report a case of an isolated ORBI without anal sphincter involvement was identified immediately following an uncomplicated spontaneous vaginal delivery in a multiparous woman with no significant risk factors. The injury was successfully managed with prompt multilayer primary repair, resulting in an uncomplicated recovery. This case highlights the importance of careful post-delivery examination and raises awareness of this uncommon but potentially serious obstetric complication.

Case report: Our patient was 31-year-old pregnant mother with previous successful cephalic vaginal birth with 3200g baby girl four years ago. This was second pregnancy diagnosed at 10weeks of gestation and had uncomplicated antenatal followup. She went into spontaneous labour at 38 + 5 weeks and delivered 3080g baby boy by vertex. She had medio-lateral episiotomy at crowning and delivery was not difficult, nor instrumental delivery. An vertical rectal buttonhole tear noted at the end of repairing episiotomy by house officer. Immediate assessment was done after removing episiotomy sutures, there was minimal bleeding from episiotomy and pulse rate of 82 beats/min, blood pressure of 100/70 mmHg and she sustained 4 cm rectal buttonhole tear involving full thickness rectal wall without sphincter muscles involvement [figure -]. MTI and informed written consent was taken and repair was done in theatre under re-

gional anaesthesia with adequate lighting. Rectal mucosa sutured with continuous 3-0 polyglactin with proctoscope and rectovaginal septum sutured with continuous 2-0 polyglactin and episiotomy sutured in three layers with 2-0 polyglactin. Post-operative was uneventful and given with oral antibiotics for 7 days and stool softeners for 14 days. She had no complications in postnatal clinic 6- and 12-week review.

Discussion: Most reported cases are associated with recognized risk factors such as instrumental vaginal delivery, prolonged second stage of labour, fetal macrosomia > 4kg, malposition [occipito-posterior] and shoulder dystocia. Interestingly, our patient did not demonstrate any of these classical risk factors. She was multiparous, had a spontaneous vaginal delivery of a normal birth weight infant and required only a mediolateral episiotomy. This case therefore highlights that rectal buttonhole tears can occur even following apparently uncomplicated vaginal births and should remain a differential diagnosis whenever unexplained rectal defects or abnormal findings are identified after delivery.

Best practice involves prompt diagnosis at labour suite with combined digital vaginal and rectal examination. In the present case, the injury was diagnosed at the end of the episiotomy suturing by house officer with digital rectal examination. This emphasis the importance of the systematic evaluation of the vagina and rectum following every vaginal delivery even with or without perineal tear.

The involvement of MTI, proper evaluation under anaesthesia and meticulous surgical techniques improves the favourable outcome and reduces complications such as fistula & incontinence. There is no universally recommended surgical technique for repair the ORBI because of limited reported cases. Some literatures suggest three layer closure including rectal mucosa, recto-vaginal septum and vaginal mucosa. In our case, a three layer repair was performed with polyglactin continuous sutures, achieving satisfactory anatomical restoration.

Postoperative management aims to reduce the risk of wound breakdown and fistula formation. The use of broad-spectrum antibiotics, stool softeners, adequate analgesia and close follow-up has been recommended in the literature. Our patient received oral antibiotics for seven days and stool softeners for fourteen days, with no complications identified at both 6- and 12-week follow-up visits. This outcome is consistent with previous reports demonstrating excellent healing and preservation of continence when diagnosis and repair are undertaken promptly.

This case contributes to the limited literature on isolated rectal buttonhole tears and reinforces several important clinical messages. First, rectal buttonhole injury can occur even in the absence of recognised risk factors and without associated anal sphincter damage. Second, meticulous postpartum examination, including rectal assessment, is essential for early detection. Finally, immediate multilayer primary repair performed under appropriate surgical conditions can result in excellent functional and anatomical outcomes while preventing the devastating consequences of delayed diagnosis.

Conclusion: ORBI is a rare but potentially serious obstetric injury that may occur even in the absence of traditional risk factors and without associated anal sphincter damage. This case highlights the importance of meticulous post-delivery perineal and rectal examination to ensure early recognition of occult anorectal injuries. Prompt diagnosis, multidisciplinary involvement and immediate multilayered primary repair under optimal surgical conditions can achieve excellent anatomical and functional outcomes while preventing complications such as recto-vaginal fistula. Increased awareness of this uncommon injury among obstetric care providers is essential to reduce missed diagnoses and associated maternal morbidity.

