



SRI LANKA COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS 59TH ANNUAL ACADEMIC CONGRESS

"BRIDGING GAPS IN WOMEN'S HEALTH: THROUGH COLLABORATION, EDUCATION, TRAINING, AND RESEARCH."

PROGRAMME BOOK

4TH TO 6TH SEPTEMBER 2026
AT UNIVERSITY OF COLOMBO,
FACULTY OF MEDICINE (UCFM) TOWER





SRI LANKA COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS

59th ANNUAL ACADEMIC CONGRESS

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

PROGRAMME BOOK

04th to 06th September 2026
at the University of Colombo
Faculty of Medicine Tower (UCFMT)

Edited by
Dr Chaminda Hunukumbure
Dr Udara Jayawardena





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THE CHIEF GUEST



Prof. Frank Louwen

President

International Federation of Gynecology & Obstetrics

Professor & Head Division Obstetrics and Fetomaternal Medicine

University of Frankfurt/ Main & University Hospital

Germany





MESSAGE FROM THE GUEST OF HONOUR



Distinguished members of the Sri Lanka College of Obstetricians and Gynaecologists, esteemed faculty, colleagues and delegates,

It is a profound honour for me as President of the Asian Oceania Federation of Obstetricians and Gynaecologists to write this welcome message for the 59th Annual Academic Congress.

This milestone reflects nearly six decades of unwavering commitment to advancing women's health across Sri Lanka.

AOFOG deeply values its partnership with SLCOG, a college renowned through our region for clinical excellence, innovative research and dedication to training future specialists.

Congresses like this allow us to share knowledge, refine best practices and collectively address the evolving challenges in maternal and reproductive health.

I commend the organising committee for curating such a rich scientific programme and I look forward to meaningful discussions over the coming days.

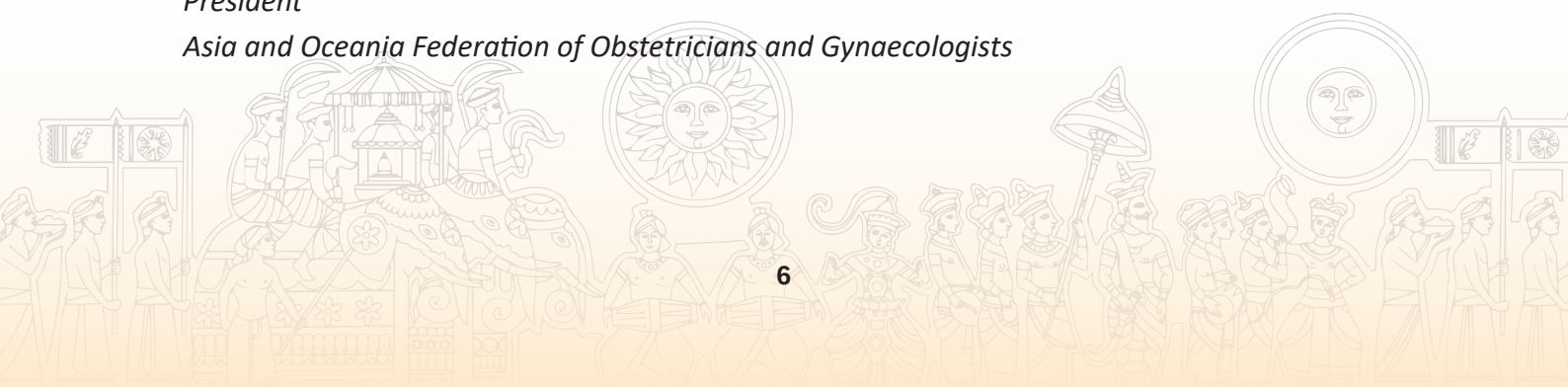
Together let us continue to improve health, health outcomes and wellness for women across our region.

Kindest regards,

Dr. John Tait

President

Asia and Oceania Federation of Obstetricians and Gynaecologists





MESSAGE FROM THE SPECIAL GUEST



Dear Professor Rukshan Fernandopulle, officers, council members and friends,

It is my great pleasure and privilege to give a message for this important congress with the theme of “Bridging gaps in women’s health through collaboration, education, training and research”.

High-quality respectful evidence-based care can be delivered only by a workforce who have the latest knowledge at the cutting edge of science and are well trained. This is possible only by collaboration with other disciplines to deliver multidisciplinary care and to get the best examples of care from international experts who are in the forefront of research. This congress with the workshops aims at achieving this goal. International academic visitors would gain by studying the advances in health care delivered in Sri Lanka that has led to the low maternal and perinatal mortality figures in the region.

Globally some centers achieve good clinical outcome and others trail behind – a phenomenon of “centers of excellence in a sea of mediocrity”. This conference focuses on collaboration, education, training and research to make more centers to excel.

The speakers are internationally renowned, and it is a great opportunity for us to learn from the experts with wisdom i.e. knowledge and experience. The conference has included social programs which would facilitate old friends to meet each other and formulate new friendship. I look forward to meeting you. Please join and enjoy this conference full of science and social activities.

With warmest regards,

Prof. Sir Sabaratnam Arulkumaran

Professor Emeritus of City St George’s University of London.

Foundation Professor of Obstetrics & Gynaecology, University of Nicosia, Cyprus.

Past President of the RCOG, BMA & FIGO.



MESSAGE FROM THE SPECIAL GUEST



Dear Colleagues,

It is indeed an honour and privilege to be able to pen a few words in commemoration of this Annual Academic Conference of the Sri Lanka College of Obstetricians & Gynaecologists.

For over a decade, I have had the pleasure of attending the SLCOG Conference, initially as an officer of the Asia Oceania Federation of OBGYN (AOFOG) and latterly as an officer of the International Federation of OBGYN (FIGO). Every year, the Conference seems to get bigger and better. This year is no exception, and it is obvious that the Organising Committee has pulled out all stops to ensure a memorable and rewarding experience for all delegates.

This Conference will not only cover the length and breadth of subjects that matter to our profession but will also afford us the opportunity to network and renew old friendships while forging new ones.

Although the world continues to present its challenges, it has also created opportunities to collaborate and innovate. This Conference is one such opportunity that will enable us to move forward with strength, clarity and shared purpose. Let's embrace the future with optimism and enthusiasm!

Congratulations to Prof. Rukshan Fernandopulle and his team and I am confident that it will be a great success!

Dr. Ravi Chandran

President-Elect

International Federation of Gynecology and Obstetrics



MESSAGE FROM THE PATRON



It is a privilege to extend my greetings to all participants, invited speakers and faculty members attending the 59th Annual Academic Congress of the Sri Lanka College of Obstetricians and Gynaecologists and to extend a warm welcome to all.

The Academic Congress represents one of the most important scientific events in the academic calendar of the SLCOG. The theme of this year's congress, *"Bridging Gaps in Women's Health: Through Collaboration, Education, Training, and Research,"* reflects a timely commitment to ensuring equitable, high-quality care for women nationwide.

The congress will provide a valuable platform for the exchange of knowledge, the presentation of innovative research, and the review of clinical standards. I am confident that the comprehensive scientific programme, enriched by the contributions of distinguished local and international experts, will inspire meaningful discussions.

I commend the Council, the Organizing Committee, and all members for their untiring efforts in elevating maternal and reproductive health standards.

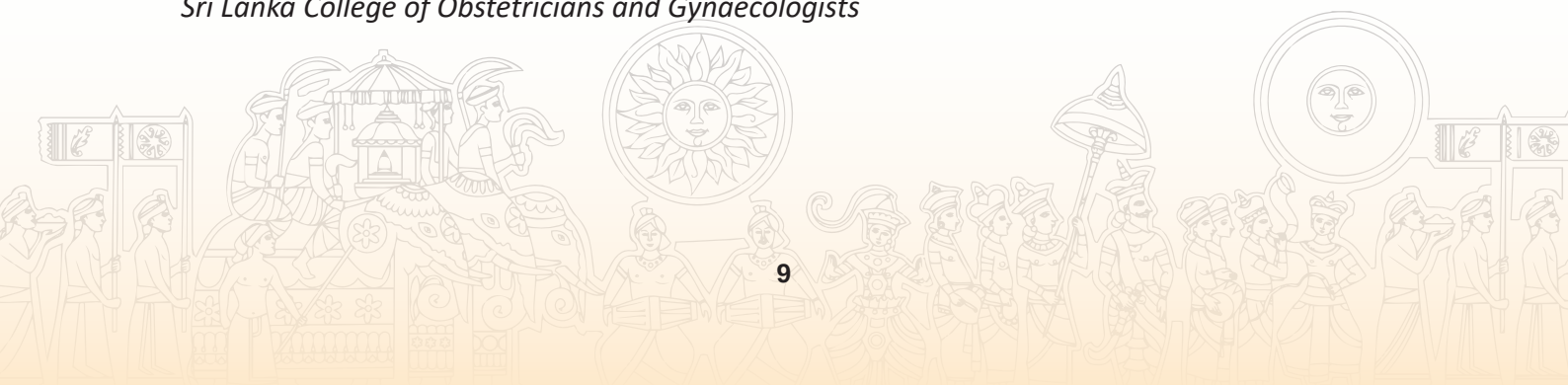
I wish the 59th Annual Academic Congress every success.

Prof. Jayantha Jayawardana

MBBS, MS, FRCOG, FSLCOG, FCCGP,

Patron

Sri Lanka College of Obstetricians and Gynaecologists





MESSAGE FROM THE PRESIDENT

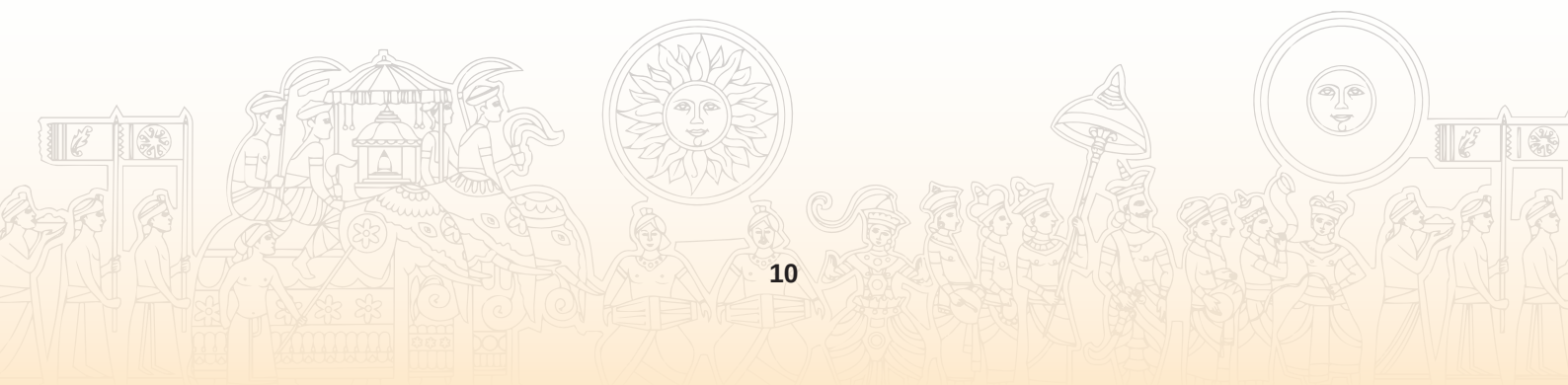


It is with great honour and privilege that I share this message welcoming you to the 59th Annual Academic Congress of the Sri Lanka College of Obstetricians and Gynaecologists (SLCOG), scheduled to be held from 04th to 06th September 2026 at the University of Colombo Faculty of Medicine Tower (UCFMT), the second oldest medical college in South Asia.

The theme of this year's congress, *"Bridging Gaps in Women's Health: Through Collaboration, Education, Training and Research,"* reflects our collective commitment to advancing equitable and evidence-based care for women. In an era of rapidly evolving medical knowledge and changing healthcare landscapes, fostering strong partnerships and continuous learning remains essential to improving outcomes in obstetrics and gynaecology. My sincere gratitude is extended to Chief Guest Prof Frank Louwen President FIGO, Guest of Honour, Dr John Tait President AFOG, and Special Guests Prof Sir Sabaratnam Arulkumaran and Dr Ravi Chandran for their gracious presence.

The key features of the congress include Prof D A Ranasinghe oration delivered by Dr Janakie Karunasingha, The Dr Rohana Haththotuwa oration delivered by Clinical Professor Sanath Lanerolle and P Dissanayake Endowment lecture delivered by Dr Ravi Chandran President Elect FIGO.

We are privileged to host a distinguished faculty, including eminent experts from leading international organizations such as **FIGO, AFOG, RANZCOG, SAFOG, and RCOG**, alongside our respected local specialists. The academic programme has been carefully curated to provide a





comprehensive and engaging platform for knowledge exchange, professional development, and meaningful dialogue.

In addition to the main congress, ten pre-congress workshops and one post congress workshop organized. The lined-up programs will be offering participants valuable opportunities for focused learning and hands-on experience in key areas of clinical practice.

An annual scientific congress with global participation is made possible by the Council members of SLCOG, resource persons, office staff of SLCOG and sponsorships extended by the industry. Also, my thanks go to AV team led by Mr Nalina, staff of UCFM, Marino Beach Hotel and Kingsbury hotel.

I am confident that this congress will serve not only as a forum for sharing the latest scientific advancements but also as an opportunity to strengthen professional networks and inspire collaborative efforts in addressing the challenges in women's health.

We warmly welcome our international colleagues not only to engage in the scientific programme but also to take the opportunity to experience the rich culture, hospitality, and natural beauty of Sri Lanka during your visit. I encourage all participants to actively engage and contribute to the success of this important academic event. Thank you, and I look forward to welcoming you in sharing knowledge and building strong lasting bonds within the fraternity of Obstetrics and Gynaecology.

Prof. Rukshan Fernandopulle

President

Sri Lanka College of Obstetricians & Gynaecologists





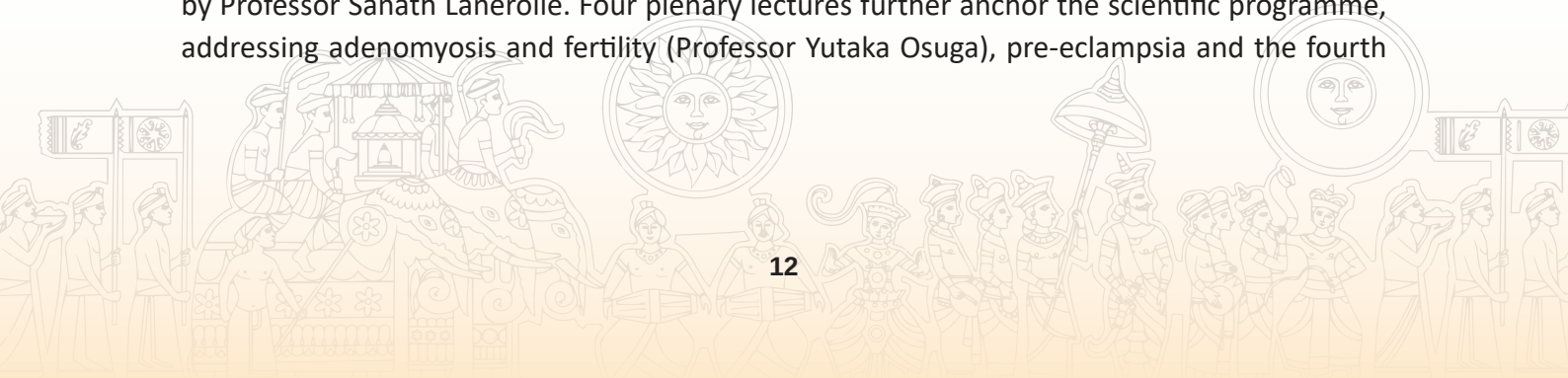
MESSAGE FROM THE SECRETARY



On behalf of the Sri Lanka College of Obstetricians and Gynaecologists, it is my profound honour and privilege to welcome you, through the pages of this proceedings book, to the 59th Annual Academic Congress, held from the 4th to the 6th of September 2026 at the UCFM Towers, Faculty of Medicine, University of Colombo — a venue of particular resonance, being the second oldest medical college in South Asia and a fitting custodian of the scholarly tradition our College continues to uphold.

This year's theme, *"Bridging Gaps in Women's Health: Through Collaboration, Education, Training and Research,"* is not merely an aspiration but a considered response to the realities of contemporary practice. As the frontiers of medical knowledge expand and the expectations placed upon women's healthcare grow more complex, the imperative to forge partnerships across disciplines and borders, and to translate rigorous evidence into everyday clinical practice, has never been more pressing. Every element of this year's scientific programme has been curated in service of that imperative.

The congress opens on 4th September with the inaugural ceremony and the Prof. D. A. Ranasinghe Memorial Oration, *"Too Young to Bear,"* delivered by Dr Janaki Karunasingha. The academic programme unfolds across a rich constellation of orations and plenary addresses: The Keynote Address on maternal stem cells in obesity and pre-eclampsia by Professor Frank Louwen, President of FIGO; the Dr P. Dissanayake Endowment Lecture, *"Paradigm Shifts in Obstetric Practice,"* by Dr Ravi Chandran, Past President of AOFOG; and the Dr Rohana Haththotuwa Oration, *"Beyond the Blade: Silent Scars – Reclaiming Health, Rights and Dignity,"* by Professor Sanath Lanerolle. Four plenary lectures further anchor the scientific programme, addressing adenomyosis and fertility (Professor Yutaka Osuga), pre-eclampsia and the fourth





trimester (Professor Sir Sabaratnam Arulkumaran), the collaborative role of AFOG (Dr John Tait, President AFOG), and the digital transformation of intrapartum care through the Electronic Labour Care Guide (Dr Kusum Thapa, President SAFOG). These are complemented by an extensive array of symposia, panel discussions, and interactive educational forums, alongside oral and poster presentations of free papers that showcase the vigour of emerging research within our fraternity. The Prof. Sir S. Arulkumaran Young Gynaecologist Award and the Prof. S. M. Sathanandan Reproductive Medicine Young Gynaecologist Award stand as a deliberate tribute to the promise of our younger colleagues.

Preceding the main congress, a comprehensive series of pre-congress workshops, running from 13th August to 4th September, offers focused, hands-on training across advanced gynaecological laparoscopy and laparoscopic suturing, labour care for both doctors and midwives, colposcopy, fetal medicine, management of hypertensive disorders in pregnancy, and preparation for RCOG and RANZCOG training pathways — a testament to our College's commitment to skill, not merely knowledge.

We are deeply privileged this year to welcome distinguished faculty from FIGO, AFOG, RCOG, RANZCOG, SAFOG and FOGSI, whose presence enriches this congress immeasurably and reflects the collaborative spirit at the heart of our theme.

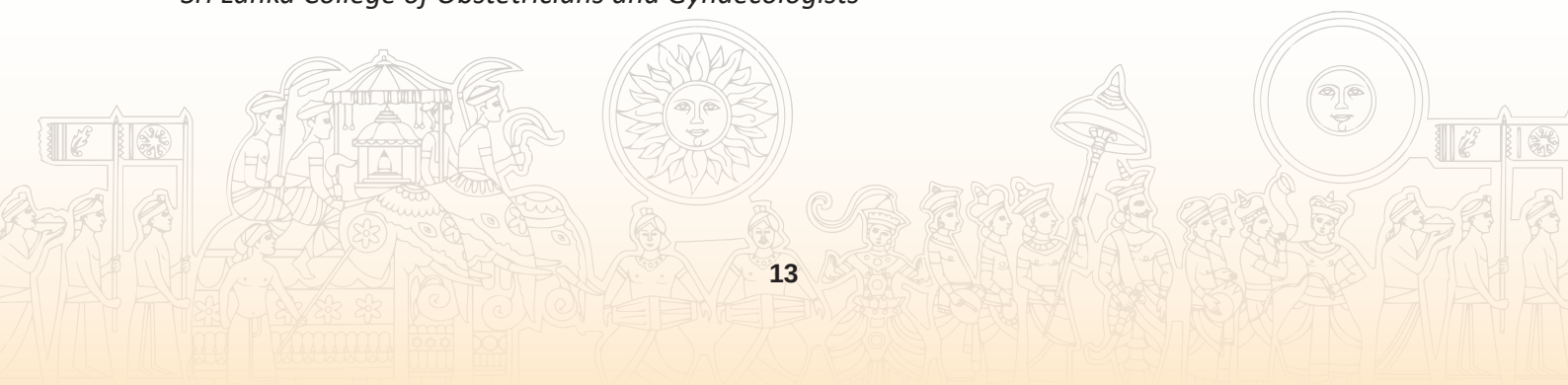
Beyond the lecture halls, we invite our international colleagues to discover Sri Lanka itself — an island of golden southern shores, mist-clad hill country, ancient cities steeped in history, and the vibrant pulse of Colombo, all offered with the warmth of Sri Lankan hospitality.

My sincere gratitude goes to our faculty, delegates, sponsors, and the organizing committee, whose collective effort has made this congress possible. I warmly invite you to engage fully in what promises to be an intellectually rewarding and memorable gathering.

Dr. Chaminda Hunukumbure

Honorary Secretary

Sri Lanka College of Obstetricians and Gynaecologists





MESSAGE FROM THE CHAIRMAN OF ACADEMIC ACTIVITIES AND RESEARCH



It is with great pleasure and honour that I welcome you to the **59th Annual Scientific Sessions of the Sri Lanka College of Obstetricians and Gynaecologists (SLCOG)**.

The SLCOG has been a pioneering institution in strengthening and advancing reproductive and women's health in Sri Lanka. Over the years, the College has remained committed to promoting excellence in clinical care, education, training and research, while contributing significantly to the advancement of women's healthcare both nationally and internationally.

This year's Annual Scientific Sessions are held under the timely and inspiring theme, **"Bridging Gaps in Women's Health: Through Collaboration, Education, Training and Research."** This theme reflects our shared responsibility to identify and address the evolving challenges in women's health and to work collectively towards equitable, evidence-based and high-quality care for all women.

The scientific programme brings together a diverse range of **symposia, plenary sessions, workshops and guest lectures**, providing an invaluable platform for the exchange of knowledge, sharing of experiences and perspectives, fostering meaningful collaborations, and inspiring scientific innovation. These interactions are essential in shaping the future of women's healthcare in Sri Lanka and beyond.

As Chairman of Academic Activities and Research, I am particularly pleased to see the emphasis placed on academic excellence, research and professional development throughout these sessions. I hope that the knowledge gained, ideas shared and collaborations established during this meeting will translate into meaningful improvements in clinical practice and ultimately better health outcomes for women.



I extend my sincere gratitude to our **distinguished speakers, moderators, resource persons and the organising committee** for their dedication, commitment and invaluable contribution towards bringing these scientific sessions to fruition. I also acknowledge the enthusiasm and participation of our colleagues, trainees and all those who have contributed to making this event a truly enriching academic gathering.

May the 59th Annual Scientific Sessions of the SLCOG serve as a catalyst for new ideas, stronger partnerships and continued progress in women's health. Let us work together to bridge existing gaps and build a future where every woman has access to compassionate, comprehensive and evidence-based healthcare.

I warmly welcome you all and wish you a stimulating, rewarding and memorable scientific experience.

Dr. A Sritharan

Chairman – Academic Activities and Research

Sri Lanka College of Obstetricians and Gynaecologists



SRI LANKA COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS COUNCIL 2026



Seated Left to Right

Dr Chaminda Hunukumbure – Hon. Secretary, Dr A. Sriharan – Chairperson – Academic Activities and Research Committee, Dr C. Randeniya – Council Member,
Dr (Mrs) Janakie Karunasingha – President Elect, Dr S.P. Akmeemana – Immediate Past President, Prof. Jayantha Jayawardana – Patron,
Prof. Rukshan Fernandopulle – President, Dr Rohana Haththotuwa – Past President, Dr U.D.P. Rathasiri – Past President,
Dr Mangala Dissanayake – Past President, Prof. Chandana Jayasundara – Treasurer

Standing – Left to Right

Dr S.M.P. Chandraratne – Council Member, Dr Jagath Dandeniya – Council Member, Dr Sampath Gnanaratne – Council Member,
Prof. Rasika Herath – Chairperson – Continuing Professional Development Committee, Dr Madhava Karunaratna – Council Member,
Dr Harsha Atapattu – Chairperson – Ethics Committee, Dr Ruwan Silva – Chairperson – Social Activities Committee, Dr Chandina Wedamestiri – Council Member,
Prof. Champika Gihan – Council Member, Dr Darshana Abeygunawardana – Chairperson – Regional Activities and Development Committee,
Dr Sumith Warnasuriya – Chairperson – Global Relationships Committee, Dr N. Saravanabhava – Council Member, Dr Achintha Dissanayake – Immediate Past Secretary,
Dr U.G. Kariyawasam – Council Member, Dr B.P.G.N. De Silva – Council Member, Dr Wedisha Gankanda – Asst. Secretary, Dr Buddhika Asela Anarasena – Council Member,
Dr Janaka Jayasinghe – Asst. Secretary, Dr Prabath Randombage – Chairperson – Education and Setting Standards Committee, Dr Diluk Senadheera – Council Member,
Dr Dinusha Liyanapatabendi – Council Member, Dr Chinthaka Banagala – Asst. Treasurer, Dr Amila Rubasinghe – Council Member

Absent

Dr Udara Jayawardana – Editor, Prof. Kumara Dissanayake – Council Member, Dr (Mrs) Shamoona Marleen – Council Member, Prof. Madura Jayawardana – Journal Editor



ORGANIZING COMMITTEE – 59TH ANNUAL ACADEMIC CONGRESS 2026

Congress Chairman	Prof Rukshan Fernandopulle	
Co- Chairmen	Dr Mangala Dissanayaka	Dr A Sritharan
Advisory Committee	Prof Sabaratnam Arulkumaran Dr Marlene Abeyewardena Dr Lakshmen Senanayaka Dr Gamini Perera Clinical Prof Sanath Lanerolle	Prof Jayantha Jayawardana Dr Rohana Haththotuwa Dr Ananda Ranathunga Dr U D P Ratnasiri Dr S P Akmeemana
International Organizations	Dr Rohana Haththotuwa	
Scientific Committee	Dr A Sritharan – Committee Chairman Prof Prabodhana Ranaweera Prof Madura Jayawardane Dr Chaminda Hunukumbure Prof Rasika Herath Dr B P G N De Silva Dr Achintha Dissanayaka	
		Dr Darshana Abeygunawardana Dr Madhava Karunaratne Dr Harsha Atapattu Prof Chandana Jayasundara Prof Kumara Dissanayake Dr Amila Rubasinghe
Abstract Committee	Dr Prabath Randombage – Committee Chairman Dr Janaki Karunasinghe Prof Cyril Randeniya Dr Dinusha Liyanapatabendige Prof Chanil Ekanayake Dr Achintha Dissanayaka Dr N. Saravanabhava Prof M. Thirukumar Dr Buddhika Asela Amarasena	
		Dr Shemoon Marleen Prof M R M Rishard Dr Chinthaka Banagala Dr Sampath Gnanarathne Dr Wedisha Gankanda Dr R. Prathapan Prof Champika Gihan





Sub committees

Inauguration

Dr Chaminda Hunukumbure
Dr Darshana Abeygunawardana
Dr Diluk Senadeera
Dr Achintha Dissanayake
Dr Chinthaka Banagala
O & G Ladies Forum

Registration

Prof Chandana Jayasundara
Dr Ruwan Silva

Publications

Prof Madura Jayawardane
Dr Udara Jayawardena

Souvenirs

Dr Madhava Karunaratne
O & G Ladies Forum

Accommodation & Transport

Dr Sumith Warnasuriya
Dr U G Kariyawasam
Dr Jagath Dandeniya

Banquet

Dr Janaki Karunasinghe
Dr Ruwan Silva

Website/Audio Visuals

Dr Udara Jayawardena

Trade & Exhibition

Dr Ruwan Silva
Dr Mangala Dissanayake
Dr S M P Chandrarathne
Dr Chandina Wedamestri



PRE CONGRESS WORKSHOP - 01 A



SRI LANKA COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS

59TH ANNUAL ACADEMIC CONGRESS

"BRIDGING GAPS IN WOMEN'S HEALTH: THROUGH COLLABORATION, EDUCATION, TRAINING, AND RESEARCH."



INTERNATIONAL MASTERCLASS IN ADVANCED GYNAECOLOGICAL LAPAROSCOPY 2026 - DAY 1

PRE-CONGRESS WORKSHOP ORGANISED BY SLCOG-RAGEC

 13th August 2026

7.45 AM - 8.30 PM

 Professorial Unit Auditorium and Theatre,
Teaching Hospital, Anuradhapura.

