



**25th ANNUAL
SCIENTIFIC CONGRESS 2026
Perinatal Society of Sri Lanka**

*“Beyond Survival : Thriving with Advanced Maternal
& Neonatal Care”*

PROGRAMME & ABSTRACTS

**26th -28th September 2026
Waters Edge, Sri Lanka**



MESSAGE FROM THE CHIEF GUEST

It is with great pleasure that I extend my warm greetings to the Perinatal Society of Sri Lanka on the occasion of its Annual Scientific Sessions.

Sri Lanka has a long-standing commitment to improving the health and wellbeing of mothers and newborns. The progress achieved in maternal and child health over the years is a testament to the strength of our healthcare system and, above all, to the dedication and commitment of our healthcare professionals. Yet, the continued reduction of preventable maternal and neonatal morbidity and mortality requires us to constantly reflect, innovate and improve the quality of care we provide.



Perinatal medicine is a rapidly evolving field, and advances in evidence-based clinical practice, technology, research and multidisciplinary care offer important opportunities to further improve outcomes. Equally important is ensuring that every mother and newborn receives safe, respectful, compassionate and equitable care, irrespective of their circumstances or place of residence.

The Annual Scientific Sessions of the Perinatal Society provide an important forum for bringing together clinicians, researchers, academics and other stakeholders to exchange knowledge, present locally relevant research and identify practical solutions to challenges in perinatal healthcare. Such collaboration is vital in translating scientific evidence into meaningful improvements in our health services.

I commend the Perinatal Society of Sri Lanka for its continued contribution to professional education, research and the advancement of perinatal care in our country. I encourage all participants to use this forum not only to share achievements, but also to envision new approaches that will shape the future of maternal and newborn health in Sri Lanka.

I wish the Society and all participants a successful and academically rewarding Annual Scientific Sessions.

Hon. Dr. Nalinda Jayatissa

Minister of Health and Mass Media

Democratic Socialist Republic of Sri Lanka

MESSAGE FROM THE PRESIDENT PERINATAL SOCIETY

It is my distinct privilege and honor to welcome you to the 25th Annual Scientific Congress of the Perinatal Society of Sri Lanka, held at The Waters Edge from 26th – 27th September 2026, followed by the Scientific Congress for Nurses and Midwives on the same venue on 28th of September 2026. The Scientific Congress is accomplished with a pregress workshop on “Practical Aspects in Advanced Neonatal Intensive Care” and two postgress workshops on “Advanced Neonatal Vascular Access Masterclass” and “First Trimester Scan Workshop for Gynaecology and Obstetrics Trainees and Consultants”. Marking our Silver Jubilee, this milestone congress reflects on 25 years of commitment to improving maternal and newborn health while charting a bold path forward under our theme: "Beyond Survival: Thriving with Advanced Maternal & Neonatal Care".



Over the decades, the Perinatal Society of Sri Lanka has worked within the healthcare system to reduce perinatal mortality rates. Yet, ensuring mere survival is only the beginning. We are actively working toward a future where every mother and neonate not only survives childbirth, but thrives physically, neurodevelopmentally, and emotionally. To realize this vision, we are working to integrate advanced care, modern technology, evidence-based guidelines and compassionate practice across all levels of healthcare.

This year's scientific programme has been curated to address these priorities across our main two-day congress and our dedicated Nurses & Midwives Congress held in collaboration with UNICEF. We have received scientific abstracts and orations including the PSSSL Oration and the Professor Indrajee Amarasinghe Oration demonstrating exceptional research within our community. Across symposia, free paper sessions and plenary lectures, our delegates will explore vital domains ranging from perinatal mental health, smart labor care, and intrapartum monitoring, to advanced neonatal bedside diagnostics, antimicrobial stewardship, primary health and family-integrated care.

I extend my heartfelt gratitude to the Council, Committees, our local and international faculty, and our partners for their dedication to bringing this congress to success. May this Silver Jubilee Congress inspire new collaborations and elevate perinatal care across Sri Lanka.

Professor Ruwanthi Perera
President
Perinatal Society of Sri Lanka

MESSAGE FROM THE SCIENTIFIC CHAIR



It is my great pleasure to welcome you to the 25th Annual Scientific Congress of the Perinatal Society of Sri Lanka, to be held on 26th and 27th September 2026 at The Waters Edge.

This year's theme, "Beyond Survival: Thriving with Advanced Maternal & Neonatal Care," reflects an important goal in modern perinatal care. Our responsibility is no longer limited to ensuring the survival of mothers and newborns. We must also strive to provide high-quality care that allows every mother, newborn and child to achieve the best possible health and well-being.

The Scientific Committee has carefully developed a programme that brings together current evidence, new ideas and practical approaches to the major challenges in maternal and newborn care. The Congress covers a wide range of important areas, including safe maternity care, prevention of perinatal deaths, neonatal care, maternal mental health, newborn screening, infections, neuroprotection, post-discharge care and the growing role of new technologies.

We are privileged to have an excellent faculty of Sri Lankan and international experts who will share their knowledge and experience through symposia, plenary lectures, orations and scientific discussions. The free-paper sessions will also provide an important opportunity for researchers to present their work and encourage further research in perinatal medicine.

A scientific congress becomes truly meaningful when the knowledge shared leads to better clinical practice and better outcomes for our patients. I hope this Congress will encourage all of us to exchange ideas, question existing practices, strengthen teamwork and translate the best available evidence into everyday care.

As we celebrate the 25th Annual Scientific Congress, I sincerely thank our speakers, researchers, reviewers, organising committees and everyone who has contributed to making this event possible.

I warmly welcome you all and wish you an enjoyable, inspiring and academically rewarding Congress.

Dr. R. M. Surantha Perera

Scientific Chair, Past President, PSSSL

25th Annual Scientific Congress 2026

Perinatal Society of Sri Lanka

MESSAGE FROM THE SECRETARY

It is a distinct honor to present this message for the Abstract Book of the 25th Annual Scientific Sessions of the Perinatal Society of Sri Lanka (PSSL), as we gather to celebrate our Silver Jubilee Commemoration. Reaching this 25-year milestone marks a pivotal moment in our history- a time to honor a rich legacy of multidisciplinary unity and clinical progress in maternal and newborn care.



Since its founding, the PSSL has brought together obstetricians, neonatologists, paediatricians, community physicians, midwives, and allied health professionals with a shared mission. Over the past quarter-century, this collaborative network has been central to elevating perinatal standards and driving continuous quality improvement across Sri Lanka.

This commemorative Abstract Book captures the spirit of our Silver Jubilee. The scientific papers, clinical audits, and original research published here showcase the intellectual rigor and resilience of our medical community, highlighting solutions tailored to local healthcare priorities.

My heartfelt gratitude goes to the President, Council members, Scientific Committee, resource persons, and industry partners whose tireless efforts made these landmark sessions possible. I also congratulate all the researchers whose work enriches this volume.

As we commemorate 25 years of excellence during these Annual Sessions, may the insights within these pages inspire new partnerships and elevate the standard of care for mothers and neonates for years to come.

Dr. Jithma Fonseka
Honorary Secretary
Perinatal Society of Sri Lanka

MESSAGE FROM THE EDITOR



It is my privilege to present the Abstract Book of the Annual Scientific Sessions of the Perinatal Society of Sri Lanka.

Perinatal medicine stands at the intersection of science, innovation, and humanity. The abstracts presented in this volume reflect the growing depth and diversity of perinatal research in Sri Lanka, while highlighting our collective commitment to improving the health and wellbeing of mothers and newborns.

Scientific progress is meaningful only when knowledge is translated into better care. The work represented here - from clinical research and innovation to quality improvement, public health, and health-system research-demonstrates the potential of locally generated evidence to shape practice and influence policy.

These sessions also provide an opportunity to look beyond individual disciplines and institutions, fostering collaboration and shared learning towards a common goal: ensuring that every mother and newborn receives safe, equitable, and high-quality care.

I extend my sincere appreciation to all authors, reviewers, scientific committee members, and the organising team whose dedication has made this publication possible.

May these contributions stimulate dialogue, inspire new ideas, strengthen collaboration, and serve as a catalyst for the next generation of advances in perinatal care in Sri Lanka.

Dr. Nimesha Gamhewage

Editor

Perinatal Society of Sri Lanka

Perinatal Society of Sri Lanka

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Towards healthier
mothers and newborns

25th ANNUAL SCIENTIFIC CONGRESS 2026

26th to 28th September 2026 - Program Layout

26th September 2026

- **Inauguration and Annual Scientific Congress**
Waters Edge, Sri Lanka

27th September 2026

- **Annual Scientific Congress**
Waters Edge, Sri Lanka

28th September 2026

- **Nurses' and Mid Wives' Congress**
Waters Edge, Sri Lanka





Towards healthier
mothers and newborns

The Perinatal Society of
Sri Lanka

NURSES' AND MIDWIVES' CONGRESS

28th September 2026 | The Waters Edge



ANNUAL SCIENTIFIC CONGRESS PROGRAMME

- NURSES & MIDWIVES -

“Beyond Survival: Thriving with Advanced Maternal & Neonatal Care”
IN COLLABORATION WITH THE FAMILY HEALTH BUREAU & UNICEF
28th Monday 2026 at The Waters Edge

7.00 am - 7.30 am	Registration	
7.30 am - 8.00 am	Pre Test	
8.00 am - 8.45 am	Oral and Poster Presentations	
8.45 am - 9.30 am	Opening Ceremony Welcome Address by Prof Ruwanthi Perera - <i>President, Perinatal Society of Sri Lanka</i> Address by Chief Guest: Dr Abner Daniel - <i>Health and Nutrition Manager, UNICEF Sri Lanka</i> Address by Dr Chandima Sirithunga - <i>Director, Family Health Bureau</i> Address by Dr Dhammica Rowel - <i>Health and Nutrition Officer, UNICEF Sri Lanka</i> Address by Mrs M B C Samanmali - <i>Director of Nursing, MOH</i> Cultural Event	
9.30 am - 09.50 am	Keynote Address Improving Perinatal Care Through Continuous Professional Development Dr. Harendra Dassanayake <i>Immediate Past President, PSSSL</i>	
9.50 am - 10.10 am	Plenary 1 Smart Work Place Design to Minimize Professional Burnout Dr. Surantha Perera <i>Consultant Paediatrician : BH Homagama</i>	
10.10 am - 10.30 am	Morning Tea	
10.30 am - 11.40 am	Hall A Symposium 1 : Quality & Equity in Care Symposium 1 A Smart Labour: Safety through WHO Guidelines Dr. Ruwan Silva - Consultant Obstetrician and Gynaecologist DMH First Breath to First Steps: Universalizing Essential New born Care Dr. Nethmini Thenuwara Programme Manager, Intranatal and Newborn Care, FHB Stabilizing High Risk Mothers In Remote Settings Dr. Sritharan Appudurai - Consultant Obstetrician and Gynaecologist CSHW	Hall B Symposium 1 B Antimicrobial Stewardship in the NICU Dr. Dharuni Weerakoon Consultant Clinical Microbiologist - CNTH Early Recognition and Prevention of Neonatal Seizures Prof. Saraji Wijesekara Professor in Paediatric Neurology - CSTH Early Intervention Strategies in the Community Dr. Nilushi Weeraperuma Consultant Community Paediatrician: Oxford, UK
11.40 am - 12.50 pm	Symposium 2 : Innovation & Zero Separation Symposium 2 A Respectful Maternity Care in the Delivery Suite Prof. Mohamed Rishard - Consultant Obstetrician & Gynaecologist DMH	Symposium 2B The Triad of Crisis in the NICU : Communicate - Document - Debrief Jane Cichero Nursing Educator: Sydney, Australia

	- o Maternal Mental Health in the Perinatal Period Prof. Chathurie Suraweera Consultant Psychiatrist: <i>NHSL</i> - o Preconception Management of NCDs in the Community Dr. Shamitha Dassanayaka Consultant Physician: <i>CSHW</i>	- o Surveillance Saved Lives: Transforming Perinatal Data into Survival Dr. Gayani Gunawardane Programme Manager, <i>Child Morbidity and Mortality Unit, FHB</i> - o Evidence Based Feeding Strategies for Preterm and LBW Neonates Prof Nishani Lucas Professor in Neonatology, <i>DMH</i>	
12.50 pm – 1.45 pm	Lunch		
1.45 pm – 4.15 pm	Practical Workshops Neonatal Loop Station 1: Preterm Stabilization Dr. Dilani Dehigama Dr. Dilusha Athukorala Dr. Bhiruntha Sivakanthan Station 2: KMC & Safe Transport Dr. Kapilani Withanaarachchi Dr. Jithma Fonseka Ms. Jane Cichero Station 3: NICU Stabilization and Golden Hour Practice Dr. Nimesha Gamhewa Dr. Sujith Gunaratne Dr. Pushpakumara Weerakoon	Obstetric Loop Station 1: Management of PPH Dr. Amila Rubasinghe Dr. R. Kajeepan Station 2: Management of Shoulder Dystocia Dr. Achintha Dissanayake Dr. Chiran Colombage Station 3: Eclampsia Drill Dr. Ruwan Silva Dr. Sharada Jayalath Dr. Indunil Piyadegama	Community Medicine Loop Station 1: Newborn at Home Setting Dr. Pushpika Chandrasekara Dr. Sathika Amarasekara Dr. Ruwanthika Liyanage Station 2: Lactation Essentials Dr. Nethmini Thenuwara Dr. Sandya Doluweera Dr. Kanchana Gamage Station 3: Perinatal Depression: Screening and Counselling in Community Dr. Sanjeewa Godakandage Dr. Deepika Herath Dr. Lasantha Wijesekera
4.15 pm onwards	Awards Ceremony Presentation of UNICEF Awards for Unit Audits in Neonatal Quality Improvement Distribution of Certificates		Closing Ceremony Closing Remarks & Vote of Thanks Dr. Jithma Fonseka <i>Secretary, PSSSL</i>



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Dr. Lasantha Wijesekera
Applied Psychologist

The Triad of Crisis in the NICU – communicate, document, debrief ACE-ing it - One Approach to Implementing After Critical Event Reviews

Authors: Jane Cichero, Nichola Concannon, Renee Byrne

Aim: To provide a framework for facilitating critical event reviews to enhance quality and safety. Clinical event debriefing has become a recognised quality improvement initiative in healthcare. This form of debriefing is a facilitated reflection on the actions and events of the case. They are often performed closely following a critical event and enable the team involved to identify any learnings and system issues. Team members are encouraged to explore aspects of care in a safe environment, share what went well, and aspects that did not go as planned and how care could be improved in future. Successes and learnings can also be shared with the wider department. Clinical event reviews are not emotional debriefs.

At Sydney Children's Hospital (SCH) the Critical Care Simulation Team implemented After Critical Event (ACE) reviews in 2020 in SCH Emergency Department. The review process is evidenced based and an integral part of our Quality and Safety Program. Since 2020, ED has conducted over 100 ACE reviews. Many of these identified system issues that have been addressed to improve patient care. To build sustainability, with the introduction, we rolled out an ACE Facilitator Workshop. The workshop is a 3-hour course aimed at developing the required skills to conduct an ACE review and promote psychological safety during an ACE review. Candidates are orientated to the ACE Facilitator resources and given the opportunity to participate in a simulated ACE review to build familiarity with the process and resources. Since 2022 the program has expanded outside the ED, with 92 staff trained as ACE facilitators. Resources are now easily available on the intranet to support implementation. This presentation will outline the ACE review processes and elements of the ACE Facilitator workshop at SCH. The resources created for an ACE facilitator will be presented and demonstrate how they can bridge the gap and support organisational change.

Home Based Newborn Care: Counselling On “Early Warning Signs”

Dr. Sathika Amarasekara

Consultant Neonatologist

The neonatal period or the first 28 days of life is the most fragile and critical time for human survival. Newborn is going through changes in getting used to the life in the world hence, babies face their highest risk of death during neonatal period compared to any other time in childhood.

According to WHO, nearly half of all deaths under 5 years happen during this critical period and majority of these deaths occurs in LMIC. Most Deaths occur in home due to lack of recognition of early warning signs and delay in seeking medical care. Therefore, close care is essential during this critical period of human life to enhance chances of survival and to lay a strong foundation for healthy life.

Although most physiologic changes in sick newborns at the early stages of illness are usually subtle, and these might indicate serious neonatal morbidities such as sepsis, respiratory distress, cardiovascular compromise and neurological disorders.

EWS are signs used by health care workers or parents to identify babies who need special care or to be referred early.

The EWS are breathing difficulties, temperature instability, feeding difficulties, abnormal neurological signs and skin colour changes. Breathing difficulties include, tachypnoea, nasal flaring, grunting and chest indrawing. Temperature above 38°C and below 36.5 °C are concerning factors. Feeding difficulties are weak sucking, refusal to feed, vomiting and reduced intake over a period of 24 hours. Lethargy,

extreme sleepiness where the infant is hard to rouse, hypotonia, irritability, or seizures/convulsions might indicate underlying neurological condition. Normal newborn is pink in colour and cyanosis and jaundice need urgent attention.

Upon identification of any of the EWS, parents should be directed to the nearest health care facility after proper counselling



Towards healthier
mothers and newborns

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Shaping a Healthy Nation: The Impact of Maternal Nutrition on Newborn Outcomes and Future NCD Risk

Snr. Prof. Pujitha Wickramasinghe

Department of Paediatrics, University of Colombo



This oration examines how maternal nutrition shapes newborn outcomes, childhood growth, and potential future noncommunicable disease (NCD) risk in Sri Lanka. Although the country has achieved major health improvements, early-life undernutrition remains persistent, with growth faltering concentrated during the first 1,000 days of life. The Sri Lanka Child Growth Cohort Study assessed 1,875 term-born children aged 12–24 months from urban, rural, and estate sectors using retrospective records, caregiver interviews, and standardized anthropometry.

Maternal nutritional vulnerability was substantial. Only half of mothers had a normal pre-pregnancy BMI; fifth of mothers were underweight and one third were overweight or obese. Little over half had used pre-pregnancy folic-acid, while more than 90% took antenatal iron, folic acid, calcium, and vitamin C. However, about sixty percent of mothers had inadequate gestational weight gain, and it was more than 80% among underweight estate-sector mothers. Estate women were shorter, had lower BMI and haemoglobin levels, and experienced greater socioeconomic disadvantage.

Low birth weight affected 13% of infants overall, but 20.8% in the estate sector. Birth weight increased independently with maternal BMI, gestational weight gain, gestational age, and parental height. It was lower among girls, first-borns, and estate-sector infants; maternal diabetes increased, while hypertension decreased, birth weight.

Low birth weight strongly predicted developing wasting and stunting at 12–24 months of age. Undernutrition was also associated with poverty, low maternal education, casual employment, inadequate gestational weight gain, and limited dietary diversity. Breastfeeding practices were generally strong, although exclusive breastfeeding to six months occurred in only 59.3%.