Clinical message:

“Routine digital rectal examination following vaginal delivery and perineal repair should be considered whenever significant perineal trauma is suspected, as early detection remains the cornerstone of successful management of rectal buttonhole tears”

YOUNG GYNAECOLOGIST AWARD PRESENTATIONS (YGA)

YGA001. ASYMPTOMATIC BACTERIURIA IN PREGNANCY: RISK FACTORS, ORGANISMS, SENSITIVITY PATTERN AND CURE RATE

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Introduction: Asymptomatic bacteriuria (ABU) in pregnancy can progress to pyelonephritis and adverse maternal and perinatal outcomes if untreated. Contemporary data on ABU burden, risk factors and antimicrobial susceptibility in Sri Lanka remain scarce.

Objectives: To determine the prevalence of ABU in pregnancy, describe associated risk factors, compare urine full report (UFR) against urine culture diagnostically, identify causative organisms and antibiotic sensitivity patterns and estimate the cure rate following culture-guided treatment.

Design: Longitudinal descriptive study

Method: This study was conducted at the Professorial Unit Antenatal Clinic, Teaching Hospital Peradeniya, Sri Lanka among 411 pregnant women. Midstream clean-catch urine samples were collected for UFR and culture on CLED agar; significant bacteriuria was defined as $\geq 10^5$ CFU/mL of a single organism. Culture-positive women received seven days of culture-guided antibiotics followed by a test-of-cure culture. Analysis used descriptive statistics, Fisher's exact test, and chi-square with Monte Carlo p-values ($p < 0.05$).

Results: Among 411 women enrolled, 12 (2.9%; 95% CI: 1.5%–5.0%) had culture-confirmed ABU. Predominant organisms were Staphylococci (41.7%), Streptococci (33.3%) and Coliforms (25.0%); Group B Streptococcus accounted for 25% of positive cultures. Nitrofurantoin was highly effective against Coliforms and Staphylococci; all Streptococcal isolates were sensitive to ampicillin/amoxicillin. Two-thirds of Coliform isolates showed cephalosporin resistance. UFR pyuria demonstrated 100% sensitivity, 29.2% specificity and 100% negative predictive value for ABU. Significant associations were identified with current gestational diabetes mellitus (OR = 13.13; p = 0.03), prior ABU history (OR = 53.33; p = 0.04) and significant pyuria (p = 0.04). Among 12 culture-positive women, 9 (75%) completed a test of cure, achieved microbiological cure and three (25%) defaulted follow up.

Conclusion: ABU prevalence was relatively low but featured a distinctive pathogen profile with Staphylococcal predominance and notable Group B Streptococcus isolation. Cephalosporin resistance underscores the need for culture-guided treatment and ongoing antimicrobial surveillance. UFR pyuria is a useful screen but cannot replace urine culture as the diagnostic gold standard.

YGA002. DEVELOPMENT AND VALIDATION OF A SINHALA SELF-ADMINISTERED ANTENATAL BOOKING HISTORY-TAKING TOOL AND COMPARISON WITH CONVENTIONAL HISTORY TAKING AT TEACHING HOSPITAL PERADENIYA

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Background: Antenatal history taking represents a critical component of maternal care, serving as the foundation for risk identification and early clinical intervention. However, conventional interview-based methods frequently lack completeness and consistency, potentially compromising care quality, particularly in resource-constrained settings such as Teaching Hospital Peradeniya.

Objectives: To develop and validate a self-administered Sinhala questionnaire for systematically collecting personal, medical, obstetric and psychosocial information from pregnant women at antenatal booking visits and to evaluate its effectiveness compared with conventional interview-based history taking.

Method: A structured Sinhala-language self-administered questionnaire was developed based on the standard Sri Lankan pregnancy record. The draft tool was refined through four focus group discussions, with 10–15 pregnant women in each group and through multidisciplinary expert consultation. Face and content validity were assessed using feedback from maternal health experts and 15 pregnant women who completed the draft questionnaire and commented on its clarity, wording, acceptability and ease of understanding. Reliability was assessed using Cronbach's alpha for selected related sections, Intraclass Correlation Coefficient for continuous variables and Cohen's kappa for categorical variables. A comparative cross-sectional study was subsequently conducted among 100 antenatal women who completed both the Sinhala self-administered questionnaire and conventional clinician-administered history taking.