Time	Session
7.45 AM	Live Surgery 01 – Laparoscopic Myomectomy: Surgical Strategies, Suturing Techniques & Optimising Outcomes Dr Rajesh Modi <i>Focused on efficient myoma enucleation, meticulous haemostasis, multilayer uterine closure, and practical operative techniques for improved surgical outcomes.</i>
9.00 AM	Opening Ceremony
9.20 AM	Keynote Update: The State of Gynaecological Endoscopy in Sri Lanka Professor Kumara Dissanayake
9.30 AM	Laparoscopic Anatomy for Advanced Gynaecological Surgery Professor Mete Gungor
9.45 AM	Live Surgery 02 – Total Laparoscopic Hysterectomy (TLH): A Standardized Stepwise Approach to Safe Hysterectomy Professor Kumara Dissanayake <i>Demonstrating key surgical steps, anatomical landmarks, dissection strategies, and a standardised operative workflow for safe laparoscopic hysterectomy.</i>
11.00 AM	Patient Selection and Surgical Decision-Making in Gynaecological Laparoscopy Dr Prabath Randombage
11.20 AM	Operating Room Setup and Ergonomics in Advanced Gynaecological Endoscopy Dr Chinthaka Banagala
11.40 AM	Live Surgery 03 – Advanced Laparoscopic Surgery for Endometriosis: Principles of Pelvic Dissection and Organ Preservation Dr Nagendra Sardeshpande <i>Including expert approaches to complex pelvic disease, retroperitoneal dissection, nerve-sparing techniques, organ preservation, and multidisciplinary surgical principles.</i>
1.20 PM	Lunch Break
2.00 PM	Live Surgery 04 – Laparoscopic Tubal Reanastomosis: Fertility Restoration through Microsurgical Principles Dr Rajesh Modi <i>Focused on patient selection, tubal assessment, precise microsurgical alignment, anastomotic techniques, and fertility outcomes.</i>
7.00 PM	Fellowship Dinner and Legends Session <i>The Early Days of Gynaecological Laparoscopy in Sri Lanka</i> • Dr Hemantha Perera Consultant Obstetrician and Gynaecologist; Past President – SLCOG • Professor Kapila Gunawardena Professor in Obstetrics and Gynaecology; Past President – SLCOG • Dr Lakshmen Senanayake Consultant Obstetrician and Gynaecologist; Past President – SLCOG • Dr Rohana Haththotuwa Consultant Obstetrician and Gynaecologist; Past President SLCOG, and Secretary-General, AOFOG

International Faculty:

- Professor Mete Gungor - Turkiye**
Senior Specialist in Gynaecological Oncology, Robotic Surgery, and Advanced Endoscopic and Minimally Invasive Surgery
- Professor Laila Najjari - Germany**
Senior Consultant, Department of Obstetrics and Gynaecology, RWTH Aachen University
- Dr Rajesh Modi - India**
IVF Specialist and Advanced Gynaecological Endoscopic and Robotic Surgeon
- Dr Nagendra Sardeshpande - India**
Consultant Gynaecological Endoscopic Surgeon, Gynaecological Onco-surgeon, and Fertility Specialist, H N Reliance Foundation Hospital

Sri Lankan Faculty:

- Professor Kumara Dissanayake**
Professor and Head, Department of Obstetrics and Gynaecology Director, Rajarata Gynaecological Endoscopy Center, Rajarata University of Sri Lanka
- Professor Madura Jayawardane**
Professor in Obstetrics and Gynaecology, University of Sri Jayawardenepura
- Dr Sampath Gnanarathne**
Head and Senior Lecturer, University of Peradeniya
- Dr Prabath Randombage**
Senior Lecturer, University of Kelaniya
- Dr Chinthaka Banagala**
Senior Lecturer, University of Colombo

Workshop Leadership:

- Professor Rukshan Fernandopulle**
President - SLCOG
- Dr Apputhurai Sritharan**
Chairman, Scientific Activities & Research SLCOG

Cash payments can be done by visiting the SLCOG House Office during normal working hours from 8.30 a.m. to 4.00 p.m.

Online fund transfers / deposits are accepted and a copy of the Payment Slip / Debit note should be emailed to slcogoffice@gmail.com or sent via WhatsApp to 077 967 8787, together with the registrant's name and contact details.

Registration will be confirmed only upon receipt of payments.

Registration fees

Foreign Consultants- USD 25
Foreign Trainees- USD 25
Local Consultants- LKR 4,000
Local PG Trainees- LKR 2,000
(Registration fee covers both days)

Payments should be made to

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

Foreign Payments should be made to

Account Name - Sri Lanka College of Obstetricians & Gynaecologists (USD Account)
Account No. - 5004 1000 0027
Bank Name & Code - Sampath Bank PLC / 7278
Branch Name & Code - Borella Branch / 004
SWIFT Code - BSAMLKX



E-mail
slcogsession2026@gmail.com



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Visit our website
<https://congress.slcog.lk/>



PRE CONGRESS WORKSHOP - 01 B



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INTERNATIONAL MASTERCLASS IN ADVANCED GYNAECOLOGICAL LAPAROSCOPY 2026 - DAY 2 PRE-CONGRESS WORKSHOP ORGANISED BY SLCOG-RAGEC

14th August 2026

8.00 AM - 4.00 PM

Professorial Unit Auditorium and Theatre,
Teaching Hospital, Anuradhapura.

Time	Session
8.00 AM	Live Surgery 05 – Laparoscopic Burch Colposuspension: Contemporary Minimally Invasive Management of Stress Urinary Incontinence Dr Sampath Gnanarathne Demonstrating anatomical landmarks, retropubic dissection, and contemporary laparoscopic continence surgery techniques.
9.00 AM	Is It Time to Shift to Direct Entry in Gynaecological Laparoscopy? Professor Kumara Dissanayake
9.20 AM	Transition from Open Burch Colposuspension to the Laparoscopic Approach Dr. Sampath Gnanarathne
9.40 AM	Live Surgery 06 – Supracervical Hysterectomy with Cervico-sacropexy (Cervico-promontory Fixation) for Pelvic Organ Prolapse and Stress Urinary Incontinence Professor Laila Najjari Demonstrating anatomical landmarks, sacral promontory dissection, mesh placement, and advanced laparoscopic pelvic-floor reconstructive techniques.
10.40 AM	Tea Break
11.00 AM	Live Surgery 07 – Total Laparoscopic Hysterectomy Using Bipolar Energy and Scissors: Cost-effective Strategies for Resource-Limited Settings Dr Rajesh Modi Demonstrating safe and effective advanced laparoscopic surgery using conventional reusable instrumentation and sound surgical principles.
12.30 PM	Lunch Break
1.30 PM	Energy Sources in Modern Endoscopic Surgery Professor Madura Jayawardane
1.50 PM	Concomitant TVT Placement for the Treatment of Pelvic Organ Prolapse and Stress Urinary Incontinence Professor Laila Najjari
2.10 PM	Video-based Panel Discussion: Laparoscopic Complications-Prevention, Recognition, and Management Moderator: Dr Rajesh Modi Panel: Senior Registrars and Faculty
3.10 PM	Interactive Q&A
3.40 PM	Closing Ceremony • Closing Remarks • Certificate Presentation • Vote of Thanks • Group Photograph

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Bank Name & Code - Sampath Bank PLC / 7278
Branch Name & Code - Borella Branch / 004
SWIFT Code - BSAMLKX

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PRE CONGRESS WORKSHOP - 02



SRI LANKA COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS

59TH ANNUAL ACADEMIC CONGRESS

"BRIDGING GAPS IN WOMEN'S HEALTH: THROUGH COLLABORATION, EDUCATION, TRAINING, AND RESEARCH."

LAPAROSCOPIC SUTURING IN GYNAECOLOGICAL SURGERY

24th August 2026

8.30 am – 2.00 pm



NHSL Skills Laboratory

International Faculty:

**Dr Manisha Singh**Senior Consultant Gynaecologist
Subspecialist in Reproductive Medicine & Surgery,
Bangalore, India

Sri Lankan Faculty:

**Prof Kumara Dissanayake**Professor and Head, Department of Obstetrics
and Gynaecology, Rajarata University of Sri Lanka**Prof Rasika Herath**Professor, Department of Obstetrics and Gynaecology,
FOM, University of Kelaniya**Dr Dinesh Biyagama**Consultant Obstetrician & Gynaecologist,
District General Hospital, Moneragala**Dr Peshala Dangalla**Consultant Obstetrician & Gynaecologist,
Colombo North Teaching Hospital**Dr Indunil Piyadigama**

Senior Lecturer, FOM, University of Colombo

**Dr Achintha Dissanayake**Senior Lecturer, Faculty of Medical Sciences,
University of Sri Jayewardenepura**Dr Prabath Randoombage**Senior Lecturer, FOM, University of Kelaniya
Chairman, Education & Setting Standards, SLCOG**Dr Dinusha Liyanapatabandi**Head, Department of Obstetrics and Gynaecology,
FOM, University of Moratuwa

Workshop Leadership:

**Professor Rukshan Fernandopulle**

President - SLCOG

**Dr Apputhurai Sritharan**Chairman, Scientific Activities & Research
SLCOG**Dr Chinthaka Banagala**

Senior Lecturer, FOM, University of Colombo

Time	Session	Faculty
8.00 – 8.30 am	Registration	
8.30 – 9.00 am	Lecture 1: Principles of Laparoscopic Suturing in Gynaecological Surgery	Prof Kumara Dissanayake
9.00 – 10.30 am	Hands-on Session I - Ergonomics and instrument handling - Needle loading and needle angles - Needle driving techniques - Tissue handling - Intracorporeal knot tying - Extracorporeal knot tying - Continuous and interrupted suturing	Faculty Prof Rasika Herath Dr Dinesh Biyagama Dr Peshala Dangalla Dr Indunil Piyadigama Dr Prabath Randoombage Dr Dinusha Liyanapatabandi
10.30 – 11.00 am	Tea Break	
11.00 – 11.20 am	Lecture 2: Barbed Sutures in Laparoscopic Gynaecological Surgery	Dr Manisha Singh
11.20 am – 1.20 pm	Hands-on Session II - Application of Barbed Sutures - Principles of barbed sutures - Needle handling with barbed sutures - Continuous myometrial closure following laparoscopic myomectomy - Two-layer uterine closure techniques - Tips, tricks and avoidance of common errors - Individual supervised practice	Faculty Dr Manisha Singh Prof Rasika Herath Dr Dinesh Biyagama Dr Peshala Dangalla Dr Indunil Piyadigama Dr Prabath Randoombage Dr Dinusha Liyanapatabandi
1.20 – 2.00 pm	Interactive Discussion, Feedback, Certificate Distribution & Closing Remarks	Dr Chinthaka Banagala Dr Chaminda Hunukumbure

Local Payments should be made to

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

Foreign Payments should be made to

Account Name - Sri Lanka College of Obstetricians & Gynaecologists (USD Account)
 Account No. - 5004 1000 0027
 Bank Name & Code - Sampath Bank PLC / 7278
 Branch Name & Code - Borella Branch / 004
 SWIFT Code - BSAMLK LX

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Registration Fees

Foreign Consultants- USD 25
 Foreign Trainees- USD 25

Local Consultants- LKR 2,000
 Local PG Trainees- LKR 1,000



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PRE CONGRESS WORKSHOP - 03



SRI LANKA COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS

59TH ANNUAL ACADEMIC CONGRESS

"BRIDGING GAPS IN WOMEN'S HEALTH: THROUGH COLLABORATION, EDUCATION, TRAINING, AND RESEARCH."



LABOUR CARE WORKSHOP FOR MIDWIVES & NURSES

Essentials of Obstetrics at your Doorstep



24TH AUGUST, 2026



08.00 AM - 01.00 PM



MAIN AUDITORIUM,
CASTLE STREET HOSPITAL FOR WOMEN

Workshop Leadership:



Professor Rukshan Fernandopulle
President - SLCOG



Dr Apputhurai Sritharan
Chairman, Scientific Activities & Research
SLCOG



Dr Darshana Abeygunawardana
Chairman, Regional Activities & Developments
SLCOG

Time	Item	Resource person
08.00 am - 08.30 am	Registration	
08.30 am - 08.35 am	Welcome Address	Prof Rukshan Fernandopulle
08.35 am - 08.50 am	Evaluation & Assessment	Dr Janakie Karunasinghe
08.50 am - 09.05 am	How to Maintain a Client Friendly Safe Environment at Labour Ward	Dr Chaminda Hunukumbure
09.05 am - 09.25 am	Respectful Maternity Care	Prof M R M Rishard
09.25 am - 09.45 am	Pain Management	Dr Darshana Abeygunawardana
09.45 am - 10.15 am	Labour Care Guide	Dr U D P Ratnasiri
10.15 am - 10.30 am	TEA BREAK	
10.30 am - 10.50 am	CTG Interpretation	Dr Asela Amarasena
10.50 am - 11.20 am	Postpartum Monitoring	Dr Amila Rubasinghe
11.20 am - 11.40 am	Early Newborn Care	Dr Nalin Gammathige
DRILLS		
11.40 am - 01.00 pm	Sholder dystocia	Dr P L D Silva
	Cord Prolapse & Delivery of the placenta	Dr Krishan Binduhewa / Dr V Kajeepan
	PPH	Dr Suthais Mohamed
	Maternal Collapse	Dr Chanaka Palansooriya
01.00 pm	LUNCH	

Faculty:



Dr U D P Ratnasiri
Senior Consultant Obstetrician and
Gynaecologist



Dr Janakie Karunasinghe
Senior Consultant Obstetrician and
Gynaecologist



Dr Chaminda Hunukumbure
Hon. Secretary, SLCOG



Prof M R M Rishard
Professor, Department of Obstetrics and
Gynaecology, FOM, University of Colombo



Dr Asela Amarasena
Consultant Obstetrician and Gynaecologists,
Base Hospital Thambuththegama



Dr Amila Rubasinghe
Consultant Obstetrician and Gynaecologist,
Castle Street Hospital for Women



Dr Nalin Gammathige
Consultant Neonatal Paediatrician,
De Soya Hospital for Women



The official Invitation Letters will be sent to the Directors of the Hospitals with the programme agenda.



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PRE CONGRESS WORKSHOP - 04



SRI LANKA COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS

59TH ANNUAL ACADEMIC CONGRESS

"BRIDGING GAPS IN WOMEN'S HEALTH: THROUGH COLLABORATION, EDUCATION, TRAINING, AND RESEARCH."

LABOUR CARE WORKSHOP FOR DOCTORS

PRE-CONGRESS WORKSHOP ORGANISED BY SLCOG



26TH AUGUST, 2026



08.00 AM - 01.45 PM



AUDITORIUM, SLCOG HOUSE

NO.112, MODEL FARM RD, COLOMBO 08

Time	Event	Details
08.00 am - 08.30 am	Registration	
08.30 am - 08.40 am	Welcome Address	Prof Rukshan Fernandopulle President SLCOG
08.40 am - 09.40 am	Interactive Session; Labour Care Guide SL	Dr U D P Ratnasiri Senior Consultant Obstetrician & Gynaecologist
09.40 am - 10.25 am	Multimodal Labour Analgesia	Dr Amal Indika Withanage Consultant Anesthesiologist Maternal & Children's Hospital, Kalutara
10.25 am - 11.10 am	Interactive Session; Physiology - based CTG Interpretation	Dr Dinuka Lankeshwara Consultant Obstetrician & Gynaecologist, BH Homagama
11.10 am - 11.25 am	TEA BREAK	
11.25 am - 11.55 am	Intrapartum Ultrasound	Dr Achintha Dissanayake Senior Lecturer, Faculty of Medical Sciences, USJP
11.55 am - 12.55 pm	Panel Discussion Labour Ward Pearls: Tips, Tricks and Lessons from decades of practice.	Dr Ajita Wijesundara Prof Kapila Gunawardane Dr U D P Ratnasiri Prof Rukshan Fernandopulle
12.55 pm - 01.35 pm	Hands-on Workshop; KIWI cup application & Uterine Tamponade Balloon	
01.35 pm - 01.45 pm	Closing Remarks	Dr Dinusha Liyanapatabandi Head, Dept of Obstetrics & Gynaecology, FOM, UOM
01.45 pm	LUNCH	

Registration fees

Foreign Consultants- USD 25
Foreign Trainees- USD 25
Local Consultants- LKR 2,000
Local PG Trainees- LKR 1,000

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Account No. - 0820 00623484 001
Bank - Seylan Bank, Borella Branch

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Branch Name & Code - Borella Branch / 004
SWIFT Code - BSAMLKLX

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Registration will be confirmed only upon receipt of payments.

Faculty:



Prof Kapila Gunawardane
Senior Consultant Obstetrician & Gynaecologist



Dr Ajita Wijesundara
Senior Consultant Obstetrician & Gynaecologist



Dr U D P Ratnasiri
Senior Consultant Obstetrician & Gynaecologist



Dr Dinuka Lankeshwara
Consultant Obstetrician & Gynaecologist,
Base Hospital, Homagama



Dr Amal Indika Withanage
Consultant Anesthesiologist
Maternal & Children's Hospital, Kalutara



Dr Achintha Dissanayake
Senior Lecturer, Faculty of Medical Sciences,
University of Sri Jayawardenepura

Workshop Leadership:



Professor Rukshan Fernandopulle
President - SLCOG



Dr Apputhurai Sritharan
Chairman, Scientific Activities & Research
SLCOG



Dr Dinusha Liyanapatabandi
Head, Dept of Obstetrics & Gynaecology, FOM,
University of Moratuwa



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PRE CONGRESS WORKSHOP - 05 A



SRI LANKA COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS

59TH ANNUAL ACADEMIC CONGRESS

"BRIDGING GAPS IN WOMEN'S HEALTH: THROUGH COLLABORATION, EDUCATION, TRAINING, AND RESEARCH."

SCIENCE OF ENERGY

"THE ART OF USING ADVANCED BIPOLAR AND HARMONIC"



28TH AUGUST, 2026



08.00 AM - 04.00 PM



AUDITORIUM, SLCOG HOUSE
NO.112, MODEL FARM RD, COLOMBO 08

Registration fees

Foreign Consultants- USD 25
Foreign Trainees- USD 25

Local Consultants- LKR 2,000
Local PG Trainees- LKR 1,000

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Faculty:



Prof Madura Jayawardane
Prof in Obstetrics & Gynaecology, FOM, USJP



Prof Dakshitha Wickramasinghe
Prof in Surgery, FOM, UOC



Dr Dipak Limbachiya
Consultant Gynaecendoscopist
Eva Women's Hospital & Gynaec Endoscopy Centre



Mr Habeeb Rehman Mangalore
Advisor for the J&J Endo surgery



Prof Rukshan Fernando
President SLCOG



Dr A Sritharan
Chairman, Scientific Activities & Research
SLCOG



Dr Prabhath Randombage
Senior Lecturer, FOM, University of Kelaniya



Dr Madhava Karunaratne
Consultant Obstetrician and Gynaecologist



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PRE CONGRESS WORKSHOP - 01 B



SRI LANKA COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS

59TH ANNUAL ACADEMIC CONGRESS

"BRIDGING GAPS IN WOMEN'S HEALTH: THROUGH COLLABORATION, EDUCATION, TRAINING, AND RESEARCH."

PROGRAMME

Time	Topic	Resource Person	Main Highlights
8.00 AM – 8.20 AM	Registration		
8.20 AM – 8.30 AM	Welcome address and opening remarks by Prof Rukshan Fernandopulle & Dr Apputhurai Sritharan		
8.30 AM – 9.15 AM	Introduction to SoE With PRACTICAL DEMONSTRATION 1	Mr Habeeb Rehman Mangalore	Principles of sealing Physics of electricity Tissue changes with heat Introduction to RF Monopolar vs Bipolar Electrosurgery (Pros and Cons)
9.15 AM – 10.00 AM	Advance bipolar technology and techniques with PRACTICAL DEMONSTRATION 2	Mr Habeeb Rehman Mangalore	Conventional Bipolar vs Advanced Bipolar Advanced Bipolar Surgical Techniques Adaptive Tissue Technology, Minimal thermal spread, Enhanced hemostasis high-frequency mechanical vibration to simultaneously cut and coagulate tissue
10.15 AM – 10.30 AM	COFFEE BREAK AND NETWORKING		
10.30 AM – 11.30 AM	Bipolar and advanced bipolar With VIDEO DEMONSTRATION 1	Prof Madura Jayawardane	Introduction to bipolar Advanced bipolar Good seal: heat, compression and time Tips for safe use.
11.30 AM – 12.00 PM	Ultrasonic and advanced ultrasonic technologies	Prof Dakshitha Wickramasinghe	Shortcomings of RF energy Introduction to harmonic How ultrasound generates heat Difference between MIN and MAX mode Various functions of harmonic Tips to manage device heat and minimize lateral thermal spread
12.00 AM – 12.30 PM	LUNCH AND NETWORKING		
12.30 PM – 01.30 PM	VIDEO LIVE STREAMING 1	Dr Dipak Limbachiya	TLH + BS
01.30 AM – 03.00 PM	VIDEO LIVE STREAMING 2	Dr Dipak Limbachiya	Laparoscopy for Endometriosis
03.00 PM – 03.45 PM	Hands on to navigate energy devices		
03.45 PM – 04.00 PM	CLOSING REMARKS		

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PRE CONGRESS WORKSHOP - 06



SRI LANKA COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS

59TH ANNUAL ACADEMIC CONGRESS

"BRIDGING GAPS IN WOMEN'S HEALTH: THROUGH COLLABORATION, EDUCATION, TRAINING, AND RESEARCH."

Common Challenges in Infertility Management

Organised by the Subfertility Committee



31ST AUGUST, 2026



08.30 AM - 12.25 PM



AUDITORIUM, SLCOG HOUSE
NO 112, MODEL FARM RD, COLOMBO 8

Registration fees

Foreign Consultants- USD 25
Foreign Trainees- USD 25

Local Consultants- LKR 2,000
Local PG Trainees- LKR 1,000

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SWIFT Code - BSAMLKX

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contact details.

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receipt of payments.

TIME	TOPIC	SPEAKER
08:30 AM - 08:45 AM	Registration and Introduction	
08:45 AM - 09:15 AM	Nutritional Optimization in the Infertile Couple	Dr Gowri Samarasekera Consultant Nutrition Physician Colombo North Teaching Hospital, Ragama
09:15 AM - 09:45 AM	Optimizing Medical Comorbidities in Infertility Care	Dr Shamitha Dassanayake Consultant Physician Castle Street Hospital for Women
09:45 AM - 10:15 AM	Sexual Dysfunction: An Overlooked Challenge in Fertility Management	Dr Prageeth Premadasa Consultant Venerologist, NSACP
10:15 AM - 10:35 AM	Tea Break	
10:35 AM - 11:05 AM	Poor Ovarian Response: Practical Approaches to a Difficult Clinical Problem	Dr Chaminda Hunukumbura Fertility Specialist Senior Lecturer and Head of Department of Obstetrics and Gynaecology, Colombo South Teaching Hospital
11:05 AM - 11:35 AM	Male Factor Infertility for the Generalist	Dr Dilini Ilukpitiya Fertility Specialist Castle Street Hospital for Women
11:35 AM - 12:05 PM	Polyendocrine Metabolic Ovarian Syndrome: Are We Getting It Right?	Dr Gayani Tissera Fertility Specialist (Acting) National Hospital Kandy
12:05 PM - 12:25 PM	Panel Discussion and Closing Remarks All Faculty	

Workshop Leadership



Prof Rukshan Fernandopulle
President SLCOG



Dr A Sritharan
Chairman, Scientific Activities &
Research, SLCOG



Dr Udara Jayawardena
Fertility Specialist
Colombo North Teaching Hospital



Dr Chaminda Hunukumbura
Fertility Specialist
Senior Lecturer and Head of
Department of Obstetrics and
Gynaecology,
Colombo South Teaching Hospital



Dr Gowri Samarasekera
Consultant Nutrition Physician
Colombo North Teaching
Hospital, Ragama



Dr Shamitha Dassanayake
Consultant Physician
Castle Street Hospital for Women



Dr Prageeth Premadasa
Consultant Venerologist, NSACP



Dr Dilini Ilukpitiya
Fertility Specialist
Castle Street Hospital for
Women



Dr Gayani Tissera
Fertility Specialist (Acting)
National Hospital Kandy



Faculty



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PRE CONGRESS WORKSHOP - 07



SRI LANKA COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS

59TH ANNUAL ACADEMIC CONGRESS

"BRIDGING GAPS IN WOMEN'S HEALTH: THROUGH COLLABORATION, EDUCATION, TRAINING, AND RESEARCH."

Cervical Cancer Screening Update and Colposcopy Workshop



01ST SEPTEMBER 2026



08.00 AM - 02.00 PM

AUDITORIUM, RAZAVI BUILDING (5TH FLOOR)
APEKSHA HOSPITAL, MAHARAGAMA

Workshop Leadership:



Prof Rukshan Fernandopulle
President SLCOG



Dr A Sritharan
Chairman, Scientific Activities & Research, SLCOG



Dr Ruwan Silva
Consultant Obstetrician & Gynaecologist, DSHW



Dr Yapa Wijeratne
Consultant Gynaecological Oncological surgeon, NH Kandy

Registration fees

Foreign Consultants- USD 25
Foreign Trainees- USD 25
Local Consultants- LKR 2,000
Local PG Trainees- LKR 1,000

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Registration will be confirmed only upon receipt of payments.

Faculty:



Dr Chinthana Hapuachchige
Consultant Gynaecological Oncosurgeon
Apeksha Hospital, Maharagama



Dr Thanuya Mahendran
Consultant Gynaecological Oncologist
Teaching Hospital, Jaffna



Dr Sumith Rathnayake
Associate specialist in Gynaecological Oncological surgery, Apeksha Hospital



Dr Nusra Fereen
Senior Registrar
Apeksha Hospital



Dr Madara Ojithmali
Senior Registrar
Apeksha Hospital

Technomedics
Healthcare Solutions

Time	Session	Faculty
7.30 - 8.00 AM	Registration	
8.00 - 8.10 AM	Welcome Address	President, SLCOG
8.10 - 8.35 AM	Current Updates in Cervical Cancer Prevention • HPV vaccination • HPV-based screening • Risk-based management and national recommendations	Dr Madara Ojithmali
8.35 - 9.00 AM	Principles of Colposcopy • Indications • Transformation zone • IFPCPC terminology • Normal and abnormal colposcopic findings	Dr Yapa Wijeratne
9.00 - 9.25 AM	Management of Abnormal Cervical Screening Results • Referral pathways • Colposcopy-directed biopsy • Conservative versus excisional treatment	Dr Sumith Rathnayake
9.25 - 9.45 AM	LLETZ and Other Treatment Modalities • Patient selection • Technique • Complications and follow-up	Dr Nusra Fereen
9.45 - 10.00 AM	Discussion & Q&A	All Faculty
10.00 - 10.30 AM	Tea Break	
10.30 - 11.45 AM	Interactive Case Discussions 1. ASC-US/LSIL 2. HSIL 3. Infection and colposcopy 4. Pregnancy and colposcopy 5. Hysterectomy specimen revealed premalignant lesion 6. Glandular abnormalities 7. Persistent HPV infection 8. Test of cure after treatment 9. Vulvoscopy	Dr Thanuya Mahendran
11.45 - 1.45 PM	Hands-on Colposcopy Workshop (Small Groups) • Colposcope setup and ergonomics • Recognition of normal and abnormal findings using image library/models • Directed biopsy techniques • LLETZ simulation • Documentation using IFPCPC terminology	Dr Chinthana Hapuachchige Dr Thanuya Mahendran Dr Yapa Wijeratne Dr Sumith Rathnayake Dr Nusra Fereen Dr Madara Ojithmali
1.45 - 2.00 PM	Closing Remarks, Certificate Distribution & Vote of Thanks	Dr Chaminda Hunukumbure



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PRE CONGRESS WORKSHOP - 08 A



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"BRIDGING GAPS IN WOMEN'S HEALTH: THROUGH COLLABORATION, EDUCATION, TRAINING, AND RESEARCH."



Spotlight on Fetal Cardiology

in collaboration with SAFOG Imaging Committee



02nd September, 2026



8:30 AM onwards



Lanka Hospital Auditorium, Sri Lanka

President SLCOG



Prof. Rukshan
Fernandopulle

President SAFOG



Dr. Kusum Thapa

Secretary General, SAFOG



Prof. Farhana Dewan

Chairman Scientific
Activities & Research SLCOG



Dr. A Sritharan

Chairperson
of Imaging Committee SAFOG



Dr. Achintha Dissanayake

Faculties



Dr. Dinesh Prakash Singh



Dr. Duminda Samarasinghe



Dr. Shemoon Marleen

Registration Fees

Local Consultants - LKR 2,000
Local PG Trainees - LKR 1,000
Foreign Consultants - USD 25
Foreign Trainees - USD 25



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PRE CONGRESS WORKSHOP - 08 B

Agenda

Time	Topic	Faculty
08:30 AM - 08:45 AM	Registration & Welcome Address	
08:45 AM - 09:00 AM	Lecture 1: Introduction to Fetal Cardiology — Screening Guidelines & Indications for Referral	Dr. Achintha Dissanayake
09:00 AM - 09:40 AM	Lecture 2: Mastering the Fetal Four-Chamber View: Beyond the Four Chambers	Dr. Dinesh Prakash Singh
09:40 AM - 10:20 AM	Lecture 3: From Outflow Tracts to the 3VT View: A Practical Approach to Fetal Cardiac Screening	Dr. Dinesh Prakash Singh
10:20 AM - 10:40 AM	Live scanning session	
10:40 AM - 11:00 AM	Tea Break	
11:00 AM - 11:40 AM	Lecture 4: Common Congenital Heart Defects — Recognition & Diagnostic Pitfalls and perioperative preparation	Dr. Duminda Samarasinghe
11:40 AM - 12:20 PM	Lecture 5: Fetal Arrhythmias — Diagnosis, Monitoring & Management	Dr. Shemoon Marleen
12:20 PM - 01:00 PM	The 11–14-Week NT Scan: Beyond Aneuploidy Screening — Including Early Fetal Cardiac Assessment	Dr. Dinesh Prakash Singh
01:00 PM - 02:30 PM	Hands-On Practical Training: Small-Group Scanning Stations with Faculty Supervision	Hands-On
02:30 PM - 02:45 PM	Closing Remarks & Certificate Distribution	

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PRE CONGRESS WORKSHOP - 09



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59TH ANNUAL ACADEMIC CONGRESS

"BRIDGING GAPS IN WOMEN'S HEALTH: THROUGH COLLABORATION, EDUCATION, TRAINING, AND RESEARCH."