The findings support integrated preconception, adolescent, antenatal, breastfeeding, and social interventions to improve maternal nutrition, prevent child undernutrition, and reduce intergenerational NCD risk.

Professor Indrajee Amarasinghe Oration

Family-Centred Neonatal Intensive Care: The Sri Lankan Experience

Dr. Nimesha Gamhewage

MBBS (Col), DCH, MD (Paed), MRCPCH (UK)

Consultant Neonatologist: Colombo South Teaching Hospital

Senior Lecturer in Paediatrics: University of Sri Jayewardenepura



There is growing recognition of Family-Centred Care (FCC) as an evidence-based model that promotes parental partnership and improves outcomes for both infants and their families. Despite these benefits, implementation of FCC in Neonatal Intensive Care Units (NICUs) has remained limited in many low- and middle-income countries. We aimed to develop, implement, and evaluate a context specific Family-Centred Care programme through the Empowering Parents in NICUs (EPiNICU) project.

A mixed-method implementation study was conducted in two tertiary NICUs in Colombo using a phased participatory quality improvement approach. The project consisted of six phases. During the first phase, maternal psychological morbidity and maternal participation in the care of their newborns in NICUs were assessed using validated questionnaires. In the second phase, key FCC interventions were identified using a structured quality improvement framework. These interventions were implemented during the third phase through staff training, supported by improvements to the NICU environment. The fourth phase evaluated staff perceptions regarding the acceptability, appropriateness, and feasibility of the interventions using a validated self-administered questionnaire. Based on staff feedback, the interventions were optimised and their feasibility was reassessed in the fifth phase. In the sixth phase, maternal psychological outcomes were re-evaluated following implementation of the FCC package.

During phase one, 300 mothers were assessed. Overall, 73% experienced stress, 87% had symptoms of depression, and 77.7% experienced anxiety. The greatest source of stress was parental role alteration. Only 13% of mothers scored 20 or more out of 30 on the Index of Parent Participation in NICU (IPP-NICU), indicating low maternal participation in neonatal care. Mothers with higher participation in neonatal care had significantly lower levels of stress (aOR 0.27, 95% CI 0.12–0.59, $p=0.001$) and anxiety (aOR 0.32, 95% CI 0.14–0.72, $p=0.005$).

During phase two, five key interventions were identified to implement FCC practices to the selected NICUs: enhancing maternal participation in neonatal care, introducing structured sibling visitation, implementing routine screening for maternal depression with referral for psychological support, providing comprehensive parent education through multilingual educational resources, and conducting structured family meetings before discharge.

Implementation during phase three resulted in substantial improvements in maternal participation. The median IPP-NICU score increased from 13 at baseline to 20 following the interventions ($p<0.001$). The proportion of mothers achieving an IPP-NICU score of ≥ 20 increased fourfold. A qualitative analysis of drawings by children aged 5–8 years who visited the NICU for the first time did not reveal any fear or anxiety related to the NICU environment. Apart from infrastructure improvements, the other interventions did not require any financial investment.

During the phase four evaluation, more than 75% of staff from both study sites responded. Pre-discharge family meetings and routine maternal depression screening received satisfactory ratings ($>75\%$) for appropriateness, acceptability, and feasibility. Parent education and promoting maternal participation were considered highly acceptable (86.2% and 83.1%, respectively) but less feasible. Sibling visits were perceived as less appropriate and more challenging to implement. The main constraints identified by staff were workload, staffing shortages, and infrastructure limitations. After incorporating staff suggestions, feasibility improved across all intervention domains to above 75%, except for facilitating maternal participation (64.6%), reflecting ongoing workload challenges.

During the sixth phase, maternal outcomes were reassessed. The prevalence of maternal depression decreased significantly from 87.0% at baseline to 68.6% following the intervention ($p<0.001$). Similarly, maternal anxiety decreased from 77.7% to 27.6% ($p<0.001$), while maternal stress decreased from 73.0% to 17.4% ($p<0.001$). Implementation of Family-Centred Care was associated with substantial and statistically significant reductions in maternal depression, anxiety, and stress. The EPiNICU project provides a practical, scalable, and adaptable model for implementing Family-Centred Care in neonatal units across Sri Lanka.

PROGRAMME OF ANNUAL SCIENTIFIC CONGRESS

DAY 01 - 26th Saturday 2026 at The Waters Edge

7.30 am - 8.30 am	Registration and Poster Viewing	
8.30 am - 11.15 am	Inauguration Ceremony Silver Jubilee Commemoration PSSL Oration – “Shaping a Healthy Nation: The Impact of Maternal Nutrition on Newborn Outcomes and Future NCD Risk” <i>Senior Professor Pujitha Wickramasinghe</i> <i>Professor in Paediatrics: Faculty of Medicine, University of Colombo</i>	
11.15 am - 11.45 am	Morning Tea & Trade Exhibition	
11.45 am - 12.45 pm	Symposium 01 – Perinatal Challenges Beyond SDG 2030 Global Architectures for Sustainable Perinatal Health <i>Dr. Rajesh Khanna</i> – Paediatrician, Medical Officer Newborn Child and Adolescent Health: <i>WHO South East Asia Regional Office</i> Managing Delayed Motherhood <i>Dr. Geetha Haripriya</i> – Consultant Obstetrician and Gynaecologist: <i>India</i> Pushing the Limits of Viability: Implications to Consider <i>Dr. Amit Gupta</i> – Consultant Neonatologist: <i>United Kingdom</i>	
12.45 pm - 01.30 pm	Symposium 02 – Integration of Perinatal Care into Primary Health Systems Front Line Perinatal Care: WHO Vision <i>Dr. Yasara Samarakoon</i> – CCP, National Professional Officer, Family Health, Gender and Life Course: <i>WHO Country Office, Sri Lanka</i> Streking Risk Stratification and Referral Pathway <i>Dr. Lakshman Senanayake</i> – Consultant in Obstetrics and Gynaecology Safeguarding Post-Discharge in Primary Care <i>Dr. Surantha Perera</i> – Consultant Paediatrician: <i>TH Homagama</i>	
01.30 pm - 02.15 pm	Lunch & Poster Viewing	
02.15 pm - 03.00 pm	Symposium 03 – “Zero Preventable Deaths”: Stopping Perinatal Sepsis Postpartum Infections and Antimicrobial Stewardship <i>Dr. Madhumanee Abeywardena</i> – Consultant Clinical Microbiologist: <i>NH Kandy</i> Mitigating Late Onset Neonatal Sepsis <i>Dr. Annaleise Howard-Jones</i> – Staff Specialist Paediatric Infectious Diseases: <i>NSW, Australia</i>	
03.00 pm - 04.00 pm	Hall A Symposium 4A – Safeguarding the Newborn Safe Passage: Optimising Neonatal Transport and Care <i>Dr. Amit Gupta</i> – Consultant Neonatologist: <i>United Kingdom</i> Newborn Early Warning Systems in Post-Natal Wards <i>Dr. Nimesha Gamhewage</i> – Consultant Neonatologist: <i>CSTH</i> Safe Transition to Home <i>Dr. Nalin Gamaathige</i> – Consultant Neonatologist: <i>DMH</i>	Hall B Symposium 4B – Transition from Partogram to Labour Care Management WHO Labour Care Guide <i>Dr. Shemoon Marleen</i> – Consultant Obstetrician & Gynaecologist: <i>SJGH</i> Implementing Labour Care Guide : Overcoming Challenges <i>Dr. Sharadha Jayalath</i> – Consultant Obstetrician & Gynaecologist: <i>TH Kalutara</i> Decoding: Art and Science of Intrapartum Fetal Monitoring <i>Dr. Sritharan Apputhurai</i> – Consultant Obstetrician & Gynaecologist: <i>CSTH</i>
04.00 pm - 04.30 pm	Plenary 1A Knowing When to Call the Endocrinologist <i>Dr. Dinendra Siriwardhane</i> – Consultant Paediatric Endocrinologist: <i>TH Ratnapura</i>	Plenary 1B Hidden Challenges of Caesarean Sections <i>Prof. Madura Jayawardane</i> – Consultant Obstetrician & Gynaecologist: <i>CSTH</i>
04.30 pm - 05.00 pm	Evening Tea & Trade Exhibition	

DAY 02 - 27th Sunday 2026 at The Waters Edge

	Hall A	Hall B
07.45 am – 08.45 am	Free Paper Session A	Free Paper Session B
08.45 am – 09.45 am	Prof. Indrajee Amarasinghe Oration - “Family-Centred Neonatal Intensive Care: The Sri Lankan Experience” Dr. Nimesha Gamhewage - Consultant Neonatologist & Senior Lecturer: Faculty of Medical Sciences, University of Sri Jayewardenepura	
09.45 am - 10.15 am	Morning Tea & Trade Exhibition	
10.15 am – 11.00 am	Symposium 05 – Enhancing Maternal Mental Health Perinatal Mindfulness and Epigenetics Dr. Sanath Mahawithanage - Senior Lecturer in Biochemistry: <i>USJ</i> From Womb to Mind: Impact of Maternal Psychological Well-being on Child Mental Health Dr. Darshani Hettiarachchi - Consultant Child & Adolescent Psychiatrist: <i>LRH</i> Catching Silent Suffering at the Doorsteps Dr. Sanjeewa Godakanda - Consultant Community Physician: <i>Family Health Bureau</i>	
11.00 am – 11.30 am	Hall A Plenary 2A Congenital Infections: When to Suspect in the Newborn? Dr. Annaleise Howard-Jones - Staff Specialist Paediatric Infectious Diseases: <i>NSW, Australia</i>	Hall B Plenary 2B Screening for Sexually Transmitted Infections in Pregnancy Dr. Manjula Rajapaksha - Consultant Venereologist: <i>DGH Negombo</i>
11.30 am – 12.00 pm	Plenary 3A Surgical Abdomen in a Neonate Dr. Maheesha Kulasinghe - Consultant Paediatric Surgeon: <i>LRH</i>	Plenary 3B Gastrointestinal and Renal Abnormalities of the Fetus Dr. Achintha Dissanayake - Consultant Obstetrician & Gynaecologist: <i>CSTH</i>
12.00 pm – 12.30 pm	Plenary 4A Beyond the Scores: Screening and Care in Neonatal Abstinence Dr. Dilani Dehigama - Consultant Neonatologist: <i>DGH Gampaha</i>	Plenary 4B Interpregnancy Care: The Ultimate Window for Risk Reduction Dr. Priyantha Liyanage - CCP/Gender and Women’s Health Unit: <i>FHB</i>
12.30 pm – 01.30 pm	Lunch	
01.30 pm – 02.15 pm	Panel Discussion – Beyond Birth, Early Detection and Timely Intervention for Better Outcomes Moderator: Dr Nalin Gamaathige - Consultant Neonatologist Every Beat Counts: Screening and Early Care Algorithms for Cyanotic CHD Dr. Duminda Samarasinghe - Consultant Paediatric Cardiologist: <i>LRH</i> Heart Under Strain: Critical Maternal Cardiac Care During Pregnancy Prof. Probhodana Ranaweera - Consultant Obstetrician & Gynaecologist: <i>DMH</i> The Critical Role of Dried Blood Spot (DBS) Screening in Identifying Biotinidase Deficiency Dr. Pyara Ratnayake - Consultant Paediatric Neurologist: <i>LRH</i> Early Detection of Metabolic Disorders Before Clinical Harm Dr. Iresha Jasinghe - Consultant Chemical Pathologist: <i>Nine Wells Hospital</i>	
02.15 pm– 03.15 pm	Symposium 06 – The First 1000 Days in Fetal Growth Restriction In-Utero Brain Protection and Placental Insufficiency Prof. Chandana Jayasundara - Consultant Obstetrician & Gynaecologist: <i>DMH</i> Nourishing the Vulnerable Brain – Prof. Nishani Lucas - Consultant Neonatologist: <i>DMH</i> Combatting Fetal Growth Restriction in the Community Dr. Himali Herath - Consultant Community Physician: <i>Patient Safety and Accreditation Bureau, MOH</i>	
03.15 pm – 04.00 pm	The Query Quest: Quiz Program	
04.00 pm – 04.30 pm	Award Ceremony & Closing Remarks	
04.30 pm – 05.00 pm	Evening Tea & Trade Exhibition	

FACULTY - ANNUAL SCIENTIFIC CONGRESS



Dr. Rajesh Khanna
*Paediatrician,
Medical Officer
Newborn Child
& Adolescent Health
WHO South-East
Asia Regional Office*



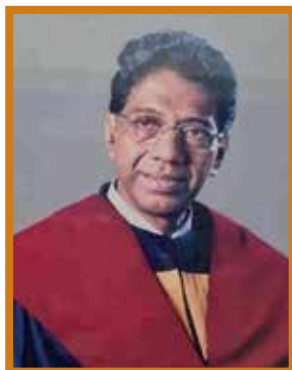
Dr. Geetha Haripriya
*Consultant Obstetrician
&
Gynecologist, India*



Dr. Amit Gupta
*Consultant Neonatologist,
United Kingdom*



Dr. Yasara Samarakoon
*Consultant Community
Physician*



**Dr. Lakshman
Senanayake**
*Consultant Obstetrics
& Gynecology*



Dr. Surantha Perera
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**Dr. Madhumanee
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**Dr. Annaliese
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Dr. Nimesha Gamhewage
*Senior Lecturer
in Paediatrics
Consultant Neonatologist*



Dr. Nalin Gamaathige
Consultant Neonatologist



Dr. Shemoon Marleen
*Consultant Obstetrician
& Gynecologist*



Dr. Sharada Jayalath
*Consultant Obstetrician
& Gynaecologist*



Dr. Sritharan Appudurai
Consultant Obstetrician
& Gynaecologist



Dr. Dinendra Siriwardhane
Consultant Paediatric
Endocrinologist



Prof. Madura Jayawardane
Consultant Obstetrician
& Gynecologist



Dr. Sanath Mahawithanage
Senior Lecturer
in Biochemistry



Dr. Darshani Hettiarachchi
Consultant Child &
Adolescent Psychiatrist



Dr. Sanjeewa Godakandage
Consultant Community
Physician



Dr. Manjula Rajapaksha
Consultant Venereologist



Dr. Maheesha Kulasinghe
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Dr. Achintha Dissanayake
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Consultant Obstetrician
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Dr. Dilani Dehigama
Consultant Neonatologist



Dr. Priyantha Liyanage
Consultant Community
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Gender and Women's Health Unit
Family Health Bureau



Dr. Duminda Samarasinghe
Consultant Paediatric
Cardiologist



Prof. Prabhodana Ranaweera
Consultant Obstetrician
& Gynecologist



Prof. Chandana Jayasundara
Consultant Obstetrician
& Gynecologist



Prof. Nishani Lucas
Professor in Neonatology



Dr. Himali Herath
Consultant Community
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Frontline Perinatal Care: The WHO Vision

Dr. Yasara Manori Samarakoon

MBBS, MSc, MD (Community Medicine)

Consultant Community Physician

National Professional Officer, Family Health, Gender and Life Course

WHO Country Office, Sri Lanka

Preventable maternal and newborn deaths and stillbirths remain a major global health challenge, despite the availability of effective interventions. Frontline perinatal care, delivered through primary and community health systems, is central to ensuring that every woman and newborn receives high-quality care from preconception through pregnancy, childbirth, the postnatal period and early life. This presentation outlines the World Health Organization vision for integrated, people-centred perinatal care and its relevance to Sri Lanka.

The WHO approach links the continuum of care with strong primary health care, competent and supported health workers, effective referral pathways, actionable information systems, essential resources and respectful care. Key priorities include quality preconception services; the eight-contact antenatal care model; skilled, evidence-based and woman-centred intrapartum care; essential newborn care; and a minimum of four postnatal contacts for the mother and baby. The approach recognizes survival, positive care experiences, dignity, autonomy, emotional support and equity as inseparable dimensions of quality.

Sri Lanka has a strong platform for implementation through its established Family Health Bureau, Medical Officer of Health and Public Health Midwife network, high antenatal registration and broad postpartum coverage. The next frontier is to close remaining quality and equity gaps, strengthen continuity between community and facility care, and respond to emerging challenges, including noncommunicable diseases in pregnancy, mental health needs, adolescent pregnancy and disparities affecting underserved populations. Digital access to WHO maternal and perinatal recommendations can further support real-time, evidence-based decisions at the frontline.

Realizing this vision requires coordinated action to institutionalize quality assurance, strengthen referral and emergency readiness, scale up essential newborn interventions, integrate screening and management of noncommunicable diseases and mental health, and ensure respectful, gender-responsive care. By transforming existing coverage into consistently high-quality, integrated care, Sri Lanka can further reduce preventable maternal and newborn deaths and stillbirths while ensuring that women, newborns and families not only survive, but thrive. This requires sustained leadership, multidisciplinary teamwork, reliable data for improvement, meaningful community engagement and accountability across every level of the health system, with particular attention to continuity during transitions between home, primary care and hospitals, and sustained investment in frontline workforce capability, supervision, learning and essential resources.

Keywords: perinatal care; primary health care; maternal health; newborn health; quality of care; Sri Lanka

Dr. H. Madhumanee Wasanthi Abeywardena

MD (USSR), Dip. Med. Micro. (Col.), MD (Med. Micro., Col.)

Consultant Clinical Microbiologist

Postpartum infections remain an important cause of maternal morbidity and mortality and are a significant contributor to maternal sepsis. Infections may arise from the genital tract, caesarean or perineal wounds, urinary tract, breast, respiratory tract or other healthcare-associated sources. Early recognition and appropriate antimicrobial therapy are essential; however, indiscriminate or prolonged antibiotic use can contribute to antimicrobial resistance, adverse drug reactions, *Clostridioides difficile* infection and disruption of the maternal microbiome. Effective postpartum infection management therefore requires a balance between timely treatment and antimicrobial stewardship.

Antimicrobial therapy should always be guided by the suspected source, severity of illness, likely pathogens, local antimicrobial resistance patterns, previous microbiology results, allergy history and relevant pregnancy or breastfeeding considerations. In women with suspected maternal sepsis, appropriate empiric antimicrobial therapy should be initiated promptly and should not be delayed unnecessarily while awaiting microbiological results. At the same time, cultures should be obtained when clinically appropriate and when this does not cause significant treatment delay.

Clinical response and microbiology results should be reviewed promptly, with antibiotics narrowed, changed or discontinued when appropriate. The shortest effective duration should be used according to the infection and relevant international or local guidelines. Importantly, antimicrobial therapy alone is insufficient when an uncontrolled source is present. Therefore, timely drainage, evacuation of retained products, wound management or removal of an infected device may be required.