Results: The questionnaire demonstrated strong psychometric properties, including high internal consistency (α=0.81), excellent test-retest reliability (ICC>0.89 for continuous variables) and substantial agreement for categorical data (κ=0.73–0.81). The Content Validity Index (S-CVI/Ave) was 0.91, indicating strong expert consensus. Comparative analysis revealed that the questionnaire captured 95% of essential history data compared to 76% through conventional interviews, with a mean completion time of 12 minutes versus 18 minutes. Additionally, higher rates of disclosure for sensitive topics and greater patient comfort were reported with the questionnaire format.

Conclusion: The self-administered questionnaire represents a valid, reliable and time-efficient tool for collecting comprehensive antenatal history. It enhances data quality, patient comfort and standardization, making it a valuable complementary or alternative approach to conventional history taking in clinical and research settings.

Keywords: Antenatal care; self-administered questionnaire; maternal health; history taking; Sri Lanka; tool validation; pregnancy booking visit

YGA003. EARLY ORAL GLUCOSE TOLERANCE TESTING IN HIGH-RISK PREGNANCIES

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Introduction: Gestational diabetes mellitus (GDM) is associated with significant maternal and fetal morbidity. Current guidelines recommend oral glucose tolerance testing (OGTT) at 24–28 weeks of gestation, which may delay diagnosis in high-risk women. Early identification of GDM may facilitate timely interventions and improve pregnancy outcomes.

Objectives: To determine the diagnostic value of performing an OGTT at 20 weeks of gestation in high-risk pregnancies with negative booking diabetic screening and to identify risk factors associated with early GDM.

Design: A descriptive cross-sectional study was conducted to evaluate the incidence and associated risk factors of GDM diagnosed at 20 and 28 weeks of gestation in a high-risk obstetric population.

Method: This study was conducted at Teaching Hospital Peradeniya, Sri Lanka, from June 2019 to October 2022. A total of 385 singleton pregnancies with one or more risk factors for GDM and negative diabetic screening at booking were recruited. Participants underwent a 75-g OGTT at 20 weeks of gestation. Women with negative results underwent routine repeat OGTT at 28 weeks. Data on maternal characteristics and GDM risk factors were collected and analysed using descriptive statistics, Chi-square tests and McNemar test.

Results: Among 385 participants, 28 (7.3%) were diagnosed with GDM at 20 weeks and 42 (10.9%) at 28 weeks, while 315 (81.8%) did not develop GDM. A previous history of GDM (78.6%, p=0.011) and a family history of diabetes mellitus (28.6%, p=0.010) were significantly associated with GDM diagnosed at 20 weeks. No statistically significant association was observed between GDM diagnosed at 20 and 28 weeks (p=0.154). Maternal age demonstrated significant variation across the study groups (p=0.001).

Conclusion: Early OGTT at 20 weeks identified a clinically important proportion of high-risk women with GDM who would otherwise have been diagnosed later in pregnancy. Incorporating a 20-week OGTT in selected high-risk pregnancies may facilitate earlier intervention. Further randomized controlled trials are warranted to determine its impact on maternal and neonatal outcomes.

YGA004. PHYSICAL ACTIVITY DURING ANTENATAL PERIOD AND ITS IMPACT ON PREGNANCY OUTCOMES: A RETROSPECTIVE COHORT STUDY ON OBSTETRIC AND NEONATAL OUTCOMES IN A SRI LANKAN COHORT

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Background: Physical activity during pregnancy is globally recommended for improving maternal health; however, its specific impact on metabolic disease prevention or labour mechanisms remains under-researched in Sri Lanka. This study is aimed to evaluate the association between duration and intensity of antenatal physical activity and key maternal clinical characteristics (Obstetric comorbidities, labour pain perception, labour duration and mode of delivery) and neonatal outcomes.

Method: A retrospective cohort study was conducted among 215 primi mothers admitted to the postnatal ward at the Obstetrics and Gynaecology unit of Teaching Hospital, Peradeniya. Physical activity level was assessed by using a Global Physical Activity Questionnaire (GPAQ) and categorized into low, moderate and high levels. Associations with maternal outcomes, intrapartum complications and neonatal outcomes were analysed using Pearson Chi-square tests, One-way ANOVA and Kruskal-Wallis tests, with statistical significance set at $p<0.05$.