RCOG & RANZCOG Training opportunities & preparation for PG trainees



03 SEPTEMBER 2026



1.00 PM - 4.30 PM



SLCOG HOUSE

NO 112, MODEL FARM RD, COLOMBO 08

Time	Lecture	Speaker
01.00 pm - 01.10 pm	Welcome Address	Dr A Sritharan
01.10 pm - 01.15 pm	Address by the President SLCOG	Prof Rukshan Fernandopulle
01.15 pm - 01.45 pm	Update on current UK obstetrics and gynaecology training pathways, workforce developments, and recent policy initiatives, including the NHS prioritisation agenda and proposed legislative changes.	Dr Sujeewa Fernando (Vice President RCOG)
01.45 pm - 02.15 pm	Navigating the RANZCOG Training Pathway: My Personal Journey	Dr Dulanthi Tudawe
02.15 pm - 02.45 pm	Overseas Training in Australia: Tips and Practical Insights	Prof Thangeswaran Rudra
02.45 pm - 03.15 pm	Medico-Legal Risk Mitigation for Overseas Trainees: Principles and Practical Strategies	Prof Hasthika Ellepola
03.15 pm - 03.45 pm	Navigating Your Foreign Training Placement in Australia	Dr Ziard Mohamed Hassim
03.45 pm - 04.15 pm	Q & A session	
04.15 pm - 04.25 pm	Vote of Thanks	Dr Chaminda Hunukumbure

Faculty:



Prof Rukshan Fernandopulle
President SLCOG



Dr A Sritharan
Chairman, Scientific Activities & Research, SLCOG



Dr Sujeewa Fernando
Vice President RCOG



Dr Dulanthi Tudawe
Consultant Obstetrician & Gynaecologist
Fertility Specialist
Associate Lecturer - The University of Queensland



Dr Ziard Mohamed Hassim
Consultant Obstetrician and Gynaecologist
Birth Suite Lead
University Hospital, Geelong.



Dr Chaminda Hunukumbure
Consultant Obstetrician and Gynaecologist,
FOM, USJP



Prof Thangeswaran Rudra
Professor University of Queensland
Clinical Director, Redcliff
Chair, Specialist International Medical Graduates, RANZCOG



Prof Hasthika Ellepola
Senior Staff Specialist, Dept. of Obstetrics & Gynaecology, Logan Hospital.
Senior Lecturer, Griffith University, School of Medicine, Australia



Registration LKR 1,000

Payments should be made to
Account Name - Sri Lanka College of
Obstetricians & Gynaecologists
Account No. - 0820 00623484 001
Bank - Seylan Bank, Borella Branch

Cash payments can be done by visiting the SLCOG House Office during normal working hours from 8.30 a.m. to 4.00 p.m.

Online fund transfers / deposits are accepted and a copy of the Payment Slip / Debit note should be emailed to slcogoffice@gmail.com or sent via WhatsApp to 077 967 8787, together with the registrant's name and contact details. Registration will be confirmed only upon receipt of payments.



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PRE CONGRESS WORKSHOP - 10



SRI LANKA COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS

59TH ANNUAL ACADEMIC CONGRESS

"BRIDGING GAPS IN WOMEN'S HEALTH: THROUGH COLLABORATION, EDUCATION, TRAINING, AND RESEARCH."

ANAL SPHINCTER INJURY REPAIR



04 SEPTEMBER 2026



8.00 AM - 1.15 PM



SLCOG HOUSE
NO 112, MODEL FARM RD, COLOMBO 08

Time	Session	Resource person
08.00 am – 08.15 am	Registration	
08.15 am – 08.30 am	Welcome Address	Prof Rukshan Fernandopulle
08.30 am – 09.00 am	Background & Management of OASIs	Dr Ruwan Fernando
09.00 am – 10.00 am	Video demonstration- Identification of Anal sphincter injury & Repair	
10.00 am – 10.15 am	Tea	
10.15 am – 12.30 pm	Hands on repair on Pig sphincter	
12.30 pm – 01.00 pm	Discussion	
01.00 pm – 01.15 pm	Closing remarks & Vote of Thanks	Dr Chaminda Hunukumbura

International Faculty:



Dr Ruwan Fernando
Consultant Obstetrician & Gynaecologist,
Urogynaecology Subspecialist, Honorary
Senior Lecturer, Imperial College
Healthcare NHS Trust

Sri Lankan Faculty:



Prof Rukshan Fernandopulle
President SLCOG



Dr A Sritharan
Chairman, Scientific
Activities & Research, SLCOG



Dr Chinthaka Banagala
Senior Lecturer, FOM, UOC



Dr Ruwan Silva
Consultant Obstetrician and
Gynaecologist, DSHW



Dr Chaminda Hunukumbura
Consultant Obstetrician and
Gynaecologist,
FOM, USIP

Registration Fees

Local Consultants- LKR 2,000 Foreign Consultants- USD 25
Local PG Trainees- LKR 1,000 Foreign Trainees- USD 25

Local Payments should be made to
Account Name – Sri Lanka College of
Obstetricians & Gynaecologists
Account No. – 0820 00623484 001
Bank – Seylan Bank, Borella Branch

Foreign Payments should be made to
Account Name – Sri Lanka College of
Obstetricians & Gynaecologists (USD Account)
Account No. – 5004 1000 0027
Bank Name & Code – Sampath Bank PLC / 7278
Branch Name & Code – Borella Branch / 004
SWIFT Code – BSAMLKX

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POST CONGRESS WORKSHOP - 01



SRI LANKA COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS
59TH ANNUAL ACADEMIC CONGRESS
 "BRIDGING GAPS IN WOMEN'S HEALTH THROUGH COLLABORATION, EDUCATION, TRAINING AND RESEARCH"

HYPERTENSIVE DISORDERS IN PREGNANCY


7 SEPTEMBER 2026


08.00 AM - 01.00 PM


SLCOG HOUSE
 NO 112, MODEL FARM RD, COLOMBO 08

Gestosis India Association:



Dr Girija Wagh
President



Dr Gorakh Mandrupkar
Vice President



Dr Priti Kumar
Secretary



Dr Charmila Ayyavoo
Vice President

World Organisation Gestosis:



Dr Hema Divakar
President



Dr Sanjay Gupte
Secretary General

Srilankan Faculty:



Prof Rukshan Fernandopulle
President, SLCOG



Dr U D P Ratnasiri
Senior Consultant Obstetrician & Gynaecologist



Dr A Sritharan
Chairman Scientific Activities & Research, SLCOG

Course Conveners:



Dr Suchitra N. Pandit
Past President
Gestosis India Association

Course Coordinators : Team from Srilanka



Dr Sumith Warnasuriya
Consultant Obstetrician & Gynaecologist
BH Dambadeniya

Time	Item	Resource Person
07.30 am - 08.30 am	Breakfast and Registration	
08.00 am - 09.00 am	Pretest Questionnaire	
09.00 am - 10.30 am	<i>Session: 1</i>	
	Chairpersons Prof. Rukshan Fernandopulle + Dr. U D P Ratnasiri	
	Definition & Classification of HDP	Dr. Charmila Ayyavoo
	Pathophysiology of HDP - Changing scenario	Dr. Gorakh Mandrupkar
	HDP- Gestosis score A boon for Prediction of Preeclampsia	Dr. Gorakh Mandrupkar
	Predictors (USG, Biochemical, Angiogenic)	Dr. Suchitra Pandit
10.30 am - 11.15 am	Diagnosis & Lab Evaluation	Dr. Charmila Ayyavoo
	Management of HDP	Dr. Girija Wagh
10.30 am - 11.15 am	<i>Inauguration & Coffee Break</i>	
11.15 am - 01.00 pm	<i>Session: 2</i>	
	Chair persons: Dr A Sritharan + Dr. Girija Wagh	
	Admission and Transfer (When, Where and How?) (Triage & referral policy)	Dr. Gorakh Mandrupkar
	When to deliver?	Dr. Girija Wagh
	Eclampsia Drills	Dr. Sumith Warnasuriya
	Fluid Management	Dr. Charmila Ayyavoo
01.00 pm - 02.00 pm	The Fourth Trimester	Dr. Suchitra Pandit
01.00 pm - 02.00 pm	<i>Case Discussion</i>	
	Moderators : Dr. Girija Wagh + Dr. Suchitra Pandit + Dr. U D P Ratnasiri	
02.00 pm - 02.30 pm	<i>Posttest Questionnaire and Certification</i>	

Registration Fees

Local Consultants- LKR 2,000
 Local PG Trainees/ doctors- LKR 1,000
 Foreign Consultants- USD 25
 Foreign Trainees- USD 25
 Nurses & Midwives - FREE

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59TH ANNUAL ACADEMIC CONGRESS

05th to 06th September 2026

University of Colombo, Faculty of Medicine, Colombo, Sri Lanka

INAUGURATION PROGRAMME

04th September 2026

at the Marino Beach Hotel, Colombo, Sri Lanka

- | | |
|-----------|--|
| 5.30 p.m. | Guests take their seats |
| 5.45 p.m. | Arrival of the Chief Guest, Guest of Honour and Special Guests |
| 6.00 p.m. | Ceremonial Procession |
| 6.10 p.m. | National Anthem and Traditional Lighting of the Oil Lamp |
| 6.20 p.m. | Welcome Address
Prof. Rukshan Fernandopulle
President
Sri Lanka College of Obstetricians and Gynaecologists |
| 6.30 p.m. | Address by the Special Guest
Prof. Sir Sabaratnam Arulkumaran
Emeritus Professor of Obstetrics and Gynaecology |
| 6.40 p.m. | Address by the Special Guest
Prof. Ravi Chandran
President Elect
International Federation of Gynaecology and Obstetrics |
| 6.50 p.m. | Address by the Guest of Honour
Dr. John Tait
President
Asia and Oceania Federation of Obstetrics and Gynaecology |
| 7.00 p.m. | Address by the Chief Guest
Prof. Frank Louwen
President
International Federation of Gynaecology and Obstetrics |
| 7.15 p.m. | Fellowship Awarding Ceremony |
| 7.30 p.m. | Prof. D.A. Ranasinghe Memorial Oration
"To Young to Bear"
Dr. Janakie Karunasingha
Consultant Obstetrician and Gynaecologist |
| 8.15 p.m. | Vote of Thanks
Dr. R.M.C.B. Hunukumbure
Hony. Secretary
Sri Lanka College of Obstetricians and Gynaecologists |
| 8.25 p.m. | Cultural Show and Reception |

Detailed Programme - 2026

DAY 01 SCIENTIFIC PROGRAMME 05 TH SEPTEMBER 2026				
TIME	HALL – A	HALL – B	HALL – C	HALL – D
8.00 AM – 9.00 AM	FREE PAPERS (1-6) - SESSION 1 <i>Chairpersons; Prof M Thirukumar / Prof Chaminda Kandauda</i>	FREE PAPERS (7-12) - SESSION 2 <i>Chairpersons; Dr Buddika Asela Amaraseena / Prof M R M Rishard</i>	FREE PAPERS (13-18) - SESSION 3 <i>Chairpersons; Dr Amila Rubasinghe / Dr Chaminda Hunukumbure</i>	SAFOG NCD ESSAY COMPETITION FINALS "PCOS in South East Asia" <i>Chairpersons; Dr Kusum Thapa / Prof Farhana Dewan / Prof Shyam Desai/ Dr Narendra Malhotra / Dr Sumith Warnasuriya</i>
9.00 AM - 9.30 AM	KEYNOTE ADDRESS Maternal Stem Cells in Obesity and Pre-Eclampsia Prof Frank Louwen (President FIGO) <i>Chairpersons; Prof Rukshan Fernandopulle / Dr Rohana Haththotuwa / Dr A Sritharan</i>			
9.30 AM - 9.55 AM	PLENARY LECTURE 1 The Influence of Adenomyosis on Fertility and Pregnancy: Effective Management Strategies – Prof Yutaka Osuga (Past President JSOG 2024, University of Tokyo School of Medicine) <i>Chairpersons; Prof Rukshan Fernandopulle / Dr Rohana Haththotuwa / Dr A Sritharan</i>			
9.55 AM - 10.20 AM	PLENARY LECTURE 2 Its Time to Change Lenses - Pre-Eclampsia, The Fourth Trimester & Beyond – Prof Sir Sabaratnam Arulkumaran <i>Chairpersons; Prof Rukshan Fernandopulle / Dr Rohana Haththotuwa / Dr A Sritharan</i>			
10.20 AM - 10.40 AM	Tea break & Poster Viewing			
10.40 AM - 11.20 AM	DR P. DISSANAYAKE ENDOWMENT LECTURE Paradigm Shifts In Obstetric Practice Dr Ravi Chandran (President-Elect FIGO) <i>Chairpersons; Prof Jayantha Jayawardana / Prof Rukshan Fernandopulle/ Dr A Sritharan</i>			
11.20 AM - 12.20 PM	RANZCOG SESSION The Rising Tide of Birth Trauma: An Obstetrician's Challenge A/Prof Thangeswaran Rudra Building Excellence in Endometriosis Management Through Multidisciplinary Collaboration and RANZCOG Training Initiatives A/Prof Hasthika Ellepola Embryo Freezing: Ethical Principles and Contemporary Clinical Practice - Dr Dulanthi Tudawe <i>Chairpersons; Dr Sanath Akmeemana/ Dr Sumith Warnasuriya</i>	UNICEF SESSION "Beyond Pills and Procedures: Lifestyle Medicine in Women's Health" Nourishing Two Generations: Lifestyle Medicine in Pregnancy - Dr Arunie Malwatta Prescription: Exercise—The Most Underused Therapy in Obstetrics and Gynaecology Dr. S. Lakmindi Gunatilake Beyond Iron-folate: Charting Sri Lanka's programmatic pathway to Maternal Multiple Micronutrient Supplement - Dr. Sanjeeva Godakandage Multiple Micronutrient Supplements for Pregnant Women in Sri Lanka: Implementation Insights Dr. Chithrangie Perera <i>Chairpersons; Dr Mangala Dissanayaka/ Dr Abner Daniel / Dr Chandima Siritunga</i>	SYMPOSIUM 1 "Applications and Implications of AI in Reproductive Healthcare" Moderator - Prof Narendra Malhotra Panellists - Dr Milhan Batcha Dr Induni Piyadigama Dr Udara Jayawardane Prof M Thirukumar Dr Madhava Karunaratne <i>Chairpersons; Prof Rasika Herath / Dr Amila Rubasinghe</i>	FREE PAPERS (19-24) - SESSION 4 <i>Chairpersons; Dr Damith Siriwardhana / Dr Manoj Perera</i>

12.20 PM - 12.40 PM	GUEST LECTURE 1 Born Too Soon and the Road Forward to Prevent Preterm Birth Prof. Bo Jacobsson <i>Chairpersons; Dr U D P Ratnasiri/ Dr Janakie Karunasinghe</i>	GUEST LECTURE 2 Maternal Mortality Reduction, the way forward for South Asia - Prof. Shyam Desai (Past President – SAFOG) <i>Chairpersons; Prof Hemantha Senanayake/ Dr Sardha Hemapriya</i>	GUEST LECTURE 3 Regenerative and Aesthetic Gynaecology: a new superspeciality Prof Narendra Malhotra <i>Chairpersons; Dr A G T U Padeniya/ Dr Kanishka Samaranyake</i>	FREE PAPERS (25-30) - SESSION 5 <i>Chairpersons; Dr Somadewa Jayaweera / Dr Sudath Senarathne</i>
12.40 PM - 1.40 PM	LUNCH & Poster Viewing			
1.40 PM - 2.40 PM	GUEST LECTURES 4,5,6,7 Ovarian Ageing - Dr Nandita Palshetkar The Environmental Effects on Pregnant Mothers: Should we be more aware of the problem - Dr Ananda Ranathunga Towards precision Medicine in Placenta Accreta Syndrome - Dr U D P Ratnasiri Fetal Cardiac Screening in the context of New ISUOG Guidelines Dr Jagath Dandeniya <i>Chairpersons: Dr U G Kariyawasam /Dr Shemoon Marleen</i>	SAFOG QUIZ COMPETITION FINALS Non-communicable Disease Quiz Moderator - Prof Suchitra Pandit <i>Chairpersons; Dr Kusum Thapa / Prof Farhana Dewan/ Prof Rukshan Fernandopulle/ Prof Shyam Desai</i>	Prof Sir Sabaratnam Arulkumaran YGA Session SLCOG <i>Chairpersons And Judges; Dr Gamini Perera / Dr Asoka Weerakkoddy</i>	FREE PAPERS (31-36) - SESSION 6 <i>Chairpersons; Dr Hiranthi Solangaarachchi / Dr Dinuka Lankeshwara</i>
2.40 PM - 3.40 PM	RCOG SESSION Anticholinergic Burden in the Management of Overactive Bladder Dr Sujeewa Fernando (Vice President RCOG) Advancing Minimally Invasive Gynaecology with Robotics Dr B A K Mahendra Childbirth and Pelvic Floor Dysfunction - Dr Ruwan Fernando <i>Chairpersons; Dr Samantha Premaratne/ Dr Ramya Pathiraja</i>	WHO SESSION "Labour care: bringing new concepts to the current practice" Labour Progress: Partogram to Decision Making Prof M R M Rishard Beyond Hypoxia: Decoding the Neuro-Inflammatory Signature of the Vulnerable Fetus Dr Buddika Asela Amaraseena Respectful Maternity Care in Sri Lanka: A mixed method analysis from 21475 data points Prof Chandana Jayasundara Family-Oriented Caesarean Delivery(FOCD): A New Approach to Positive Childbirth Prof Prabodana Ranaweera <i>Chairpersons; Dr Chandina Wedamestiri / Prof Madura Jayawardane</i>	Clinical Professor Dr S M Sathanandan Reproductive Medicine YGA Session SLCOG <i>Chairpersons And Judges; Dr Sanath Akmeemana/ Dr Madhava Karunaratne</i>	
3.40 PM - 4.40 PM	FIGO SESSION Welcome & Introduction - Dr Ravi Chandran Climate Change – “Heat” of the matter - Prof Krishnendu Gupta Gamete donation – Sowing Ethical Seeds - Dr Suchitra Pandit Between Duty & Danger - Violence against HCP in South Asia Dr Rubina Sohail Discussion & Closing Remarks - Prof Frank Louwen <i>Chairpersons; Prof Frank Louwen / Dr Ravi Chandran</i>	SYMPOSIUM 2 "Assisted Reproductive Technology" Overcoming Endometrial Problems In ART Prof Yutaka Osuga How to Overcome Difficult Embryo Transfers Dr Noushin Abdul Majid Recurrent Implantation Failure: Evidence and Practice - Dr Soumya Nair Fertility Preservation: From Global Standard to Local Practice - Dr Madhura Jayasingam Hope Against the Odds: Assisted Reproductive Technology in Resource-Limited Settings - Prof S Raguraman <i>Chairpersons; Dr Udara Jayawardana/ Dr Chamintha Hunukumbura</i>	SYMPOSIUM 3 Panel Discussion "Post-partum Haemorrhage" Moderator - Prof Sir Sabaratnam Arulkumaran Panelists - Prof Rukshan Fernandopulle Dr Janakie Karunasinghe Dr A Sritharan Prof Chandana Jayasundara Dr Prabath Randombage Prof M R M Rishard <i>Chairpersons; Dr U D P Ratnasiri/ Dr N Saravanabhava</i>	FREE PAPERS (37-42) - SESSION 7 <i>Chairpersons; Dr Rohan Liyanage / Dr Suranga Hettipathirana</i>
4.40 PM - 5.00 PM	Tea Break			

DAY 02 | SCIENTIFIC PROGRAMME | 06TH SEPTEMBER 2026

TIME	HALL – A	HALL – B	HALL – C
8.00 AM – 9.00 AM	FREE PAPERS (43-48) - SESSION 8 <i>Chairpersons; Prof Prabhodana Ranaweera / Dr Maithri Chandraratne</i>	FREE PAPERS (49-54) - SESSION 9 <i>Chairpersons; Dr Dinusha Liyanapatabandi / Dr Sampath Gnanaratne</i>	FREE PAPERS (55-60) - SESSION 10 <i>Chairpersons; Prof Madura Jayawardane / Dr Indunil Piyadigama</i>
9.00 AM - 9.25 AM	PLENARY LECTURE 3 Collaboration and Partnership: the role of AFOG Dr. John Tait (President AFOG) <i>Chairpersons; Dr Rohana Haththotuwa / Dr Hemantha Perera</i>		
9.25 AM - 9.50 AM	PLENARY LECTURE 4 Paper to Pixels: Revolutionizing Intrapartum Care with the Electronic LCG Dr Kusum Thapa (President, SAFOG) <i>Chairpersons; Prof W I Amarasinghe/ Dr Kanishka Karunaratne</i>		
9.50 AM - 10.30 AM	DR ROHANA HATHTHOTUWA ORATION Beyond the Blade: Silent Scars: Reclaiming Health, Rights, and Dignity Clinical Prof Dr Sanath Lanerolle <i>Chairperson; Prof Rukshan Fernandopulle/ Dr Marlene Abeyewardena/ Dr A Sritharan</i>		
10.30 AM - 10.50 AM	Tea break & Poster Viewing		
10.50 AM - 11.10 AM	GUEST LECTURE 8 Handling Near Misses in Obstetrics Practice; "Lessons Learnt" Prof K Muhunthan <i>Chairpersons; Prof Tiran Dias / Dr Ajita Wijesundara</i>	GUEST LECTURE 9 Prenatal Testing: Evidence, Economics and Equity Dr Oshadhi Nallaperuma <i>Chairpersons; Dr Chinthaka Banagala / Dr Gayan De Silva</i>	GUEST LECTURE 10 The Role of Intrapartum Ultrasound in the Management of Second Stage Labour Dystocia - Dr B Yohan De Silva <i>Chairpersons; Prof Deepal Weerasekara/ Prof Kapila Gunawardana</i>
11.10 AM - 11.30 AM	GUEST LECTURE 11 Post Graduate Training Gaps in South Asian Countries Prof Rashid Latif Khan (Founder President SAFOG) <i>Chairpersons; Dr Wimalasiri Abeykoon/ Dr Champika Gihan</i>	GUEST LECTURE 12 PMOS (Poly Endocrine Metabolic Ovarian Syndrome) Dr Jaideep Malhotra <i>Chairpersons; Prof Chanil Ekanayake / Dr M A G Iresha</i>	GUEST LECTURE 13 Fertility Preservation: Current Evidence and Future Directions Dr Ruchi Hooda <i>Chairpersons; Prof Athula Kaluarachchi / Dr Milhan Batcha</i>
11.30 AM - 12.30 PM	AFOG SESSION by SRH Committee "Evidence-Based Practice Across the Woman's Life Course" Welcome address - Dr John Tait (President AFOG) Emergency contraception: looking into the future - Dr Raymond Li WHO Recommendations for the Prevention and Treatment of Maternal Peripartum Infections - Prof Pisake Lumbiganon Evidence-Based Micronutrient Strategies for Midlife Women Prof Unnop Jaisamran Discussion / Q & A <i>Chairpersons; Dr. John Tait / Dr. Darshana Abeygunawardana</i>	SYMPOSIUM 4 "Gestosis Panel Discussion" Moderators - Dr Suchitra Pandit Panelists - Gestosis Score: An innovative Promising Tool for Prediction & Prevention of Preclampsia - Dr Gorakh Mandrupkar Anthypertensive Drugs; Challenges faced - Dr Girija Wagh Eclampsia Drills - Dr Sumith Warnasuriya Postpartum Complications (HELLP, PREZ, Cerebral Thrombosis) Principles of Management - Dr Charmila Ayyavoo Postpartum Period; Future Thoughts - Dr Kamrun Nessa Runa <i>Chairpersons; Prof P S Wijesinghe / Dr T B Dissanayake</i>	SYMPOSIUM 5 "Endometrioma: What to Do and What Not to Do" by Endometriosis Society of SL Moderator - Dr Indunil Piyadigama Panelists - Prof Hemantha Senanayake Prof Madura Jayawardane Prof Prabhodana Ranaweera Dr Samanthi Premaratne Dr Chaminda Hunukumbure <i>Chairpersons; Dr Jagath Dandeniya / Dr Sampath Gnanaratne</i>
12.30 PM – 1.30 PM	LUNCH & Poster Viewing		

1.30 PM - 2.30 PM	SAFOG SESSION "Hypertensive Disorders in Pregnancy: From Prevention to Precision Care" Moderator - Dr Mariam Iqbal Key note speech - Hypertensive Disorders in Pregnancy – key to reducing maternal mortality in South Asia - Prof Sir Sabaratnam Arulkumaran Prevention and Risk Assessment - Prof Farhana Dewan Early Recognition and Accurate Diagnosis - Prof Jaideep Malhotra Precision Care: Individualized Management Dr Rajendraseelan Thuvathippan Improving Maternal and Perinatal Outcomes - Prof Padam Raj Pant Beyond Delivery: Lifelong Health and Future Directions Prof Yousaf Latif Khan Audience participation Q&A <i>Chairpersons; Dr Kusum Thapa, Dr Rohana Hatthothuwa, Prof Rubina Sohail</i>	SYMPOSIUM 6 by Menopause Society of SL Testosterone; Current Evidence for Clinical Practice Dr Prabath Randombage Neurokinin for Hot Flashes; Efficacy and Safety Dr Rashanthi Perera Latest Safety Guidelines for ERT - Dr Darshana Abeygunawardana <i>Chairpersons; Dr M D P Gunaratne / Dr Ruwan Silva</i>	SYMPOSIUM 7 "Medical Disorders" Thyroid Disorders in Pregnancy: An Update for Clinical Practice Dr Shemoon Marleen Diabetes in Pregnancy Controversies and Consensus Prof Madura Jayawardane Modern Anticoagulation in Women's Health: Pregnancy, Gynaecology, ART and the DOAC Era Dr Wedisha Gankanda <i>Chairpersons; Dr Janaka Jayasinghe / Dr Ruwan Senaka Gamage</i>
2.30 PM - 3.30 PM	SYMPOSIUM 8 MISCELLANEOUS Multisystemic Ageing Transition Care in 2026: A Longevity Framework Beyond Menopause Hormone Therapy - Dr Indu Asanka Jayawardane Mental Disorders in Pregnancy - Dr Luckshika Amarakoon Vasa Previa: Current Evidence, Clinical Controversies and Guideline Perspectives - Dr Kajendran logarasah <i>Chairpersons; Dr Ananda Ranathunga / Dr Janakie Karunasinghe</i>	SYMPOSIUM 9 "Shielding the Newborn Brain: Joint Perinatal Strategies against Hypoxic Ischaemic Encephalopathy" by Perinatal Society of SL The Intrapartum Window: Timely Interventions and Risk-Stratification to Prevent Fetal Hypoxia - Dr Ruwan Silva Beyond the Cooling Blanket: Biomarkers, Neuroprotection, and Prognosticating HIE - Prof Saraji Wijesekara The Continuum of Care: Community Surveillance and Early Intervention Networks for HIE - Dr Asiri Hewamalage <i>Chairpersons; Dr A Sritharan / Dr Harsha Atapattu</i>	SYMPOSIUM 10 "Urogynaecology" Prevention of Urinary Tract Injuries During Laparoscopic Surgery Clinical Prof Nishendra Karunaratne Getting the Diagnosis Right Before Surgery: Preoperative Assessment in Female SUI - Dr Malith Perera The Changing Landscape of Stress Urinary Incontinence Surgery: Is Burch Still the Gold Standard? - Dr Chinthaka Banagala <i>Chairpersons; Clinical Prof Sanath Lanerolle / Prof Chandana Jayasundara</i>
3.30 PM - 4.30 PM	SYMPOSIUM 11 "Gynaecological Oncology" Pregnancy and Gynaecological Cancer: Balancing Maternal Cure and Fetal Safety - Dr Kanishka Karunaratne From Genes to Targeted Therapy: Molecular Genetics in Gynecological Cancer - Dr Thanuya Mahendran Cervical Cancer Management: From Radical Surgery to Precision Care Dr Yapa Wijeratne Vulval Premalignant Lesions: Early Recognition, Modern Management and Cancer Prevention - Dr Madara Ojithmali <i>Chairpersons; Dr Chinthana Hapuchchige / Dr Indu Asanka Jayawardane</i>	SYMPOSIUM 12 "Intrapartum Pyrexia: Early Recognition, Timely Intervention and Optimising Maternal-Newborn Outcomes" Intrapartum Pyrexia: Pathophysiology, Differential Diagnosis and Early Recognition - Dr Dinusha Liyanapatabandi Management of Intrapartum Pyrexia: An Obstetrician's Perspective - Dr Dinuka Lankeshwara Management of the Newborn Following Maternal Intrapartum Pyrexia - Dr Kasun Jayasundara <i>Chairpersons; Prof C Randeniya / Prof Kumara Dissanayake</i>	SYMPOSIUM 13 "When Experience Matters: Mastering Difficult Deliveries Lessons from Masters of Obstetrics" Making Vaginal Delivery Possible: The Art of Clinical Judgement Prof Hemantha Senanayake The Difficult Caesarean Section: Surgical Pearls from the Masters Prof Athula Kaluarachchi Mastering Breech Birth: Anticipating and Overcoming Challenges Prof P.S. Wijesinghe The Difficult Outcome: Wisdom Beyond the Delivery Room Prof Kapila Gunawardane <i>Chairpersons; Dr Lakshmen Senanayake / Prof Chathura Rathnayake</i>
4.30 PM - 5.00 PM	Valedictory & Conclusion		
5.00 PM - 5.15 PM	Tea break		