Finally, optimal management of postpartum infections requires a **“right antibiotic, right patient, right dose, right route, right duration and right indication”** approach. Antimicrobial stewardship should not delay life-saving treatment; rather, it ensures that treatment is targeted, evidence-based and continually reviewed. Integrating infection prevention and control, early recognition of sepsis, appropriate antimicrobial prescribing, microbiological support and effective source control can improve maternal outcomes while reducing unnecessary antimicrobial exposure and antimicrobial resistance.

Dr. Annaleise R Howard-Jones

Department of Infectious Disease and Microbiology, The Children's Hospital at Westmead, Westmead, NSW, Australia

Sydney Infectious Diseases Institute (Sydney ID), The University of Sydney, Sydney, NSW, Australia

Faculty of Medicine and Health, The University of Sydney, Sydney, NSW, Australia

Late-onset neonatal sepsis (LOS) - defined as infection occurring after 72 hours of life - remains a major cause of morbidity and mortality, particularly among preterm and very low birth weight neonates. As neonatal survival improves globally, the epidemiology of LOS is changing, with increasing importance of healthcare-associated infections, antimicrobial resistance and risk from invasive devices. The burden disproportionately affects low- and middle-income countries with implications for diagnosis and empiric management regimens.

Here we discuss contemporary global and regional trends in LOS, including changing pathogen profiles, antimicrobial resistance and outcomes. Current international recommendations for the recognition, investigation and management of suspected LOS will be discussed. Recent World Health Organization recommendations provide an updated framework for serious bacterial infections in young infants aged 0-59 days, while international guidelines emphasise the importance of local microbiological and antimicrobial-resistance data to guide empiric therapy.

Particular attention will be given to the differing epidemiology of LOS in Sri Lanka and the region, and to the challenges of applying evidence generated in low-antimicrobial resistance (AMR) settings to neonatal intensive care units in higher-AMR regions with varying diagnostic and clinical frameworks. Recent research provides important insights into these challenges, highlighting the substantial burden of healthcare-associated infection, Gram-negative predominance and escalating prevalence of AMR in the South and South East Asian regions. These findings highlight the need for locally informed empiric therapy and prudent use of broad-spectrum agents, balancing individual patient need with population risk.

The discussion will consider practical strategies for neonatal units to reduce the prevalence and impact of LOS through infection prevention and control, antimicrobial stewardship, improved microbiological surveillance and timely, evidence-based treatment. Optimising outcomes for neonates with late onset sepsis is a challenging endeavour with best outcomes reliant on data-informed strategies and a multidisciplinary approach.

Dr. Nimesha Gamhewage

MBBS (Col), DCH, MD (Paed), MRCPCH (UK)

Consultant Neonatologist and Senior Lecturer in Paediatrics

Clinical deterioration in newborns on postnatal wards may be subtle and non-specific, resulting in delayed recognition and escalation. Unlike neonatal intensive care, continuous physiological monitoring is not feasible or appropriate for most postnatal newborns. Newborn-specific early warning systems have therefore been developed to facilitate systematic identification of deterioration and timely clinical response.

Neonatal early warning systems incorporate serial assessment of physiological parameters, clinical signs and, increasingly, functional indicators such as feeding and activity. The Newborn Early Warning Track and Trigger (NEWTT2) framework developed by the British Association of Perinatal Medicine provides a structured approach to identifying at-risk newborns, monitoring clinical status, defining triggers and facilitating escalation across delivery suite, postnatal and transitional care settings. However, the neonatal evidence base remains less developed than that for adult and paediatric early warning systems, with heterogeneity in parameters, thresholds and outcome measures. Importantly, early warning scores should complement rather than replace clinical assessment, as deterioration may evolve through trends that are not captured by individual threshold values.

Effective newborn early warning is fundamentally a systems intervention. Its effectiveness depends on appropriate risk stratification, reliable observations, recognition of trends, defined escalation pathways, timely senior review and reassessment following intervention. Parental observations may provide additional information regarding changes in feeding, activity and behaviour and should be incorporated into safety processes.

Future development of newborn early warning systems should move beyond isolated scores towards integrated, risk-stratified surveillance and response pathways. For Sri Lanka, implementation should prioritise a validated, feasible and context-appropriate model that strengthens early recognition while minimising unnecessary monitoring and workload.

Dr. (Mrs) Dinendra Siriwardhane

MBBS DCH MD in Paediatrics

Consultant Paediatric Endocrinologist

Teaching Hospital Ratnapura

Neonatal endocrine emergencies represent high-stakes clinical challenges where prompt recognition and targeted intervention are critical to preventing mortality and long-term neurodevelopmental morbidity. This clinical framework outlines an operational guide detailing key thresholds for specialist Paediatric endocrine consultation across four cardinal neonatal presentations. First, refractory hypoglycemia—defined by a glucose infusion rate exceeding 8 mg/kg/min or hypoglycemia persisting beyond 48 to 72 hours of life—mandates immediate collection of a pretreatment "critical blood sample" and urine ketone bodies to differentiate congenital hyperinsulinism and panhypopituitarism from intermediary metabolic defects before advancing pharmacotherapy. Second, the presentation of atypical genitalia, bilateral impalpable gonads, or circulatory collapse accompanied by hyponatremia and hyperkalemia between Days 7 and 14 points to salt-wasting congenital adrenal hyperplasia (CAH). Hemodynamic resuscitation is utmost important with isotonic saline and stress-dose hydrocortisone alongside 17-hydroxyprogesterone with Synacthen test to assess the adrenal axis, and other hormonal investigations and karyotype, while strictly deferring sex assignment until endocrine and multidisciplinary evaluation is established. Third, neonatal thyroid derangements demand distinct urgency: infants with elevated newborn screening TSH require prompt venous confirmation and early levothyroxine initiation (10–15 mcg/kg/day) to safeguard cognitive potential, while infants born to mothers with Graves' disease require vigilant surveillance for transplacental TSH-receptor antibody (TRAb)-mediated thyrotoxicosis requiring antithyroid therapy and beta-blockade. Fourth, late-onset neonatal hypocalcemia presenting with neuromuscular irritability or seizures requires paired assessment of calcium, phosphate, magnesium, and parathyroid hormone (PTH) to identify primary hypoparathyroidism, 22q11.2 microdeletion syndrome, or fetal parathyroid suppression secondary to unrecognized maternal hyperparathyroidism. Mastering these definitive referral triggers—escalated dextrose requirements, genital ambiguity, electrolyte derangements, and abnormal newborn metabolic screens—ensures frontline clinicians capture essential pre-treatment diagnostic windows, institute safe initial stabilization, and facilitate seamless collaborative management with Paediatric endocrinology teams.

Congenital infections: When to suspect in the newborn?

Dr. Annaleise R Howard-Jones

Department of Infectious Disease and Microbiology, The Children's Hospital at Westmead, Westmead, NSW, Australia

Sydney Infectious Diseases Institute (Sydney ID), The University of Sydney, Sydney, NSW, Australia
Faculty of Medicine and Health, The University of Sydney, Sydney, NSW, Australia

Congenital infections are an important, and often under-recognised, cause of neonatal morbidity and mortality. Although the classical TORCH infections remain relevant, the epidemiology of congenital infections is changing, with emerging and re-emerging pathogens, persistent inequalities in antenatal screening and treatment, and substantial differences between high-income and low- and middle-income settings. For neonatologists, an important challenge is recognising infection when clinical manifestations are subtle, non-specific or absent at birth.

This discussion will review global and regional trends in congenital infections, with particular emphasis on congenital cytomegalovirus (CMV) and congenital syphilis.

Approaches to delineating congenital from postnatally-acquired CMV infections will be discussed alongside the state-of-play for management of congenital CMV to minimise long term neurodevelopmental complications.

Globally, congenital syphilis cases are resurging at an alarming rate. Syphilis is an important case study since antenatal screening and penicillin treatment can prevent most adverse outcomes, including still-birth, prematurity, neonatal disease and long-term disability. Current international recommendations in standard-risk and higher-risk regions will be discussed including enhanced maternal screening, neonatal assessment, investigation, treatment and follow-up, as well as best approach to managing infants born to mothers with untreated or inadequately treated infection.

The Sri Lankan experience provides a valuable perspective in the field of congenital syphilis. Sri Lanka achieved WHO validation for elimination of mother-to-child transmission of syphilis in 2019. Recent data highlight both the success of antenatal prevention programmes in Sri Lanka and the continuing importance of vigilance and surveillance in pregnant women and neonates. Recent surveillance data, however, reveal a 4-5x increase in rates of adult syphilis cases from 2019 to 2025, highlighting the need for close vigilance to ensure Sri Lanka does not follow the rest of the world in terms of congenital syphilis trends.

The discussion will explore ongoing surveillance efforts and how neonatologists can contribute to case detection, notification and management. Practical advice on universal surveillance, risk factor assessment and clinical signs for congenital infections will be adapted to a pragmatic framework regarding when to suspect congenital infection, how to investigate and when to treat to optimise outcomes for neonates.

Dr. Manjula Rajapakshe

Consultant Venereologist, DGH, Negombo

Pregnancy provides a valuable opportunity to identify and treat sexually transmitted infections (STIs), protecting not only the health of the mother but also that of the unborn child and newborn. In an era of advanced maternal and neonatal care, our goal should be more than ensuring survival—we should aim to give every child the healthiest possible start in life.

Sri Lanka has demonstrated what can be achieved through systematic antenatal screening. Universal screening has contributed to the country's success in eliminating mother-to-child transmission (EMTCT) of HIV and syphilis, and we are now moving towards triple elimination; an integrated approach to eliminate vertical transmission of HIV, syphilis and hepatitis B. These achievements raise an important question: while we screen effectively for these infections, are there other STIs affecting pregnancy and newborn health that we may be missing?

This lecture will explore why STI screening during pregnancy matters and how it can be approached in practice. It will begin with HIV, syphilis and hepatitis B—the established pillars of efforts to prevent mother-to-child transmission—and their role in preventing maternal, fetal and neonatal disease.

The discussion will then move beyond the traditional EMTCT framework to consider other clinically important infections, including Chlamydia trachomatis, Neisseria gonorrhoeae, genital herpes simplex virus and hepatitis C. Their potential impact on pregnancy and newborns—from adverse pregnancy outcomes and neonatal conjunctivitis to severe neonatal infection and longer-term morbidity—will be explored. The opportunities and challenges of risk-based and broader screening approaches within antenatal care will also be considered.

Practical aspects of screening will include the limitations of relying on symptoms alone, the role of laboratory testing, appropriate timing and repeat testing, partner management, timely linkage to treatment, and integration of STI services into routine maternal and newborn care.

Ultimately, STI screening in pregnancy is about more than detecting infections. It is an opportunity to prevent avoidable illness and adverse outcomes across two generations. As we strengthen efforts to prevent mother-to-child transmission, we must look beyond helping babies simply survive and work towards giving every child the opportunity to truly thrive.

Dr. Dilani Dehigama

Consultant Neonatologist

DGH Gampaha

Neonatal Abstinence Syndrome (NAS) is a group of withdrawal symptoms experienced by newborns following prenatal exposure to certain substances, particularly opioids. The increasing use of drugs during pregnancy has made NAS an important neonatal and public health concern. Infants with NAS may develop neurological, gastrointestinal, respiratory, and autonomic symptoms after birth. Common manifestations include irritability, excessive crying, tremors, poor feeding, vomiting, diarrhoea, sleep disturbances, and difficulties with weight gain. The severity and duration of symptoms vary depending on factors such as the type of substance, timing and duration of exposure, amount of drug taken, how recently drugs were taken, use of multiple drugs simultaneously, maternal health, and individual infant characteristics.

Early recognition and appropriate management of NAS are essential to reduce complications and support healthy infant development. Assessment may involve standardized clinical tools and careful observation of feeding, sleep, consolability, and other withdrawal-related behaviours. Management should be individualized and may include non-pharmacological and pharmacological interventions. Non-pharmacological interventions include minimizing environmental stimulation, swaddling, skin-to-skin contact, rooming-in with the mother when appropriate, and providing supportive feeding. Pharmacological treatment may be considered for infants with severe symptoms that interfere significantly with feeding, sleeping, or other essential functions.

A family-centered approach is increasingly emphasized in the care of infants with NAS. Supporting maternal and infant bonding, encouraging caregiver involvement, and addressing maternal substance-use and social needs can improve outcomes. Continued follow-up is important because some infants may experience developmental, behavioural, or feeding difficulties after discharge. Overall, effective management of NAS requires coordinated multidisciplinary care involving neonatologists, nurses, social workers, and other healthcare professionals. Greater awareness, prevention strategies, early intervention, and long-term follow-up are important for improving outcomes for infants affected by prenatal substance exposure.

Dr. Priyantha Liyanage

MBBS, MSc, MD (Community Medicine)

Consultant Community Physician,

National Program Manager Newly Married Couples Program

The period between pregnancies is a critical yet frequently underutilized opportunity to improve maternal health and reduce risks in a subsequent pregnancy. It should not be considered merely a period for birth spacing, but as an active window for maternal recovery, identification of risks, modification of preventable factors and preparation for a planned, healthier pregnancy. The Family Health Bureau, Sri Lanka defines the true interpregnancy interval as the period between the end of a previous pregnancy and the beginning of the next pregnancy. Global guidance emphasizes adequate spacing between pregnancies to optimize maternal and neonatal outcomes.

To develop an evidence-informed approach to interpregnancy care that utilizes the interval between pregnancies for systematic assessment, risk reduction, health promotion and preparation for the next pregnancy.

An integrated interpregnancy care framework was developed using global evidence and guidance, together with the existing maternal and child health service platform. The previous pregnancy is used as a roadmap to identify maternal and fetal risks, followed by four sequential actions: recovery, risk modification and preparation for a planned pregnancy. Six key domains of care are addressed: family planning; nutrition and anemia; chronic disease management; mental health; infection prevention and care; and medication review. Particular attention is given to previous gestational diabetes and hypertensive disorders, maternal anemia, preterm birth, stillbirth and previous caesarean delivery. The framework promotes integration into routine contacts through MOH and PHM services, postpartum and family-planning care, well-child and immunization visits, and medical consultations. A frontline Screen–Counsel–Refer–Follow-up model, supported by an Ask–Assess–Advise–Act–Follow-up approach, facilitates continuity of care.

The interpregnancy period represents a strategic window to break the cycle of recurrent maternal and neonatal risks. Integrating structured interpregnancy care into existing primary healthcare and maternal and child health services can strengthen continuity of care, promote planned pregnancies, and contribute to improved maternal and newborn outcomes.

The maternal mortality of Sri Lanka has changed over riding the direct causes by Indirect causes.

Safe Transition to Home

Dr. Nalin Gamaathige

MBBS, DCH, MD (Paed)

Consultant Neonatologist

De Soysa Maternity Hospital for Women

Discharge from a neonatal unit represents a major transition in the care of sick and preterm infants. Although the infant may no longer require hospital-based intensive care, physiological immaturity, feeding difficulties, respiratory vulnerability, impaired thermoregulation and neurodevelopmental risks may persist after discharge. At the same time, parents and caregivers move from a highly supported hospital environment to assuming primary responsibility for their infant's care. Therefore, discharge planning should be viewed as a structured process of safeguarding the infant and supporting the family rather than simply determining a discharge date.

Safe transition home therefore is a shared responsibility between the neonatal team, family and community healthcare system. A structured discharge pathway that combines physiological readiness, parental competency, preventive care, effective communication and planned follow-up can reduce avoidable risks and support better outcomes for vulnerable newborns. The goal is not simply to discharge a baby safely, but to make the transition from hospital to home safe.

OP 01 : CLOSING THE COMPETENCY GAP IN T-PIECE VENTILATION DURING NEONATAL RESUSCITATION: A CLINICAL AUDIT AND QUALITY IMPROVEMENT INITIATIVE FROM A TERTIARY CARE MATERNITY HOSPITAL IN SRI LANKA

Govinnage DPS¹, Doluweera DSP¹, Mannapperuma T¹, Madawala PS¹, Rathnayake AARMNS¹

¹Castle Street Hospital for Women, Colombo, Sri Lanka

Introduction

Effective ventilation is a key component of successful neonatal resuscitation. The T-piece device allows controlled positive pressure ventilation by providing appropriate peak inspiratory pressure (PIP) and positive end-expiratory pressure (PEEP). Gaps in knowledge and practical skills may affect its effective use. This audit assessed competency in T-piece device use among healthcare workers in labour wards and identified areas requiring further training.

Objectives

To assess knowledge, practical competency and confidence in T-piece device use, identify gaps in knowledge and practice, provide targeted training and evaluate changes in knowledge, confidence and participant satisfaction following training.

Method

A prospective clinical audit was conducted over four weeks from 10 August to September 2025 in the labour wards of Castle Street Hospital for Women, Colombo. Participants completed a structured baseline questionnaire assessing knowledge, previous exposure, training and practical aspects of T-piece use. Identified gaps were addressed through guideline-based teaching, device demonstrations and simulation-based hands-on training. Knowledge, confidence and satisfaction were assessed immediately after training. Descriptive statistics were used for analysis.

Results

Of 61 participants; 50.8% were midwifery nursing officers, 29.5% house officers and 16.4% midwives. Although 83.6% had seen a T-piece device, only 44.3% had used one and 19.7% had received formal training. Knowledge was higher for basic device principles (72%) than for technical and practical aspects (52%). Important gaps included recommended gas flow (27.9%), PEEP adjustment (34.4%) and initial PEEP settings for preterm newborns (41.0%). Following training, among 48 participants, 93.8% correctly identified the device's primary function, 85.4% recognised essential pre-use safety checks and 79.2% identified appropriate troubleshooting for inadequate chest rise. Confidence in adjusting PIP/PEEP and device setup was high, while overall training satisfaction was 4.85/5.

Conclusion

The audit demonstrated a clear gap between exposure to the T-piece device and formal competency-based training, particularly in technical and practical skills. A structured, simulation-based programme was highly acceptable and was associated with improved knowledge and confidence. Regular competency-based refresher training, simulation practice and periodic re-audit are recommended to strengthen preparedness for neonatal resuscitation.

OP 02 : EVERY DEGREE MATTERS: IMPROVING ADMISSION NORMOTHERMIA IN NEONATES THROUGH A CLOSED-LOOP AUDIT

Abeyesiriwardana KE¹, Dissanayake NW¹, Hettiarachchi BT¹

¹Neonatal Intensive Care Unit/Special Care Baby Unit, New District General Hospital, Matara, Sri Lanka

Introduction

Admission hypothermia remains an important cause of morbidity and mortality in newborns, particularly in those born preterm. A baseline audit in our Neonatology Unit found a high prevalence of admission hypothermia despite routine thermal care measures. This prompted a quality improvement initiative aimed at strengthening the neonatal warm chain, followed by a re-audit to assess its impact.

Objectives

To measure the prevalence of admission hypothermia among newborns admitted to the NICU, identify gaps in thermal care, implement targeted quality improvement measures, and assess their effectiveness by completing the audit cycle.