Results: The analysis revealed no statistically significant association between antenatal physical activity levels and the prevalence of Gestational Diabetes Mellitus (p=0.191) or Pregnancy-Induced Hypertension (p=0.431). However, physical activity demonstrated a significant impact on the functional mechanics of birth. Active mothers showed significantly higher rates of vaginal delivery (88.6% Moderate, 76.9% High) compared to the sedentary mothers (55.1%) ($p< 0.001$). Furthermore, higher activity levels were associated with a shorter duration of the active stage of labour ($p < 0.001$) and significantly lower labour pain scores ($p < 0.001$). Neonatal safety was not compromised, with no significant differences in 5th-minute APGAR scores (p=0.325) or adverse birth weight outcomes with antenatal physical activity. Moderate activity was associated with improved foetal weight gain. (p=0.037).

Conclusion: In this study population, antenatal physical activity acted primarily as a functional enhancing factor in labour rather than a metabolic preventative. While it did not significantly reduce the risk of GDM or PIH, physical activity showed significantly association to obstetric efficiency by shortening labour, reducing pain perception and decreasing the need for surgical intervention without compromising foetal safety. These findings support the promotion of antenatal physical activity as a vital, non-pharmacological strategy for improved birth outcomes in Sri Lanka.

Keywords: Antenatal Physical Activity, Mode of Delivery, Labor Duration, Birth Weight.

YGA005. PREVALENCE AND RISK FACTORS OF ISTHMOCELE AMONG POST- CAESAREAN WOMEN IN A SELECTED TERTIARY CARE HOSPITAL IN SRI LANKA: A PROSPECTIVE OBSERVATIONAL STUDY

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Background: Isthmocele is a condition that develops at the site of a cesarean section (CS) scar, characterized by a pouch-like indentation in the myometrium associated with a range of complications, including abnormal uterine bleeding, secondary infertility, chronic pelvic pain, placenta accreta spectrum (PAS) disorders and cesarean scar pregnancy. With rising cesarean section rates worldwide, the preva-

lence, risk factors and clinical impact of isthmocele remain understudied, particularly in low and middle income countries. To date, there are no published data on the prevalence or risk factors of isthmocele in Sri Lanka, highlighting a significant knowledge gap. By conducting this study, we aim to generate the first epidemiological data on isthmocele in Sri Lanka.

Objectives: To estimate the prevalence and risk factors of isthmocele among post-cesarean women from March 2025 to February 2026.

Method: A prospective observational study was conducted among all pregnant women who underwent cesarean section (CS) deliveries at Colombo South Teaching Hospital in Professorial Obstetrics unit during the study period of March 2025 to February 2026. Transvaginal scan (TVS) was done at 6 weeks and 12 weeks postpartum using standardized imaging protocols to assess for the presence of isthmocele. Surgical data were collected retrospectively using a data sheet and analysed using SPSS (Statistical Package for the Social Sciences).

Results: Prevalence of isthmocele among the study participants was 31.7%. Only 5.9% was found to have fluid in the TVUS. A statistically significant association was observed between previous history of LSCS and the presence of isthmocele (p=0.019). Women with a previous LSCS had 2.16 times higher odds of having an isthmocele compared with women without a previous LSCS (OR=2.16, 95% CI: 1.13–4.14). Need for additional suture during caesarean section (Fisher's exact test=0.029, OR=2.85, 95% CI=2.85), PIH (P=0.002, OR=1.33, 95% CI: 0.46–3.80) and presence of fluid (OR cannot be reliably calculated) was significantly associated with isthmocele (Fisher's exact test, p<0.001). Factors like Maternal age, number of cesarean sections and obesity did not have statistically significant associations.

Discussion: This study demonstrates an isthmocele prevalence of 31.7%, highlighting that cesarean scar defects are a common finding among women with previous cesarean delivery. Previous cesarean section, pregnancy-induced hypertension, the requirement for additional uterine haemostatic sutures and the presence of intracavitary fluid were significantly associated with isthmocele. The necessity for additional uterine sutures may reflect technically challenging cesarean deliveries or impaired wound healing. Intra cavitary fluid may represent a consequence of the niche, which will later contribute to symptoms such as postmenstrual spotting and subfertility. These findings emphasise the importance of optimising cesarean section techniques and identifying women at increased risk to facilitate early diagnosis and appropriate follow up.