FACULTY

SRI LANKA



Prof. Rukshan Fernandopulle



Prof. P S Wijesinghe



Prof. Kapila Gunawardene



Prof. Hemantha Senanayake



Prof. Athula Kaluarachchi



Prof. K Muhunthan



Prof. M Thirukumar



Prof. Saraji Wijesekara



Prof. Chandana Jayasundara



Prof. M R M Rishard



Prof. Madura Jayawardane



Prof. S. Raguraman



Prof. Prabhodana Ranaweera



Clinical Prof. Sanath Lanerolle



Clinical Prof. Nishendra Karunaratne



Dr. Janakie Karunasinghe



Dr. A. Sritharan



Dr. Oshadhi Nallaperuma



Dr. Sumith Warnasuriya



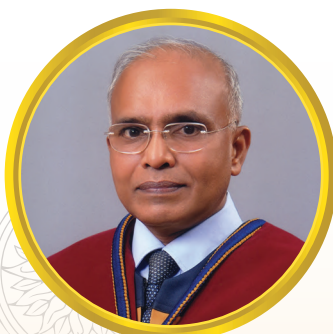
Dr. Prabath Randombage



Dr. Indunil Piyadigama



Dr. Madhava Karunaratne



Dr. Ananda Ranathunga



Dr. Kanishka Karunaratne



Dr. U D P Ratnsiri



Dr. Rashanthie Perera



Dr. Indu Asanka Jayawardena



Dr. Darshana Abeygunawardana



Dr. Jagath Dandeniya



Dr. Aruni Malwatte



Dr. Udara Jayawardane



Dr. Milhan Batcha



Dr. Lakmindi Gunatilake



Dr. Sanjeewa Godakandage



Dr. Chithranganie Perera



Dr. Buddhika Asela Amarasena



Dr. Shemoon Marleen



Dr. Wedisha Gankanda



Dr. Ruwan Silva



Dr. Asiri Hewamalage



Dr. Dinusha Liyanapatabandi



Dr. Chinthaka Banagala



Dr. Samanthi Premaratne



Dr. Chaminda Hunukumbure



Dr. Luckshika Amarakoon



Dr. Yapa Wijeratne



Dr. Malith Perera



Dr. Kajendran Jogarasah



Dr. Thanuya Mahendran



Dr. Madara Ojithmali



Dr. Dinuka Lankeshwara



Dr. Kasun Jayasundara



Dr. Thuvarathipan Rajendraseelan

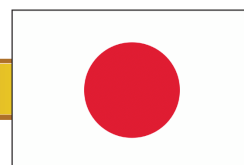


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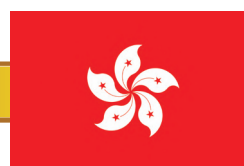
Prof. Frank Louwen

JAPAN



Prof. Yutaka Osuga

HONG KONG



Dr. Raymond Li





ENGLAND



Prof. Sir Sabaratnam Arulkumaran



Dr. B A K G Mahendra



Dr. Ruwan Fernando



Dr. Sujeewa Fernando

SWEDEN



Prof. Bo Jacobsson



AUSTRALIA



A/Prof. Thangeshwaran Rudra



A/Prof. Hasthika Ellepola



Dr. Dunlathi Thudawe



Dr. B Yohan De Silva



Dr. Madhura Jayasingam

THAILAND



Prof. Pisake Lumbiganon



Prof. Unnop Jaisamrarn



INDIA



Prof. Narendra Malhotra



Dr. Jaideep Malhotra



Dr. Nandita Palshetkar



Dr. Noushin Ashraf



Dr. Ruchi Hooda



Dr. Soumya Nair



Prof. Kusum Thapa



Prof. Shyam Desai



Prof. Suchitra Pandit



Dr. Girija Wagh



Dr. Charmila Ayyavoo



Dr. Gorakh Mandrupkar



Prof. Krishnendu Gupta

BANGLADESH



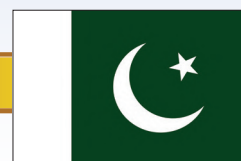
Dr. Kamrun Nessa Runa



Prof. Farhana Dewan



PAKISTAN



Prof. Rashid Latif Khan



Prof. Yousaf Latif Khan

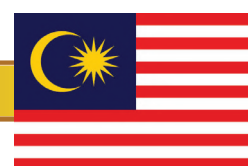


Prof. Rubina Sohail

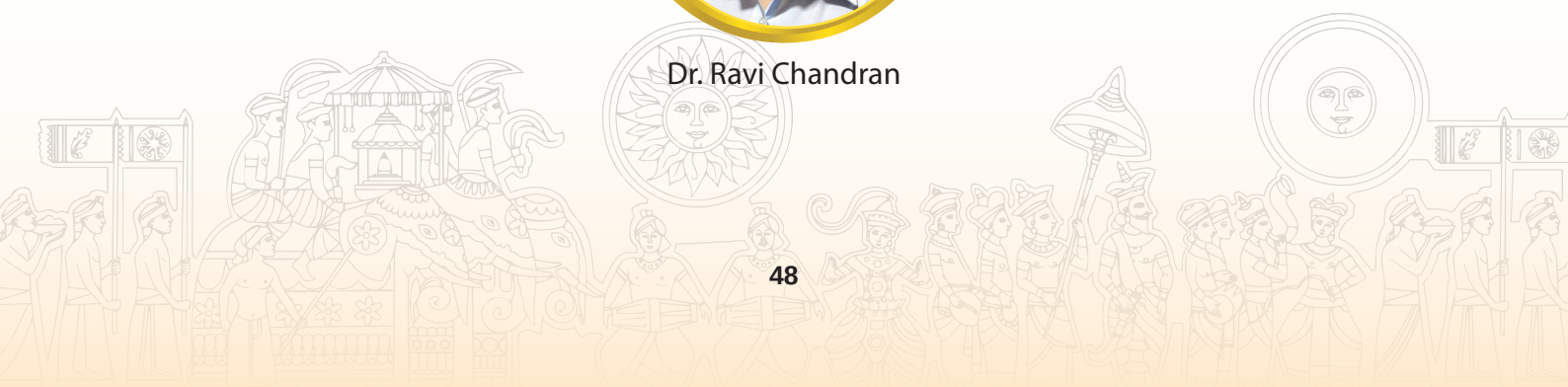


Dr. Mariam Iqbal

MALAYSIA



Dr. Ravi Chandran



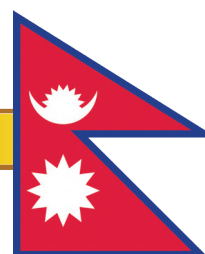


NEW ZEALAND



Dr. John Tait

NEPAL



Prof. Padam Raj Pant



CONFERENCE PROCEEDINGS

KEYNOTE SPEECH

Maternal stem cells in obesity and pre-eclampsia

Prof Frank Louwen (President FIGO) - Professor and Director of the Department of Obstetrics and Prenatal Medicine at Goethe University and University Hospital Frankfurt, Germany.

DR. P. DISSANAYAKE ENDOWMENT LECTURE

Paradigm shifts in obstetric practice

Dr Ravi Chandran (President-Elect FIGO) - Consultant Obstetrician & Gynaecologist at Gleneagles Medical Center, Kuala Lumpur, Past President AOFOG.

Since the emergence of the “man-midwife” in the 17th century, obstetric practice has advanced dramatically, particularly over the past three decades. Major changes have transformed the care of pregnant patients across all three trimesters, while the concept of a fourth trimester has become part of a broader life-course approach. Today’s practice has been shaped not only by experience and evidence, but also by litigation, media influence, and technological progress. The continued rise of social media and technology will undoubtedly mold how we care for obstetric patients in the years ahead.

GUEST LECTURES

Day 01

PLENARY LECTURE 01

The influence of adenomyosis on fertility and pregnancy: Effective management strategies

Prof Yutaka Osuga (Past President JSOG 2024, Professor Emeritus, The University of Tokyo, Director and Professor, Teikyo Academic Research Center, Teikyo University, Specially Appointed Professor of Obstetrics and Gynecology, Teikyo University Hospital.

Adenomyosis is increasingly recognized as an important reproductive disorder, particularly among women seeking assisted reproductive technology (ART). Its effects on fertility and pregnancy are multifactorial and appear to depend on the severity, location, and phenotype of the disease, as well as the reproductive treatment employed.

Adenomyosis may impair fertility through alterations in endometrial receptivity, anatomical distortion, mechanical effects of adenomyotic lesions, abnormal uterine contractility, and inflammatory and

biochemical factors. Clinical evidence indicates an overall reduction in pregnancy rates in women with adenomyosis; however, the magnitude of this effect varies according to controlled ovarian stimulation protocols, fresh versus frozen embryo transfer, the presence of symptoms, and the severity and localization of adenomyotic lesions. Appropriate ART strategies, including frozen embryo transfer after medical suppression of adenomyosis, may improve reproductive outcomes in selected patients.

Adenomyosis also adversely affects pregnancy outcomes and is associated with increased risks of miscarriage, preterm birth and preterm premature rupture of membranes, preeclampsia, abnormal placentation, and fetal growth restriction. These risks also differ according to the extent and type of adenomyosis. Conversely, pregnancy itself may suppress the progression of adenomyosis, illustrating a complex bidirectional relationship between adenomyosis and pregnancy.

For patients with severe adenomyosis and refractory infertility, adenomyomectomy may improve fertility and some obstetric outcomes. However, subsequent pregnancy carries important risks, including uterine rupture and placenta accreta spectrum. Therefore, surgical intervention should be considered selectively, balancing potential reproductive benefits against maternal and obstetric risks.

Optimal management of adenomyosis requires individualized strategies based on disease characteristics, reproductive history, and the planned fertility treatment.

PLENARY LECTURE 02

It's time to change lenses – pre-eclampsia, the fourth trimester and beyond

Prof Sir Sabaratnam Arulkumaran – Professor Emeritus of O&G, St George's University of London; Foundation Professor of O&G, University of Nicosia, Past President of FIGO, BMA and RCOG (UK); Knight Bachelor (2009), National Active Citizen Award, Cyprus (2019), and National Ranjana Award, Sri Lanka (2019).

As obstetricians we need to consider our role as guardians of women's and their babies' health on the long run and not just during pregnancy and childbirth. Up to now we have considered our job done once the puerperium is over, with little thought about the preventative health of the mother beyond routine breast and cervical cancer screening. Women with GDM or PE are seldom followed up unless they continue to exhibit impaired glucose tolerance or raised BP. Up to 40% of women with GDM subsequently go on to develop frank diabetes within 10 years as well as having significantly higher risk of CVD. The same fate awaits their babies as they grow up with a four-fold increase in the risk of DM and the metabolic syndrome. Women with pre-eclampsia (PE) or growth-restricted (IUGR) babies are rarely considered to be at special risk until their next pregnancy. But women complicated by pre-eclampsia and IUGR are at increased risk of developing chronic hypertension, diabetes mellitus, ischemic heart disease, cerebrovascular disease, kidney disease, thromboembolism, hypothyroidism, and even impaired memory. Maternal hypertensive disorders during pregnancy also predispose the baby to subsequent impaired cognitive development and adiposity. Hence, we should take an active health screening stance as well as develop systematic follow-up and referral strategies. Pregnancy, with its dramatic hormonal and haemodynamic upheavals, could be viewed as Nature's stress test (because of pumping additional 50% of blood volume) for women and we should be vigilant in following up the abnormalities it reveals. In countries where healthcare systems permit, it is time for obstetricians to view their roles with a different set of lenses. We should not see ourselves as doctors of women who need our intervention but as facilitators of natural physiology, knowing when to step in before things go wrong. We should not miss the opportunity to promote the subsequent health of women and their babies. Occurrence of obstetric complications are signals for future CVD. Globally the main cause of premature deaths in women is CVD and this can be reduced if we undertake the following steps.

Check BP prenatally and control in addition to weight optimization.

Screening for possibility of pre-eclampsia and prophylactic aspirin to reduce Preterm – PE.

Treatment of BP in pregnancy to reduce cardiac stress.

Monitoring mother and fetus for optimal time of delivery – to prevent prolonged stress to the heart.

The 4th trimester monitoring of BP and treatment in addition to giving lifestyle advice – diet, rest, exercise, avoid excess coffee and alcohol.

Long term follow up to detect HT early and treat.

The acquisition of any new lenses will cause some discomfort initially but is essential if our vision is to remain clear and steer us in the right direction.

Day 02

PLENARY LECTURE 03

Collaboration and Partnership: the role of AOFOG

Dr. John Tait (President AOFOG) – Chair, Perinatal and maternal Mortality Review Committee (2017-2024). Chair, National Maternity monitoring Group (2016-2018). Vice President RANZCOG (2014-2021). Chief Medical Officer, Capital and Coast District Health Board Wellington NZ (2016-2022). Obstetrician and Gynaecologist, Wellington New Zealand (1986-2025).

PLENARY LECTURE 04

Paper to Pixels: Revolutionizing Intrapartum Care with the Electronic LCG

Dr Kusum Thapa – President of the South Asian Federation of Obstetrics & Gynaecology

Background

For over four decades, the paper-based partograph served as the global standard for intrapartum monitoring to prevent prolonged and obstructed labor. Rooted in Friedman's labor curve and Philpott's alert lines, its core assumption—that all women progress at an identical rate—proved flawed, resulting in persistently low completion rates across low-resource settings. To address these deficiencies, the World Health Organization (WHO) initiated the Better Outcomes in Labour Difficulty (BOLD) project, culminating in the 2020 WHO Labour Care Guide (LCG). Developed through expert consultations and multicountry usability studies, the LCG shifts intrapartum care from rigid clinical thresholds toward respectful, evidence-based, and woman-centered care that embeds shared decision-making and continuous labor companionship into routine practice.

Clinical Evidence and Need for Digitalization

Empirical evaluation underscores the LCG's transformative impact. A pragmatic, stepped-wedge, cluster-randomized trial across four public hospitals in India demonstrated a 5.5% absolute reduction in caesarean sections among nulliparous women in spontaneous labor (39.7% vs. 45.2%), alongside a meaningful decrease in oxytocin augmentation. Clinicians in Sri Lanka have argued the traditional WHO partogram failed to show meaningful clinical benefit, making the LCG a timely alternative — provided it is implemented in a form that actually gets used at the bedside. However, paper-based delivery inherits systemic weaknesses; primary care studies in Bangladesh revealed routine partograph utilization rates ranging from a sparse 1.4% to 33.0%. Digitization resolves these completion gaps by introducing structured interval prompts, standardized documentation, and point-of-care decision support.

Way Forward

Transitioning from paper to digital platforms provides the operational mechanism for consistent clinical practice, but technological deployment alone is insufficient. Sustainable scaling requires deliberate change management, including peer-led cascade training, usability-informed error-correction tools, and routine institutional data reviews embedded into facility culture. Looking ahead, digital LCG infrastructure lays the groundwork for AI-enabled intrapartum tools capable of pattern recognition across fetal heart rate and contraction dynamics to deliver context-calibrated early warnings. Ultimately, digitization paired with robust implementation strategies transforms routine intrapartum monitoring into responsive, dignified maternity care.

ABSTRACTS OF SESSIONS

Day 01

RANZCOG SESSION

The Rising Tide of Birth Trauma: An Obstetrician's Challenge

A/Prof Thangeswaran Rudra – Director at Redcliffe Hospital in Queensland, Australia. Specialty Lead / Deputy Head of Mayne Academy of Obs & Gynae at the University of Queensland, Specialist International Graduates Chair at RANZCOG.

Approximately one-third of mothers are reported to experience birth trauma during childbirth. The incidence is rising globally, and Sri Lanka is no exception. The definition of birth trauma has broadened in recent decades to include the psychological effects on the woman and her family. These physical and psychological injuries have economic consequences for families and the country. Obstetric violence, a subset of birth trauma, is a relatively new phenomenon, with women initiating legal and criminal actions against obstetricians and midwives for allegedly providing standard obstetric care during labour. We address mitigation strategies for healthcare providers involved in maternity care during labour. These measures aim to reduce harm to women and families while safeguarding clinicians and institutions in resource-limited settings such as Sri Lanka.

Building Excellence in Endometriosis Management Through Multidisciplinary Collaboration and RANZCOG Training Initiatives

A/Prof Hasthika Ellepola – Acting Director of Gynaecology and Senior Staff Specialist at Logan Hospital. Associate Professor and Academic Lead at the University of Griffith Medical School. Former President of the Brisbane Medical Association. Clinical Lead of the Perineal Clinic at Logan Hospital.

Endometriosis affects approximately one in seven women and people assigned female at birth and remains a major cause of chronic pelvic pain, infertility, and reduced quality of life. Despite increasing awareness, delays in diagnosis and fragmented care continue to challenge patients and healthcare providers. Recent RANZCOG guidance emphasises early recognition, patient-centred care, and evidence-based management tailored to individual symptoms, fertility goals, and disease severity. This presentation explores how multidisciplinary collaboration can transform endometriosis care by

integrating gynaecologists, pain specialists, colorectal and urological surgeons, fertility experts, physiotherapists, psychologists, specialist nurses, and primary care clinicians into a coordinated model of care. It also highlights the role of RANZCOG and AGES training frameworks in developing progressive surgical competency and ensuring safe management of increasingly complex disease. By embedding multidisciplinary practice within structured training pathways, healthcare services can improve diagnostic timeliness, optimise clinical outcomes, enhance patient experience, and build sustainable expertise for the future of endometriosis care.

Embryo Freezing: Ethical Principles and Contemporary Clinical Practice

Dr Dulanthi Tudawe – Staff Specialist in Obstetrics & Gynaecology at Logan Hospital, Queensland, Gynaecologist & Fertility Specialist at City Fertility. Associate Lecturer at The University of Queensland

Oocyte cryopreservation is an established component of contemporary assisted reproductive technology. It enables fertility preservation before gonadotoxic treatment and offers women an opportunity to preserve reproductive potential when childbearing is delayed. Elective oocyte freezing may be considered in the context of advancing reproductive age, reduced ovarian reserve, the absence of a suitable partner, or concerns about future reproductive regret.

Female fertility declines with age because of progressive reductions in both oocyte quantity and quality, with the decline becoming more clinically significant after 35 years. Cryopreservation at an older age is associated with lower oocyte yield, higher rates of aneuploidy and miscarriage, and reduced live-birth potential. Conversely, freezing at a younger age may result in stored oocytes never being used, despite the financial costs and procedural burden of ovarian stimulation and retrieval.

Approximately 10% of individuals return to use their cryopreserved oocytes, although reported utilisation rates range from 3% to 38%. Around 85–90% of vitrified oocytes survive warming, and a single stimulation cycle may yield approximately 8–12 oocytes. For women younger than 35 years, freezing 10 mature oocytes has been estimated to provide an approximately 70% chance of at least one live birth, increasing to approximately 90% with 20 oocytes. These estimates are age dependent and should not be interpreted as guarantees.

Contemporary practice requires individualised counselling about age, ovarian reserve, anticipated oocyte yield, the possible need for multiple stimulation cycles, procedural risks, storage costs, and realistic live-birth expectations. When cryopreserved oocytes are used, they are warmed and fertilised with partner or donor sperm through in vitro fertilisation, typically using intracytoplasmic sperm injection.

Ethical practice is founded on informed decision-making, realistic counselling, equitable access, and the avoidance of misleading expectations. Women should understand that oocyte freezing preserves a reproductive opportunity rather than guaranteeing a future pregnancy. Counselling should also address the emotional, cultural, and financial implications of long-term storage and potential non-use.

Addressing gaps in women's health requires collaboration among patients, gynaecologists, fertility specialists, oncologists, embryologists, counsellors, and researchers. Public education can improve awareness of age-related fertility decline; professional training can strengthen counselling; and ongoing research can refine success estimates and support safe, equitable, evidence-based oocyte cryopreservation.

UNICEF SESSION

“Beyond Pills and Procedures: Lifestyle Medicine in Women's Health”

Nourishing Two Generations: Lifestyle Medicine in Pregnancy

Dr Arunie Malwatta – Consultant Clinical Nutrition Physician, National Hospital for Respiratory Diseases, Welisara; President, Sri Lankan Society of Lifestyle Medicine; Visiting Faculty, Sabaragamuwa University, PGIM and University of Colombo. Clinical Nutrition fellowships in the USA.

Pregnancy is a critical period during which maternal health and lifestyle profoundly influence both pregnancy outcomes and the long-term health of the offspring. The Developmental Origins of Health and Disease (DOHaD) paradigm demonstrates that the intrauterine environment shapes fetal development through metabolic, hormonal, inflammatory, and epigenetic mechanisms, with lasting effects on susceptibility to obesity, type 2 diabetes, cardiovascular disease, and other non-communicable diseases.

Lifestyle Medicine offers an evidence-based approach to optimizing maternal and fetal health through six core pillars: whole-food, predominantly plant-based nutrition, regular physical activity, restorative sleep, stress management, avoidance of harmful substances, and positive social connections. Clinical evidence indicates that these interventions reduce the risk of gestational diabetes mellitus, hypertensive disorders of pregnancy, excessive gestational weight gain, preterm birth, and perinatal complications while improving maternal mental health and quality of life.

This presentation will review the biological mechanisms linking maternal lifestyle to fetal programming, including placental function, maternal microbiome, inflammation, and epigenetic regulation. It will also examine current evidence supporting Lifestyle Medicine interventions during pregnancy and discuss practical strategies for integrating these principles into routine antenatal care. By promoting healthy behaviours during this pivotal life stage, Lifestyle Medicine has the potential to improve maternal outcomes while fostering lifelong health in the next generation, making pregnancy a powerful opportunity for intergenerational disease prevention.

Prescription: Exercise—The Most Underused Therapy in Obstetrics and Gynecology

Dr. S. Lakmindi Gunatilake – Consultant Physician in Sports & Exercise Medicine at the National Hospital of Sri Lanka, Colombo, Team Physician to the Sri Lanka Women's National Cricket Team, Honorary Consultant Physician at Sri Lanka Air Force Hospital and Sri Lanka Cricket Medical Board.

Introduction

Inactivity during pregnancy remains common despite evidence that physical activity promotes maternal health and reduces pregnancy comorbidities. The 2015 American College of Obstetricians and Gynecologists (ACOG) recommendations emphasize that exercise during uncomplicated pregnancy carries minimal risk and should be encouraged. Pregnancy is a window for lifestyle modification because women have contact with healthcare services.

Objective

To highlight principles of exercise prescription during pregnancy and advocate incorporation of exercise into obstetric care.

Discussion

ACOG recommends that women with uncomplicated pregnancies participate in aerobic and strength-conditioning exercise before, during and after pregnancy. Previously sedentary women may

initiate exercise during pregnancy, while active women can continue moderate- to high-intensity activity in the absence of contraindications. Exercise promotes fitness, assists weight management, improves psychological wellbeing, and may reduce risks of gestational diabetes mellitus and preeclampsia. Pregnancy-related physiological adaptations, including increased cardiopulmonary demands, altered biomechanics and ligamentous laxity, necessitate modification rather than avoidance of exercise. Prescription should follow frequency, intensity, time and type (FITT) principles, with perceived exertion or the talk test providing methods for monitoring intensity. Walking, swimming, stationary cycling, low-impact aerobics, selected yoga/Pilates and appropriately modified resistance training are considered safe. Clinical assessment is essential to identify contraindications. Women should be counselled regarding warning symptoms requiring cessation of exercise and medical review, while activities associated with trauma or falls should be avoided. This approach extends into the postpartum period, with gradual resumption according to medical advice.

Conclusion

Exercise should no longer be regarded as optional lifestyle advice in obstetrics and gynaecology. For most women with uncomplicated pregnancies, it is a safe, evidence-supported therapeutic intervention with benefits extending from pregnancy into long-term maternal and offspring health. Obstetricians and gynaecologists are well positioned to ask, advise, assess, assist and arrange exercise as part of antenatal care.

Keywords

Exercise Prescription, Pregnancy, FITT principles, Aerobic Exercise, Resistance Exercise

Beyond Iron-folate: Charting Sri Lanka's programmatic pathway to Maternal Multiple Micronutrient Supplement

Dr. Sanjeeva Godakandage – Consultant Community Physician at the Family Health Bureau, Ministry of Health, Sri Lanka.

Background

Despite a robust public health system, persistent mild-to-moderate anaemia and stagnant low birth weight rates highlight the limitations of traditional iron-folic acid (IFA) supplementation, which only addresses single deficiencies.

Program Objectives

To transition Sri Lanka's National Maternal Care Programme from IFA to Multiple Micronutrient Supplementation (MMS)—delivering 15 essential vitamins and minerals—following approvals by the Technical Advisory Committee on Maternal Health and Family Planning and National Committee on Family Health.

Implementation Methods

Initially supported by UNICEF and Kirk Humanitarian International. The rollout involves four pillars: strengthening supply chains, training healthcare workers, driving community awareness against myths and close monitoring. This was a major focus of the National Nutrition Month activities 2026 also.

Conclusions

This programmatic shift establishes a valuable model for sustainable maternal nutrition interventions in low- and middle-income countries.

Multiple Micronutrient Supplements for pregnant women in Sri Lanka: Implementation insights

Dr. Chithranganie Perera – Public Health Specialist, Head of the Research Unit, Family Health Bureau.

The MMS combines iron and folic acid with additional vitamins and minerals in one daily supplement. The commonly studied UNIMMAP formulation contains 15 micronutrients, including 30 mg iron and 0.4 mg folic acid. The rationale is broader than prevention of iron-deficiency anaemia: pregnancy increases requirements for several micronutrients, and deficiencies can affect maternal health, fetal growth and birth outcomes; prematurity, still births, small for gestational age, low birth weight...etc. The key point is that Sri Lanka began island-wide provision of MMS to pregnant mothers from April 2024 as a single tablet per day by substituting iron, folate, and Vitamin C. The stocks of MMS come either in a bottle of 180 tablets or 30 tablets in blister packs. It has to be issued to pregnant women at the beginning of the second trimester for a period of 6 months till the delivery takes place. During the outcome assessment survey initiated in 2025, more than one year after MMS implementation, the assessment mainly focused on coverage, adherence, and supply chain-related issues. Based on the findings, favourable recommendations were drawn to support the smooth and effective functioning of this cost-effective intervention.

RCOG Session

Anticholinergic Burden in the Management of Overactive Bladder

Dr. Sujeewa Fernando – Vice President for Workforce, Royal College of Obstetricians and Gynaecologists, Consultant Urogynaecologist. Clinical Director, Obstetrics & Gynaecology, Wrexham Maelor Hospital. Urogynaecology Preceptor for Wales.

Overactive bladder (OAB) is a common and increasingly prevalent condition characterised by urinary urgency, usually accompanied by frequency and nocturia, with or without urgency urinary incontinence. Although not life-threatening, OAB can have a profound impact on quality of life, affecting sleep, psychological wellbeing, social interaction, relationships and the ability to work. Effective management begins with a structured clinical assessment to establish the diagnosis, identify reversible or contributing factors, exclude red-flag pathology and understand the individual patient's symptom burden and treatment goals. Bladder diaries, appropriate examination and targeted investigations support this assessment. Lifestyle modification and conservative interventions – including optimisation of fluid and caffeine intake, weight management, bladder training and pelvic floor muscle training – remain fundamental first-line approaches. Pharmacological treatment should be individualised, with particular attention to anticholinergic burden (ACB). Many commonly prescribed and over-the-counter medicines possess anticholinergic activity, and cumulative exposure is particularly relevant in older people and those with polypharmacy. Increasing evidence links long-term exposure to strong anticholinergic medicines with cognitive impairment and an increased risk of dementia. Medication review and assessment of total anticholinergic burden should therefore form an integral part of OAB management. Beta-3 adrenoceptor agonists, including mirabegron, provide an effective non-anticholinergic therapeutic option for appropriate patients, while recognising the need for appropriate blood-pressure monitoring and consideration of contraindications. A contemporary OAB pathway should therefore move beyond simply treating bladder symptoms. Personalised assessment, conservative therapy, minimisation of avoidable anticholinergic exposure, shared decision-making and regular treatment review are central to achieving safe, sustainable and patient-centred outcomes.

Advancing Minimally Invasive Gynaecology with Robotics

Dr. Kingsley Mahendra – Substantive NHS Consultant Obstetrician & Gynaecologist at Barking, Havering and Redbridge University Hospitals NHS Trust (Queen's Hospital).

Advanced gynaecological surgery often involves the management of complex pathology that traditionally required open surgery. This presentation will explore how robotic-assisted surgery has expanded the scope of minimally invasive gynaecology, enabling increasingly complex procedures to be performed through small incisions while achieving improved precision and surgical control. The benefits include reduced postoperative pain, shorter hospital stay, faster recovery, and excellent long-term patient outcomes. The presentation will also discuss how enhanced surgeon ergonomics may prolong surgical careers, allowing experienced surgeons to continue delivering high-quality care for longer. As robotic surgery continues to evolve in Sri Lanka, this session aims to highlight its potential to improve patient care and support the future development of advanced minimally invasive gynaecological surgery.