Method

A closed-loop clinical audit was carried out in two phases. The initial audit included all newborns admitted to the NICU between 1 June and 17 November 2025 (n=109). Following analysis of the findings, several interventions were introduced, including postponing routine weighing until thermal stability was achieved, maintaining recommended delivery room temperatures, pre-warming transport incubators, and reinforcing staff education on evidence-based thermal care. The re-audit was performed between 1 December 2025 and 30 April 2026 using the same inclusion criteria and WHO definitions of neonatal temperature. Admission temperatures were classified as normothermia ($\geq 36.5^{\circ}\text{C}$), cold stress ($36.0\text{--}36.4^{\circ}\text{C}$), moderate hypothermia ($32.0\text{--}35.9^{\circ}\text{C}$), and severe hypothermia ($<32.0^{\circ}\text{C}$).

Results

During the initial audit, only 34 of 109 newborns (31.2%) were normothermic on admission. Moderate hypothermia was present in 73 (67.0%), while two infants (1.8%) had severe hypothermia. The re-audit included 81 newborns and demonstrated a marked improvement, with 62 (76.5%) achieving normothermia on admission. Cold stress was observed in 13 infants (16.0%), moderate hypothermia fell to six (7.4%), and no cases of severe hypothermia were identified. Normothermia was achieved in 88.9% of term infants compared with 73.0% of preterm infants, highlighting the continuing susceptibility of preterm babies to heat loss.

Conclusions

Introducing a targeted thermal care bundle was associated with a substantial improvement in admission temperatures and the elimination of severe hypothermia. Practical, low-cost measures focused on delivery room care, neonatal transport, and staff education strengthened the neonatal warm chain. Continued surveillance and sustained attention to thermal care, particularly for preterm infants, are essential to maintain these gains.

OP 03 : SUICIDAL IDEATION IN PREGNANCY: PREVALENCE AND PSYCHOSOCIAL PREDICTORS AMONG ANTENATAL CLINIC ATTENDEES IN GALLE

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Introduction

Suicidal ideation during pregnancy is a significant yet under-recognized mental health concern with potentially serious consequences for both the mother and fetus. Routine screening of antenatal suicidal ideation is rare, and thus literature is scarce on its effects, especially in the local context.

Objectives

To assess the prevalence, associated factors and predictors of suicidal ideation among third-trimester pregnant women attending antenatal clinics in two Medical Officer of Health (MOH) areas in Galle district.

Method

A cross-sectional study was conducted among 450 pregnant women in their third trimester attending antenatal clinics in Bope-Poddala and Galle MOH areas. Participants were recruited using multi-stage cluster sampling. Suicidal ideation and symptoms of antepartum depression (APD) were screened with the locally validated Columbia Suicide Severity Rating Scale (C-SSRS) and Edinburgh Postnatal Depression Scale, respectively. Obstetric and psychosocial factors were assessed through a self-administered questionnaire.

Results

The majority of women were Sinhalese (59%) with a mean age of 29.43 years (SD±5.24). Suicidal ideation was present among 2% of women in the third trimester during the past month with a majority (55.5%) having low levels of suicidal ideation. In the sample, 1.1% had attempted suicide prior to the pregnancy, 12.2% had symptoms of APD and 5.6% were exposed to DV. Out of those with suicidal ideation, 66.6% screened positive for symptoms of APD and exposure to DV, respectively. In bivariate analysis, symptoms of APD ($p=0.002$), past suicidal attempts ($p=0.003$), having a special person to confide in ($p\leq 0.028$), relationship with in-laws ($p<0.00$) and with extended family ($p=0.041$), support for housework ($p=0.021$), and exposure to DV ($p<0.00$) were significantly associated with suicidal ideation. In the logistic regression model, exposure to DV (OR=20.49, $p=0.001$) emerged as a significant predictor for the presence of suicidal ideation after controlling for confounders.

Conclusion

Suicidal ideation is present among pregnant women even in the third trimester, and risk is higher among pregnant women with poor family relationships, support, symptoms of APD, and exposure to DV. Integrating routine screening of DV and symptoms of APD into antenatal services with a special focus on suicidal ideation among those who screen positive, and strengthening psychosocial support systems throughout pregnancy are recommended for early identification and prevention of consequences.

Keywords - antepartum, suicidal ideation, domestic violence, antepartum depression

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OP 04 : CLOSING THE PAIN MANAGEMENT GAP: NATIONAL STUDY ON KNOWLEDGE, ATTITUDES, AND PRACTICES OF NEONATAL PAIN MANAGEMENT AMONG HEALTHCARE PROFESSIONALS WORKING IN LEVEL III AND LEVEL IV NICUS IN SRI LANKA

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Background

Neonatal pain is frequently underestimated despite evidence of adverse short- and long-term consequences. Healthcare professionals' knowledge, attitudes, and practices (KAP) play a crucial role in effective neonatal pain management. This study aims to assess KAP regarding neonatal pain management among doctors and nurses working in Level III and IV NICUs in Sri Lanka.

Objectives

To assess the knowledge, attitudes, and practices among healthcare professionals (Nurses and Doctors) regarding neonatal pain management in Level III and Level IV NICUs in Sri Lanka.

Method

A nationwide cross-sectional study was conducted among 342 NICU healthcare professionals (Consultants, medical officers, and nursing officers) from 24 government-sector Level III and IV NICUs. Data were collected using a self-administered questionnaire.

Results

Among 342 healthcare professionals, 51.5% were nursing officers, 39.5% medical officers, and 8.8% consultants. Majority of participants were female (79.2%) and aged 31–40 years (45.6%). Although 88.6% recognized that neonates can experience pain, only 17.0% used neonatal pain assessment tools, and 46.5% had received formal pain management training. Crying (95.6%), tachycardia (86.8%), and tachypnoea (76.9%) were the most frequently recognized pain indicators. Non-pharmacological interventions were commonly practiced, particularly swaddling (84.8%) and breastfeeding/expressed breast milk (83.0%). Majority of participants considered neonatal pain management important (98.0%), while 75.7% perceived neonatal pain as underrecognized and undertreated. The main barriers were the time-consuming nature of pain management (38.3%), lack of training (34.2%), and inadequate resources (20.8%).

Conclusion

Healthcare professionals working in Sri Lankan Level III and IV NICUs demonstrated good knowledge and positive attitudes toward neonatal pain management; however, important deficiencies in clinical practice persist. Strengthening capacity-building initiatives and implementing evidence-based pain assessment protocols are recommended to improve neonatal pain management and clinical outcomes.

OP 05 : MOTHERS' EXPERIENCES OF CARE DURING THE LABOUR IN FOUR SELECTED HOSPITALS IN SRI LANKA

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Introduction

Respectful postnatal care is fundamental to improving maternal experiences and promoting positive health outcomes after childbirth. Understanding mothers' perceptions of postnatal care can identify strengths and opportunities for improving the quality of maternity services.

Objectives

To assess mothers' experiences of postnatal care following childbirth in four selected hospitals in Sri Lanka.

Method

A descriptive cross-sectional study was conducted in four maternity units across the country (Colombo South Teaching Hospital, De Soysa Maternity Hospital, Base Hospital-Nuwara Eliya, Teaching Hospital-Peradeniya) among 253 postpartum mothers. Data were collected using a validated self-administered questionnaire available in Sinhala, Tamil, and English that assessed communication, information sharing, emotional support, and overall satisfaction with postnatal care. Descriptive statistics were used to summarise the findings.

Results

Having a female labour companion was encouraged in 16%. Pain relief during labour was received by 68%, while 60% received local analgesia during episiotomy. Different positions were allowed during labour in 57%, and fluids or light snacks were allowed in 60% mothers. 62% stated that baby was delivered to abdomen. 5.2% mentioned that they felt abandoned during the labour, while 17% perceived verbal disrespect during labour. Staff introduced themselves to 26.5% of mothers always and 19.8% very often. Health staff informed 75.9% of mothers about their baby's time of birth, sex, and birth weight, while 71.9% received refreshments after delivery.

Conclusion

The findings indicate important gaps in respectful maternal care during labour in the selected hospitals. Opportunities for improvement remain in supporting labour companions, allowing maternal choice of position and oral intake, during labour. Providing immediate skin-to-skin contact to the neonate should be encouraged. The experiences of verbal disrespect and feeling abandoned reported by some mothers highlight the need for continued staff training and strengthening of respectful maternity care practices.

OP 06 : MOTHERS' EXPERIENCES IN THE NEONATAL INTENSIVE CARE UNITS/ SPECIAL CARE BABY UNITS: A DESCRIPTIVE CROSS-SECTIONAL STUDY IN FOUR SELECTED HOSPITALS IN SRI LANKA

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Background

Admission of a newborn to a Neonatal Intensive Care Unit (NICU) or Special Care Baby Unit (SCBU) can be a stressful experience for mothers. Understanding mothers' experiences during their newborn's admission is important for identifying areas that can be improved in neonatal care and maternal support.

Objective

To assess mothers' experiences during their newborns' admission to the NICU/SCBU in selected hospitals in Sri Lanka.

Method

A descriptive cross-sectional study was conducted among 100 postpartum mothers whose newborns were admitted to the NICU/SCBU in four maternity units across Sri Lanka (Colombo South Teaching Hospital, De Soysa Maternity Hospital, Base Hospital-Nuwara Eliya, Teaching Hospital-Peradeniya). Data were collected using a validated and pretested self-administered questionnaire available in Sinhala, Tamil, and English. The questionnaire assessed communication regarding the newborn's condition, maternal access to the newborn, breastfeeding support, availability of maternal amenities, and satisfaction with NICU/SCBU services. Descriptive statistics were used to summarize the findings.

Results

Regarding communication, 92% of mothers reported that the indication for their newborn's admission was explained to them, while 64% saw their baby before admission. Daily or more frequent updates regarding their newborn's condition were received by 88% of mothers.

Regarding access to the newborn, 18% of mothers visited their baby within 12 hours of delivery, while 58% first visited within 12–24 hours. Overall, 63% visited their baby more than once daily. Daily or more frequent visitation by the father was reported by 74% of mothers. Breast milk was expressed in the NICU/SCBU by 61% of mothers, while 89% received instructions on the technique of expressing breast milk. A separate room for maternal rest was available to 54% of mothers.

Overall, 73% of mothers reported being extremely satisfied with the care they received, while 82% were extremely satisfied with the care provided to their baby.

Conclusion

Mothers reported generally positive experiences and high levels of satisfaction with NICU/SCBU care. However, opportunities remain to improve maternal access to newborn units, breastfeeding support, and the availability of facilities for mothers. Addressing these areas may further improve mothers' experiences during their newborns' admission to neonatal units.

OP 07 : DECISION-TO-INCISION INTERVAL FOR CATEGORY 2 CAESAREAN SECTIONS AT A SRI LANKAN DISTRICT GENERAL HOSPITAL: A RETROSPECTIVE AUDIT

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Introduction

Category 2 caesarean sections make up the majority of emergency caesareans in most obstetric units, yet decision-to-incision (DTI) interval performance against international standards is rarely audited in South Asian secondary care settings.

Objectives

To determine the DTI interval for Category 2 caesarean sections at a single obstetric unit of a Sri Lankan district general hospital, and assess compliance with the RCOG 75-minute standard.

Method

A retrospective audit of 418 consecutive deliveries at one obstetric unit of Negombo District General Hospital (August–October 2025) identified 67 Category 2 caesarean sections by documented decision and skin-incision times. Eight cases were excluded due to missing incision-time records, leaving 59 cases for interval analysis.

Results

Median DTI interval was 30 minutes (mean 33.9, range 10–110 minutes). Fifty-seven of 59 cases (96.6%) met the RCOG 75-minute standard; two exceeded it.

Conclusion

Category 2 response times met international benchmarks in the large majority of evaluable cases, despite infrastructural constraints at this unit. Incomplete time-interval documentation in 12% of cases is itself a quality-improvement target. Prospective, real-time DTI recording is recommended to strengthen future audit.

OP 08: MOTHERS' EXPERIENCE ON EARLY POSTNATAL CARE IN FOUR SELECTED HOSPITALS IN SRI LANKA

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Introduction

Supporting mothers during the postnatal period is a key component of quality postnatal care and contributes to successful breastfeeding initiation and maternal confidence. Assessing mothers' experiences of support can help identify areas for improving maternity and newborn services.

Objectives

To evaluate mothers' experiences of support following childbirth in four selected hospitals in Sri Lanka

Method

A descriptive cross-sectional study was conducted in four hospitals across the country (Colombo South Teaching Hospital, De Soysa Maternity Hospital, Base Hospital-Nuwara Eliya, Teaching Hospital-Peradeniya) among 253 postpartum mothers. Data were collected using a validated, self-administered questionnaire available in Sinhala, Tamil, and English that assessed breastfeeding initiation, staff support, breastfeeding education, and maternal confidence. Descriptive statistics were used to summarise the findings.

Results

Skin-to-skin contact immediately after birth was reported by 62% of mothers. Breastfeeding was initiated immediately after birth in 21.7% of mothers and within the first hour in another 34.8%. The first feed lasted only 5-10 minutes in 36.8%. More than half (56.1%) were extremely satisfied with the assistance received for the first breastfeed. More than 95% of mothers stated that breastfeeding instructions were provided, and they felt confident in breastfeeding before discharge. Nurses (74.3%) and midwives (60.5%) were the main providers of education. Despite these positive findings, only 35.2% of mothers who expressed breast milk reported receiving instruction on the correct expressing technique. 70.8% received information about the Lactation Management Centre. Following birth, 81.8% of mothers were updated regarding their baby's neonatal examination, 62.5% expressing extreme confidence in breastfeeding at discharge. Satisfaction with care was high, with 66.8% reporting being extremely satisfied with the care provided to their baby.

Conclusion

Mothers reported positive experiences with early breastfeeding support, particularly regarding staff assistance, education, and confidence at discharge. Strengthening practical lactation counselling, especially breast milk expression techniques, may further enhance breastfeeding outcomes.

OP 09: ASSESSMENT OF DOCUMENTATION AND FEASIBILITY OF TRIPS SCORE CALCULATION IN NEONATAL INTER-HOSPITAL TRANSFERS: A CLINICAL AUDIT

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Background

Safe neonatal transport is essential to minimise physiological deterioration and improve neonatal outcomes. The Transport Risk Index of Physiologic Stability (TRIPS) score is a validated tool for assessing physiological stability and predicting mortality among transported neonates. Accurate documentation of physiological parameters before and after transfer is essential for its calculation and for evaluating the quality of neonatal transport.

Objective

To assess the completeness of clinical documentation required for TRIPS score calculation among neonates transferred to a tertiary neonatal intensive care unit (NICU).

Method

A retrospective clinical audit was conducted among neonates transferred from 12 referring hospitals to the NICU of the German Srilanka Friendship Hospital for Women, over a three-month period. Data were extracted from transfer records and clinical documentation. The availability of parameters required for TRIPS score calculation, including temperature, blood pressure, respiratory status and neurological status, was assessed before and after transfer. Documentation of transfer duration and hospital outcomes was also reviewed.

Results

Twenty-five neonates were included, of whom 15 (60%) were preterm and 10 (40%) were term infants. Pre-transfer documentation was incomplete, with temperature missing in 13 (52%) and blood pressure in 11 (44%) cases. Respiratory status was documented in 24 (96%), while neurological status was absent in 3 (12%). Consequently, pre-transfer TRIPS scores could not be calculated in 18 (72%) neonates. Post-transfer documentation was relatively better; however, temperature and blood pressure remained undocumented in 3 (12%) and 7 (28%) cases, respectively. Transfer duration was not documented in any case. Six neonates (24%) died during the hospital stay.

Conclusion

Significant deficiencies in physiological monitoring and documentation limit the use of TRIPS scoring in neonatal transport. Implementation of a standardised transfer documentation tool and staff education may improve assessment of transport quality and support strategies to optimise neonatal outcomes.

OP 10: TURNING AUDIT INTO ACTION: ENHANCING THE NEONATAL RESUSCITATION COMPETENCE THROUGH CLINICAL GOVERNANCE

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Objectives

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

Method

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

Results

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

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

Conclusion

The knowledge and skills on neonatal resuscitation of the staff members working in the maternity care unit are a critical determinant of neonatal survival and the long-term outcome. Clinical audit is one of the pillars of clinical governance practices to improve the quality of care. Therefore, identification of the knowledge gap and the implementation of continuous professional development is important for quality improvement in neonatal care.

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PP 01 : AUDIT ON EXCLUSIVE BREASTFEEDING RATE AMONG NEONATES IN THE PROFESSORIAL POSTNATAL WARD, COLOMBO NORTH TEACHING HOSPITAL-RAGAMA

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Introduction

Exclusive breastfeeding is defined by the World Health Organization (WHO) as feeding infants only with breast milk (direct or expressed), without any additional food or drink except prescribed medications. The WHO recommends the initiation of breastfeeding within the first hour of birth and exclusive breastfeeding for the first six months of life. Hospital practices during the immediate postnatal period strongly influence breastfeeding success.

Objectives

To audit the unit compliance with the international recommendations on breastfeeding and to determine the rates and factors associated with non-exclusive breastfeeding to improve exclusive breastfeeding rates within the unit.

Method

Existing practices were assessed using one hundred randomly selected term neonates born in the professorial obstetric unit, Colombo North Teaching Hospital, during January and February 2026. Babies admitted to the neonatal intensive care unit and discharged through the mother-baby unit of the pediatric ward were excluded. Education on breastfeeding recommendations was then provided to nursing officers and midwives through a lecture and a practical demonstration. A re-audit of the change of practice was conducted in another 100 term neonates during March and April 2026.

Results

All 200 babies were initiated on breastfeeding within the first hour of birth. Eight babies among the first hundred babies (pre-education) received formula supplementation during the hospital stay. Therefore, the rate of exclusive breastfeeding was 92%. The indications for formula supplementation were excessive newborn weight loss with inadequate milk flow (6%), severe maternal illness requiring intensive care (1%), and neonatal hypoglycemia despite optimum breastfeeding support (1%). All mothers were assessed daily and supported regarding correct breastfeeding technique, and all the babies were discharged on exclusive breastfeeding. Re-audit following lecture demonstration to healthcare staff reduced the rate of formula supplementation to 6%, improving the exclusive breastfeeding rate to 94%.

Conclusion

Exclusive breastfeeding practices are already being followed at a satisfactory level in the unit, and there is still space for improvement and sustained best practice with regular updates and training of the staff.

PP 02 : A BABY WITH PERSISTENT TACHYPNEA: DELAYED DIAGNOSIS OF A CONGENITAL LARGE HYPERLUCENT LOBE

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Introduction

Congenital large hyperlucent lobe (CLHL), previously termed as congenital lobar emphysema or overinflation is a rare bronchopulmonary malformation characterized by over-inflation of one or more lung lobes, mostly affecting the left upper (42%) and right middle (35%) lobe. Around 50% of cases present in the neonatal period, while others present later in infancy. This can be diagnosed during antenatal period. If not, may present later as respiratory distress or can be an incidental finding on a CXR. Initial diagnosis might be missed in a resource limited setting like Sri Lanka, where the routine antenatal anomaly scan facilities are unavailable.