Conclusion: Isthmocele is a common postpartum finding among women with previous cesarean delivery in Sri Lanka. As the first study to provide local prevalence data and associated risk factors, these findings support meticulous cesarean surgical technique and targeted sonographic surveillance in women at increased risk. Larger longitudinal studies are warranted to further elucidate the long term reproductive, gynecological and obstetric outcomes associated with isthmocele

REPRODUCTIVE MEDICINE YOUNG GYNAECOLOGIST AWARD PRESENTATIONS (RMYGA)

RMYGA001. COST-EFFECTIVE INNOVATIONS IN MALE FERTILITY TESTING IN LOW-RESOURCE SETTINGS: EVALUATION OF LOW-COST SPERM COUNTING CHAMBERS

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Introduction: Accurate seminal fluid analysis is an essential component of male fertility evaluation. The Makler counting chamber is widely used and recommended for semen analysis; however, its high cost limits accessibility in resource-limited settings such as Sri Lanka. This study evaluates the efficacy and clinical applicability of two low-cost sperm counting chambers, Rohem and Shukratara, compared with the standard Makler counting chamber, to determine their suitability for cost-effective semen analysis in low-resource settings.

Method: Two comparative cross-sectional studies conducted in the Andrology laboratory at the Department of Obstetrics and Gynaecology, University of Jaffna, were combined for this manuscript. In the first study, fresh semen samples from 100 men were analyzed using Makler and Rohem chambers. In the second study, different frozen-thawed semen samples from 70 men were analyzed using Makler and Shukratara chambers. Statistical analyses included paired and independent-samples t-tests and Bland–Altman analysis.

Results: The Rohem chamber demonstrated significantly higher sperm concentration than the Makler chamber (117.79 ± 96.04 vs 56.38 ± 50.01 × 106/mL, $p < 0.001$), indicating poor agreement and overestimation of sperm concentration. Additionally, the Bland-Altman analysis revealed a lower likelihood of clinical agreement between the two chambers. In contrast, the Shukratara chamber showed no statistically significant difference compared with the Makler chamber (61.9 ± 72.9 vs 62.1 ± 60.4 × 106/mL, $p > 0.05$). Furthermore, the Bland-Altman analysis demonstrated good agreement between the two chambers for sperm concentration measurements.

Conclusion: The Shukratara chamber demonstrated performance comparable to that of the Makler chamber and may serve as a cost-effective alternative for semen analysis in Sri Lanka. Conversely, the Rohem chamber showed substantial variability and poor agreement, limiting its clinical applicability.

Keywords: Sperm concentration, Makler chamber, Shukratara chamber, Rohem chamber, Semen analysis, Male infertility, Cost-effective diagnostics.

RMYGA002. ENDOMETRIAL THICKNESS IN INTRAUTERINE INSEMINATION: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Introduction: Endometrial thickness (EMT) is routinely measured before intrauterine insemination (IUI), yet whether it predicts reproductive success, should trigger cycle cancellation, or can be usefully modified remains uncertain.

Objectives: To determine the prognostic value of EMT in IUI, quantify the effect of ovarian stimulation regimens on EMT and evaluate interventions for thin endometrium.

Design: Systematic review and meta-analysis of human IUI studies, registered in PROSPERO (CRD420261398545). Prognostic, stimulation-regimen, therapeutic-intervention and endometrial-phenotype evidence streams were analysed.

Method: MEDLINE, Scopus, Cochrane CENTRAL, ScienceDirect, Google Scholar, WHO ICTRP and ClinicalTrials.gov were searched upto May 2026. Randomised trials and prospective or retrospective cohorts reporting EMT, pattern, vascularity or related biomarkers were eligible. Extractable continuous prognostic data were pooled as event-minus-non-event mean differences (MDs) using inverse-variance random-effects models.

Stimulation-regimen effects on EMT were analysed separately. Risk of bias was assessed using RoB 2, ROBINS-I or QUIPS and certainty using GRADE. Retracted studies were excluded from primary quantitative analyses.