Childbirth and Pelvic Floor Dysfunction

Dr Ruwan Fernando – Consultant Obstetrician and a Urogynaecology Subspecialist at Imperial College Healthcare NHS Trust, St Mary's Hospital, London, the co-director of the Urogynaecology Subspecialty Training Programme at St Mary's Hospital, London. Honorary Senior Lecturer at the Imperial College, London.

Over the past century, worldwide maternal mortality has come down considerably. However, significant maternal morbidity associated with childbirth remains a cause for concern. Immediate complications following vaginal birth such as perineal trauma, wound infection and pain affect bonding, breastfeeding as well as maternal mental wellbeing. The long-term impact of pelvic floor dysfunction (PFD) following childbirth leads to pelvic organ prolapse, urinary incontinence, and faecal incontinence. About one third of women over the age of sixty have been complaining of more than one pelvic floor disorder. In addition, there has been an increase in litigation following childbirth and pelvic floor trauma. There are human evolutionary changes towards bipedalism, where the human pelvis has reduced in size compared to the fetal head. Childbirth in an evolutionarily compromised pelvis added by other factors such as anatomical and physiological changes in pregnancy, inherent weakness of connective tissues and menopause leads in to PFD in later life. During vaginal birth, there is direct muscle and connective tissue trauma as well as nerve injury. All these factors have an adverse effect on the pelvic floor, leading to the subsequent development of pelvic organ prolapse, urinary incontinence, and faecal incontinence. Studies have shown that the first vaginal birth is associated with a significant pelvic floor muscle trauma, with a cumulative effect with subsequent vaginal births. This effect is further worsened with prolonged labour, instrumental deliveries, and large babies. Having a pre-labour elective caesarean section has been considered as the optimal approach to prevent PFD following childbirth. However, caesarean section itself has its own complications as well as cost implications. There is limited evidence to guide the clinicians to prevent PFD following childbirth. Each woman should be individually assessed with existing symptoms and risk factors for pelvic floor dysfunction, and counselled regarding worsening of existing pelvic floor dysfunction with vaginal birth, and also counselled regarding the risks and complications of caesarean section and vaginal birth. Finally, the woman should be able to make an informed decision about the mode of delivery.

WHO Session

“Labour care: bringing new concepts to the current practice”

Labour progress: Partogram to decision making

Prof M R M Rishard – Professor in Obstetrics and Gynaecology at the Faculty of Medicine, University of Colombo, and Consultant at De Soysa Hospital for Women.

For nearly five decades, labour has been monitored against the partograph's fixed rule of 1 cm/hour cervical dilatation, with alert and action lines derived from Friedman's observations and operationalised by Philpott and Castle in 1972, then endorsed globally following the 1994 WHO multicentre trial. Despite widespread adoption, accumulating evidence from large prospective cohorts and systematic reviews has demonstrated substantial individual variation in normal labour progression, poor predictive accuracy of the alert and action lines for adverse outcomes, and real-world completion rates as low as a few per cent. In response, the 2018 WHO intrapartum care recommendations redefined the onset of the active first stage at 5 cm and revised the minimum normal dilatation rate to 0.5 cm/hour, placing the woman's experience of care at the centre of labour management. The new WHO Labour Care Guide (LCG), introduced in 2020, is a one-page, next-generation partograph with evidence-based time thresholds for each centimetre of dilatation from 5 to 9 cm, a dedicated section for the second stage of labour, and combined recording of supportive care and maternal and fetal wellbeing indicators within a single continuous record. One of the key features of the LCG is its assess-record-check-plan framework, in which any deviation from threshold requires a documented clinical assessment, an individualised plan of management, and decision-making together with the woman. Emerging evidence supports the benefits of LCG implementation. A pragmatic stepped-wedge cluster-randomised trial of 26,331 women in India demonstrated a 5.5% reduction in caesarean section and an 18% reduction in labour augmentation. An ambispective cohort study in southwestern Uganda revealed significantly better recognition of prolonged and obstructed labour along with a higher monitoring tool completion rate. A systematic review and meta-analysis of three randomised trials with 25,171 women revealed lower caesarean section rates (OR 0.82) and oxytocin augmentation without higher postpartum haemorrhage, perineal trauma, or neonatal intensive care unit admission. Comparative studies revealed a shorter active first stage and second stage of labour in the LCG group compared to the modified partograph. The FIGO position statement for 2025 recommended universal use of the LCG over the partograph to improve maternal and perinatal mortality. Successful introduction of the LCG requires proper training, sufficient staffing, facility readiness, and regular audit and quality improvement. Implementing the LCG in Sri Lankan labour wards is a chance to shift from a passive partograph to an active, individualised, evidence-based approach centred on the woman in labour.

Beyond Hypoxia: Decoding the Neuro-Inflammatory Signature of the Vulnerable Fetus

Dr. Buddika Asela Amarasekera – Consultant Obstetrician and Gynaecologist currently practicing at Base Hospital, Thambuttegama.

Background

Traditional labor care frameworks overwhelmingly focus on recognizing hypoxic-ischemic fetal injury. However, intra-amniotic infection and the resulting Fetal Inflammatory Response Syndrome (FIRS) represent a critical, parallel pathway to neurological impairment that standard clinical guidelines often overlook until late-stage maternal signs manifest. Bringing new physiological concepts to current intrapartum practice is essential to protect the vulnerable fetus from non-hypoxic sources of brain injury.

Physiological Insights & Signal Decoding

Intrapartum infection triggers a systemic cytokine response that compromises the immature fetal blood-brain barrier, inducing direct neuroinflammation and myocardial depression. When combined with the mechanical and hypoxic stresses of labor, this inflammatory cascade creates a synergistic threat that drastically lowers the fetal threshold for cerebral palsy and multi-organ damage. Modern labor care must evolve beyond static heart rate thresholds by decoding the subtle CTG signature of Systemic Onset of Fetal Inflammation (SOFI). Early indicators—such as an unprovoked >10% baseline increase, loss of sleep-wake cycling, myometrial irritability, and autonomic instability (ZigZag and sinusoidal patterns)—provide a crucial diagnostic window before overt maternal pyrexia or terminal decompensation occurs.

Translational Practice & Management

Integrating these neuro-inflammatory concepts into routine practice enables proactive management. Suspicion of early fetal inflammation warrants immediate intrapartum broad-spectrum intravenous antimicrobial therapy to achieve rapid placental transfer, alongside expedited delivery decisions tailored to the compromised fetus's reduced physiological reserve.

Conclusion

Expanding intrapartum monitoring "beyond hypoxia" to decode neuro-inflammatory signatures transforms reactive labor care into proactive fetal protection, offering a modern clinical strategy to prevent devastating long-term neurological sequelae.

Respectful maternity care in Sri Lanka : A mixed method analysis from 21475 data points

Prof D.M.C.S. Jayasundara – Professor and Head of Department, Department of Obstetrics and Gynaecology Faculty of Medicine University of Colombo. Honorary Consultant Obstetrician and Gynaecologist, De Soysa Hospital for Women and National Hospital of a Sri Lanka. Secretary of the BOS in Obstetrics and Gynaecology, PGIM.

Background

Sri Lanka has achieved near-universal institutional childbirth and high coverage of skilled birth attendance, with strong maternal and neonatal outcomes. However, clinical indicators do not capture whether childbirth is experienced as safe, dignified and respectful. Patient-reported experience has not been systematically integrated into maternity quality assessment. This study addresses that gap by examining respectful maternity care across Sri Lankan health facilities.

Objective:

To generate a comprehensive evidence base on respectful maternity care; quantify key indicators across sentinel facilities; identify gaps in consent, communication, companionship and protection from mistreatment; and triangulate women's experiences with provider reports and medical records to inform evidence-based improvements.

Methods

A multisource mixed-methods analysis was undertaken across 15 sentinel health facilities in Sri Lanka. Data were synthesised from a retrospective review of 14,681 medical records, a prospective predischARGE survey of 5,799 women, and a cross-sectional survey of 865 maternity-care providers. Audio computer-assisted self-interviewing was used for the women's survey to reduce literacy barriers, enhance privacy and minimise social-desirability bias. Findings were triangulated across sources to identify system-level gaps. The multisource approach demonstrates the value of combining clinical

documentation with women's and providers' reports to reveal discrepancies that routine outcome surveillance may overlook.

Results

Among women, 90% reported feeling respected, 94% reported adequate privacy and 96% were satisfied with their care. Health workers informed 93.9% of women about decisions regarding their care, while 88.5% reported that consent was obtained before procedures or examinations on their baby. Nevertheless, important gaps were identified. Only 18.6% of women who wanted a companion during labour and 26.2% of those who wanted a companion during birth had one. Consent before vaginal examinations remained incomplete, with approximately one in four women not reporting that consent had been sought before vaginal examination. Verbal and physical mistreatment were reported by 8.4% and 3.1% of women, respectively; providers reported witnessing verbal abuse in 13.9% and physical abuse in 5% of cases. Pharmacological pain relief was documented in 89.3% of medical records and reported by 85.6% of women.

Conclusion

Sri Lanka demonstrates strong foundations for respectful maternity care, but substantial, addressable gaps persist in companionship, informed consent and prevention of mistreatment. Respectful care is a core component of quality and a fundamental human right, not an optional addition to safe childbirth. Clear institutional policies, provider training, routine experience measurement and robust accountability mechanisms are needed to make respectful maternity care the standard across all facilities.

Keywords

respectful maternity care; childbirth; maternal experience; informed consent; companionship; Sri Lanka

Family-Oriented Caesarean Delivery (FOCD): A New Approach to Positive Childbirth

Prof Prabhodana Ranaweera – Professor of Obstetrics & Gynaecology, University of Colombo, and Honorary Consultant Obstetrician & Gynaecologist at De Soysa Hospital for Women and National Hospital of Sri Lanka.

With increasing Caesarean section rates worldwide, a growing proportion of women experience childbirth within an operating theatre. While maternal and neonatal safety remain paramount, the emotional experience of childbirth and active involvement of both parents may receive less attention during operative delivery. A Caesarean birth should not preclude a positive, memorable and family-centred childbirth experience.

Family-Oriented Caesarean Delivery (FOCD) is a novel approach developed to transform Caesarean birth from a predominantly surgical event into a positive experience shared by the mother, father and baby, while maintaining established principles of maternal and neonatal safety.

FOCD incorporates a series of modifications to conventional Caesarean delivery. The operating theatre is prepared to facilitate parental participation; maternal hand dominance and monitoring arrangements are considered, and both the mother and father are encouraged to actively participate in receiving and welcoming their baby at birth. At the appropriate stage of delivery, the screen is lowered, allowing the parents to witness and participate in the birth. Immediate parent–baby interaction, skin-to-skin contact, delayed cord clamping and further involvement of the father, including the opportunity to cut the umbilical cord, are incorporated where appropriate. Early mobilisation and recovery are also encouraged.

The presentation will demonstrate the FOCD technique through a step-by-step operative video, highlighting the practical modifications and safety considerations involved.

Clinical experience with FOCD to date has been encouraging. Most parents report a highly positive and memorable childbirth experience, with mothers and fathers appreciating the opportunity to become active participants in receiving their baby. Maternal, neonatal and partner-related complications observed to date have been minimal. A structured evaluation of parental experience, acceptability and short-term maternal and neonatal outcomes is being undertaken to further assess the approach.

FOCD represents a change in perspective: a Caesarean section need not be experienced merely as an operation. It can remain childbirth—a positive experience in which a mother and father actively receive and welcome their baby into the world.

FIGO SESSION

Climate change – “Heat” of the matter

Prof Krishnendu Gupta – Deputy Secretary General AOFOG, Chair, FIGO Committee on Climate Change and Toxic Environmental Exposures, 2025 – 2027. Chair, AOFOG Climate Change and Environmental Pollution Working Group, 2022 – 2026.

Gamete donation – Sowing Ethical Seeds

Dr Suchitra N. Pandit – Senior Consultant OBGYN at Surya Hospitals and former Head of Dept. at Kokilaben Dhirubhai Ambani Hospital, Mumbai.

Gamete donation has become a crucial part of Assisted Reproductive Technologies (ARTs), providing hope to individuals, including those who may have no other option for parenthood. This process comes with a wide range of ethical, medical, and legal challenges that need to be carefully addressed to protect the well-being and rights of all parties involved: donors, recipients, and offspring. Navigating these complexities requires strict ethical standards, robust regulatory frameworks, and international collaboration.

By standardizing these, the field of gamete donation can continue to develop while ensuring that all parties are well informed and safeguarded. This presentation explores the ethical concerns and core principles surrounding gamete donation, offering recommendations to ensure safe, equitable, and ethically responsible practices that protect and support all parties involved. Gamete donation raises deep ethical, legal, and social questions around bodily autonomy, family definitions, and the commercialization of reproductive cells.

Core Ethical Dilemmas

- **Anonymity and Identity:** Direct-to-consumer genetic testing makes traditional donor anonymity hard to maintain. Donor-conceived children increasingly demand the right to know their genetic heritage.
- **Body Commodification:** Paying donors creates a commercial market for human cells. This raises concerns about exploiting vulnerable financial groups and treating biological material as a mere commodity.

- **Informed Consent:** processes for both donors and recipients, ensuring transparency and autonomy in all decisions
- **Genetic Screening:** Rigorous testing protects recipients and offspring from hereditary diseases. However, excessive screening can create psychological burdens or lead to discriminatory selection practices.

FIGO strongly advocates for a globally standardized approach to gamete donation that prioritizes ethical, legal, and medical considerations. It emphasizes the importance of ensuring equitable access to gamete donation services, minimizing disparities based on economic, social, and cultural factors. FIGO calls for a rigorous adherence to informed consent processes for both donors and recipients, ensuring transparency and autonomy in all decisions. The safety and quality of gamete donation procedures must be upheld through strict donor screening, quality control measures, and appropriate medical supervision. There are growing challenges around confidentiality and anonymity, particularly with the rise of genetic databases, and advocate for the protection of privacy while balancing the rights of all parties involved. Acknowledging cultural and religious diversity is crucial in guiding respectful practices in gamete donation. A continued long - term follow - up of both donors and recipients to address medical, psychological, and obstetric risks, ensuring the ongoing health and well-being of all stakeholders. Through this position, FIGO aims to provide a comprehensive, ethically sound framework that supports safe and equitable gamete donation practices worldwide.

Between Duty and Danger – Violence against HCP in South Asia

Dr Rubina Sohail – Professor of Obstetrics & Gynaecology & Consultant, Hameed Latif Hospital, Lahore. Chair - FIGO Committee on Violence against Women. Past President, South Asian Federation of Obstetrics & Gynaecology). Vice President, Menopause Society of Pakistan.

Day 02

AOFOG SESSION by SRH Committee

Emergency contraception: looking into the future

Dr. Raymond Hang Wun Li – Specialist in Obstetrics and Gynaecology, and Subspecialist in Reproductive Medicine, Clinical Associate Professor at the Department of Obstetrics and Gynaecology, The University of Hong Kong, Honorary Consultant at Queen Mary Hospital and Kwong Wah Hospital, Hong Kong, Honorary Specialist at the Family Planning Association of Hong Kong.

Emergency contraception (EC) is a useful back-up method in cases of failure or omission of one's regular contraception to reduce the likelihood of unplanned pregnancies. The Yuzpe regimen, consisting of high doses of oestrogen and progestogen, was the first evidence-based EC regimen introduced in the 1970s and has significant side effects, notably nausea and vomiting. The regimen containing levonorgestrel (LNG) only was first reported in 1993 to have significantly lower side effect profile, and subsequent studies in the 1990s confirmed its better efficacy, making it the most popular EC method worldwide. In the mean time, mifepristone was studied as an EC in the 1990s, and its efficacy is higher than LNG at both low- (less than 25mg) and mid-doses (25-50mg). Its availability at these doses for EC, however, is only limited to a few countries. Since the early 2010s, ulipristal acetate (UPA) has emerged as a newer EC option with superior efficacy and extended action up to five days after unprotected sexual intercourse. Both LNG and UPA, however, still have a failure rate of about 1-3%. They mainly act by inhibiting or

postponing ovulation, and have little effects when administered post-ovulation. Continual efforts have been made to explore more effective EC methods. Theoretically, an EC method with post-ovulatory in addition to pre-ovulatory actions should offer better overall efficacy. Cyclooxygenase (COX) inhibitors have been explored as a useful adjunct in this regard. COX inhibitors reduce the production of prostaglandins which mediate a number of reproductive processes like ovulation, fertilisation and embryo implantation. Studies in animals and human have suggested that some COX inhibitors (such as meloxicam and celecoxib), either used alone or in synergy with LNG or UPA, could contribute to inhibition of ovulation. The first randomised, placebo-controlled trial on the use of piroxicam, a long-acting COX inhibitor, in combination with the LNG-EC pill, was published in 2023. It showed that LNG-piroxicam combination had significantly lower failure rate (0.2%) than that of LNG alone (1.7%). The percentages of pregnancies that could be prevented by LNG with and without adding piroxicam were 95% and 63% respectively, significantly higher in the former. There was no significant difference in the adverse effect profile. Insertion of a copper-bearing intrauterine contraception device (IUD), on the other hand, serves as an EC with the highest efficacy, and the device can be retained for ongoing long-term contraception. The first randomised controlled trial comparing LNG-IUD with copper IUD for EC was published in 2021, confirming its non-inferiority. Future studies of larger sample size may hopefully provide more robust data to support the use of LNG-IUD for this purpose. There have been growing evidence supporting that if there are recurrent episodes of unprotected intercourse within the same cycle, a repeat dose of LNG or UPA can be used, but the same agent should be used to avoid possible drug interaction. This infers that current EC regimens can be developed as on-demand pericoital contraceptives, particularly for couples with low coital frequency.

WHO Recommendations for the Prevention and Treatment of Maternal Peripartum Infections

Prof Pisake Lumbiganon – Professor of Obstetrics and Gynecology, Senior Research Scholar. Immediate Past President, Asia Oceania Federation of Obstetrics and Gynecology (AFOG). Director, WHO Collaborating Centre for Research Synthesis in Reproductive Health Convenor, Cochrane Thailand. Former President, The Royal Thai College of Obstetricians and Gynaecologists. Former dean, Faculty of Medicine, Khon Kaen University.

Bacterial infections occurring around the time of childbirth are responsible for approximately 10% of maternal deaths worldwide. Beyond causing severe illness and death, women who develop peripartum infections face increased risk of long-term complications, including chronic pelvic pain, fallopian tube obstruction, and secondary infertility. Additionally, maternal infections that occur before or during delivery are linked to an estimated one million newborn deaths each year.

Several factors are associated with an increased risk of maternal peripartum infections. These include pre-existing maternal conditions such as malnutrition, diabetes, obesity, severe anemia, bacterial vaginosis, and group B streptococcus infections. Additional risk factors encompass spontaneous or provider-initiated events during labor and delivery, including prolonged rupture of membranes, multiple vaginal examinations, manual removal of the placenta, and cesarean section. Consequently, strategies to reduce maternal peripartum infections and their associated short- and long-term complications have primarily focused on preventive measures that address these identified risk factors.

Globally, the primary strategy for preventing illness and death from maternal infections is the use of antibiotics for both prophylaxis and treatment. However, the misuse of antibiotics for obstetric conditions and procedures perceived to carry infection risks remains common in clinical practice. This

inappropriate use during childbirth has significant implications for global efforts to contain the emergence of drug-resistant bacterial strains and, consequently, for global public health.

The WHO global strategy for containment of antimicrobial resistance emphasizes the critical need for appropriate antimicrobial use at all levels of the health system. This approach aims to mitigate the impact of resistance while ensuring patients still have access to the best available treatments. Therefore, providing health professionals and policymakers with clear guidance on the necessity and selection of antibiotics for preventing and treating maternal peripartum infections is essential. Such guidance would not only align with the WHO strategy but also ultimately improve health outcomes for both mothers and newborns.

This WHO recommendation aims to consolidate evidence-based guidance for effective interventions needed to reduce the global burden of maternal infections and their complications around the time of childbirth. It forms part of WHO's broader efforts to improve the quality of care for leading causes of maternal death, particularly those occurring during the peripartum period, in the post-MDG era. Specifically, this guideline presents evidence-based recommendations on interventions for preventing and treating genital tract infections during labor, delivery, and the postpartum period, with the goal of improving outcomes for both mothers and newborns.

Evidence-Based Micronutrient Strategies for Midlife Women

Prof Unnop Jaisamrarn – Director of the Women's Health Program, School of Global Health, Chulalongkorn University, Bangkok, and Senior Executive Advisor to its WHO Collaborating Centre.

The menopausal transition represents a critical window in women's health, characterized by hormonal changes accompanied by increasing risks of osteoporosis, sarcopenia, metabolic syndrome, cognitive changes, and other age-related conditions. Adequate micronutrient status is essential for maintaining physiological function and resilience during this transition. However, micronutrient insufficiency may remain clinically unrecognized, particularly when inadequate nutrient intake coexists with adequate or excessive energy intake. This presentation reviews current evidence on micronutrient status and nutritional challenges among midlife women, with particular emphasis on Asian populations. Available evidence indicates substantial variation in micronutrient intake and status across the region, while data specific to midlife women remain limited. Calcium and vitamin D are particularly important for skeletal health, while magnesium, vitamin B12, folate, iron, zinc, and selenium contribute to multiple aspects of metabolic, neuromuscular, cognitive, and overall health. The concept of "hidden hunger" highlights that micronutrient inadequacy may coexist with overweight and obesity. Importantly, micronutrients act through interconnected biological pathways, suggesting that nutrient interactions and overall dietary patterns may be more relevant than isolated supplementation. An evidence-based approach should prioritize dietary diversity and nutritional adequacy, identify women at increased risk of deficiency, correct clinically relevant deficiencies, and avoid unnecessary high-dose supplementation. Micronutrient strategies should complement—not replace—established menopause interventions, including physical activity, weight management, and menopausal hormone therapy when indicated. Midlife provides an important opportunity to optimize nutrition and influence the trajectory of healthy ageing. Moving beyond the prevention of overt deficiency toward individualized optimization of micronutrient status and nutrient synergy may become an increasingly important component of comprehensive menopause care. Further high-quality research, particularly among Asian women, is needed to define effective and clinically meaningful strategies.

SAFOG SESSION

"Hypertensive Disorders in Pregnancy: From Prevention to Precision Care"

Key note speech

Hypertensive Disorders in Pregnancy – key to reducing maternal mortality in South Asia

Prof Sir Sabaratnam Arulkumaran – Professor Emeritus of O&G, St George's University of London; Foundation Professor of O&G, University of Nicosia; Visiting Professor, Imperial College London. Past President of FIGO, BMA and RCOG (UK); Knight Bachelor (2009), National Active Citizen Award, Cyprus (2019), and National Ranjana Award, Sri Lanka (2019).

Preeclampsia and eclampsia are major drivers of maternal mortality in South Asia, accounting for roughly 80,000 annual deaths – 10% to 15% of all maternal fatalities. The heavy burden of these preventable hypertensive disorder related deaths are due to systemic and local barriers i.e. poor maternity eco system. The pre-disposing factors are adolescent pregnancies, inadequate ante-natal, intra-partum and postnatal care on the background of poor socio-economic environment leading to poor nutrition, lack of knowledge related to inadequate education and the three delays i.e. in seeking treatment, transport delays and delay in treatment at the institution. Rural and impoverished women face higher risks due to limited access to emergency obstetric care and trained medical staff. Late diagnosis of high BP and slow progression to treatment often lead to fatal seizures or multi-organ failure (eclampsia and HELLP syndrome). Resource Shortages i.e. Short supply of life-saving medicines like effective antihypertensives and magnesium sulfate for severe preeclampsia adds to the burden of fragmented antenatal tracking and lack of well-equipped local clinics. Of the observed 40% reduction in the global maternal mortality rates, 61.2% were attributed to improvement in maternity care, 38.8% due to reduction in fertility while 24% or 77 400 women's lives were saved due to contraception. Sri Lanka reduced their maternal mortality by expanding midwifery services and improving access to rural and remote areas, which strengthens the importance of midwifery care and universal access to health care of quality. India improved the maternity eco-system by removing the financial and physical barriers. The Government of India (GOI) promoted institutional births that would allow the complications of pregnancy, labour and delivery to be reduced by mothers attending institutions that are well equipped and have adequate staff. The mothers who attend institutional care were given cash vouchers to manage their expenses. The Government made arrangements with the private sector hospitals for them to provide care for those mothers who could not access government hospitals to be treated and their charges to be reimbursed at a previously arranged price – the "Chiranjeevi Yojana programme". They introduced a system where taxis and public transport system were obliged to take a pregnant woman in labour to the hospital and the GOI would reimburse the taxi fare. The Government also introduced quality improvement programs for the Government and private sector care providers supported by the Federation of Obstetricians and Gynaecologists of India (FOGSI) – the Manyatta & LaQshya programmes. The Manyata program is a quality assurance initiative, led by FOGSI, to improve private maternity care, focused on training, mentorship, and certification for small facilities based on WHO standards. It boosts skills in critical areas like haemorrhage, PE and infection control, ensuring safer, more respectful care for mothers through evidence-based standards, leading to significant improvements in provider knowledge and clinical practices. The LaQshya Program ensures respectful maternity care, by standardizing clinical protocols, and improved patient satisfaction. These activities have enabled MMR of over 500 in 2000's to below 80 in 2025. The MMR has been below 30/100,000 e.g. Kerala, Tamil Nadu, Telunganu. The SAFOG country governments have to enhance the health systems by improving the maternity eco system by providing good communication, transport, free institutional services and incentives to attend hospitals if we are to reduce MM due to PE.

Prevention and Risk Assessment

Prof Farhana Dewan – Immediate Past President of OGSB, Secretary General of SAFOG, Chairman of OGSB Hospital & IRCH, and Head of Ob/Gyn at Ibn Sina Medical College.

Early Recognition and Accurate Diagnosis

Prof Jaideep Malhotra – Managing Director, ART Rainbow IVF, Agra; President, INSARG (2025–27); Past Chair, FIGO REI Committee; Regional Director, Ian Donald School of Ultrasound; Professor, Dubrovnik International University, Croatia.

Introduction

Hypertensive disorders of pregnancy (HDP) are among the leading causes of maternal and perinatal morbidity and mortality worldwide. Their clinical spectrum ranges from gestational hypertension to pre-eclampsia, pre-eclampsia with severe features, chronic hypertension with superimposed pre-eclampsia, and eclampsia. Because disease progression can be rapid and clinical manifestations may be subtle, early recognition and accurate diagnosis are critical for preventing maternal and fetal complications.

Objective

To emphasize a structured approach to the early recognition, accurate diagnosis, risk assessment and timely management of hypertensive disorders of pregnancy, with particular focus on identifying women at risk of developing pre-eclampsia before severe disease occurs.

Methods

A systematic approach incorporating accurate blood pressure measurement, clinical assessment, maternal history, risk-factor stratification, urine protein assessment, relevant laboratory investigations and fetal surveillance was reviewed. The role of first-trimester screening, including maternal characteristics, mean arterial pressure, uterine artery Doppler and biochemical markers where available, was considered for early identification of women at increased risk. Diagnostic criteria for gestational hypertension, pre-eclampsia and severe disease were reviewed in accordance with contemporary international recommendations.

Results

Early recognition requires more than identifying an elevated blood pressure reading. Correct BP measurement, confirmation of hypertension, assessment for proteinuria and evaluation for maternal organ dysfunction are fundamental to accurate diagnosis. Women with risk factors such as previous pre-eclampsia, chronic hypertension, diabetes, renal disease, autoimmune disorders, multifetal pregnancy and adverse obstetric history require enhanced surveillance. Importantly, pre-eclampsia may occur without significant proteinuria when other maternal organ dysfunction is present. Platelet count, renal and hepatic function, neurological symptoms, pulmonary status and fetal growth should therefore be incorporated into assessment. Appropriate risk stratification can facilitate preventive interventions and closer monitoring before clinical deterioration occurs.

Conclusion

HDP should be approached as a dynamic, multisystem disorder rather than simply an elevation of blood pressure. Accurate BP measurement, early risk prediction, recognition of atypical presentations, systematic assessment of maternal organ involvement and appropriate fetal surveillance are essential for

timely diagnosis. A structured “Recognize–Confirm–Risk Stratify–Monitor–Act” pathway can help clinicians identify pre-eclampsia earlier, prevent progression to severe disease and improve maternal and perinatal outcomes.

Keywords

Hypertensive disorders of pregnancy; pre-eclampsia; gestational hypertension; early recognition; accurate diagnosis; risk prediction; maternal surveillance; fetal surveillance; uterine artery Doppler; maternal morbidity.

Precision Care: Individualized Management

Dr Rajendraseelan Thuvarathipan – Senior Lecturer in the Department of Obstetrics and Gynaecology, University of Jaffna, Consultant Obstetrician and Gynaecologist at the Teaching Hospital Jaffna.

Hypertensive disorders complicate about one in ten pregnancies and are among the leading causes of maternal and perinatal mortality and morbidity worldwide, with more than 99% of the resulting maternal deaths occurring in under-resourced settings. Many follow not from missed diagnosis but from management that treats a heterogeneous group of conditions as one disease. Two women may share a gestation and a blood pressure yet face wholly different risks; precision care is the discipline of recognising that difference and acting upon it.

This presentation offers a practical framework built on five dimensions: maternal phenotype, gestational age, the maternal condition and its trajectory, the fetal and placental condition, and the resources available. Each is illustrated with current evidence and translated into decisions that can be made at the bedside.