Case

A 2-month-and-15-day-old infant baby was brought to a local hospital due to poor feeding and gradually worsening breathing difficulty for 1 week. She was born at 37 weeks' gestation with 3040g birth weight and Apgar scores of 7, 9, 9. She was treated for presumed neonatal sepsis and was discharged on day 5 of life. Initial CXR following birth was documented as normal. Mother noticed a persistent fast breathing, but she was reassured. On current admission she had tachypnea (RR 72/min) with reduced air entry on left side. Chest radiography demonstrated overexpansion of the left upper lobe with significant mediastinal shift to right side. She was transferred for further management to tertiary care. CECT chest revealed hyperinflation of the left upper lobe with reduced lung vascular markings, and mediastinal deviation to the right side. She subsequently underwent left upper lobectomy. Histopathological examination demonstrated large alveolar spaces with loss of alveolar wall and totally collapsed alveolar areas. Overall, the radiological and histopathological findings were consistent with CLHL of left upper lobe.

Conclusion

In CLHL, initial CXR may occasionally demonstrate an opaque lung field, which subsequently clears and the affected lung becomes overinflated and hyperlucent. This case highlights that congenital thoracic malformations such as CLHL should be considered in neonates and infants presenting with unexplained respiratory distress particularly when symptoms are persistent and progressive. High degree of clinical suspicion and appropriate use of chest imaging such as CXR and CT are vital to establish an early diagnosis to prevent morbidity and potential mortality in this treatable condition.

PP 03 : A CASE OF SEVERE REFRACTORY PERSISTENT PULMONARY HYPERTENSION OF NEWBORN WITH DIAGNOSTIC AND MANAGEMENT CHALLENGES

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Introduction

Persistent pulmonary hypertension of the newborn (PPHN) affecting approximately 1–2 per 1000 live births, results from failure of pulmonary vascular resistance to fall normally after birth, causing persistent right-to-left shunting and severe hypoxaemia. Increased PVR may result from failure of normal pulmonary vasodilation, abnormal pulmonary vascular remodelling, pulmonary hypoplasia, or obstruction to pulmonary blood flow.

Case Report

We present a case of a neonate, born at 40 weeks' gestation following an uncomplicated antenatal period at a local hospital. Birth weight was 3040 g, with Apgar scores of 9, 10, and 10. Soon after birth, she developed profound cyanosis and hypoxaemia with pre- and post-ductal saturations of 30% and 24%, respectively, necessitating ventilatory support. She was subsequently transferred to a tertiary care centre for further management. Initial CXR showed normally expanded lungs without air-space opacification, but with reduced pulmonary vascularity, and no significant, parenchymal abnormality. Serial echocardiography demonstrated severe PPHN with evolving ductal shunting, progressing from bidirectional to right-to-left and subsequently predominantly left-to-right as pulmonary vascular resistance improved. Later, chest radiographs demonstrated bilateral patchy air-space opacities which, together with a rising CRP, were suggestive of secondary pulmonary infection, including possible ventilator-associated pneumonia, with evolving ARDS. Her course was further complicated by multiorgan dysfunction. She required HFOV from day 1, and cardiovascular support with four inotropic agents. Management included surfactant, inhaled nitric oxide, sildenafil, intravenous antibiotics and supportive management. Despite improvement in echocardiographic features of PPHN, she continued to have profound, fluctuating pre- and post-ductal hypoxaemia with a differential of up to 40% and recurrent hypotension. She progressively deteriorated and died on day 14 of life. Post-mortem examination revealed no significant congenital structural abnormality, no histological evidence of congenital pneumonia, and no significant pulmonary vascular remodeling.

Discussion

Despite extensive evaluation, no definitive underlying cause for the severe PPHN was identified, the overall findings were most consistent with possible idiopathic PPHN.

Conclusion

This neonate had fatal, treatment-refractory course despite maximal ventilatory, pulmonary vasodilator and cardiovascular support, highlights the therapeutic challenges of severe refractory PPHN.

PP 04 : A CLINICAL AUDIT ON ADMISSION TEMPERATURE OF NEONATES TO AN INTENSIVE CARE UNIT, THE RISK FACTORS AND THE ADVERSE OUTCOMES

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Introduction

Neonatal hypothermia is an important determinant of neonatal morbidity and mortality. The World Health Organization (WHO) has defined hypothermia as an axillary temperature less than 36.5°C. This quality improvement audit described the admission temperatures of neonates admitted to the Neonatal Intensive Care Unit (NICU) of Colombo North Teaching Hospital (CNTH), Sri Lanka and determined the impact of a structured staff education intervention on improving thermal care practices.

Methodology

Data were collected from 80 neonates admitted to the University NICU of CNTH, Ragama, Sri Lanka from January to April 2026. Forty neonates were initially recruited, and data were collected regarding birth condition, delivery room and transport conditions, admission temperature and neonatal outcomes. Then, an educational workshop was conducted for the front-line healthcare staff working in the delivery room and operating theatre regarding the importance and prevention of hypothermia. Another 40 neonates were recruited following the workshop using the same inclusion criteria. Paired sample t-test was used in the analysis.

Results

Out of 80 neonates recruited, 39 (48.7%) were hypothermic on admission with a mean temperature of 35.36±0.76°C. Among them, 31 (79.5%) were preterm, 32 (82.1%) had low birth weight, and 18 had very low birth weight below 1500g. 30/39 (76.9%) hypothermic neonates were delivered via lower segment cesarean section and 23/39 (58.9%) needed varying degrees of resuscitation at birth. All the hypothermic admissions were managed for presumed sepsis, while 24 (61.5%) and 34 (87.2%) had hypoglycemia and respiratory distress, respectively. There was no significant difference in the mean admission temperature (35.96 ±0.91°C vs 36.15 ± 0.90°C, p=0.415) before and after the structured staff education intervention.

Conclusion

Nearly half of the neonates were hypothermic on admission to the NICU. Prematurity, low birth weight, and birth asphyxia were the important risk factors for hypothermia. Over 60% of hypothermic neonates had hypoglycemia and over 80% had respiratory distress. A structured staff education workshop did not result in a significant improvement in the prevalence of neonatal hypothermia on admission.

PP 05 : CLINICAL AUDIT ON ANTIBIOTICS USE AND STEWARDSHIP IN NICU AND POST-NATAL WARDS AT COLOMBO SOUTH TEACHING HOSPITAL

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Introduction

Neonatal infections remain a leading cause of morbidity and mortality in Sri Lanka. Early empirical antibiotic therapy is recommended due to nonspecific presentation; however, rational use is essential to reduce antimicrobial resistance and improve outcomes.

Objectives

To evaluate antibiotic use and stewardship practices in neonates, including documentation, blood culture practices, guideline compliance, timing of administration, 48–72-hour review, and discontinuation.

Methodology

A retrospective clinical audit was conducted at CSTH NICU and postnatal wards from 1st February to 31st March 2026. Thirty-three neonates (≤ 28 days) on antibiotics were included. Data were collected using a structured proforma. Audit standards were: blood cultures prior to antibiotics $\geq 90\%$, guideline-compliant empirical therapy $\geq 85\%$, review at 48–72 hours $\geq 90\%$, and appropriate duration $\geq 80\%$.

Results

Most neonates (93%) were treated for suspected early-onset sepsis. Indications were documented in 96% of cases. Blood cultures were obtained prior to antibiotics in 100%. Empirical antibiotic choice was guideline-compliant in 54%. Antibiotics were administered within one hour in 51% of cases.

All neonates had review at 48–72 hours (100%); however, blood culture results were available at review in only 24%. Antibiotics were discontinued at 48–72 hours in only 15.5% of clinically well neonates with negative cultures. Antibiotics were escalated in 30% of cases. Appropriate duration of therapy was seen in 82%.

Conclusion

While initial assessment and review practices were satisfactory, significant gaps exist in antibiotic stewardship, particularly in guideline adherence, timely administration, availability of culture results, and discontinuation practices. Strengthening these areas is essential to optimize neonatal care and reduce antimicrobial resistance. Re-audit will be followed in due time.

PP 06 : CLOSING GAPS IN EMERGENCY PREPAREDNESS : A CLINICAL AUDIT

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Introduction

Immediate availability of functional emergency equipment and medications is essential for effective resuscitation in neonatal settings where rapid deterioration may occur. Emergency trolleys should therefore be appropriately stocked, functional, standardised and routinely checked. This audit assessed emergency preparedness across clinical areas involving neonates of the German–Sri Lanka Friendship Hospital for Women.

Objectives

To assess the availability and functionality of essential equipment and medications in emergency trolleys, evaluate compliance with routine checking practices, and identify deficiencies requiring corrective action. Readiness of transport incubators in neonatal care areas was also assessed.

Method

A hospital-wide clinical audit was conducted across 14 clinical areas, including postnatal wards, neonatal intensive care and mother-baby units, labour rooms, operating theatres and the emergency treatment unit. Emergency trolleys were assessed using a structured checklist for the availability and functionality of essential airway, resuscitation and other equipment; availability and expiry status of emergency medications; and evidence of routine trolley checking. Transport-incubator readiness was additionally evaluated in relevant neonatal areas. Findings were summarised using frequencies and percentages.

Results

Important deficiencies were identified despite good availability of several essential items. Availability of neonatal face masks varied from 85.7% for size 1 to 64.3% for size 00. Size-0 laryngoscopes were available in 92.9% of areas, whereas size-1 laryngoscopes were available in only 14.3%. Availability of 2.0-mm endotracheal tubes was 28.6%, while 5-Fr and 7.5-Fr suction catheters were unavailable. Adrenaline was available in 92.9% of areas, normal saline in 85.7%, 10% dextrose and sodium bicarbonate in 78.6% each, and naloxone in 42.9%. Expired 10% dextrose was identified in two locations. Gaps were also observed in equipment functionality and routine checking practices.

Conclusions

Although overall emergency-trolley preparedness was satisfactory for several essential items, clinically important deficiencies existed, particularly in neonatal airway equipment, selected emergency medications, equipment functionality and routine checking. Standardised trolley contents, clearly assigned accountability, systematic daily checks and regular re-auditing are recommended to improve emergency preparedness and patient safety.

PP 07 : SUSPECTED APERT SYNDROME IN A NEONATE: A CLINICAL DIAGNOSIS AWAITING GENETIC CONFIRMATION

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Background

Apert syndrome is a rare autosomal dominant craniosynostosis syndrome caused by pathogenic variants in FGFR2 gene. It is characterized by premature cranial suture fusion, midface hypoplasia and complex syndactyly. We report a clinically diagnosed neonate with classical craniofacial features managed in a tertiary neonatal unit in Sri Lanka.

Case Report

A female infant was born at 39 weeks by normal vaginal delivery to a 22-year-old healthy primigravida following an uncomplicated pregnancy except prolonged rupture of membranes (14 hours) and untreated maternal hypothyroidism. Birth weight was 2790 g with APGAR scores of 9 and 10 at one and five minutes. Soon after birth she developed respiratory distress with inspiratory stridor requiring humidified heated high-flow oxygen. Right choanal atresia was initially suspected due to inability to pass the NG tube for feeding and later confirmed with CT Brain. Detailed examination revealed a small anterior fontanelle, brachycephalic tower-shaped skull with flattened occiput, marked bilateral proptosis, down-slanting palpebral fissures, frontal bossing, maxillary hypoplasia, low-set ears and a high arched palate. Echocardiography showed only a patent foramen ovale. Cranial ultrasonography demonstrated prominent lateral ventricles, a thin corpus callosum and a small posterior fossa. Skull radiography confirmed brachycephaly secondary to craniosynostosis, frontal prominence, maxillary hypoplasia and increased convolutional markings (copper-beaten appearance). Xray neck showed fusion of C4-C5 vertebral bodies which is present in 50% of apert syndrome babies. Septic evaluation including blood cultures was negative, however conjunctival swab grew ESBL coliforms which was treated appropriately. The infant was supported with oxygen, Naso gastric tube feeding, antibiotics and ophthalmology care before referral for multidisciplinary assessment including ENT, plastic surgery, neurosurgery and clinical genetics. Molecular confirmation is currently awaiting.

Conclusion

This neonate demonstrated the classical phenotypic features of Apert syndrome, allowing a confident clinical diagnosis before genetic confirmation. Early recognition is essential to facilitate airway management, visual protection, nutritional support and timely multidisciplinary intervention. This case highlights the importance of careful neonatal clinical examination in recognizing rare craniosynostosis syndromes, particularly in resource limited settings where genetic testing may not be freely available.

PP 08 : COEXISTING DUAL PATHOLOGY-MIDGUT MALROTATION AND CAECAL DUPLICATION CYST CAUSING INTESTINAL OBSTRUCTION IN AN INFANT – A CASE REPORT

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Abstract

Midgut malrotation and enteric duplication cysts are important surgical concerns in an infant presenting with bilious vomiting. Intestinal obstruction in an infant is most commonly caused by inguinal herniae and congenital anomalies, such as malrotation with volvulus, Hirschsprung disease, and intestinal duplication cysts. The coexistence of dual independent obstructive pathologies is exceedingly rare and poses diagnostic and management challenges.

We report a 4-month-old male infant presenting with acute bilious vomiting, irritability, and progressive drowsiness over 4 days. His abdomen was soft but distended. Initial Plain abdominal X-ray revealed dilated small bowel loops with absent colonic gas at a peripheral hospital. Subsequent contrast meal suspected midgut malrotation, with contrast not progressing beyond the duodenum. A laparotomy revealed midgut malrotation without volvulus. However, there was a large caecal mass causing complete bowel obstruction with the resultant dilated terminal ileum (all on the Upper left side) exerting external pressure on the duodenum. A Ladd's procedure and limited ileocaecal resection with ileocolic anastomosis were performed. The postoperative course was uneventful, and full enteral feeding was successfully established. Histology confirmed the diagnosis of a caecal duplication cyst.

This case highlights the importance of considering coexisting pathologies in infants with persistent obstructive symptoms. In suspected or confirmed cases of midgut malrotation, early surgical intervention is crucial to avoid adverse outcomes. It should be noted that dilated small bowel loops with absent colonic gas on the X-ray, with the absence of volvulus during the surgery, led us to look for a second pathology.

Keywords

Bilious vomiting, Midgut malrotation, Caecal duplication cyst, Infant, Ladd's procedure

PP 09 : SUCCESSFUL MEDICAL MANAGEMENT OF FEMORAL ARTERY THROMBOSIS WITH SEVERE LIMB ISCHEMIA IN A PRETERM NEONATE

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Introduction

Arterial thrombosis causing limb ischemia is rare but potentially limb and life-threatening. We report a preterm neonate with femoral-artery thrombosis and severe limb ischemia successfully managed medically.

Case Report

A preterm neonate weighing 1.78 kg was delivered at 30 weeks' gestation. Pregnancy was complicated by stage II twin-to-twin transfusion. This neonate was the recipient with early hydrops fetalis. The mother was A positive, and the neonate was O positive.

The early hours were complicated by surfactant deficiency, circulatory instability, indirect hyperbilirubinemia exceeding the exchange transfusion threshold, and polycythaemia (haematocrit 65.5%). Umbilical arterial and venous catheters were inserted on day 1, and exchange transfusion was performed at 32 hours. At 59 hours, he developed cyanosis of the left lower limb. The umbilical-arterial catheter, with a heparin infusion, was removed due to suspected catheter-related thrombosis. Cyanosis progressed with feeble distal circulation. Doppler ultrasonography confirmed left femoral artery thrombosis, absent distal flow without extension to adjacent vessels.

Thrombectomy was considered impossible due to the unavailability of appropriate catheter sizes for very-low-birthweight neonates. Following multidisciplinary discussion, unfractionated heparin was commenced with 90-unit/kg loading dose followed by 18-unit/kg/hour infusion, adjusted every 6–8 hours to maintain APTT between 60 and 80 seconds. Supportive management included limb positioning, warm saline packs, meticulous fluid management, skin care, analgesia, sedation, and close monitoring for altered coagulation. Clinical improvement was noted after 36 hours. Ten days later, intravenous anticoagulation was changed to subcutaneous enoxaparin (1 mg/kg every 12 hours) for two weeks and aspirin (1 mg/kg/day) for one month. He developed dry gangrene over the left thigh, dynamic knee contracture, and sepsis. The contracture was managed with gentle physiotherapy and gradual knee extension, while gangrene was managed conservatively. No major anticoagulation-related complications occurred. Doppler-ultrasonography on day 22 demonstrated biphasic flow, confirming successful recanalization.

Conclusion

This demonstrates successful medical management of severe limb ischemia secondary to femoral artery thrombosis. Thrombosis was likely multifactorial, with polycythaemia, exchange transfusion, umbilical arterial catheterisation, fluid imbalance, and sepsis as possible contributors. Multidisciplinary decision-making, close monitoring, and therapeutic anticoagulation enabled arterial recanalization without major complications, potentially avoiding invasive thrombolytic or surgical intervention.

PP 10 : IMPROVING NEONATAL CARE THROUGH DATA-DRIVEN AUDIT: DOCUMENTATION COMPLIANCE IN THE CHILD HEALTH DEVELOPMENT RECORD (CHDR)

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Introduction

The Child Health Development Record (CHDR) plays a vital role in ensuring continuity of neonatal care in Sri Lanka. Accurate documentation supports growth monitoring, early risk identification, screening follow-up, and medico-legal safety. However, incomplete documentation may compromise quality of care and long-term outcomes.

Objective

To assess the completeness of documentation of key neonatal parameters in the Child Health Development Record (CHDR) and identify gaps requiring quality improvement.

Method

A prospective clinical audit was conducted over five weeks at the Well Baby Clinic, GSFHW. Eighty-five first-visit infants with CHDRs completed by healthcare staff were evaluated using a structured proforma. Ten key neonatal parameters from the first and seventh pages of the CHDR were assessed for documentation completeness.

Results

Documentation compliance was highest for birth weight (98%), occipitofrontal circumference (75%), and birth length (75%). Moderate compliance was observed for APGAR score (69%), vitamin K administration (88%), and breastfeeding establishment (68%). Significant gaps were identified in discharge weight documentation (48%) and congenital hypothyroidism screening (61%). Among infants with identified risk factors (n=54), only 28% had documentation indicating the need for special care. Additionally, 25% of records lacked documentation for critical congenital heart disease screening, highlighting a key patient safety concern.

Conclusion

This audit demonstrates critical gaps in essential neonatal documentation despite good recording of basic parameters. Translating audit data into action—through structured checklists, staff training, accountability, and potential digital documentation systems—can enhance data quality, improve clinical decision-making, and strengthen continuity of neonatal care.