Results: Thirty-five studies were eligible. Eight study arms comprising 365 event and 1,160 non-event observations showed a small, statistically uncertain EMT difference (MD 0.51 mm, 95% CI -0.05 to 1.07; I^2=74.2%). Excluding the principal heterogeneity driver reduced the estimate to 0.15 mm (95% CI -0.13 to 0.43; I^2=0%); restriction to independent or first-cycle observations yielded 0.14 mm (95% CI -0.26 to 0.53; I^2=18.8%). Clomiphene citrate produced slightly thinner EMT than gonadotrophins (MD -0.33 mm, 95% CI -0.64 to -0.01), while letrozole produced thinner EMT than gonadotrophins (MD -1.31 mm, 95% CI -2.08 to -0.53); these were EMT effects, not reproductive-effectiveness estimates. Contemporary adjusted analyses showed poor discriminatory performance of EMT alone and live births occurred even at EMT ≤5 mm, although very thin EMT was associated with poorer outcomes in some cohorts. Platelet-rich plasma was promising but lacked live-birth data; estradiol increased EMT without improving clinical pregnancy or live birth.

Conclusion: EMT has limited independent prognostic value in IUI and should not be used as a stand-alone cancellation threshold. It is strongly influenced by stimulation biology and increasing thickness does not necessarily improve reproductive outcomes. Clinical decisions should integrate EMT with age, diagnosis, follicular response, stimulation regimen, sperm parameters and endometrial phenotype. Live-birth-powered trials are needed before thin-endometrium therapies become routine.

RMYGA003. PREVALENCE AND CLINICAL CORRELATES OF ADENOMYOSIS DIAGNOSED BY REVISED MUSA CRITERIA AMONG WOMEN ATTENDING A FERTILITY CLINIC IN SRI LANKA: A PRELIMINARY SINGLE-CENTRE ANALYSIS OF A MULTICENTRE STUDY

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Introduction: The incidence of adenomyosis as an isolated pathology in symptomatic women remains uncertain, with retrospective studies reporting a wide estimated incidence ranging from 4% to 70%. The Morphological Uterus Sonographic Assessment (MUSA) group introduced a standardised classification and reporting system to improve the consistency of sonographic diagnosis of Adenomyosis. This study aims to assess the prevalence of adenomyosis diagnosed using MUSA criteria and determine its association with clinical symptoms among women undergoing TVS in routine gynaecological outpatient care.

Objectives: To assess the prevalence of adenomyosis using the MUSA criteria at the Fertility Outpatient Clinic in Castle Street Hospital(CSHW), Women, Sri Lanka.

Design: A Descriptive Cross-Sectional Study.

Method: After informed consent, women aged 18 years or older until menopause, without gynaecological malignancy or pregnancy, who underwent TVS as part of a gynaecological assessment were recruited. The study was conducted at the Fertility Clinic, Castle Street Hospital for Women, Sri Lanka. Clinicians recorded TVS findings according to revised MUSA criteria, while clinical information was collected using an operator-administered questionnaire. This preliminary analysis included participants recruited from the Fertility unit of CSHW.

Results: A total of 189 participants were included in this preliminary analysis, with 8 women declining consent. The mean age of

participants was 32.71 years and the mean BMI was 33.13 kg/m2. The majority were employed (58.0%), had completed education up to Advanced Level (55.8%) and were Sinhalese (93.9%). Adenomyosis was identified in 52 participants, yielding a prevalence of 28.7% (95% CI: 22.5%–35.7%), based on the presence of at least one direct MUSA feature or two or more indirect MUSA features. Myometrial cysts were the most common direct sonographic feature (23.8%), while asymmetrical myometrial thickening was the most frequently observed indirect feature (13.8%). Among women with indirect features alone, 20% met the criteria for having two or more indirect features. The symptomatic-to-asymptomatic ratio was 1.45:1. No statistically significant associations were observed between adenomyosis and heavy menstrual bleeding(p=0.291), impaired quality of life(p=0.402), anaemic complications(p=0.107), dysmenorrhoea(p=0.083), pelvic pain(p=0.493), dyspareunia(p=1.000), or psychological impact(p=0.323).

Conclusion: In this preliminary single-centre analysis of women attending a Fertility Unit, adenomyosis diagnosed using MUSA criteria was identified in approximately one-third of participants. Even though statistically significant differences were not demonstrated between adenomyosis and assessed clinical symptoms or symptom-related impacts, the observed high prevalence of ultrasonographic features of Adenomyosis indicates the need to assess the association of adenomyosis among the infertile population.