Thresholds are the first point of individualisation. The CHAP trial established that treating mild chronic hypertension to a target below 140/90 mmHg improves outcomes without excess fetal growth restriction, a position now endorsed by SMFM and the 2025 AHA/ACC guideline. The threshold matters more than the agent: Giant PANDA, the first adequately powered head-to-head comparison, found nifedipine and labetalol broadly comparable, so selection should follow comorbidity, tolerability, availability and the woman's preference. Where intravenous access is impractical, oral nifedipine retard, labetalol and methyldopa are each effective for severe hypertension.

Severity is then judged on trajectory rather than on isolated values. ISSHP states that the degree of proteinuria should not determine the timing of birth in pre-eclampsia, and models such as fullPIERS and PIERS-ML stratify short-term maternal risk more reliably than any single result. Maternal and placental severity demand independent assessment, since a woman with modest hypertension and a failing placenta is not at low risk. Angiogenic biomarkers refine probability without replacing judgement: NICE supports PIGF-based testing in suspected preterm pre-eclampsia, and StopPRE shows that safe de-escalation is equally a form of precision.

The timing of birth is the most individualised decision of all. The 2026 Cochrane update found that planned birth from 34 weeks nearly halves serious maternal morbidity and reduces stillbirth without increasing neonatal unit admission; CRADLE-4 confirmed this in India and Zambia. At term, the evidence for planned early birth in gestational or chronic hypertension alone remains inconclusive, leaving genuine room for shared decision-making.

Precision, finally, is not synonymous with expense. Low-dose calcium, universal magnesium sulphate in pre-eclampsia, oral antihypertensive regimens and trajectory-driven referral deliver individualised care where resources are limited. The objective is not more technology, but better discrimination between women who differ.

Improving Maternal and Perinatal Outcomes

Prof Padam Raj Pant (President Nepal Society of Obstetricians & Gynaecologists) – Professor and former Head of the Department of Obstetrics and Gynaecology at Tribhuvan University Teaching Hospital, Kathmandu, Nepal

Maternal and neonatal mortality remain major public health challenges despite substantial global progress over the past two decades. Although maternal mortality has declined significantly worldwide, nearly 260,000 women continue to die annually from pregnancy-related causes, and approximately 2.3 million newborns die within the first 28 days of life. South Asia has contributed substantially to these improvements, yet marked disparities persist across and within countries.

This presentation reviews recent global trends in maternal and neonatal health, with a particular focus on South Asia, highlighting successful strategies and persistent challenges. Drawing on experiences from Sri Lanka and Nepal, it explores how investments in universal access to skilled birth attendance, emergency obstetric and newborn care, maternal and perinatal death surveillance and response (MPDSR), respectful maternity care, and quality improvement initiatives have translated into improved outcomes. Nepal's remarkable reduction in maternal mortality over the past two decades illustrates the impact of sustained policy commitment, expansion of institutional delivery services, and strengthened health systems, while also underscoring the need to address geographical inequities, referral delays, and quality-of-care gaps.

The presentation also examines the leading causes of maternal and neonatal mortality, emphasizing evidence-based interventions across the continuum of care—from preconception and antenatal care to intrapartum management, essential newborn care, and the postnatal period. Emerging innovations, including digital health technologies, simulation-based training, and data-driven quality improvement, will be discussed as opportunities to accelerate progress.

Achieving the Sustainable Development Goal targets for maternal and newborn survival requires moving beyond increasing service coverage toward ensuring equitable, high-quality, and respectful care for every woman and every newborn. Strengthening health systems, fostering regional collaboration, and translating evidence into practice are essential to sustaining progress across South Asia and ensuring that preventable maternal and neonatal deaths become increasingly rare.

Beyond Delivery: Lifelong Health and Future Directions

Prof Yousaf Latif Khan – Professor Obstetrics & Gynaecology, Rashid Latif Medical College Lahore, Pakistan. Consultant / Director, Hameed Latif Hospital, Lahore Institute of Fertility and Endocrinology, Arif Memorial Teaching Hospital.

ABSTRACTS OF SYMPOSIA

Day 01

Symposium 01: Panel discussion on “Applications and Implications of AI in Reproductive Healthcare.”

Panelists -

Prof Narendra Malhotra, Dr Milhan Batcha, Dr Indunil Piyadigama, Dr Udara Jayawardane, Prof M Thirukumar, Dr Madhava Karunarathne

Symposium 02: Assisted Reproductive Technology

Overcoming Endometrial Problems In ART

Prof Yutaka Osuga (Past President JSOG 2024, Professor Emeritus, The University of Tokyo, Director and Professor, Teikyo Academic Research Center, Teikyo University, Specially Appointed Professor of Obstetrics and Gynecology, Teikyo University Hospital.

Successful implantation requires both a competent embryo and a receptive endometrium. Even with advances in embryo selection and assisted reproductive technology (ART), endometrial factors remain important potential contributors to implantation failure. Major endometrial problems include thin endometrium, embryo–endometrium asynchrony, hormonal and luteal phase defects, structural abnormalities, chronic endometritis, impaired endometrial blood flow, and immunological factors.

Thin endometrium is associated with reduced implantation potential and adverse obstetric outcomes. Numerous treatments—including estrogen, growth hormone, sildenafil, granulocyte colony-stimulating factor, platelet-rich plasma (PRP), stem cells, and other regenerative approaches—have been investigated. Although some appear promising, evidence supporting most interventions remains limited or heterogeneous.

Temporal synchronization between embryo development and endometrial maturation is biologically essential. A displaced window of implantation may occur in some patients; however, current evidence does not demonstrate that endometrial receptivity analysis (ERA)-guided personalized embryo transfer improves live-birth rates. Thus, biological plausibility should be distinguished from demonstrated clinical utility.

Chronic endometritis represents another controversial area. Histological examination with CD138 immunostaining, hysteroscopy, and endometrial microbiome testing assess different aspects of the endometrial environment and may yield discordant results. Our recent study in patients with recurrent implantation failure demonstrated limited concordance among these diagnostic approaches. Emerging evidence suggests that dysbiosis and disruption of Lactobacillus-dominant microbiota may be clinically relevant, raising the possibility of treatment strategies combining appropriately selected antibiotics with restoration of the endometrial microbial environment.

In conclusion, endometrial dysfunction encompasses heterogeneous biological and clinical conditions rather than a single entity. Although multiple diagnostic tests and therapeutic interventions are available, robust evidence supporting routine use of many of them remains insufficient. Careful patient selection, recognition of the limitations of current evidence, and shared decision-making are essential when attempting to overcome endometrial problems in ART.

How to Overcome Difficult Embryo Transfers

Dr. Noushin Abdul Majiyd – Director at NOVA CRAFT Hospitals in Kochi. Consultant in Reproductive medicine.

Recurrent Implantation Failure: Evidence and Practice

Dr Soumya Nair – Infertility Specialist, & Laparoscopic Surgeon, CIMAR The Women's Hospital Edappal, Kerala, India.

Background

Recurrent implantation failure (RIF) remains a challenging and controversial problem in assisted reproductive technology (ART). Traditionally defined by a fixed number of failed embryo transfers, the concept of RIF has evolved towards an individualized, probability-based definition. The 2023 ESHRE recommendations emphasize that RIF should be considered when viable embryos have repeatedly failed to result in a positive pregnancy test at a frequency that justifies further evaluation or intervention.

Objective

To review the contemporary evidence on the definition, evaluation and management of RIF, and to highlight practical approaches that distinguish evidence-based interventions from unproven or potentially unnecessary add-ons.

Discussion

A diagnosis of RIF should be made only after considering factors that may explain expected implantation failure, particularly maternal age, embryo aneuploidy, ovarian reserve, the underlying cause of infertility and the effect of individual oocyte cohorts. Evaluation should be systematic, beginning with assessment of embryo quality and the uterine cavity, including appropriate ultrasound assessment and targeted hysteroscopy. Difficult embryo transfer and previously unrecognized uterine pathology should also be considered. Selected investigations, including assessment for chronic endometritis and antiphospholipid antibodies, may have a role in appropriately selected patients. Conversely, routine immune testing, sperm DNA fragmentation testing, microbiome profiling and several other investigations lack sufficient evidence for routine use.

Management should similarly be individualized. Treatment of identified pathology should take precedence over empirical therapies. Evidence for interventions such as endometrial scratching, intrauterine hCG, low-molecular-weight heparin, prolonged down-regulation and immunomodulatory therapies remains limited or conflicting. Emerging approaches such as platelet-rich plasma (PRP), ERA-guided personalized embryo transfer and PGT-A may have a role in selected patients, but should be applied judiciously.

Conclusion

Effective management of RIF requires a shift from counting failed transfers to individualized assessment of implantation probability. A rational approach prioritizes the embryo and uterine environment, addresses identifiable pathology, selectively applies emerging interventions and avoids unsupported add-ons. Honest counselling regarding realistic treatment outcomes and recognition of when further intervention is unlikely to be beneficial are essential components of evidence-based RIF care.

Fertility Preservation: From Global Standard to Local practice

Dr Madhura Jayasingam – Senior Medical Scientist at the Royal Women's Hospital, Melbourne.

Fertility preservation (FP) encompasses a range of medical interventions designed to protect reproductive potential in individuals whose fertility may be compromised by disease or its treatment. The field of oncofertility brings together oncology and reproductive medicine to ensure that patients are informed of, and have access to, fertility preservation options before undergoing potentially gonadotoxic treatment. Cancer incidence in Sri Lanka has continued to rise over the past two decades in both adults and children. Beyond cancer, conditions such as thalassemia, aplastic anaemia, sickle cell disease, and galactosemia also place patients at significant risk of gonadal damage and infertility. As survival rates improve, more children, adolescents, and young adults are living beyond their diagnosis and facing the long-term consequences of treatment, including the loss of fertility. International guidelines from the European Society of Human Reproduction and Embryology (ESHRE), the American Society of Clinical Oncology (ASCO), and the American Society for Reproductive Medicine (ASRM) recognise fertility preservation as an essential part of patient care and recommend that counselling takes place before gonadotoxic therapy begins. Established fertility preservation options include sperm, oocyte, and embryo cryopreservation, as well as ovarian tissue cryopreservation (OTC) and testicular tissue cryopreservation (TTC). OTC has been successfully used in clinical practice for more than two decades and has resulted in over 200 live births worldwide. It remains the only established fertility preservation option for prepubertal girls, while TTC is currently the only potential option for prepubertal boys. Although sperm, oocyte, and embryo cryopreservation are available through IVF services in Sri Lanka, ovarian and testicular tissue cryopreservation are not yet available. This leaves many patients, including children, those requiring urgent treatment, and individuals with non-malignant conditions without appropriate fertility preservation options. This presentation explores how we can establish a sustainable, gynaecology-led fertility preservation programme by building on existing IVF infrastructure and surgical expertise. It outlines a practical, phased roadmap for developing coordinated oncofertility services and referral pathways to ensure that all patients at risk of treatment-related infertility have access to fertility preservation.

Hope Against the Odds: Assisted Reproductive Technology in Resource-Limited Settings

Prof S Raguraman – Professor and Head of the Department of Obstetrics and Gynaecology at the University of Jaffna, Consultant Obstetrician and Gynaecologist at the Teaching Hospital Jaffna.

Subfertility is a significant global public health concern and is recognised by the World Health Organisation as a disease. Its burden is particularly important in resource-limited settings, where approximately 17.5% of couples globally experience subfertility. Beyond its medical implications, subfertility is associated with substantial psychosocial distress and financial consequences. Assisted reproductive technology (ART) is increasingly needed in these settings, with an estimated 30-40% of affected couples potentially requiring ART. However, financial, infrastructural, human-resource, and healthcare-system constraints limit access to ART.

Establishing and maintaining ART services requires substantial initial investment in laboratory infrastructure and equipment, and treatment costs rise due to expensive medications and consumables. High out-of-pocket expenditure, coupled with minimal government or insurance support, further restricts accessibility. Resource-limited settings also face shortages of trained embryologists, specialists, and support staff. Limited laboratory facilities, inadequate public-funded ART programmes, delayed investigations, late referral and back-referral, lack of appropriate ART regulation, and misconceptions regarding ART contribute to inequitable access and delayed presentation.

A low-cost ART model may offer a practical strategy to expand access while maintaining acceptable standards of care. Appropriate patient selection is important, particularly for couples who have a low probability of success with basic IVF but a higher likelihood of benefit from ART. Simplified ovarian stimulation protocols using oral medications with minimal gonadotropin supplementation can reduce treatment requirements; the proposed approach has demonstrated a 34% reduction in gonadotropin requirements in selected couples. Laboratory costs may also be reduced through conventional IVF rather than routine ICSI, use of CO₂ incubators instead of tri-gas incubators, and simplified embryo culture systems such as the Walking Egg Project.

Cost reduction should be accompanied by rigorous quality assurance. Quality-control systems, key performance indicator-based audits, capacity building, and structured training for embryologists and support staff are essential. Research should establish the effectiveness and safety of low-cost ART models and encourage locally manufactured consumables. Financial mechanisms, including governmental or insurance support and public-private partnerships, together with appropriate regulations and professional guidance, are necessary to ensure sustainable implementation.

The need for ART in resource-limited settings is increasing despite significant financial and healthcare-system constraints. Resource limitations should stimulate innovation rather than restrict access to fertility care. A carefully designed low-cost ART model, supported by trained human resources, quality assurance, research, financial support, locally appropriate innovation, and effective regulation, could provide a practical and sustainable approach to improving access to ART without compromising quality, safety, or ethical standards.

Symposium 03: Panel discussion on “Post-partum Haemorrhage.”

Moderator - Prof Sir Sabaratnam Arulkumaran

Panelists -

Prof Rukshan Fernandopulle, Dr Janakie Karunasinghe, Dr A Sritharan, Prof Chandana Jayasundara, Dr Prabath Randombage, Prof M R M Rishard

Day 02

Symposium 04: Gestosis Panel Discussion

Gestosis Score; An innovative Promising Tool for Prediction & Prevention of Preeclampsia

Dr Gorakh Mandrupkar – Sr. Vice President, Gestosis India Association. Member, National Health Mission, Govt. of India, PPH Committee. Member, National Health Mission, Govt. of India.

Antihypertensive Drugs; Challenges faced

Dr Girija Wagh – Senior Obstetrician-Gynaecologist. Professor & HOD (Obstetrics & Gynaecology) at BVDTUMC; Director at Primrose Wellness and Care; President of Menopausal Society of Pune & Gestosis India Association.

Eclampsia Drills

Dr Sumith Warnasuriya – Senior Consultant Obstetrician & Gynaecologist at Base Hospital, Dambadeniya, Sri Lanka.

This is an all important practiced team simulation for treating a sudden seizure in a pregnant or postpartum woman involving Multi Disciplinary Team input lead by an experienced obstetrics team supported by specialties involving Anaesthesia, Transfusion Medicine and Neonatology. Standby units include the Labour Room, Operating Theatre, Obstetric Intensive Care Unit and the Special Care Baby Unit / Premature Baby Unit.

Principals of Management include avoiding injury to the patient, maintenance of airway and oxygenation, preventing aspiration, administration of MgSO₄ without delay, control of elevated blood pressure and proceeding with delivery of the baby with or without administration of steroids to the mother as indicated. Close monitoring and postpartum care is an absolute necessity thereafter.

Postpartum complications (HELLP, PREZ, Cerebral thrombosis); Principles of management

Dr Charmila Ayyavoo – Director at Aditi Hospital and Aditi Pluro Fertility & IVF Centre, and Assistant Professor at Dhanalaxmi Srinivasan Medical College.

Postpartum Period; future thoughts

Dr Kamrun Nessa Runa – Vice Principal & HOD, MC Medical College, Bangladesh, and Immediate Past President/Vice President (Ex) of OGSB.

Symposium 05: Panel discussion on "Endometrioma: What to Do and What Not to Do" by Endometriosis Society of SL

Moderator -

Dr Indunil Piyadigama

Panelists -

Prof Hemantha Senanayake, Prof Madura Jayawardane, Prof Prabhodana Ranaweera, Dr Samanthi Premaratne, Dr Chaminda Hunukumbure

Symposium 06: by Menopause Society of SL

Testosterone; current evidence for clinical practice

Dr Prabath Randoombage – Senior Lecturer at the Faculty of Medicine, University of Kelaniya, Consultant Obstetrician and Gynaecologist at Teaching Hospital Ragama

Testosterone is increasingly used in women's health and menopause care, but its role is misunderstood at times. Current evidence supports targeted use for a clearly defined indication, rather than testosterone as a general treatment for menopause, fatigue, low mood, poor concentration, weight gain or ageing. The strongest evidence is for **hypoactive sexual desire disorder (HSDD)** in postmenopausal women. A low serum testosterone level alone does not diagnose HSDD or predict who will respond to treatment. Total testosterone is mainly useful for safe prescribing and monitoring. A meta-analysis of 36 randomized trials involving 8,480 women found approximately 0.85 additional satisfactory sexual events per month with testosterone, together with improvements in sexual desire, arousal, orgasm and responsiveness and a reduction in sexual distress. Evidence is strongest after natural or surgical menopause, while evidence in premenopausal women remains limited. Tibolone, with estrogenic, progestogenic and weak androgenic activity, may be a useful alternative in selected postmenopausal women, particularly when low sexual desire occurs together with other menopausal symptoms. When testosterone is indicated, low-dose transdermal therapy is preferred, aiming to keep testosterone within

the normal physiological premenopausal female range. Acne and increased facial or body hair are the most common adverse effects. Treatment should be viewed as a therapeutic trial and stopped if there is no meaningful benefit within 3–6 months. Short-term safety data are generally reassuring, but long-term breast, cardiovascular and endometrial safety remains incompletely defined. Testosterone also has a distinct role in **transgender** people seeking masculinization. In this setting, treatment is goal-directed rather than treatment of a testosterone deficiency. Expected effects include menstrual suppression, voice deepening, facial and body hair growth and changes in body composition. Some effects may be irreversible. Testosterone is not contraception, even when menstruation stops and fertility and pregnancy intentions should be discussed. Monitoring should include testosterone exposure and haemoglobin/haematocrit, with erythrocytosis being an important dose- and route-related safety concern.

Keywords

Testosterone; women; menopause; hypoactive sexual desire disorder; sexual function; tibolone; transgender.

Neurokinin for hot flashes; efficacy and safety

Dr Rashanthi Perera – Consultant Obstetrician & Gynaecologist at District General Hospital, Avissawella.

Menopausal vasomotor symptoms, particularly hot flushes and night sweats, can significantly affect women's quality of life. While menopausal hormone therapy remains an effective treatment for many women, there is an increasing need for effective non-hormonal treatment options. Neurokinin signalling plays an important role in the regulation of the hypothalamic thermoregulatory pathway. Increased understanding of the **KNDy (kisspeptin, neurokinin B and dynorphin)** neuronal pathway has led to the development of novel neurokinin-targeted therapies for the management of menopausal vasomotor symptoms. This presentation will provide an overview of the **role of neurokinins in menopause**, the rationale behind neurokinin receptor antagonism, current evidence regarding its efficacy and safety, and its potential role within the modern, individualized approach to menopause care.

Latest safety guideline for ERT

Dr Darshana Abeygunawardana – Fellowship in Cosmetic Gynaecology by ISAGSS & ASCOP, President Elect, Menopause Society of Sri Lanka. Regional activity chairman, Sri Lanka College of Obstetricians & Gynaecologists. Committee member for Maternal and Perinatal Health Committee of South Asian Federation of Obstetrician & Gynaecologist – SAFOG. Committee member of the Sexual & Reproductive Health Committee – Asia and Oceania Federation of Obstetrics and Gynaecology (AFOG.)

Estrogen replacement therapy (ERT) remains the most effective treatment for menopausal vasomotor symptoms and genitourinary syndrome and to prevent related bone loss. However, safety concerns arising from early interpretations of the Women's Health Initiative is still continue to contribute for inappropriate avoidance of treatment. Current guidelines emphasize that menopausal hormone therapy does not carry the same level of risk for every woman. Its safety depends on individual factors, including age, time since menopause, existing health risks, type and dose of hormone, route of administration, and whether progestogen is required to protect the endometrium.

This presentation critically reviews the available studies and recommendations on the safe use of ERT. In most healthy, symptomatic women younger than 60 years or within 10 years of menopause onset, the benefit–risk balance of systemic therapy is generally advisable. Estrogen-only therapy is recommended following hysterectomy, whereas women with an intact uterus require addition of progestogen to prevent endometrial hyperplasia and cancer. Transdermal estradiol is preferred when venous

thromboembolism is a concern because it avoids first-pass hepatic effects and appears to have a more favourable thrombotic profile than oral estrogen. Safe prescribing requires assessment of unexplained vaginal bleeding, breast and endometrial cancer risk, cardiovascular disease, venous thromboembolism, liver disease and relevant comorbidities. Systemic therapy is generally avoided in women with estrogen-sensitive malignancy, previous thromboembolic or major arterial events, active liver disease or unexplained bleeding before thorough evaluation. Low-dose vaginal estrogen has minimal systemic absorption and may be considered in selected cancer survivors following shared decision-making.

Current recommendations don't support arbitrary limits on treatment duration. However these promote to use an appropriate effective dose for relevant duration, with periodic reassessment of symptoms, benefits and risks. The central safety principle is therefore not simply whether estrogen is prescribed, but prescribing the right preparation, by the right route, to the right woman, at the right time.

Symposium 07: “Medical Disorders.”

Thyroid Disorders in Pregnancy: An Update for Clinical Practice

Dr Shemoon Marleen – Consultant Obstetrician and Gynaecologist, Special Interest in Fetal Medicine, Sri Jayewardenepura General Hospital.

Thyroid dysfunction is among the most common endocrine complications of pregnancy, and its interpretation is complicated by physiological changes unique to gestation. Pregnancy alters thyroid function through hCG cross-reactivity with the TSH receptor, rising thyroxine-binding globulin, increased renal iodine loss, and placental deiodination, with the fetus entirely dependent on maternal thyroxine until its own gland matures around 18–20 weeks. Consequently, thyroid function tests must be interpreted against trimester- and, ideally, population-specific reference ranges rather than standard non-pregnant values; locally derived ranges in Sri Lanka run higher than standard ATA cut-offs, underscoring the risk of over-diagnosis when international ranges are applied.

Current guidance supports targeted rather than universal screening, based on risk factors such as personal or family thyroid history, autoimmune disease, or recurrent pregnancy loss. Overt hypothyroidism should be treated promptly, with existing levothyroxine doses increased by 25–30% as soon as pregnancy is confirmed and TFT rechecked every 4–6 weeks thereafter. Subclinical hypothyroidism and isolated thyroid-antibody positivity warrant more selective treatment, guided by TSH threshold, antibody status, and mode of conception, informed by trial evidence including the TABLET study, which found no benefit from treating euthyroid, antibody-positive women. In Graves' disease, antithyroid drug choice should be matched to trimester (propylthiouracil in the first trimester, carbimazole thereafter), with the lowest effective dose used to avoid fetal hypothyroidism, and TRAb monitored throughout given its ability to cross the placenta and affect fetal thyroid function independent of maternal status. Thyroid storm, though rare, requires prompt recognition and multidisciplinary emergency management, while postpartum thyroiditis remains a frequently under-recognised biphasic condition affecting up to 10% of postpartum women.

Diabetes in pregnancy controversies and consensus

Prof Madura Jayawardane – Professor of Obstetrics & Gynaecology, University of Sri Jayewardenepura; Editor of the Sri Lanka Journal of Obstetrics and Gynaecology.

Hyperglycaemia in pregnancy, including pre-existing type 1 and type 2 diabetes and gestational diabetes mellitus (GDM), is associated with increased maternal, fetal and neonatal morbidity. Optimal

management requires coordinated antenatal, intrapartum and postpartum care; however, being the commonest medical disorder during pregnancy, several aspects of management remain controversial and robust evidence are still lacking in certain areas. Antenatal care focuses on early identification and classification of hyperglycaemia, individualized glycaemic targets, nutritional and lifestyle interventions, glucose monitoring, pharmacological treatment when indicated, and surveillance for maternal and fetal complications. All the guidelines agree on the importance of glycaemic control, there remains variation regarding optimal glycaemic targets, particularly the balance between preventing fetal overgrowth and avoiding maternal hypoglycaemia. Early pregnancy screening and treatment of hyperglycaemia below the diagnostic threshold for diabetes also remain areas of uncertainty, with evidence and recommendations differing between professional organizations. Intrapartum management aims to maintain maternal glucose within a safe range while minimizing neonatal hypoglycaemia. However, the optimal intrapartum glucose target, frequency of monitoring and routine use of intravenous insulin and glucose remain areas of variation between protocols. Timing and mode of birth also require individualized assessment. Recommendations differ according to diabetes type, glycaemic control, fetal growth and maternal or fetal complications, with less agreement regarding intervention in uncomplicated GDM. Postpartum care includes adjustment or cessation of glucose-lowering therapy, breastfeeding support, contraception and long-term metabolic follow-up. Postpartum screening after GDM is strongly recommended, although adherence remains challenging and the optimal strategy for long-term screening and prevention continues to evolve. Recognizing areas of consensus alongside ongoing controversies is essential for providing individualized, evidence-based and woman-centred care throughout the pregnancy continuum.

Modern Anticoagulation in Women's Health: Pregnancy, Gynaecology, ART and the DOAC Era

Dr Wedisha Gankanda – Consultant Obstetrician & Gynaecologist and Senior Lecturer, Faculty of Medicine, University of Moratuwa.

Venous thromboembolism (VTE) remains an important and potentially preventable cause of maternal morbidity and mortality. Contemporary obstetric and gynaecological practice presents an increasingly complex thrombotic risk profile, with rising maternal age, obesity, caesarean delivery, assisted reproductive technology (ART), ovarian hyperstimulation syndrome (OHSS), major gynaecological surgery and malignancy. At the same time, the emergence of direct oral anticoagulants (DOACs), particularly rivaroxaban, has transformed anticoagulation outside pregnancy and raises important questions regarding their place in women's health. This presentation will provide a focused, clinically relevant update on VTE prevention, diagnosis and anticoagulation, based primarily on the SLCOG Guideline on Prevention and Treatment of Venous Thromboembolism in Obstetrics and Gynaecology-2025, with reference to RCOG guidance and contemporary practice. In obstetrics, emphasis will be placed on dynamic VTE risk assessment throughout pregnancy and the puerperium, appropriate use of thrombophilia testing, interpretation of D-dimer, investigation of suspected deep-vein thrombosis and pulmonary embolism, and practical selection of imaging including compression ultrasonography, V/Q scanning and CTPA. The role of LMWH, management of life-threatening pulmonary embolism, and the timing of anticoagulation around delivery and neuraxial anaesthesia will be highlighted. The discussion will then extend beyond pregnancy to VTE prophylaxis in benign and oncological gynaecological surgery, including the importance of recognising risk despite minimally invasive surgery and identifying women requiring extended thromboprophylaxis. ART-related thrombosis will be explored, particularly the association between OHSS and VTE, including thrombosis at unusual anatomical sites. Finally, the evolving role of DOACs will be considered alongside LMWH and warfarin.

While rivaroxaban and other DOACs are increasingly important in general and selected gynaecological practice, pregnancy remains a setting in which LMWH retains a central role. The presentation aims to translate current guidance into practical decisions that trainees can apply immediately in obstetric, gynaecological and reproductive medicine practice.

Symposium 08: Miscellaneous

Multisystemic Ageing Transition Care in 2026: A Longevity Framework Beyond Menopause Hormone Therapy

Dr Indu Asanka Jayawardane – Senior Lecturer in Obstetrics & Gynaecology, Faculty of Medicine, University of Colombo, Honorary Consultant Obstetrician & Gynaecologist, Professorial/University Unit, De Soysa Hospital for Women/National Hospital, Colombo.

Menopause is no longer viewed simply as a transient gonadal phase to be managed by Menopause Hormone Therapy (MHT) but a critical, multi-systemic aging transition. This presentation establishes a modernized, evidence-based framework for the gynecologist, functioning as a "midlife and beyond longevity clinician". The presentation explores personalized medicine for targeted vasomotor control and highlights the cardiovascular risk stratification and cognitive health and evaluates multimodal, non-hormonal management of Genitourinary Syndrome of Menopause (GSM). It also explores the role of the gynaecologist at the forefront of frailty prevention and the pelvic floor dysfunction in the elderly focusing on difficulties in surgical decision-making for pelvic floor disorders in the aged person.

Mental Disorders in Pregnancy

Dr Luckshika Amarakoon – Head and a Senior Lecturer in the Department of Psychiatry, Faculty of Medical Sciences, University of Sri Jayewardenepura. Honorary Consultant Psychiatrist at the Colombo South Teaching Hospital, Secretary of the Sri Lanka College of Psychiatrists.

Mental health is an essential component of maternal health, highlighting the importance of early recognition and collaborative management by obstetricians and psychiatrists. Pregnancy and the postpartum period can increase vulnerability to depression, anxiety, OCD, bipolar disorder, trauma-related disorders and postpartum psychosis. Particular attention should be given to maternal suicide and the potential consequences of untreated mental illness both in mother and infant. Mental-health assessment should form an integral part of antenatal and postnatal care. Emphasis should be given to screening for mental illnesses, comprehensive risk assessment, psychoeducation, counselling, psychological interventions and appropriate referral.

Vasa Previa: Current Evidence, Clinical Controversies and Guideline Perspectives

Dr Kajendran Jogarasah – Consultant Obstetrician & Gynaecologist at Teaching Hospital Jaffna, Sri Lanka.