PP 11 : CONGENITAL LARGE HYPERLUCENT LOBE: LOBAR EMPHYSEMA OR CONGENITAL PULMONARY AIRWAY MALFORMATION? - A DIAGNOSTIC OVERLAP

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Introduction

Congenital Large Hyperlucent lobe (CLHL), previously called Congenital Lobar Emphysema is a rare pulmonary developmental abnormality characterized by over-inflation of lung lobes due to partial obstruction of the feeding bronchus. While, Congenital Pulmonary Airway Malformations (CPAM), formerly called Congenital Cystic Adenomatoid Malformation (CCAM) is another rare pulmonary development anomaly with multiple cystic lesions.

Case Report

1 month 19 days old baby who was first born to consanguineous parents at 28+5 POA with birth weight 1260g and APGAR was 7,9,9 and managed for respiratory distress, neonatal sepsis and neonatal jaundice following birth and discharged on day 30 of life. At 44 days of life, the infant was admitted with respiratory distress to a local hospital and required mechanical ventilation. Chest radiography demonstrated overexpansion of the right lung with possible CLHL. HRCT of the chest showed overexpanded right lower lobe with multiple cystic lesions and mediastinal shift to the opposite side. The average diameter of the cysts was 20 mm. The baby underwent right lower lobectomy with wedge resection of the right middle lobe. Histopathological examination of the resected lobe showed multiple small cysts on surface measuring 50 × 60 × 20 mm, alveolar spaces with emphysematous alveoli and cysts in lungs lined by denuded ciliated columnar epithelium. Although CXR was compatible with CLHL, CT and histology were suggestive of CPAM.

Conclusion

Markedly overdistended air spaces in CLHL can sometimes look cyst-like, on imaging and can mimic CPAM. Although, histology provides the final diagnosis of these lesions, histopathological differentiation between CLHL and CPAM may be limited by sampling technique, distortion of lung architecture due to hyperinflation and collapse, epithelial denudation, and overlapping morphological features. Therefore, clinical-radiological-pathological correlation is essential in diagnosing CLHL.

PP 12 : FROM BIRTH TO FIRST FEED: A CLINICAL AUDIT OF TIMELY BREAST MILK INITIATION WITHIN SIX HOURS IN NICU AND SCBU

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Introduction

Early breast milk feeding is an essential component of neonatal care, particularly for preterm and low-birth-weight infants. Human milk provides nutritional, immunological, and developmental benefits, and early initiation supports optimal neonatal outcomes. Current neonatal recommendations encourage initiation of breast milk as early as possible after birth, ideally within six hours in clinically stable infants. This audit evaluated compliance with this standard and explored factors associated with delayed initiation among neonates requiring specialised care.

Objectives

To assess compliance with breast milk initiation within six hours of birth among neonates admitted to the neonatal intensive care unit (NICU) and special care baby unit (SCBU), and to identify factors associated with delayed initiation.

Method

A clinical audit was conducted among 72 neonates admitted to the NICU and SCBU immediately after birth. Data collected included gestational age, birth weight, mode of delivery, time to first breast milk feed, and documented reasons for delay. Initiation within six hours of birth was considered compliant. Factors associated with delayed initiation (>6 hours) were analysed using the chi-square test or Fisher's exact test, as appropriate, with statistical significance defined as $p < 0.05$.

Results

Breast milk was initiated within six hours in 60/72 neonates (83.3%), with a median time to first feed of 3 hours (IQR 2–5). Delayed initiation occurred in 12 neonates (16.7%). Delays were significantly more common among infants born at <32 weeks (44.4%) than among those born at 32–36+6 weeks (16.7%) and ≥ 37 weeks (9.1%) ($p = 0.042$). Similarly, delayed initiation occurred in 35.7% of infants weighing <1500 g, 20.8% weighing 1500–2499 g, and 5.9% weighing ≥ 2500 g ($p = 0.033$). Mode of delivery was not significantly associated with delayed initiation ($p = 0.507$). Maternal critical illness, including intensive care admission, was the most frequently documented reason for delayed initiation.

Conclusion

Most neonates requiring specialised care received breast milk within six hours of birth. Delayed initiation was more frequent among very preterm and low-birth-weight infants. Improving antenatal counselling, supporting early expression of breast milk, and strengthening systems for timely delivery of expressed milk may further enhance early human milk feeding practices.

PP 13 : MATERNAL WAITING TIME AND EXPERIENCE DURING COMPLETION OF ROUTINE POSTNATAL INVESTIGATIONS AT A WELL BABY CLINIC: A CLINICAL AUDIT

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Introduction

Well Baby Clinic visits provide an important opportunity for comprehensive postnatal assessment of mothers and infants, including completion and review of routine investigations. Delays in investigation processing and reporting may result in prolonged hospital stays, maternal discomfort, inconvenience and additional costs. This clinical audit assessed maternal waiting time and experience related to routine postnatal investigations at the Well Baby Clinic of Castle Street Hospital for Women.

Objectives

To assess waiting time for completion and reporting of routine postnatal investigations and evaluate maternal comfort and satisfaction during the clinic visit. Secondary objectives were to identify causes of prolonged waiting, assess government versus private-sector utilization, identify factors influencing maternal preferences, and explore potential service improvements.

Method

A questionnaire-based clinical audit was conducted among 35 mothers attending the Well Baby Clinic. Data was collected regarding travel distance, total clinic duration, timing and location of investigations, time taken to receive reports and medical review, requirements for prolonged stay or return visits, additional expenditure, maternal comfort and satisfaction. Mothers also reported difficulties encountered and suggestions for service improvement.

Results

Of the 35 mothers, 26 (74.3%) spent more than six hours at the hospital, while 9 (25.7%) spent four to six hours at the hospital. Prolonged clinic stay was attributed to completion of investigations in 33 (94.3%) mothers, and all mothers reported requiring a prolonged stay. The main difficulties reported were breastfeeding difficulties (94.3%), overcrowding and lack of privacy (80%), and inadequate seating (40%). Twenty-seven mothers (77.1%) waited more than two hours to receive investigation reports, while 26 (74.3%) received medical reviews within 30 minutes of obtaining reports. All investigations completed during the clinic visit were performed in the government sector. Three mothers (8.6%) required a return visit to collect reports. Overall, 34 mothers (97.1%) were satisfied with the report review and service received.

Conclusion

This audit identified substantial delays associated with completion and reporting of routine postnatal investigations, resulting in prolonged clinic stays and considerable maternal discomfort. Improved coordination between clinic and laboratory services, clear pre-visit instructions, appointment or time-slot systems, streamlined patient flow, and dedicated breastfeeding and waiting facilities may reduce waiting time and improve maternal experience. Re-audit following implementation of these interventions would help determine their effectiveness.

PP 14 : BORN WITHIN THE VEIL: EMERGENCY EN CAUL DELIVERY IN A 30-WEEK PRETERM INFANT

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Introduction

En caul delivery, where a newborn is delivered completely enclosed within the intact amniotic sac, is a rare and striking obstetric event, occurring in approximately one in eighty thousand births and more often in preterm and caesarean deliveries. While the intact sac may offer brief protection from mechanical trauma and cord compression, it can delay immediate access to the airway. In very preterm infants, even short delays in ventilation and thermal care can compromise early physiological adaptation.

Case Rreport

A 30-week preterm infant with antenatal oligohydramnios, weighing 1.46 kg, was delivered by emergency caesarean section completely enclosed within the amniotic sac. The neonatology team promptly opened the sac, exposing the face and chest first, placed the infant in a polythene wrap, and transferred the baby under a radiant warmer to secure the airway and access the umbilical cord. At birth, the infant had poor respiratory effort with bradycardia. Standard neonatal resuscitation was initiated with airway positioning and positive pressure ventilation, while strict thermal protection and continuous monitoring was ensured. Following initial stabilization baby transferred to the neonatal intensive unit for ongoing supportive care.

Conclusion

Preterm En caul delivery represents a high-risk birth scenario that demands calm, coordinated action. Anticipation, clear communication, and protocol-based care are essential to minimize hypoxia, hypothermia, accidental cord injury, and delays in life-saving interventions during the first critical minutes after birth. Therefore, En caul delivery is a time-critical situation that requires anticipation, team readiness, and strict adherence to neonatal resuscitation protocols to ensure a safe transition to extrauterine life.

PP 15 : AUDIT OF EARLY INITIATION OF BREAST MILK FEEDING AND PROGRESSION TO FULL ENTERAL FEEDING IN NEONATES ADMITTED TO NICU

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Introduction

Early initiation of breast milk feeding and timely progression to full enteral feeding are essential components of neonatal intensive care. These practices promote gastrointestinal maturation, reduce the risk of necrotizing enterocolitis and sepsis, shorten hospital stay, and improve outcome. National Hospital Galle Neonatal Intensive Care Unit (NICU) receives transferred neonates from peripheral hospitals without an attached maternity unit, potentially delaying the availability of expressed breast milk (EBM) and initiation of feeding.

Objectives

To evaluate current practices regarding early initiation of enteral feeding and progression to full enteral feeding among neonates admitted to the NICU, and to assess compliance with recommended feeding standards.

Method

A prospective clinical audit was conducted over seven weeks (15 March–26 April 2026) in the NICU of National Hospital Galle. Twenty-five consecutive neonatal admissions were included. Data were collected using a structured audit tool through direct observation and review of feeding records. Audit parameters included timing of first feed, feed advancement, achievement of full enteral feeding, EBM availability, feed interruptions, gastric residual checks, NEC occurrence, and duration of NICU stay. Performance was assessed against predefined audit standards.

Results

Only 4 of 25 neonates (16%) received their first feed within the first 24 hours, indicating poor compliance. Fast feed advancement (30 mL/kg/day) was achieved in 59% of neonates, while 40% received slower advancement (20 mL/kg/day). The mean time to achieve full enteral feeding was 5.8 days. Poor EBM availability (23%), largely due to delayed maternal transfer, was the main barrier to early feeding. NEC incidence remained low at 9%, despite relatively rapid feed advancement. Unnecessary gastric residual checks and perceived feed intolerance contributed to feed interruptions.

Conclusion

Compliance with early initiation of enteral feeding was poor, primarily because of delayed EBM availability. Despite this, progression to full enteral feeding was achieved within an acceptable timeframe for many neonates, with a low incidence of NEC. Strengthening feeding initiation protocols, improving EBM availability, and standardizing feeding practices may enhance neonatal nutritional outcomes and reduce delays in achieving full enteral feeding.

PP 16 : WHEN THE MIDLINE FAILS TO FORM: ISOLATED HOLOPROSENCEPHALY SEQUENCE IN EARLY INFANCY

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Introduction

Holoprosencephaly (HPE) sequence is a rare brain malformation caused by incomplete division of the fore-brain during early embryonic life. It shows a wide spectrum of severity and is commonly associated with characteristic midline craniofacial anomalies. Although many cases are linked to chromosomal disorders and multisystem syndromes, isolated holoprosencephaly with a normal karyotype is uncommon. About twelve percent of cases are non-syndromic and linked to pathogenic variants in SHH, ZIC2, SIX3, and TGIF genes, most often affecting the Sonic hedgehog signalling pathway, with variable clinical expression.

Case Report

We report a two-month-old infant born to healthy non-consanguineous parents with a healthy sibling, who presented with recurrent subtle motor seizures. Typical facial features were present, including hypotelorism, microphthalmia, cleft lip and palate, microcephaly, and absence of the philtrum and nasal septum. Brain imaging confirmed holoprosencephaly with agenesis of the corpus callosum. Chromosomal analysis was normal (46,XX). Radiology showed no significant renal structural anomalies or gallbladder agenesis. Endocrine evaluation excluded hypopituitarism, and no hypoglycaemic episodes occurred. Seizures were partially controlled with multiple anticonvulsants, with burst-suppression on EEG. Nutritional support was provided via nasogastric feeding. Hearing and vision assessments were reassuring, with no cataracts, coloboma, or sensorineural hearing loss. Cardiac assessment revealed a small ASD. No genitourinary, skeletal, neural tube were identified. Chest radiography showed no diaphragmatic hernia or thymic hypoplasia. Despite optimal supportive care, the infant demonstrated suboptimal growth and weight gain.

Conclusion

Non-syndromic isolated holoprosencephaly sequence requires detailed genomic evaluation for prognostication, family counselling and multidisciplinary interventions.

PP 17 : IDENTIFYING BARRIERS AND DEFICIENCIES IN KANGAROO MOTHER CARE (KMC) IMPLEMENTATION IN THE POSTNATAL WARD: AN INTERNAL AUDIT OF MEDICAL AND NURSING STAFF

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Introduction

Kangaroo Mother Care (KMC) significantly reduces neonatal morbidity and mortality, yet systemic implementation gaps often limit its optimal delivery.

Objectives

This internal audit aimed to evaluate postnatal ward staff knowledge, assess environmental and staff-related root causes for compliance deficiencies against institutional targets, and guide a targeted quality improvement program.

Method

A cross-sectional study was conducted over 10 days targeting medical, nursing, and midwifery staff across four postnatal wards (Wards 2, 4, 5, and 8) at CSHW. A validated questionnaire evaluated practices against three core institutional standards (100% target for universal initiation, counseling, and barrier documentation). Data from 32 multidisciplinary participants (including PBU medical officers, pediatric registrars, nursing officers, midwives, and interns) were collected and analyzed.

Results

The audit achieved a high mean response rate of 98.5%. A critical training gap was identified: 56.3% of staff had never received formal KMC training, leading 97% to rely on informal lateral education sources. Consequently, the collective mean correct clinical knowledge score was poor (39.25%). Specific deficiencies included:

- **Timing & Duration:** Only 59.4% knew the correct timing of initiation, and only 29% correctly identified the minimum duration required for an individual session.
- **Attitudinal Paradox:** While 87.5% of staff believed KMC is highly beneficial, 55.2% felt it actively interfered with routine ward procedures.
- **Infrastructure & Policy Barriers:** Environmental obstacles affected 46.1% of staff, highlighted by an absolute shortage of dedicated KMC garments (50%) and the total absence of a formalized written unit policy. Routine KMC monitoring during ward rounds was limited to 71.9%.

Conclusion

Institutional targets of 100% compliance for KMC delivery remain unmet due to administrative and educational deficiencies rather than active staff resistance. To resolve these deficits, the unit must transition to a structured quality improvement framework combining mandatory staff training, formalized bedside documentation protocols, and the procurement of basic KMC infrastructure.

PP 18 : MULTIPLE JOINT SEPTIC ARTHRITIS CAUSED BY TWO DIFFERENT MICROORGANISMS IN A PRETERM NEONATE: A CASE REPORT

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Introduction

Neonatal septic arthritis is a serious but rare condition which can result in progressive joint destruction. Here, we report a preterm neonate with septic arthritis involving multiple joints due to two different microorganisms; methicillin-resistant *Staphylococcus aureus* and *Enterococcus*.

Case Report

A first-born male twin of a monochorionic monoamniotic pregnancy was delivered via elective lower-segment caesarean section at 33+2 weeks of gestation with a birth weight of 1.53 kg. The antenatal and immediate postnatal period was uncomplicated. The initial septic screening was negative. On day 8 of life, the baby developed fever, reduced activity and poor feeding. On examination an infected cannula site on the left foot was noted. CRP was 238 mg/L, Blood culture yielded methicillin-resistant *Staphylococcus aureus* and treatment was continued according to the sensitivity pattern.

On day 16, swelling of the left knee was noted and subsequently progressed to bilateral knee joints. Initial ultrasonography suggested suprapatellar bursitis, but repeat imaging confirmed bilateral septic arthritis. Despite ongoing antimicrobial therapy, the infant developed recurrent fever on day 34, accompanied by restricted movement of the right hip and swelling of the right elbow, wrist, and ankle joints. Ultrasonography demonstrated right hip and elbow joint effusions with synovial thickening and bony changes involving the femoral head.

Arthrotomy of the right hip joint was performed. Tissue culture yielded *Enterococcus* species sensitive to linezolid. The infant received prolonged intravenous antimicrobial therapy, including meropenem, vancomycin, clindamycin, and amikacin, followed by a two-week course of oral linezolid. Immunodeficiency screening was unremarkable. The infant demonstrated gradual clinical and biochemical improvement.

After an eight-week hospital stay, the infant was discharged with multidisciplinary follow-up. At six-week review, he remained clinically well with marked improvement in joint mobility. Follow-up ultrasonography demonstrated mild asymmetry of the right femoral head without hip dislocation.

Conclusion

This case emphasises the challenges of early diagnosis of septic arthritis due to its nonspecific clinical presentation. Furthermore, this case underscores the value of prompt medical management in conjunction with surgical exploration, even in cases of delayed diagnosis, to achieve favourable clinical outcomes.

PP 19 : A UNIQUE CASE OF POSTNATAL COLLAPSE DUE TO DYSPLASTIC AORTIC VALVE CAUSING CRITICAL AORTIC STENOSIS

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Introduction

Congenital dysplastic aortic valve causing severe aortic stenosis is a rare but identified cause of post-natal collapse. It is common in males and can have a syndromic association. Cardiac catheterization and balloon aortic valvuloplasty are the treatment of choice.

Case Report

A baby boy, born at 36 weeks of gestation with a birthweight of 2500 g, presented at two hours of life with mild respiratory distress, respiratory acidosis, and the chest X-ray revealed right upper lobe pneumonia for which IV antibiotics were started. The mother had peripartum myocardialopathy.

On day five of life, the baby presented with post-natal collapse and a grade three long systolic murmur at the upper sternal edge. There was no ductal saturation difference, and the capillary blood gas showed metabolic acidosis with a high lactate level. Progression of neonatal sepsis was concluded.

However, despite fluid and antibiotic optimization, the neonate deteriorated, developing low systolic blood pressures, a convulsion, and the lactate level peaked to 13.5 mmol/L. The echocardiogram revealed severe aortic stenosis, moderate left ventricular dysfunction, and a small patent ductus arteriosus. Following initiation of prostaglandin E1 infusion, the lactate level, liver transaminase values, and urine output were normalized. Blood pressures were normalized with IV Adrenalin infusion.

Following hemodynamic stabilization, cardiac catheterization with successful balloon aortic valvuloplasty was performed, using a coronary balloon followed by an Osypka balloon. During the procedure, the baby developed atrial flutter, which settled after 1J/Kg DC shock. Post-procedure prostaglandin and adrenaline infusions were systematically tapered off.

Post-operative complications included reduced perfusion in the right lower limb caused by an occluded femoral artery, which was managed with an intravenous heparin infusion. Additionally, blood and umbilical venous catheter (UVC) cultures returned positive for coliform bacteria, necessitating a targeted 14-day course of intravenous antibiotics. Oral propranolol was initiated post-procedure to manage tachycardia and allow growth of the small left ventricle.

Conclusion

Critical aortic stenosis can manifest uniquely as a post-natal collapse without a ductal saturation difference. Recognizing a prominent systolic murmur is a vital clinical trigger for the urgent initiation of a life-saving prostaglandin E1 infusion.

PP 20 : AUDIT OF ADHERENCE TO A SERIAL CRANIAL ULTRASOUND SCREENING PROTOCOL FOR INTRAVENTRICULAR HAEMORRHAGE IN HIGH-RISK NEONATES ADMITTED TO A TERTIARY NEONATAL INTENSIVE CARE UNIT

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Introduction

Intraventricular haemorrhage (IVH) is a major complication of prematurity and contributes significantly to neonatal mortality and long-term neurodevelopmental impairment. Serial cranial ultrasound (CUS) screening facilitates early diagnosis and timely intervention. This audit evaluated adherence to the local IVH screening protocol and the IVH detection rate among high-risk neonates admitted to a tertiary neonatal intensive care unit (NICU).

Objectives

To assess adherence to the unit CUS screening protocol, determine the incidence and severity of IVH, identify associated modifiable risk factors, and recognize opportunities for quality improvement in neonatal care.

Method

A retrospective clinical audit was conducted in the NICU of De Soysa Hospital for Women, Colombo, including eligible neonates admitted over a three-month period. Data were obtained from bed head tickets, NICU admission records, and cranial ultrasound reports. Adherence to scheduled CUS examinations (Days 1, 3, 7, 14, 21, 28, and before discharge) was assessed. IVH incidence, grade distribution, timing of detection, and associated clinical risk factors were analysed descriptively against unit and international standards.

Results

Fifteen high-risk neonates were included in the audit. Three infants were diagnosed with IVH, giving an incidence of 20%. Two infants had Grade III IVH and one had Grade IV IVH, with one-third exhibiting bilateral involvement. IVH was first detected on Day 1 (n=1), Day 3 (n=1), and Day 14 (n=1), highlighting the vital importance of serial screening. Overall adherence to the screening protocol was satisfactory, with most infants undergoing CUS on Days 1, 3, 7, and 14 and prior to discharge; however, incomplete follow-up imaging was identified in a small subset of infants. Severe IVH occurred predominantly in extremely preterm (<32 weeks) and extremely low birth weight (<1000g) infants and was frequently associated with mechanical ventilation, coagulopathy, blood transfusion, patent ductus arteriosus, thrombocytopenia, and carbon dioxide instability. While baseline documentation of antenatal and postnatal protective measures was robust, gaps remained in completing full serial cUS sequences.

Conclusion

Adherence to the IVH screening protocol was generally good; however, incomplete serial imaging risks delaying the detection of evolving pathology. The predominance of severe Grade III/IV haemorrhage among extremely preterm infants highlights the need to strengthen protocol adherence, optimize the prevention of modifiable hemodynamic and respiratory risk factors, and standardize ultrasound surveillance to improve neonatal outcomes.

PP 21 : UNDERSTANDING PARENTAL STRESS IN THE NICU: : USING DATA TO REDESIGN THE NICU EXPERIENCE

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Introduction

Admission of a newborn to the Neonatal Intensive Care Unit (NICU) is an emotionally overwhelming experience that disrupts bonding and challenges early parental roles. Objectives -This clinical audit aimed to quantify parental stress using the validated Parental Stressor Scale: NICU (PSS:NICU) and identify key stress domains to inform family-centered care improvements.

Method

A cross-sectional descriptive audit was conducted among 25 parents. Stress was assessed across four domains—infant appearance, parental role alteration, sights and sounds, and communication—using a 1–5 Likert scale. Mean scores were categorized as low (1.0–1.9), mild (2.0–2.9), moderate (3.0–3.9), and severe (4.0–5.0).

Results

The overall mean stress score was 1.73 (low stress). However, domain-specific analysis revealed nuanced burdens. The infant appearance domain (2.24) recorded the highest stress, with procedural pain (~2.8), sudden clinical changes (~2.7), and attached medical devices (~2.6–2.7) as major triggers. The parental role alteration domain (2.08) showed separation as the single most distressing factor (3.36), exceeding all other stressors. Environmental stress was lower (1.64), with machine noise (~2.0) and alarms (~1.9) causing mild distress. The communication domain (1.16) showed the lowest stress, though gaps in clarity and information remained (~1.3).

Conclusion

Overall, emotional stress outweighed environmental stress, with visual triggers and separation dominating parental distress. What parents see and feel had greater impact than what they hear or are told. Targeted interventions—minimizing separation, preparing parents for procedures, visual counselling, and sustaining effective communication—are essential to improving the NICU experience.

PP 22 : TRACHEAL BRONCHUS: A RARE CONGENITAL TRACHEOBRONCHIAL ANOMALY

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Introduction

Tracheal bronchus is a rare congenital airway anomaly in which an aberrant bronchus arises directly from the trachea, and supply part or whole upper lobe. It's more common on the right side and often coexists with other congenital anomalies. It's a normal finding in pigs and hence, its also called a pig bronchus. Majority of people with tracheal bronchus are asymptomatic and may be an incidental finding. However, obstruction of the tracheal bronchus may lead to lobar collapse, hyperinflation and recurrent pneumonia.

Case Report

We present a case of 3-month-old male infant, the firstborn child of non-consanguineous parents, delivered by caesarean section at 37 weeks of gestation with a birth weight of 2,630 g, found to have a complicated tracheal bronchus. The child had a stormy neonatal period with respiratory distress with upper-airway obstruction requiring tracheostomy. Baby also has bilateral hydronephrosis and hydroureter requiring PU valve ablation, congenital heart disease and cleft lip with cleft palate. Following a prolonged neonatal intensive care stay, he was subsequently discharged with tracheostomy and nasogastric tube feeding. Following discharge, the child was readmitted with shortness of breath and increased tracheal secretions. He was managed for aspiration pneumonia and required ICU care and mechanical ventilation and was difficult to wean from ventilatory support. A CT scan of chest demonstrated collapse-consolidation of the apical segment of the right upper lobe with bronchial dilatation, supplied by a tracheal bronchus. Further airway evaluation with bronchogram confirmed the abnormal bronchial anatomy. Finally, the baby underwent right apical segmentectomy.

Conclusion

Diagnosis of tracheal bronchus is often incidental and established by bronchoscopy or CT chest. Management depends on severity of symptoms and ranges from observation to surgical resection of the affected bronchus, segment, or lobe in selected cases.

PP 23: TWIN PREGNANCY WITH A COMPLETE HYDATIDIFORM MOLE AND LIVE FETUS FOLLOWING IVF; A CASE REPORT.

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Objectives

Twin pregnancy with a coexisting hydatidiform-mole and a live fetus is a rare obstetric condition associated with significant maternal and fetal morbidity. Such pregnancies following in-vitro-fertilization (IVF) are uncommon, particularly when complicated by severe placentomegaly, gestational hypertension, hyperthyroidism and mid-trimester haemorrhage. This case highlights the diagnostic challenges, multidisciplinary management, and ethical-considerations involved in balancing maternal safety against continuation of a highly-valued pregnancy.

Case Report

A 44-year-old primigravida with 20-years of primary subfertility conceived following IVF. At 12-weeks, ultrasound showed a live fetus with an abnormal honeycomb-appearing placental mass suggestive of a co-existing molar-pregnancy. Further assessment confirmed a complete-hydatidiform mole with a live fetus. Following counselling regarding significant maternal and fetal risks, the couple elected to continue the pregnancy.

During antenatal follow-up, fundal height exceeded gestational age and gestational hypertension developed, requiring antihypertensive therapy. Serial ultrasounds demonstrated a structurally normal fetus and NIPT was negative. However, progressive placentomegaly developed, with abnormal placental tissue compressing the fetus and covering the internal cervical os.

At 21-weeks, she presented with severe per-vaginal bleeding requiring transfusion of three-units of packed-red-blood-cells. Following stabilization, a multidisciplinary team concluded that continuation carried substantial maternal risk while fetal survival was extremely unlikely. After counselling, termination was undertaken by elective-hysterotomy at 22+2 weeks via an extended Pfannenstiel-incision. A 360g newborn with no gross anomalies was delivered; comfort-care was provided. Molar-tissue was evacuated, and histopathology confirmed a complete-hydatidiform mole.

Post-procedure serum β -hCG monitoring was commenced and follow-up is ongoing. She subsequently developed clinical and biochemical hyperthyroidism as a complication of molar pregnancy.

Discussion

This case demonstrates the complex clinical and ethical challenges associated with coexisting molar-pregnancy and a live fetus. Despite advances in prenatal diagnosis and surveillance, maternal complications such as haemorrhage and hyperthyroidism remain significant. Management requires individualized decision-making and close multidisciplinary collaboration, particularly when maternal safety conflicts with the desire to continue a long-awaited pregnancy.

Conclusion

Coexisting hydatidiform mole and live fetus following IVF is a rare but high-risk condition. Early diagnosis, vigilant maternal surveillance, and multidisciplinary counselling are essential to optimize outcomes. Further studies are needed to improve risk-stratification and guide evidence-based management of these uncommon pregnancies.

PP 24 : UNILATERAL CONGENITAL UPPER EYELID EVERSION WITH SEVERE CONJUNCTIVAL HEMORRHAGE AND CHEMOSIS IN A NEWBORN BABY

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Abstract

Congenital eyelid eversion is a rare condition which is generally associated with subconjunctival hemorrhage, prolapsed eyelid and chemosis. It generally involves the upper eyelid and is usually bilateral. Early recognition and treatment are important to prevent corneal complications and visual impairment. Here, we present a case of unilateral upper eyelid eversion with chemosis in an otherwise healthy newborn.

Case Rreport

We report a newborn boy with unilateral congenital upper eyelid eversion associated with severe chemosis. He was born by an emergency lower segment cesarean section due to fetal distress and lack of progression. Examination revealed complete eversion of the right upper eyelid with significant chemosis resulting in complete closure of right eye. His eye examination was normal without associated eye proptosis. Corneas were clear, pupils were reactive and red reflexes preserved, and conjunctiva were healthy without associated vascular or lymphatic abnormalities. There were no other gross abnormalities or dimorphism noted. There was a large cephalohematoma resulting due to difficult labor. There was no sonographic evidence of intracranial hemorrhage. He was treated with immediately application of a saline pack to cover the eyelid and tried manual repositioning. The condition was not progressive but painful to the baby and a few hours later aspiration of blood was done by using a syringe to reduce chemosis and gently correct the protrusion. Intravenous antibiotics started to cover secondary infections. After twenty-four hours his eyelid eversion and chemosis were completely resolved without sequelae.

Conclusion

Although its rare, prompt diagnosis and conservative management results rapid complete recovery.

PP 25: SEVERE UPPER AIRWAY OBSTRUCTION IN A NEONATE WITH DE NOVO CROUZON SYNDROME: A CASE REPORT

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Introduction

Crouzon syndrome is the most common syndromic craniosynostosis, with an estimated birth prevalence of ~16.5 per million (roughly 1 in 60,000). It results from pathogenic FGFR2 variants; approximately 50% arise de novo, the remainder inherited in an autosomal dominant pattern. Diagnosis is primarily clinical; molecular confirmation is not essential, reserved mainly for recurrence-risk counselling. Neonatal complications may include upper airway obstruction, raised intracranial pressure, hydrocephalus, corneal exposure, and feeding difficulty.

Case Report

A female infant was born to non-consanguineous, phenotypically normal parents at 39 weeks' gestation, birth weight 2790 g, Apgar scores 9, 10 and 10 at 1, 5 and 10 minutes. She had a cloverleaf-shaped skull, bicoronal craniosynostosis, frontal bossing, proptosis, hypertelorism, and midface hypoplasia, consistent with a probable de novo FGFR2 variant; hand and foot examination was normal. Bilateral choanal narrowing caused severe upper airway obstruction; a trial of nasopharyngeal tube insertion provided initial airway relief, but persistent obstruction necessitated tracheostomy on day 39, with nasogastric feeding for feeding difficulty. CT brain confirmed bicoronal synostosis with cloverleaf skull morphology, a small posterior fossa with tonsillar herniation, hypoplastic orbits, and midface hypoplasia. Echocardiography, abdominal ultrasound, microlaryngobronchoscopy and ophthalmological review were unremarkable. At 4 months, she remains clinically stable; diagnosis is clinical, with FGFR2 sequencing deferred. She is planned for staged anterior cranial vault remodelling, with multidisciplinary follow-up involving neurology, neurosurgery, ENT and ophthalmology.

Discussion

Staged surgical management is standard practice. Anterior cranial vault remodelling, as planned here, is the established first-line approach at most centres, with well-documented efficacy in correcting morphology and reducing raised intracranial pressure; long-term cohort data show affected children typically require an average of two cranial expansion procedures, with a low complication rate. Initial airway management with a nasopharyngeal tube, as used in this infant, can effectively bridge upper airway obstruction and defer tracheostomy until clearly necessary, avoiding premature surgical intervention while allowing time for multidisciplinary assessment. Midface advancement is typically required later for residual airway and orbital sequelae.

Conclusion

This case illustrates the classical phenotype and staged surgical pathway of Crouzon syndrome, from acute neonatal airway rescue to long-term cranial and midface correction.

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Introduction

Neonatal screening is vital for early detection and prevention of severe complications in newborns. Establishing an equitable, resilient network across all healthcare tiers is essential to lower infant mortality, protect developmental outcomes, and transition from fragmented service to a seamless, universal care model.

Objectives

To evaluate the three core newborn screening programs, pulse oximetry, heel prick testing, and hearing screening and identify service gaps, operational challenges, and priority policy actions across all hospital tiers.

Method

A descriptive cross-sectional study evaluated 57 hospitals in Sri Lanka (Levels 2, 3, and 4) using a validated, self-administered questionnaire on three newborn screening programs. Data were analyzed using descriptive statistics (frequencies and percentages) and multivariate logistic regression to determine associated factors.

Results

Pulse oximetry for Congenital Heart Disease is highly successful, achieving 98.2% coverage and 24 hour delivery in 94.6% of units. Execution is mostly nurse-led (67.9%) with medical officer sign-off in 96.2% of cases. Most screenings occur within the optimal 24–48 hour window (53.6%) or early (<24 hours; 41.1%), with abnormal results triggering cardiology referrals (67.9%) or daily repeats (22.6%). The main bottleneck is limited access to pediatric cardiologists.

Heel prick screening for Congenital Hypothyroidism is widely available (96.5%) with 100% nurse-led collection. However, its effectiveness is severely limited by centralized testing delays (51.9% of units send samples weekly or less), quality assurance gaps (41.7% lack formal collection training; 66.7% receive no specimen quality feedback), and poor communication (56.6% do not routinely inform parents of normal results).

Neonatal hearing screening represents a critical national deficit, absent in 76.8% of facilities and operating irregularly in 84.4% of the few active units (23.2% coverage). Primarily delivered by specialized ENT nurses (71.0%), its implementation is severely hindered by key obstacles including diagnostic equipment shortages (65.3%), staff shortages (30.6%), unestablished routine protocols (28.6%), and broken machinery (22.4%).

Conclusion

Sri Lanka's neonatal screening exhibits a major three-part imbalance: strong, near-universal pulse oximetry implementation; a widely available heel prick program hindered by transport delays and training gaps; and a severely neglected hearing screening system. Achieving equitable, universal care requires targeted investments in supply chains, staff training, automated parental notifications, and diagnostic equipment distribution.

PP 27 : IMPACT OF RESUSCITATION TRAINING ON KNOWLEDGE AND CONFIDENCE ON NEONATAL LIFE SUPPORT AMONG HEALTHCARE STAFF: A CLINICAL AUDIT

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Introduction

Neonatal resuscitation is a critical skill that is essential to be mastered by front-line healthcare staff in order to reduce neonatal morbidity and mortality.

Objectives

This audit aim to describe the knowledge and confidence on neonatal life support among nurses in an obstetric operating theatre before and after a structured resuscitation training workshop.

Method

A paired pre–post study was conducted among 20 nurses working in the obstetric operating theatre at Colombo North Teaching Hospital. Knowledge of resuscitation principles was assessed using 10 single best response questions and 10 True/False items, while self-reported decision-making confidence was assessed using 14 questions on a 5-point Likert scale. Responses to the knowledge questions were converted to numerical scores (correct = 1; incorrect = 0), with a total possible score of 20. A paired t-test was used for the analysis.

Results

A significant improvement in the mean knowledge score was observed post-workshop (16.4 ± 1.9) compared to pre-workshop (13.6 ± 2.5 , $p < 0.001$). Similarly, the mean score for self-reported decision-making confidence was significantly higher post-workshop (57.6 ± 5.0) compared to pre-workshop (42.9 ± 13.3 , $p < 0.001$). Sub-section analysis revealed that knowledge of drug administration, cardiovascular management and equipment handling showed a significant gain of knowledge after the workshop ($p < 0.001$). some, ($p = 0.965$) ($p = 0.2$), did not following the workshop.

Conclusion

The neonatal resuscitation workshop resulted in a significant improvement in knowledge and confidence in neonatal resuscitation among nurses in obstetric theatres. Notable improvements were reported in relation to drug administration, cardiovascular management, and equipment handling; however, no significant improvement was observed in hypothermia prevention and airway management.

PP 28 : PARENTAL VISITATION PATTERNS AND BARRIERS TO KANGAROO MOTHER AND FATHER CARE IN A LEVEL III NEONATAL INTENSIVE CARE UNIT, SRI LANKA , A CLINICAL AUDIT

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Introduction

Family-centred care is an essential component of modern neonatal intensive care. Parental involvement through unrestricted visitation, Kangaroo Mother Care (KMC), and Kangaroo Father Care (KFC) may improve neonatal outcomes.

Objectives

1. To describe parental visitation patterns in the NICU.
2. To describe current practices of Kangaroo Care (KC).
3. To identify barriers to parental visitation, KMC, and KFC.
4. To assess staff knowledge and attitudes regarding parental participation.

Method

This study was conducted in two level III NICUs in Galle. A convenience sample of 50 parents of babies eligible for KC and 65 staff members was recruited. Both groups were administered separate interviewer-administered questionnaires.

Results

Of the 50 parents, 28 (56%) were mothers and 22 (44%) were fathers. Among them, 22 (78%) mothers and 21 (95.9%) fathers visited the NICU. However, only 18 (63.3%) mothers and 1 (4.5%) father provided KC. Thirty-seven (77.1%) parents visited the NICU daily, while 39 (78%) spent less than 30 minutes per visit. Twenty (40%) parents spent less than 30 minutes in the NICU over a 24-hour period.