Vasa previa is a rare but potentially catastrophic obstetric condition associated with a high risk of fetal exsanguination and perinatal death if unrecognized before the onset of labour or rupture of membranes. Advances in prenatal ultrasound have enabled reliable antenatal diagnosis, transforming vasa previa from a frequently fatal condition into one with excellent perinatal outcomes when appropriately managed. Despite this progress, several aspects of clinical management remain controversial, including the role of universal versus targeted screening, optimal timing of antenatal corticosteroid administration, inpatient versus outpatient management, and the ideal gestational age for planned caesarean delivery.

This presentation will critically review the latest evidence on the epidemiology, pathophysiology, risk factors, ultrasound diagnosis, antenatal surveillance, and management of vasa previa.

Symposium 09: “Shielding the Newborn Brain: Joint Perinatal Strategies against Hypoxic Ischaemic Encephalopathy” by Perinatal Society of SL

The Intrapartum Window: Timely Interventions and Risk-Stratification to Prevent Fetal Hypoxia

Dr Ruwan Silva – Consultant Obstetrician & Gynaecologist at North Colombo Teaching Hospital, Chairman of Social Activities, SLCOG.

Intrapartum hypoxia remains an important contributor to neonatal morbidity and mortality, including hypoxic-ischaemic encephalopathy, cerebral palsy, stillbirth and neonatal death. The progression from fetal hypoxaemia to metabolic acidosis and tissue injury is not instantaneous, creating a critical “intrapartum window” during which appropriate recognition and intervention may prevent adverse outcomes.

Importance of antenatal and dynamic intrapartum risk stratification, appropriate fetal monitoring, physiological interpretation of cardiotocography (CTG) are highlighted during presentation and timely intervention is discussed to prevent fetal hypoxic injury.

Fetal oxygenation depends on maternal respiration and circulation, placental perfusion and gas exchange, and umbilical and fetal circulation. Disturbances at any of these levels may result in hypoxaemia and hypoxia. Initial respiratory acidemia may be rapidly reversible following restoration of placental gas exchange; however, persistent hypoxia results in anaerobic metabolism, lactic acid accumulation and metabolic acidosis, ultimately leading to cellular and tissue injury. Identification of maternal, placental and fetal risk factors before labour allows appropriate planning and selection of fetal surveillance. During labour, risk is dynamic and should be reassessed at key clinical points, including admission, after epidural analgesia, commencement of oxytocin, artificial rupture of membranes, development of meconium or maternal fever, and during the second stage. Monitoring should correspond to the level of risk, with intermittent auscultation for low-risk pregnancies and continuous CTG for high-risk situations. Physiological interpretation of CTG can facilitate early recognition of evolving fetal compromise.

Prevention of fetal hypoxic injury requires more than recognition of an abnormal CTG at the point of decompensation. A structured approach combining early risk stratification, continuous dynamic assessment, appropriate monitoring and prompt corrective action can maximise the intrapartum window for intervention. Timely escalation, including cessation of oxytocin, correction of maternal hypotension, tocolysis when indicated, and expedited delivery when necessary, may reduce the consequences of prolonged fetal hypoxia.

Beyond the Cooling Blanket: Biomarkers, Neuroprotection, and Prognosticating HIE

Prof Saraji Wijesekara – Professor in Paediatric Neurology, Department of Paediatrics, Faculty of Medical Sciences. University of Sri Jayewardenepura, Honorary Consultant in Paediatric Neurology, Teaching Hospital Colombo South. Current President of Sri Lanka Child Neurology Association.

Therapeutic hypothermia remains the cornerstone of treatment for moderate-to-severe neonatal HIE, but advances in biomarkers, adjunctive neuroprotective therapies, and multimodal prognostication are

improving clinicians' ability to individualize care, predict outcomes, and potentially enhance long-term neurodevelopment. Many adjunctive therapies remain investigational, with erythropoietin among the most extensively studied candidates.

The Continuum of Care: Community Surveillance and Early Intervention Networks for HIE

Dr Asiri Hewamalage – Consultant Community Physician and public health specialist, National Program Manager for Child Care, Early Childhood Development, and Children with Disabilities, Ministry of Health, Sri Lanka.

Hypoxic-ischemic encephalopathy (HIE) remains a leading cause of neonatal brain injury and is associated with a substantial risk of cerebral palsy, cognitive impairment, epilepsy, and other neurodevelopmental disabilities. While advances in obstetric and neonatal care have improved survival, optimizing long-term developmental outcomes requires a coordinated continuum of care that extends beyond the neonatal intensive care unit. The Sri Lankan Neonatal Care Pathway, developed within the Inclusive Early Childhood Development (IncluDe) Programme, addresses this need through systematic risk stratification, developmentally supportive neonatal care, structured parental education, discharge planning, and integrated follow-up that links neonatal services with community-based surveillance by Public Health Midwives and multidisciplinary Child Development Intervention Clinics. This presentation will examine how an integrated health system can bridge the transition from hospital to home for infants with HIE, emphasizing the complementary roles of obstetricians, neonatologists, primary care providers, and public health services. Particular focus will be placed on early developmental surveillance, family-centered care, responsive parenting, and timely multidisciplinary intervention as evidence-informed strategies to harness early neuroplasticity, strengthen developmental outcomes, and reduce the lifelong burden of disability.

Symposium 10: “Urogynaecology”

Prevention of Urinary Tract Injuries During Laparoscopic Surgery

Clinical Prof Nishendra Karunaratne – Consultant Obstetrician & Gynaecologist at Lanka Hospitals, Colombo, and Consultant in its Fertility Centre/IVF Services.

Urinary tract injuries remain an important potential complication of laparoscopic pelvic surgery, with an overall incidence of approximately 1%, although the risk varies considerably depending on the complexity and type of procedure. Prevention relies on several factors, but a thorough understanding of pelvic anatomy, recognition of anatomical variations, and mastery of appropriate surgical techniques are fundamental. Accurate identification of the ureter, safe ureterolysis, and meticulous dissection in the presence of bladder adhesions require considerable surgical skill and experience. Importantly, pelvic anatomy is not identical in every patient, and subtle variations in the position and relationship of pelvic organs may significantly increase the risk of urinary tract injury. Recognising these variations and adapting the surgical approach accordingly are essential for safe pelvic surgery. The use of appropriate surgical principles, together with practical tips and techniques during pelvic dissection, can substantially reduce the risk of injury while allowing complex procedures to be completed safely. In this presentation, I will demonstrate a series of surgical techniques, anatomical concepts, and practical tips and tricks that can help surgeons identify the ureter and bladder safely, perform challenging pelvic dissections, and minimise the risk of urinary tract injuries during laparoscopic surgery.

Getting the Diagnosis Right Before Surgery: Preoperative Assessment in Female SUI

Dr Malith Perera – Consultant Obstetrician & Gynaecologist and Senior Lecturer, Faculty of Medicine, University of Ruhuna/German Sri Lanka Friendship Hospital for Women, Galle.

Female stress Urinary incontinence (SUI) is a common condition that can affect a woman's quality of life significantly. The mainstay for the treatment is the pelvic floor exercises. However, when this fails, surgery remains the next step in the management. Successful surgical treatment depends fundamentally on accurate diagnosis and appropriate patient selection. Pre-operative assessment provides an opportunity to confirm the underlying mechanism of incontinence, identify co-existing urinary symptoms and recognize conditions that may influence surgical outcome.

This session will focus on a structured approach to the pre-operative evaluation of a woman presenting with SUI. Key components include a detailed history, characterization of the urinary symptoms, assessment of bother and quality of life impact, physical examination and appropriate use of investigations. The role of cough stress testing, assessment of urethral mobility and indications for urodynamic testing will be discussed. The aim is to highlight a practical strategy for ensuring that the diagnosis is correct before proceeding to surgery. A careful assessment will allow individualized counselling, selection of the most appropriate surgical approach and identification of potential risk factors for treatment failure thus improving the patient expectations and outcome.

The Changing Landscape of Stress Urinary Incontinence Surgery: Is Burch Still the Gold Standard?

Dr Chinthaka Banagala – Senior Lecturer in Obstetrics & Gynaecology, Faculty of Medicine, University of Colombo.

Background

Stress urinary incontinence (SUI) affects a substantial proportion of women worldwide, with surgical intervention indicated for those who fail conservative and pharmacological management. For over three decades, Burch colposuspension was regarded as the surgical gold standard for SUI, offering durable long-term continence rates through retropubic elevation of the bladder neck. However, the surgical landscape has undergone significant transformation since the introduction of minimally invasive midurethral sling procedures in the 1990s.

Aim

This review examines the evolution of SUI surgery, evaluates current evidence comparing Burch colposuspension with contemporary alternatives, and critically appraises whether Burch colposuspension retains its position as the gold standard in light of recent controversies surrounding synthetic mesh.

Discussion

The introduction of the tension-free vaginal tape (TVT) and subsequent transobturator tape (TOT) procedures revolutionised SUI management by offering comparable efficacy to Burch colposuspension with reduced operative time, shorter hospital stay, and faster recovery, leading to their rapid adoption as first-line surgical options. Landmark trials, including the Trial of Mid-Urethral Slings (TOMUS), demonstrated equivalent subjective and objective cure rates between retropubic slings and Burch colposuspension, further cementing the shift toward minimally invasive approaches. However, the global mesh controversy, driven by reports of chronic pain, mesh erosion, and dyspareunia, has prompted

regulatory restrictions and even outright bans on synthetic mesh slings in several countries, including the United Kingdom and parts of Australia. This has renewed clinical interest in non-mesh alternatives, including autologous fascial slings and laparoscopic or robotic-assisted Burch colposuspension, which combine the proven durability of the open technique with the benefits of minimally invasive surgery. Comparative studies suggest laparoscopic Burch achieves outcomes similar to the open approach while reducing morbidity, positioning it as a viable option in mesh-restricted settings. Nevertheless, Burch colposuspension is not without limitations, including higher rates of postoperative voiding dysfunction, de novo detrusor overactivity, and the need for greater surgical expertise compared with sling procedures.

Conclusion

The management of SUI has shifted from a single dominant technique toward an individualised, patient-centred approach that weighs efficacy, complication profiles, surgeon expertise, and evolving regulatory guidance. While midurethral slings remain widely used where mesh is available and appropriate, the resurgence of interest in Burch colposuspension—particularly via minimally invasive routes—reflects its enduring relevance as a mesh-free, durable option. Rather than being definitively surpassed, Burch colposuspension appears to be undergoing a renaissance, reaffirming its role as a benchmark against which newer techniques continue to be measured. Future research should focus on long-term comparative outcomes and patient-selection criteria to guide evidence-based surgical decision-making.

Symposium 11: “Gynaecological oncology”

Pregnancy and Gynecological Cancer: Balancing Maternal Cure and Fetal Safety

Dr Kanishka Karunaratne – Senior Consultant Gynaecological Oncologist, Visiting Lecturer, Faculty of Medicine, University of Colombo.

From Genes to Targeted Therapy: Molecular Genetics in Gynecological Cancer

Dr Thanuya Mahendran – Consultant Gynaecological Oncologist, Teaching Hospital Jaffna.

Gynaecological oncology is shifting from morphology- and stage- based discipline towards precision oncology. Tumours of similar histology are now known to carry distinct molecular alterations that drive different biological behaviour, prognosis and treatment response. Molecular characterization improves diagnostic reproducibility, refines prognostic assessment, identifies hereditary cancer syndromes and directs targeted and immune-based therapy. This lecture reviews the molecular alterations that have already changed clinical practice. In endometrial carcinoma, the four-group classification derived from The Cancer Genome Atlas — POLE-ultramutated, mismatch repair deficient, p53-abnormal and no specific molecular profile — now sits alongside histological grade in risk stratification and adjuvant treatment decisions, and can be approximated using immunohistochemistry with a single sequencing test. In ovarian cancer, BRCA1/2 mutation and wider homologous recombination deficiency predict response to platinum agents and PARP inhibitors, and carry implications for family members. Across sites, mismatch repair deficiency identifies both Lynch syndrome and candidates for checkpoint inhibition. The lecture also addresses HPV-associated versus HPV-independent cervical and vulvar carcinoma. For the practicing gynaecological oncologist, understanding the molecular identity of a tumor is increasingly essential for delivering personalized, evidence-based care.

Cervical Cancer Management: From Radical Surgery to Precision Care

Dr Yapa Wijeratne – Consultant in Gynaecological Oncology at National Hospital Kandy.

Cervical cancer management has undergone one of the most remarkable transformations in surgical oncology, evolving from highly morbid radical procedures to individualized, evidence-based precision care. Historically, treatment reflected limited understanding of disease biology. Early descriptions by Hippocrates advocated palliation rather than intervention, while the nineteenth century witnessed the advent of hysterectomy by Langenbeck and Freund. The introduction of radical hysterectomy by Wertheim revolutionized surgical treatment despite considerable operative mortality, and subsequent advances in pathology, radiotherapy, and cervical cytology fundamentally altered disease detection and management. For much of the twentieth century, radical hysterectomy with systematic pelvic lymphadenectomy remained the standard treatment for early-stage cervical cancer. However, the past decade has witnessed a paradigm shift driven by high-quality clinical evidence. The LACC trial (2018) demonstrated inferior disease-free and overall survival following minimally invasive radical hysterectomy compared with open surgery, resulting in a global return to open abdominal radical hysterectomy for patients requiring radical resection. Subsequently, the SHAPE trial (2024) established that simple hysterectomy is non-inferior to radical hysterectomy in carefully selected women with low-risk early-stage disease (IA2–IB1, tumour ≤ 2 cm, limited stromal invasion and no parametrial involvement), while significantly reducing urinary, sexual and quality-of-life morbidity. Concurrently, sentinel lymph node (SLN) mapping using indocyanine green has replaced routine pelvic lymphadenectomy in many specialist centres. Evidence from the SENTIX, SENTICOL and PHENIX studies has demonstrated excellent oncological outcomes with substantially lower surgical morbidity, supporting SLN biopsy with ultrastaging as the preferred nodal staging strategy in appropriately selected patients. Modern cervical cancer surgery has therefore shifted from maximally radical treatment to precision surgery. Contemporary management integrates high-resolution magnetic resonance imaging, expert pathological assessment, sentinel node ultrastaging, tumour characteristics, fertility considerations and patient-reported outcomes to tailor the extent of surgery. Radical hysterectomy is now reserved for women with a significant risk of parametrial involvement, while conservative procedures are increasingly offered to selected patients without compromising oncological safety. The future of cervical cancer surgery lies in further refinement of patient selection, integration of molecular and imaging biomarkers, and ongoing evaluation of robotic surgery through the RACC trial. The evolution from radical surgery to precision care exemplifies how robust clinical evidence has transformed cervical cancer management, achieving optimal oncological outcomes while minimizing treatment-related morbidity.

Vulval Premalignant Lesions: Early Recognition, Modern Management and Cancer Prevention

Dr Madara Ojithmali – Senior Registrar in Gynecology Oncology, National Hospital, Maharagama.

Background

Vulval premalignant and pre-invasive conditions encompass a diverse group of epithelial disorders with varying risks of progression to vulval malignancy. These include vulval intraepithelial neoplasia, (differentiated VIN, HPV-related squamous intraepithelial lesions), vulval Paget's disease, and chronic inflammatory dermatoses such as lichen sclerosus and lichen planus. Early recognition and appropriate management are essential to prevent malignant transformation and minimize morbidity.

Overview

Vulval disease may present with persistent pruritus, pain, burning, ulceration, pigmentation, architectural change, or a visible or palpable lesion. HPV-related VIN is particularly associated with high-risk HPV infection, while differentiated VIN is commonly associated with chronic vulval dermatoses,

especially lichen sclerosus. Lichen sclerosus and lichen planus require long-term clinical management because of their association with vulval squamous cell carcinoma. Vulval Paget's disease is an uncommon intraepithelial adenocarcinoma that may mimic benign inflammatory or dermatological conditions, often resulting in delayed diagnosis.

Early recognition and diagnosis

A high index of suspicion is required for persistent, atypical or treatment-resistant vulval lesions. Detailed examination of the entire vulva, recognition of changes in pigmentation, texture and architecture, and appropriate biopsy are fundamental. Histopathological assessment allows differentiation between HPV-associated VIN, differentiated VIN, inflammatory dermatoses and Paget's disease, while identifying areas of occult invasion.

Modern management

Management should be individualised according to the underlying pathology, extent of disease, presence or absence of invasion, symptoms, patient factors and risk of recurrence. Surgical excision remains important when invasion is suspected or cannot be excluded. Selected HPV-associated VIN may be treated with conservative approaches such as topical imiquimod, while differentiated VIN generally requires surgical management because of its higher invasive potential. Lichen sclerosus and lichen planus are primarily managed with potent topical corticosteroids and long-term surveillance. Paget's disease requires careful assessment for underlying invasive disease and associated malignancy, with treatment ranging from local excision to more extensive surgery depending on disease extent and invasion.

Prevention and surveillance: HPV vaccination, smoking cessation, management of chronic vulval dermatoses, patient education and regular follow-up are important preventive strategies. Women with VIN, lichen sclerosus, lichen planus or Paget's disease require appropriate long-term surveillance because recurrence and malignant transformation may occur.

Conclusion

Vulval premalignant and pre-invasive disease represents a spectrum of HPV-related, HPV-independent, inflammatory and glandular disorders. Improving recognition of subtle vulval abnormalities, maintaining a low threshold for biopsy, providing pathology-directed treatment and ensuring long-term surveillance can facilitate earlier diagnosis, reduce progression to invasive vulval cancer and improve quality of life.

Symposium 12: "Intrapartum Pyrexia: Early Recognition, Timely Intervention and Optimising Maternal–Newborn Outcomes"

Intrapartum Pyrexia: Pathophysiology, Differential Diagnosis and Early Recognition

Dr Dinusha Liyanapatabandi – Head/ Senior Lecturer, Department of Obstetrics & Gynaecology, Faculty of Medicine, University of Moratuwa.

Intrapartum pyrexia is a relatively common clinical finding that ranges from benign, transient temperature elevation to a marker of serious maternal and neonatal infection. Accurate interpretation can be challenging because fever during labour may arise from infectious and non-infectious mechanisms, while clinical features may be masked by the physiological changes associated with labour. Early recognition and appropriate management are therefore essential to reduce preventable maternal and neonatal morbidity.

The pathophysiology of intrapartum pyrexia includes both infectious and inflammatory mechanisms. Infectious causes include intra-amniotic infection, urinary tract infection, respiratory infection and other

maternal sources, while non-infectious causes include epidural-associated maternal fever, dehydration, prolonged labour and environmental factors. The relationship between maternal temperature, inflammatory responses, fetal tachycardia and other clinical indicators is important, particularly because fever alone has limited specificity for intra-amniotic infection.

A structured approach to assessment incorporates maternal observations, fetal assessment, relevant history, clinical examination and targeted investigations. Clinical features warranting escalation include persistent or rising maternal temperature, maternal or fetal tachycardia, uterine tenderness, offensive liquor and other evidence of maternal or fetal compromise. Principles of timely multidisciplinary communication, antimicrobial therapy and supportive management when infection is suspected are addressed, together with neonatal implications and appropriate postnatal assessment.

A practical, evidence-based framework for differentiating infectious from non-infectious intrapartum pyrexia can facilitate early identification of evolving maternal or fetal compromise, guide appropriate investigations and treatment, and minimise unnecessary interventions. Particular emphasis is placed on avoiding diagnostic delay while maintaining antimicrobial stewardship and recognising situations requiring urgent obstetric and neonatal intervention appropriately.

Management of Intrapartum Pyrexia: An Obstetrician's Perspective

Dr Dinuka Lankeshwara – Consultant Obstetrician and Gynecologist, Base Hospital Homagama.

Intrapartum pyrexia is a relatively common clinical finding but presents a significant diagnostic and management challenge for the obstetrician. Maternal fever is a clinical sign rather than a diagnosis and may result from intra-amniotic infection, urinary or other maternal infections, viral illness, dehydration, environmental factors, or non-infectious inflammatory and medication-related causes. Neuraxial analgesia-associated maternal fever is an important differential where applicable, but the possibility of infection must not be overlooked. This presentation will provide an evidence-based, clinically focused approach to the woman who develops pyrexia during labour, integrating contemporary guidance from ACOG, NICE, SMFM and RCOG with relevant evidence from the obstetric literature. Particular emphasis will be placed on distinguishing isolated maternal fever from suspected intra-amniotic infection and maternal sepsis, recognizing that temperature alone is insufficient to determine the underlying diagnosis. Maternal tachycardia, fetal tachycardia, uterine tenderness, purulent or foul-smelling liquor and laboratory abnormalities should be interpreted within the overall clinical context. Management requires simultaneous assessment of maternal and fetal wellbeing, appropriate investigation and timely antimicrobial treatment when infection is suspected. The presentation will discuss the practical role of maternal observations, microbiological investigations, inflammatory markers, lactate and assessment for organ dysfunction, while recognizing the limitations of individual clinical or laboratory parameters. Where maternal sepsis is suspected, treatment and resuscitation should begin promptly, with appropriate cultures obtained without causing clinically significant delays to antimicrobial therapy. The management of fetal wellbeing will also be explored, including the implications of maternal pyrexia for continuous cardiotocographic monitoring and interpretation of fetal tachycardia in the context of maternal temperature and suspected infection. The appropriate use of antipyretics will be considered, emphasizing that reduction of maternal temperature does not treat the underlying cause and must not delay investigation or treatment of suspected sepsis. A major focus will be the decision to deliver. Intra-amniotic infection or maternal pyrexia alone does not automatically constitute an indication for caesarean birth. Decisions regarding induction, continuation or augmentation of labour, instrumental

birth or caesarean section should be based on the maternal clinical condition, fetal status, progress of labour and conventional obstetric indications. When the genital tract or uterus is the suspected source of maternal sepsis, however, timely birth may be required as part of source control. The presentation will therefore address the key consultant-level questions: when to investigate, when to commence antibiotics, when to escalate to sepsis management, how to monitor the fetus, and when—if ever—pyrexia should alter the timing or mode of birth.

Management of the Newborn Following Maternal Intrapartum Pyrexia

Dr Kasun Jayasundara – Lecturer in Paediatrics and Neonatology, Faculty of Medicine, University of Moratuwa.

Symposium 13: “When Experience Matters: Mastering Difficult Deliveries - Lessons from Masters of Obstetrics”

Making Vaginal Delivery Possible: The Art of Clinical Judgement

Prof Hemantha Senanayake - Emeritus Professor of Obstetrics & Gynaecology at the University of Colombo. President of the Endometriosis and Adenomyosis Association of Sri Lanka, President of the Asian Society of Endometriosis and Adenomyosis (ASEA).

Sri Lanka is witnessing a drastic decline in births, which means more attention could be given to laboring mothers. Cesarean section rates have risen year on year, reaching almost 50%. Despite this, perinatal mortality remains unchanged.

Health systems recognize the short- and long-term hazards of cesarean section. High cesarean section rates indicate weaknesses in the delivery of maternal care.

The only way to promote normal delivery is adherence to solid science. Several interventions are well recognized to improve the chances of a normal delivery. These include non-supine positions and ambulation during labor, continuous support by a companion, and allowing more time for labor and recognition of active labor. Interventions known to reduce the chances of normal delivery include induction of labor and unnecessary augmentation. Sri Lanka has a reputation for a high rate of induction of labor. Other structural issues, such as poor pain relief in labor, need to be addressed. The notion that a nonengaged fetal head indicates disproportion is a common myth that leads to unnecessary cesarean sections. The notion that Southern Asian women experience a decline in placental function sooner than in their Caucasian counterparts is based on two population-based studies from the UK and New Zealand that did not stratify perinatal mortality according to fetal growth, an important indicator of placental function.

The Difficult Caesarean Section: Surgical Pearls from the Masters

Prof Athula Kaluarachchi – Professor of Obstetrics & Gynaecology, Dept. of Obstetrics & Gynaecology, Faculty of Medicine, University of Colombo, Past President, SLCOG.

Difficult caesarean section remains a significant challenge in obstetric practice and is associated with increased maternal and neonatal morbidity. Surgical difficulty may result from a deeply impacted fetal head, advanced labour, previous caesarean delivery with dense intra-abdominal adhesions, abnormal fetal lie or presentation, placenta accreta spectrum, uterine incision extensions, or unexpected major

haemorrhage. Safe management requires anticipation, meticulous preparation, sound knowledge of pelvic anatomy, appropriate surgical judgement, and timely escalation.

The management of a difficult caesarean section should be guided by a systematic and controlled surgical approach. Preoperative recognition of potential difficulties allows appropriate preparation, including the involvement of experienced obstetric, anaesthetic and neonatal teams and availability of blood and other resources when required. During abdominal entry, careful identification of altered anatomy and controlled adhesiolysis are essential, particularly in women with previous caesarean deliveries. Dense vesicouterine adhesions require meticulous bladder dissection, with avoidance of blind traction or sharp dissection when anatomical planes are uncertain.

Appropriate selection of the uterine incision is critical to safe fetal delivery. An inadequate incision should be enlarged when necessary, rather than overcome by excessive traction. In the presence of a deeply impacted fetal head, the objective should be to create space and disengage the head using an appropriate technique, such as vaginal disimpaction, reverse breech extraction or the Patwardhan manoeuvre. Abnormal lie and difficult breech extraction similarly require modification of the delivery technique according to the fetal position and uterine anatomy.

Recognition and controlled management of uterine incision extensions are essential to prevent major haemorrhage and injury to adjacent structures. Identification of the apex of an extension and restoration of normal anatomy should precede definitive repair. In broad-ligament bleeding, adequate exposure and identification of the bleeding source are fundamental. In suspected placenta accreta spectrum, attempts at forced placental separation should be avoided and management should follow an appropriately planned multidisciplinary strategy.

The successful management of difficult caesarean section depends on the integration of surgical expertise, anatomical knowledge, anticipation, judgement and teamwork. A fundamental surgical principle is to avoid force when resistance is encountered and instead create space, improve exposure and modify the surgical approach. Early recognition of difficulty and timely involvement of an experienced surgeon are central to preventing avoidable maternal and neonatal morbidity.

Mastering Breech Birth: Anticipating and Overcoming Challenges

Prof P. S. Wijesinghe – Professor Emeritus, Faculty of Medicine, University of Kelaniya, Sri Lanka, Past President, SLCOG. Former Deputy Director of the Postgraduate Institute of Medicine, University of Colombo.

In modern day obstetric practice, the decision for a vaginal breech delivery must be reached antenatally after careful consideration of maternal and fetal factors as well as the availability of skilled practitioners. Yet, it is prudent to anticipate the challenges in order to overcome them. In a normally grown fetus one should anticipate issues relating to the delivery of lower limbs, upper limbs and the after-coming head. Timely and appropriate action will lead to a favourable outcome. If the fetus is congenitally abnormal or in the event of fetal demise, in labour destructive procedures may be necessary. However, delivery by caesarean section has to be considered. In all eventualities, prior counselling and informed consent are important.

The Difficult Outcome: Wisdom Beyond the Delivery Room

Desabandu Prof Kapila Gunawardana - Professor Emeritus of Obstetrics & Gynaecology, University of Peradeniya, Past President of Sri Lanka College of Obstetricians & Gynaecologists

ABSTRACTS OF GUEST LECTURES

Day 01

Guest Lecture 01

Born Too Soon and the Road Forward to Prevent Preterm Birth

Prof. Bo Jacobsson – Chair, Department of Obstetrics & Gynecology at Sahlgrenska Academy, University of Gothenburg, Sweden, Deputy Head of Obstetrics at Sahlgrenska University Hospital.

In May 2023, the global health community initiated a crucial campaign titled "Born Too Soon - Decade of Action." This initiative addresses the persistent and pressing issue of preterm births worldwide. The primary aim is to significantly reduce the incidence of preterm births, which remain a leading cause of neonatal mortality and long-term health complications.

Background

Preterm birth, defined as birth before 37 completed weeks of gestation, affects approximately 15 million infants annually. These premature infants are at an increased risk of death and a range of health issues, including respiratory problems, developmental delays, and chronic health conditions. Despite advancements in medical science, the rates of preterm births have not significantly declined, necessitating a concerted global effort.

Objectives

The "Born Too Soon - Decade of Action" aims to:

- Enhance public awareness about the causes and consequences of preterm births.
- Implement evidence-based interventions to prevent preterm births and improve outcomes for preterm infants.
- Strengthen healthcare systems to provide comprehensive care for preterm infants and their families.
- Promote research and innovation to understand better and address the underlying causes of preterm births.
- Foster global collaboration among governments, healthcare providers, researchers, and non-governmental organizations (NGOs).

Key Strategies

The initiative employs several strategies to achieve its objectives:

- **Public Education Campaigns:** These aim to educate communities about the risk factors associated with preterm births, such as poor maternal health, inadequate prenatal care, and lifestyle factors.
- **Healthcare Improvements:** Investing in maternal and neonatal care facilities, training healthcare professionals, and ensuring the availability of essential medical supplies and technologies.
- **Policy Advocacy:** Advocating for policies that support maternal and child health, including paid maternity leave, access to quality healthcare, and nutrition programs.
- **Research and Development:** Funding and supporting research initiatives to uncover the biological, environmental, and social determinants of preterm births.
- **Monitoring and Evaluation:** Establishing robust systems to track progress, assess the effectiveness of interventions, and make necessary adjustments.

Global Collaboration

A cornerstone of the "Born Too Soon - Decade of Action" is fostering partnerships among various stakeholders. Governments, international organizations such as the World Health Organization (WHO) and UNICEF, healthcare providers, researchers, and NGOs are encouraged to collaborate. This multidisciplinary approach ensures that efforts are unified, resources are optimized, and successful practices are shared globally.

Conclusion

The launch of the "Born Too Soon - Decade of Action" in May 2023 marks a significant step towards addressing the global challenge of preterm births. By raising awareness, promoting research, improving healthcare, and fostering global collaboration, this initiative aims to create a future where every child has a healthy start to life.

Guest Lecture 02

Maternal mortality reduction the way forward for South Asia

Prof. Shyam Desai – Past President, South Asian Federation of Obstetrics & Gynaecology

Guest Lecture 03

Regenerative and Aesthetic Gynaecology a new superspeciality

Prof Narendra Malhotra – Managing Director, Global Rainbow Healthcare (Ujala-Cygnus-Rainbow Hospital), Director of Rainbow IVF/ART, Director of FOGSI SMRITI Manyata CSE, National Director of Ian Donald School of Ultrasound, Professor at Sarajevo School of Science & Technology and Dubrovnik International University.

Guest Lecture 04

Ovarian Ageing

Dr Nandita Palshetkar - Medical Director, Bloom IVF,. Past President of FOGSI, ISAR, IAGE, AMOGS, MOGS and MSR.

Guest Lecture 05

The environmental effects on pregnant mothers – Should we be more aware of the problem

Dr Ananda Ranatunga – Senior Consultant Obstetrician & Gynaecologist, Past President, SLCOG, Past President of Menopause Society of Sri Lanka.

Reproductive health is fundamental to human sustainability. There is growing evidence that it faces an ever threat from environmental pollution. Preconception and prenatal exposure to toxic environmental contaminants can significantly affect reproductive and developmental health. Pregnancy and early life are critical sensitive windows of susceptibility. Environmental factors such as air pollution, toxic chemicals, heavy metals, extreme heat, and maternal stress, can significantly impact fetal development through placental problems. Adverse outcomes associated with exposure include miscarriages, preterm birth, low birth weight, and neurodevelopmental delays (such as autism and ADHD). Environmental adversities can present in many ways. Various studies have linked adverse pregnancy outcomes to specific environmental exposures.

- Air Pollution: Poor air quality, especially exposure to fine particulate matter, Toxic Chemicals: Harmful substances like pesticides, solvents, and (PM_{2.5}) and nitrogen dioxide (NO₂), is linked to adverse outcomes.
- Extreme Heat, prolonged high temperatures and climate-related weather disasters increase risks for high blood pressure, gestational diabetes, and Preterm labor.
- Heavy metals can lead to pregnancy loss, stillbirth, preterm birth, and congenital anomalies
- Toxic Chemicals
 1. Persistent Organic Pollutants (POPs): Substances like polychlorinated biphenyls (PCBs) and dioxins may impact fetal development and contribute to neurodevelopmental delays.
 2. Endocrine-Disrupting Chemicals: Phthalates and bisphenol A (BPA) can interfere with hormonal balance and affect pregnancy outcomes.
 3. Water Contaminants: Arsenic, nitrates, and disinfection by-products in drinking water pose risks to fetal health.

Obstetricians don't need to be experts in environmental health, but awareness of toxic effects is crucial. Educating pregnant individuals about potential sources of exposure during the pre-pregnancy period is essential. The obstetricians should be knowledgeable about toxic environmental agents in relation to environmental health risk assessment, exposure reduction, and clinical counseling. Environmental health history including assessment for exposures from the workplace, home, or recreational activities. This should be an important segment of the patient's history during prepregnancy counselling and antenatal care visits. Although exposure to toxic environmental agents is widespread across populations, many environmental factors that are harmful to reproductive health disproportionately affect underserved populations and are subsumed in issues of environmental justice.

The pregnant mother has the power to mitigate the effects of environmental pollution and the toxic effects of the chemicals and heavy metal exposure. Receiving good antenatal care with good health education, making right choices about your home environment, habits, lifestyle and products used, you can reduce exposure to these harmful agents.

Raising awareness for an expectant mother requires a balance of empathy and clear non-frightening facts, focusing on empowerment rather than inducing panic by highlighting simple, everyday changes that protect both her and the baby. As care givers we should play a significant role in promoting awareness and education. Disseminating the knowledge among the junior doctors, nurses, midwives and other health workers will be essential. The importance of collective responsibility in addressing environmental risks is crucial. Our college along with other colleges and the entire medical community should take the leadership to guide the civil society and the government.

Guest Lecture 06

Towards Precision Medicine in Placenta Accreta Syndrome

Dr U. D. P. Ratnasiri – Senior Consultant Obstetrician and Gynecologist. Head, Examination Unit Sri Lanka Medical Council, Vice President of SAFOG, Advisor to the MFM Committee, AOFOG. Immediate Past Chairperson, IRC RCOG Sri Lanka. Past President of SLCOG. Past President of PSSL.

Background

Placenta accreta spectrum (PAS) has emerged as a critical global health challenge driven by rising cesarean delivery rates worldwide. Traditional histopathological classifications (accreta/ increta/ percreta) have proven inadequate for clinical decision-making as they fail to correlate with prenatal

imaging findings, do not predict surgical complexity, and cannot guide individualized patient management. Recent advances have fundamentally reshaped our understanding of PAS pathophysiology, recognizing it as a disorder of uterine scarification rather than inherently invasive placental tissue.

Methods

This session presents the PAS Topographic Classification, a novel intraoperative surgical staging framework that enables tailored management strategies based on lesion location, surgical difficulty, and patient-specific factors. The classification identifies two distinct surgical zones—the upper uterine segment (Sector 1) where dissection is straightforward, and the lower segment/cervix (Sector 2) characterized by extreme complexity, vascularity, and proximity to critical pelvic structures. Standardized prenatal ultrasound protocols facilitate preoperative mapping and surgical planning.

Results

Evidence demonstrates that uterine-sparing approaches, when technically feasible, are associated with decreased operative time, lower blood loss, reduced transfusion needs, and alignment with patient preferences regarding fertility preservation. A survey-based evaluation of 91 participants from 41 countries who attended structured virtual academic webinars revealed that 97% reported changes in clinical practice, with 90.1% adopting topographic classification and 94.5% implementing ultrasound staging. Tele-education proved invaluable for bridging training gaps and promoting international collaboration.

Conclusions

Embracing precision medicine principles in PAS management—moving beyond routine hysterectomy to individualized, topography-guided care—represents the future of obstetric surgery. Continued professional society support and prospective multicenter research are essential for generating robust evidence and standardizing care globally.

Guest Lecture 07

Fetal Cardiac Screening in the Context of New ISUOG Guidelines

Dr Jagath Dandeniya - Consultant Obstetrician and Gynaecologist, German Sri Lanka Friendship Hospital For Women, Galle.

Despite the well-documented utility of the four-chamber and outflow-tract views, one should be aware of the potential diagnostic pitfalls that can prevent timely detection of CHD. Detection rates can be optimized by performing a thorough screening examination of the heart, recognizing that the four-chamber and three-vessel views require much more than a simple count of cardiac structures, understanding that some lesions are not discovered until later in pregnancy, and being aware that certain types of abnormality (e.g. transposition of the great arteries, aortic coarctation) may not be evident in the four-chamber plane alone. Complementing the four-chamber view with outflow-tract and great-vessel views in the cardiac screening examination has played an important role in improving detection of fetal cardiac anomalies.

Guest Lecture 08

Handling near misses in Obstetrics Practice; "lessons learnt"

Prof K Muhunthan - Chair Professor of Obstetrics and Gynaecology at Faculty of Medicine, University of Jaffna.

A maternal near-miss (MNM) is defined by the World Health Organization (WHO) as a woman who nearly died but survived a complication that occurred during pregnancy, childbirth, or within 42 days of termination of pregnancy. Analyzing near misses offers a profound educational advantage over studying maternal mortality alone. Because the patient survived, teams can interview the woman directly about her care, and healthcare providers face a less threatening review environment free from the immediate fear of blame or legal punishment. This psychological safety fosters transparent reflection and systemic improvements.

To effectively operationalize these lessons and build institutional resilience, clinical environments should deploy a four-step response framework namely:

Establish a No-Blame System: Frame audits as "learning opportunities" rather than punitive tribunals. Focus strictly on system processes rather than individual mistakes.

Deploy the WHO Near-Miss Criteria: Utilize standard organ-dysfunction markers (cardiovascular, respiratory, renal, hepatic, metabolic, coagulation, or neurological) to remove subjectivity from what constitutes a near-miss.

Calculate Clinical Indicators: Regularly track your institution's Maternal Near-Miss Mortality Ratio (MNM : 1 Death). A higher ratio generally indicates a highly responsive, effective emergency obstetric care (EmOC) system capable of rescuing critically ill patients.

Enact Rapid-Cycle Simulation: Take real near-miss scenarios from your facility and turn them into mock code scenarios (e.g., massive postpartum hemorrhage drills) to train staff on immediate error recovery.

In Sri Lanka, the FHB carries out data collection of MNMs but to have a systematic analysis as mentioned above, which will help improve healthcare quality and further reduce maternal morbidity and mortality in future.

Guest Lecture 09

Prenatal Testing: Evidence, Economics and Equity

Dr Oshadhi Nallaperuma – Senior Lecturer and Consultant in Obstetrics and Gynaecology, Department of Obstetrics and Gynaecology, Faculty of Medicine, Sabaragamuwa University of Sri Lanka

Prenatal screening has evolved from maternal age-based assessment and second-trimester biochemical testing to first-trimester combined screening and cell-free DNA-based non-invasive prenatal testing (NIPT). While these advances have improved screening performance, selecting an appropriate population strategy requires consideration of not only accuracy, but also affordability, accessibility and the wider clinical value of each test.

Evidence demonstrates clear differences in performance. Triple and quadruple screening detect approximately 70% and 80% of trisomy 21 respectively, while first-trimester combined screening, incorporating maternal age, nuchal translucency (NT), PAPP-A and free β -hCG, approaches 90%. NIPT offers superior performance, detecting over 99% of trisomy 21 with a very low false-positive rate. However, NIPT remains a screening test, and high-risk results require confirmation by invasive diagnostic testing.

This improved performance comes at a considerable economic cost. Based on current local estimates, triple, combined and quadruple screening cost approximately LKR 14,700, 17,500 and 20,300 respectively, compared with approximately LKR 57,500 for NIPT. Universal NIPT may therefore be difficult to sustain within a resource-constrained public health system. Contingent strategies, where NIPT is

selectively offered following first-line risk assessment, may retain much of its benefit while reducing programme costs and unnecessary invasive procedures.

Conventional prenatal assessment also provides information beyond aneuploidy. The 11–14-week ultrasound assesses viability, dating, chorionicity, early fetal anatomy and NT. Biochemical markers provide additional information regarding placental function. Low PAPP-A is associated with fetal growth restriction (FGR), pre-eclampsia and other placenta-mediated complications, while elevated AFP is associated with open neural tube defects and adverse placental outcomes. Although these biomarkers are insufficient as stand-alone predictors of placental disease, abnormal results can identify pregnancies requiring enhanced surveillance.

Equity is therefore fundamental. A highly accurate test accessible only to women who can afford it represents technological advancement without necessarily achieving equitable prenatal care. Equity should mean universal access to an effective screening pathway rather than simply offering everyone the same test.

For Sri Lanka, a pragmatic approach could build upon existing public-sector obstetric ultrasound capacity. A structured first-trimester assessment incorporating the 11–14-week scan and NT, complemented by PAPP-A and second-trimester AFP where appropriate, could provide information on aneuploidy, fetal anatomy and placental dysfunction. NIPT could then be strategically used as a second-line test for women at increased risk, followed by diagnostic testing when indicated.

The goal should therefore be universal access to the best achievable evidence-based pathway balancing accuracy, affordability and equity.

Guest Lecture 10

The Role of Intrapartum Ultrasound in the Management of Second Stage Labour Dystocia

Dr B Yohan De Silva – Senior Obstetrician & Gynaecologist at Gosford Hospital, New South Wales, Australia (2000 - 2025). Former Senior Lecturer in Obstetrics & Gynaecologist, University of Newcastle, NSW, Australia (2000 -2012).

Introduction

Extensive evidence in the literature indicate that digital pelvic examination for the determination of foetal head position (OA or OP) and foetal head station in the second stage of labour is subjective, poorly reproducible and not very reliable. This can have major implications in deciding the mode of delivery in prolonged second stage. Recent studies suggest that the use of intrapartum ultrasound can overcome these problems by providing a series of objective measurements for progress of labour and prediction of successful vaginal delivery (spontaneous or instrumental).

Different sonographic parameters assessed in labour

1. Head position (OA/OP)
 - Trans abdominal imaging
 - Translabial – Angle of Rotation
2. Head Station (Translabial imaging)
 - Head direction
 - Head progression distance (HPD)
 - Head symphysis distance (HSD)
 - Angle of Progression (AoP)

The most reproducible measurement was Angle of Progression (AoP). AoP was the only sonographic predictor of mode of delivery in the Second stage of Labour. AoP > 120 degrees was associated with a 90% probability of Vaginal delivery in Occipito Anterior position. Head Symphysis distance (HSD) was more reliable than Angle of Progression (AoP) in Occipito Posterior positions. Ultrasound assessment of Foetal head position and Station is easier to learn than digital assessment. The most important indication for Intrapartum Ultrasound was in the management of Second stage Labour Dystocia. Intrapartum ultrasound should be welcomed as a complimentary tool and should not undermine clinical skills.

Conclusion

The ideal sonographic method to evaluate fetal head station has yet to be found. Randomized studies are lacking and difficult to perform. Future - ? Use of Sonopartograms.

Guest Lecture 11

Post Graduate Training Gaps in South Asian Countries

Prof Rashid Latif Khan – Founder, Past President South Asian Federation of Obstetrics & Gynaecology, Professor Emeritus (PGMI, Lahore, Pakistan)

Guest Lecture 12

PMOS (Poly Endocrine Metabolic Ovarian Syndrome)

Prof Jaideep Malhotra – Managing Director, ART Rainbow IVF, Agra; President, INSARG (2025–27); Past Chair, FIGO REI Committee; Regional Director, Ian Donald School of Ultrasound; Professor, Dubrovnik International University, Croatia.

Introduction

Polycystic ovary syndrome (PCOS) is a heterogeneous disorder with diverse reproductive, metabolic, endocrine and psychological manifestations. The traditional diagnostic approach identifies PCOS as a single syndrome, whereas the wide variation in clinical presentation, metabolic risk and reproductive outcomes suggests the need for a more refined phenotype-based approach. The concept of Phenotypes of Metabolic Ovarian Syndrome (PMOS) provides an opportunity to move beyond the conventional diagnosis of PCOS toward individualized risk assessment and personalized management.

Objective

To explore the concept of PMOS and its potential role in identifying clinically relevant reproductive and metabolic phenotypes of women with PCOS and guiding personalized preventive and therapeutic strategies.

Methods

The PMOS framework integrates clinical, biochemical, metabolic, ovarian and reproductive characteristics, including menstrual dysfunction, hyperandrogenism, insulin resistance, obesity, dyslipidaemia, polycystic ovarian morphology, fertility status and associated psychological and cardiometabolic risks. The phenotypes were considered across the reproductive life course, recognizing that the expression of PCOS may change with age, lifestyle, weight and reproductive goals.

Results

PCOS represents a spectrum rather than a single phenotype. Some women predominantly demonstrate reproductive dysfunction and hyperandrogenism, while others have a marked metabolic phenotype characterized by obesity, insulin resistance, dysglycaemia and dyslipidaemia. A further group may

present predominantly with infertility, whereas others may have relatively subtle reproductive manifestations but significant long-term metabolic risk. Importantly, metabolic risk may exist even in women who are not obese. The PMOS approach therefore emphasizes risk stratification rather than diagnostic labelling alone. Assessment of phenotype can facilitate individualized interventions involving lifestyle modification, nutritional optimization, weight management, ovulation induction when required, metabolic risk reduction and psychological support.

Conclusion

PMOS offers a clinically meaningful framework for understanding the heterogeneity of PCOS. Recognition of individual metabolic–reproductive phenotypes may allow earlier identification of high-risk women and enable personalized, preventive and life-course management. The future of PCOS care should move from “Do you have PCOS?” to “What is your phenotype, what are your risks, and what intervention is appropriate for you?” PMOS may therefore represent an important step toward precision medicine in reproductive endocrinology.

Keywords

PMOS; PCOS; phenotyping; metabolic ovarian syndrome; insulin resistance; hyperandrogenism; infertility; cardiometabolic risk; personalized medicine; precision medicine.

Guest Lecture 13

Fertility Preservation: Current Evidence and Future Directions

Dr Ruchi Hooda – Senior Consultant Infertility Specialist, Ridge IVF and Gouri Hospital, Delhi. Associate Member, RCOG, and member of FOGSI, ISAR, IFS, PCOS Society, AOGD, NARCHI and FPSI.



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FIGO (International Federation of Gynaecology & Obstetrics)

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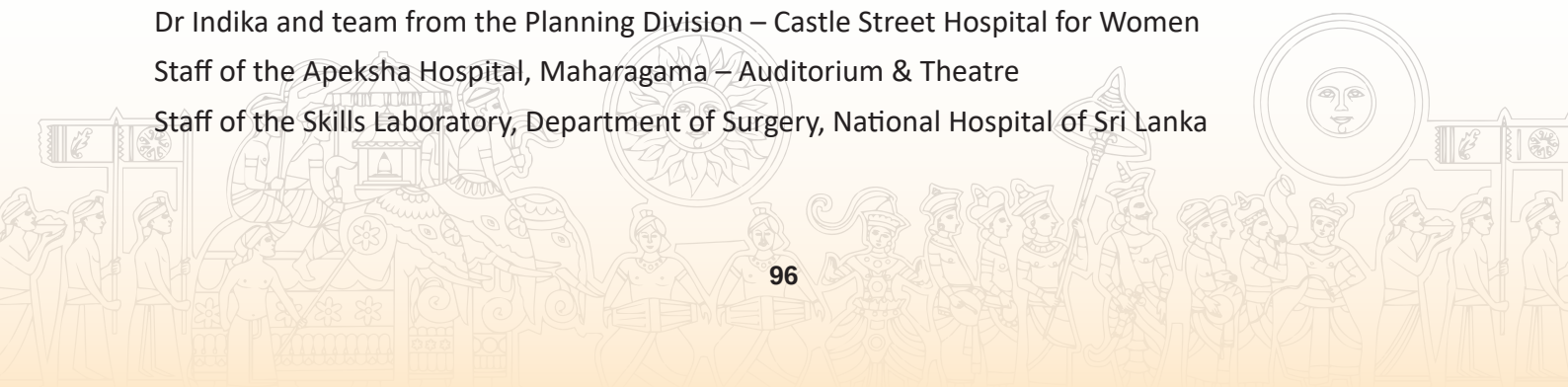
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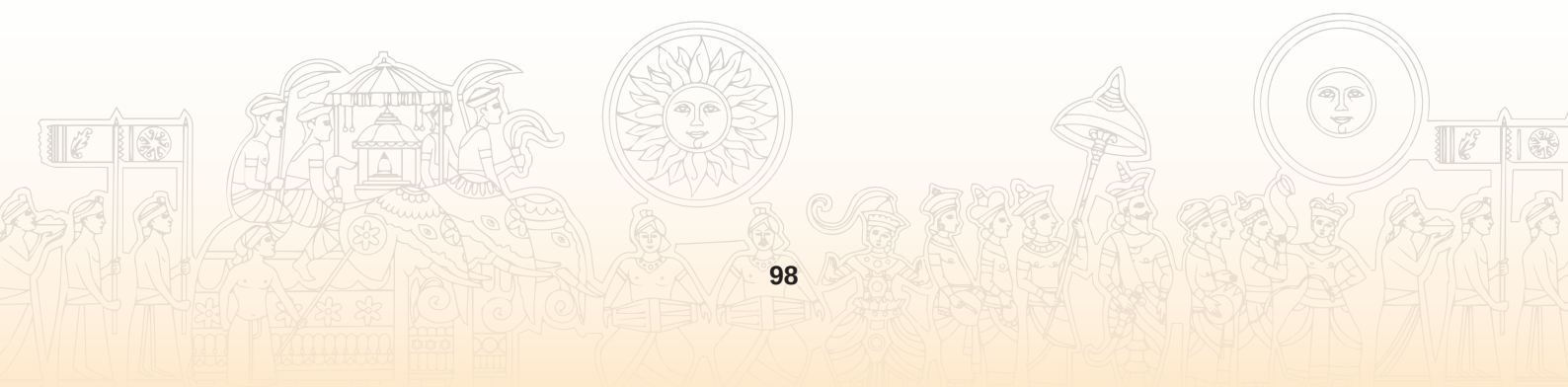
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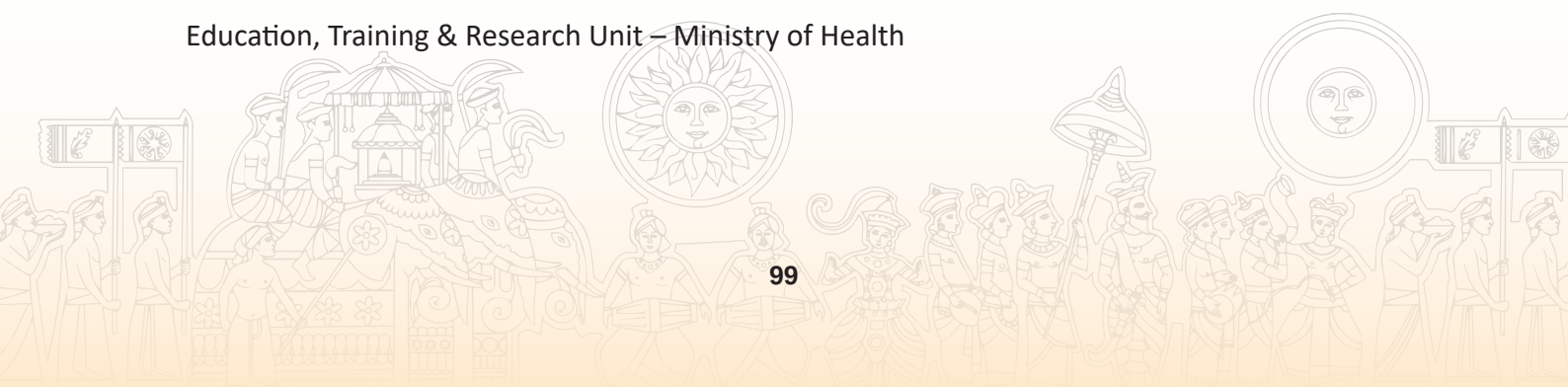
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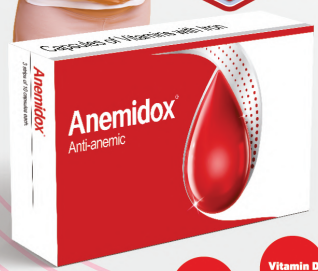
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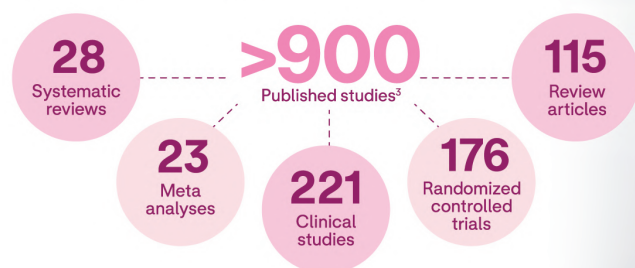
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References:
1. Data on file (IOVIA / Market Data). 2. ESHRE 2025 Guideline on Ovarian Stimulation for IVF/CSI. <https://www.eshre.eu/Guidelines-and-Legal/Guidelines/Ovarian-Stimulation-in-IVF-CSI> 3. Search Results - Duphaston - Pubmed. Accessed May 26, 2025.

Abbreviated Prescribing Information:

Dydrogesterone Tablets (P. Duphaston®) LABEL CLAIM: Each film-coated tablet contains: Dydrogesterone IP 10 mg. Excipients: q.s. Colour: Titanium dioxide IP. INDICATION: Progesterone deficiency; Treatment of dysmenorrhoea; Treatment of endometriosis; Treatment of secondary amenorrhoea; Treatment of irregular cycles; Treatment of dysfunctional uterine bleeding; Treatment of pre-menstrual syndrome; Treatment of threatened miscarriage; Treatment of habitual miscarriage; Treatment of infertility due to luteal insufficiency; Luteal support as part of an Assisted Reproductive Technology (ART) treatment and Hormone replacement therapy (To counteract the effects of exogenous oestrogen on the endometrium in hormone replacement therapy for women with disorders due to natural or surgical induced menopause with an intact uterus). DOSAGE AND ADMINISTRATION: Dysmenorrhoea: 10 or 20 mg dydrogesterone per day from day 5 to day 25 of the menstrual cycle. Endometriosis: 10 to 30 mg dydrogesterone per day from day 5 to day 25 of the cycle or continuously. Dysfunctional uterine bleeding: When treatment is started to arrest a bleeding episode, 20 or 30 mg dydrogesterone per day is to be given for up to 10 days. Secondary amenorrhoea: 10 or 20 mg dydrogesterone per day, to be given daily for 14 days during the second half of the theoretical menstrual cycle to produce an optimum secretory transformation of an endometrium that has been adequately primed with either endogenous or exogenous oestrogen. Pre-menstrual syndrome: 10 mg dydrogesterone twice daily starting with the second half of the menstrual cycle until the first day of the next cycle. The starting day and the number of treatment days will depend on the individual cycle length. Irregular cycles: 10 or 20 mg dydrogesterone per day starting with the second half of the menstrual cycle until the first day of the next cycle. The starting day and the number of treatment days will depend on the individual cycle length. Threatened miscarriage: An initial dose of up to 40 mg dydrogesterone may be given followed by 20 or 30 mg per day until symptoms remit. Habitual miscarriage: 10 mg dydrogesterone twice daily until the twentieth week of pregnancy. Infertility due to luteal insufficiency: 10 or 20 mg dydrogesterone daily starting with the second half of the menstrual cycle until the first day of the next cycle. Treatment should be maintained for at least three consecutive cycles. Luteal support as part of an Assisted Reproductive Technology (ART) treatment: 10 mg dydrogesterone three times a day (30 mg daily) starting at the day of oocyte retrieval and continuing for 10 weeks if pregnancy is confirmed. Hormone replacement therapy: Continuous sequential therapy: An oestrogen is dosed continuously and one tablet of 10mg dydrogesterone is added for the last 14 days of every 28-day cycle, in a sequential manner. Cyclic therapy: When an oestrogen is dosed cyclically with a treatment-free interval, usually 21 days on and 7 days off. One tablet of 10 mg dydrogesterone is added for the last 12-14 days of oestrogen therapy. CONTRAINDICATIONS: Known hypersensitivity to the active substance or to any of the excipients. Known or suspected progesterone-dependent neoplasms (e.g. meningioma). Undiagnosed vaginal bleeding. Treatment for luteal support as part of an Assisted Reproductive Technology (ART) treatment should be discontinued upon diagnosis of abortion/miscarriage. Contraindications for the use of oestrogen when used in combination with dydrogesterone. WARNINGS & PRECAUTIONS: Before initiating dydrogesterone treatment for abnormal bleeding the aetiology for the bleeding should be clarified. Breakthrough bleeding and spotting may occur during the first months of treatment. If breakthrough bleeding or spotting appears after some time on therapy, or continues after treatment has been discontinued, the reason should be investigated, which may include endometrial biopsy to exclude endometrial malignancy. If any of the following conditions are present, have occurred previously, and/or have been aggravated during pregnancy or previous hormone treatment, the patient should be closely supervised. It should be taken into account that these conditions may recur or be aggravated during treatment with dydrogesterone and ceasing the treatment should be considered: Porphyria, Depression and Abnormal liver function values caused by acute or chronic liver disease. PREGNANCY & LACTATION: It is estimated that more than 10 million pregnancies have been exposed to dydrogesterone. So far there were no indications of a harmful effect of dydrogesterone use during pregnancy. Dydrogesterone can be used during pregnancy if clearly indicated. Breastfeeding: No data exist on excretion of dydrogesterone in mother's milk. Experience with other progestogens indicate that progestogens and the metabolites pass to mother's milk in small quantities. Whether there is a risk to the child is not known. Therefore, dydrogesterone should not be used during the lactation period. Fertility: There is no evidence that dydrogesterone decreases fertility at therapeutic dose. ADVERSE REACTIONS: The most commonly reported adverse drug reactions of patients treated with dydrogesterone in clinical trials of indications without oestrogen treatment are migraines/headache, nausea, menstrual disorders and breast pain/tenderness. Undesirable effects in adolescent population. Based on spontaneous reports and limited clinical trial data, the adverse reaction profile in adolescents is expected to be similar to that seen in adults. Undesirable effects that are associated with an oestrogen-progestogen treatment: Breast cancer, endometrial hyperplasia, endometrial carcinoma, ovarian cancer; Venous thromboembolism; Myocardial infarction, coronary artery disease, ischemic stroke. Issued date as 26/08/2021. Source: Prepared based on full prescribing information (version 9) dated 26/08/2021. © Registered Trademark of the Abbott Products Operations AG. For full prescribing information, please contact: Abbott India Limited, 16th Floor, Godrej BKC Plot C-68, 'G' Block, BKC, Near MCA Club, Bandra East, Mumbai-400 051. www.abbott.co.in Copyright © 2026 Abbott. All rights reserved.



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