Only 22 (44%) parents were aware of KC, and 15 (29.2%) had knowledge of its benefits. The predominant parental barriers to KC were the perception that the baby was too sick (16, 38.1%), fear of handling the baby (16, 38.1%), lack of awareness (16, 38.1%), and concerns regarding personal cleanliness (10, 23.8%). Among staff, only 34 (52.3%) had received training in KMC, while 30 (46.2%) strongly agreed that KMC should be encouraged. Thirty (46.2%) staff members encouraged maternal visits and 41 (63.1%) encouraged KMC. However, only 28 (43.3%) encouraged fathers to visit and 7 (11.9%) encouraged KFC. Staff-identified barriers included the baby being insufficiently stable (50, 83.3%), parental cleanliness concerns (29, 48.3%), NICU workload (26, 43.3%), and parental fear or lack of confidence (22, 36.7%).

Conclusion

Parental and staff awareness regarding parental visitation and KC practices, particularly KFC, should be improved. Changes in NICU practices may help facilitate greater parental participation and improve neonatal outcomes.

PP 29 : NON-IMMUNE HYDROPS FETALIS WITH PERSISTENT PERIPHERAL OEDEMA AND A NOONAN-LIKE PHENOTYPE IN A NEONATE: A CASE REPORT

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Introduction

Non-immune hydrops fetalis (NIHF) is a heterogeneous condition caused by chromosomal, genetic, cardiovascular, infectious, haematological, metabolic, or lymphatic disorders. Turner syndrome, Noonan syndrome and other RASopathies are important genetic causes associated with lymphatic dysfunction and hydrops. Distinguishing these disorders can be challenging due to overlapping phenotypic and cardiac features.

Case Report

A 30-year-old P2C1 mother delivered a baby girl at 34+2 weeks by elective caesarean section. Birth weight was 2.4 kg with a normal Apgar score. Pregnancy was complicated by antenatally diagnosed hydrops fetalis, without Doppler abnormalities excluding anaemia. Parents were non-consanguineous.

The neonate was generally oedematous, with marked palmar and pedal oedema, in addition to thin pleural and peritoneal fluid noted antenatally. Mother was O-positive and baby B-positive, with negative direct antiglobulin testing. Haemoglobin was normal with no evidence of haemolysis. Rubella, toxoplasmosis and CMV testing were negative.

The neonatal course was complicated by hypocalcaemia, indirect hyperbilirubinaemia, late-onset sepsis, acute kidney injury, and suspected pseudomembranous colitis following prolonged antibiotic use. Echocardiography demonstrated a small partially restrictive pieces VSD, small ASD and mild valvar pulmonary stenosis.

Persistent neck hyperextension prompted further evaluation. Mild laryngomalacia was identified with normal vocal cords. Neurological examination revealed mild central hypotonia but cranial ultrasound had no anomalies. Significant reflux was identified and treated, with optimisation of positioning.

Dysmorphic features included telecanthus, broad nasal bridge, micrognathia, widely spaced nipples, redundant neck skin and high-arched palate. Karyotyping demonstrated 46,XX. Chromosomal microarray and RASopathy testing were unavailable. A paternal relative and two children had short stature and features suggestive of Noonan syndrome.

Persistent pedal and dorsal oedema despite resolution of hydrops and normal serum albumin suggested underlying lymphatic dysfunction. Although Turner syndrome was initially suspected, the normal karyotype, pulmonary stenosis, dysmorphism and possible familial phenotype favoured Noonan syndrome/RASopathy. RIT1- and PTPN11-related disease are recognised causes of severe prenatal Noonan phenotypes with hydrops.

Conclusion

This case highlights the importance of considering RASopathies in unexplained NIHF with persistent oedema and Noonan-like features, even with a normal conventional karyotype. Chromosomal microarray and targeted RASopathy testing, followed by exome/genome sequencing, are important for diagnosis, prognosis and genetic counselling.

PP 30 : KNOWLEDGE VERSUS PRACTICE IN CONGENITAL HYPOTHYROIDISM NEWBORN SCREENING IN SRI LANKA: A CLOSED LOOP AUDIT OF SCREENING-CARD QUALITY

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Introduction

Newborn screening for congenital hypothyroidism enables early diagnosis and treatment, preventing avoidable neurodevelopmental impairment. Screening quality depends not only on theoretical knowledge but also on its practical application. Pre-analytical errors may result in unsuitable samples, repeat sampling and delays in diagnosis.

Objectives

To assess nurses' knowledge of the congenital hypothyroidism newborn screening programme, identify deficiencies in sample collection and transportation through direct observation, implement targeted quality-improvement interventions, and evaluate their impact through re-audit.

Method

A baseline audit was conducted in November 2025 at Castle Street Hospital for Women among 30 nurses involved in the congenital hypothyroidism screening programme. Nurses' knowledge regarding the programme, sample collection, storage and transportation was assessed using a self-administered questionnaire. In addition, 50 screening cards were directly assessed for pre-analytical quality indicators, including adequacy of circle filling, water marks, clots, leakage and transportation delays (exceeding three days). Following identification of deficiencies, targeted interventions comprising nurse education, visual reminders at collection points and measures to reduce transportation delays were implemented. A re-audit using the same indicators was conducted in August 2026 on further 50 screening cards.

Results

Baseline knowledge was satisfactory, with more than 70% of nurses answering correctly across all assessed domains. However, direct assessment of screening cards demonstrated important practice deficiencies. All 50 baseline cards (100%) had two or more circles filled, but none had all required circles adequately filled. Water marks were observed in 2 (4%), leakage in 13 (26%) and transportation delays in 19 (38%); no clots were identified.

Following the interventions, a marked improvement in sample collection was observed. All 50 re-audit cards (100%) had two or more circles filled, while 43 (86%) had all required circles adequately filled. Water marks decreased from 4% to 2% (50% relative reduction), leakage from 26% to 10% (61.5% relative reduction), and transportation delays exceeding three days from 38% to 16% (57.9% relative reduction). Again, no clots were identified.

Conclusion

Despite satisfactory baseline knowledge, direct assessment of screening cards identified a substantial gap between knowledge and actual practice, which showed marked improvement following targeted interventions. Sustained monitoring, periodic feedback and reinforcement of practical skills are essential to maintain improvements and minimise pre-analytical errors.

PP 31 : AORTIC ATRESIA WITH INTERRUPTED AORTIC ARCH TYPE B , A RARE CONGENITAL HEART DEFECT

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Introduction

Aortic atresia with interrupted aortic arch (IAA) is a rare, life-threatening congenital heart disease characterized by complete anatomical separation between the ascending and descending aorta. IAA Type B—where the interruption occurs between the left common carotid and left subclavian arteries—is the most common variant. Hallmarks include critical aortic stenosis or atresia, severe hypoplasia of the ascending aorta, and varying mitral valve or left ventricular hypoplasia. Commonly associated anomalies include ventricular septal defects (VSD), patent ductus arteriosus (PDA), and aorto-pulmonary (AP) windows. Systemic, coronary, and cerebral perfusion strictly depend on ductal and arterial shunts maintaining retrograde blood flow.

Case Report

A 3-day-old male neonate was delivered vaginally with meconium-stained liquor to a 25 years of age mother as her 3rd child. On Day 1, he developed respiratory distress and grunting, initially managed as suspected meconium aspiration syndrome (MAS) using nasal prone oxygen (NPO₂), intravenous antibiotics, and supportive care. On Day 2, persistent hypoxemia prompted a two-dimensional echocardiogram (2D Echo) to evaluate for persistent pulmonary hypertension of the newborn (PPHN). The 2D Echo revealed aortic atresia with Type B IAA, an aorto-pulmonary fistulous tract giving origin to the right coronary artery, a large inlet VSD, a moderate ostium secundum atrial septal defect (ASD), a moderate PDA, bilateral superior vena cavae (SVCs), and bilateral branch pulmonary artery stenosis.

Management & Clinical Outcome

Neonatal survival is solely dependent on retrograde blood flow originating from the descending aorta alongside key shunts—such as a PDA, VSD, and/or an aorto-pulmonary fistulous tract—to adequately supply oxygenated blood to the coronary and cerebral circulations. The definitive surgical intervention—a modified Norwood–Rastelli biventricular repair is currently unavailable in Sri Lanka. Consequently, palliative medical management was established, and comprehensive counseling was provided to the family regarding the diagnosis, prognosis, and management limits.

Conclusion

Aortic atresia with Type B IAA combined with an aorto-pulmonary-coronary fistula represents a unique structural arrangement permitting temporary extra-uterine survival. Without complex surgical reconstruction (Norwood/Norwood–Rastelli repair), long-term survival remains exceptionally poor.

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Introduction

Dengue is a mosquito-borne viral infection endemic to Sri Lanka. Classical features include fever, leucopenia, thrombocytopenia and, in severe disease, plasma leakage, bleeding and shock. Dengue infection in neonates is rare and may be under-recognized as its presentation can mimic neonatal sepsis. It may occur through vertical transmission or through mosquito exposure during the early neonatal period. The present case is notable for the absence of fever despite marked thrombocytopenia and positive dengue IgM.

Case Report

A term female neonate with birth weight 3.2 kg was delivered by emergency caesarean section for fetal tachycardia. Her 37-year-old mother developed fever on the first postpartum day, tested positive for dengue NS1, and was managed as dengue hemorrhagic fever. Maternal dengue IgM was positive on postpartum day 7, with negative IgG.

The neonate remained afebrile and was closely monitored from day 2. Initial NS1 was negative, with a WBC count of $9.2 \times 10^9/L$, platelet count of $220 \times 10^9/L$ and PCV of 40%. The platelet counts subsequently fell to $84 \times 10^9/L$ on day 6, reaching a nadir of $12 \times 10^9/L$. Leucopenia with lymphocytic predominance was also noted. IgM became positive on day 7, while IgG remained negative.

The infant was monitored for vital signs, mean arterial pressure and urine output. Breastfeeding was continued and intravenous fluids were given when required. Daily fluid requirement was kept in between 120–150 milliliter. PCV remained stable at 40–41%. Abdominal ultrasonography showed gallbladder wall edema without free fluid. Antibiotics were given while neonatal sepsis was excluded. There was no bleeding or hemodynamic instability. Urine output remained above 1.5 mL/kg/hour. Platelet transfusions were given twice daily for two days because of severe thrombocytopenia. The infant recovered, with platelet count rising to $260 \times 10^9/L$ by day 11, and was discharged on day 12.

Conclusion

Neonatal dengue should be considered in a neonate born to a mother with dengue infection around delivery, even without fever. Progressive thrombocytopenia and leucopenia may provide important clues with subsequent IgM positivity. Close clinical and laboratory monitoring, careful fluid management and exclusion of neonatal sepsis are essential.

PP 33 : NON-IMMUNE HYDROPS FETALIS IN A LATE PRETERM INFANT SECONDARY TO CONGENITAL NEPHROTIC SYNDROME

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Introduction

Non-immune hydrops fetalis (NIHF) is characterized by abnormal fluid accumulation in two or more fetal compartments and has a broad range of underlying causes. Although Congenital Nephrotic Syndrome is usually diagnosed in the neonatal period, severe cases may present antenatally with hydrops fetalis.

Case Report

A male infant was born at 35 weeks and 1 day of gestation to a G4P1 mother. Antenatal ultrasonography demonstrated pulmonary hypoplasia, anhydramnios, hydrocele, and hydrops fetalis. He was delivered by emergency lower-segment caesarean section with a birth weight of 2.72 kg. Following delivery, he required intubation and high-frequency oscillatory ventilation until day 3, followed by synchronized intermittent mandatory ventilation and subsequently high-flow nasal oxygen. He was successfully maintained in room air from day 13.

The postnatal course was complicated with gross ascites, requiring repeated therapeutic peritoneal drainage. Full enteral feeds were established by day 10. Echocardiography demonstrated a small ostium secundum atrial septal defect, moderate patent ductus arteriosus, and moderate persistent pulmonary hypertension of the newborn. Abdominal ultrasonography showed gross ascites, normal solid organs, mild diffuse bladder wall thickening, and normal bilateral kidneys.

Investigations for congenital infection were negative, including CMV DNA, Toxoplasma IgM, Rubella IgM, serological screening for hepatitis B and C, congenital syphilis, and HIV. Mycobacterium tuberculosis Xpert testing of ascitic fluid was negative. Karyotyping is normal.

Biochemical investigations demonstrated hypoproteinemia, hypoalbuminemia, and persistent nephrotic-range proteinuria. Spot urine protein-to-creatinine ratios were markedly elevated at 1,757, 3,007, and 3,753 mg/g on days 2, 4, and 14, respectively. Serum creatinine decreased from 1.1 mg/dL on day 2 to 0.62 mg/dL on day 4 and remained stable at 0.66 mg/dL on day 14. The combination of antenatal NIHF, persistent heavy proteinuria, and hypoproteinemia/hypoalbuminemia was strongly suggestive of CNS. He made a complete recovery with resolution of ascites and spontaneous resolution of albuminuria.

Conclusion

Congenital nephrotic syndrome should be considered among the renal causes of non-immune hydrops fetalis, particularly when hydrops is accompanied by persistent heavy proteinuria and hypoproteinemia. Early recognition of this association may facilitate targeted neonatal management, further genetic evaluation, and appropriate genetic counselling.

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Introduction

Laryngeal cleft is a rare congenital anomaly caused by incomplete development of the posterior cricoid lamina and tracheoesophageal septum, resulting in abnormal communication between the larynx and esophagus. Its incidence is approximately 1 in 10,000–20,000 live births. Clinical manifestations mainly result from aspiration and range from mild cough and feeding difficulties to severe aspiration with cyanosis and respiratory distress. As symptoms may overlap with more common neonatal respiratory and feeding disorders, diagnosis can be delayed.

Case Report

We present a case of a neonate, born at 37 weeks' gestation at CSHW with 3125g birth weight. Apgar scores were 9, 10, 10. Antenatal ultrasound scan revealed polyhydramnios. From day 1 of life, he had respiratory distress and then he developed post feed vomiting and pooling of oropharyngeal secretions. He was transferred to LRH on day 8 of life for further management. Microlaryngobronchoscopy demonstrated type III laryngotracheal cleft. An upper gastrointestinal contrast study revealed significant aspiration during swallowing. Bronchoscopy demonstrated tracheomalacia and bronchomalacia. CT of the neck and chest revealed an approximately 7 mm posterior laryngeal defect extending from the tip of the epiglottis to just below the level of the vocal cords, with marked expiratory collapse of the distal trachea and proximal left main bronchus. Abdominal ultrasonography and echocardiography were normal. While awaiting corrective surgery, he was medically managed for aspiration pneumonia, neonatal sepsis and other systemic complications. A Witzel feeding jejunostomy was inserted and enteral feeding commenced. Tracheostomy was subsequently performed; however, his respiratory status later deteriorated, requiring endotracheal intubation and mechanical ventilation. Despite ongoing management, he died on day 49 of life.

Discussion

Laryngeal clefts are classified into four types according to their anatomical extent, and management is guided by the type and severity of symptoms. Conservative measures include swallowing therapy and feed thickening to minimise aspiration. Persistent smaller clefts may be repaired endoscopically, while more extensive defects require open surgical repair, as in our patient.

Conclusion

This case highlights the diagnostic and management challenges of congenital laryngotracheal cleft, emphasizing early recognition in neonates with feeding-related respiratory symptoms and the impact of associated airway abnormalities on outcomes.

PP 35 :NEONATAL RESUSCITATION TRAINING STATUS AND PREPAREDNESS AMONG DELIVERY ROOM, OPD AND THEATRE STAFF: A CLINICAL AUDIT

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Introduction

Birth asphyxia is an ongoing cause of NICU admission at Castle Street Hospital for Women. Across June 2023 - July 2026, the monthly proportion of NICU admissions attributable to birth asphyxia has been highly variable, averaging 8.4% in months with recorded admissions and reaching a new peak of 21.1% in April 2026. International guidelines mandate neonatal resuscitation (NLS equivalent) certification renewal every two years for delivery and theatre staff. This audit assessed whether staff met this standard and evaluated self-rated preparedness.

Objectives

To determine the proportion of Delivery Room, OPD and Theatre staff meeting the two-year NLS equivalent training standard, to assess self-rated preparedness for neonatal resuscitation, and to generate recommendations for improving training coverage.

Method

A concurrent audit using a self-administered questionnaire was conducted among 50 staff (doctors, nursing officers and midwives) across the Delivery Room, OPD and Theatre. Findings were compared against two standards: 100% of staff holding current NLS equivalent certification within the last two years (AAP renewal policy), and a locally defined supportive indicator of $\geq 90\%$ of staff self-rating preparedness as “Good” or above.

Results

Sixty-four percent of staff (32/50) had never completed formal NLS training. Only 36% (18/50) had ever completed training, of whom 89% were trained by the hospital’s own neonatology team; among these, most certifications were out of date, and only 16% of all staff (8/50) met the current two-year standard - far short of the 100% target. Self-rated preparedness was “Good” or above in 58% (29/50), also below target. The most frequently reported barriers were inadequate training (78%), high-stress situations (58%), communication issues (52%), lack of equipment (42%), and staff shortages (38%). Overall, 84% of staff were either overdue for renewal or had never received formal training.

Conclusion

Neither training-completion nor preparedness standards were met, with the large majority of delivery-area staff either overdue for renewal or never formally trained in neonatal resuscitation. Set against the recent peak in NICU birth asphyxia admissions, these findings support urgent introduction of mandatory two-yearly NLS equivalent training, a scheduled refresher cycle, regular simulation exercises, and a central training register, with re-audit planned at 6–12 months using identical methodology.

PP 36 : PATTERNS AND CAUSES OF NEONATAL MORTALITY IN A TERTIARY CARE HOSPITAL : A TWO-YEAR COMPARATIVE STUDY USING ICD-PM CLASSIFICATION

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Introduction

Neonatal mortality is an important indicator of newborn care quality. Although Sri Lanka has a relatively low neonatal mortality rate compared with many low- and middle-income countries (LMICs), mortality rates in tertiary referral centres cannot be directly compared with national estimates, as these centres manage disproportionate numbers of high-risk pregnancies, complicated deliveries, and critically ill neonates referred from other institutions. Standardized classification systems such as WHO ICD-PM can identify cause-specific patterns and guide targeted interventions.

Objective

To describe the patterns, timing, and causes of neonatal deaths at Colombo South Teaching Hospital during 2024–2025 using ICD-PM, and to compare annual neonatal mortality rates.

Method

A retrospective descriptive study was conducted using records of neonatal deaths during 2024–2025. Causes of death were classified using ICD-PM. Neonatal mortality rates were calculated per 1,000 live births. Differences between years and associations between cause of death and neonatal characteristics were assessed using chi-square or Fisher's exact tests, as appropriate, using SPSS version 25.

Results

Of 74 deaths, 41 (55.4%) occurred in 2024 and 33 (44.6%) in 2025. Early neonatal deaths accounted for 53 (71.6%), while late neonatal deaths accounted for 21 (28.4%). The majority were male neonates (n=44, 59.5%). Leading causes were respiratory and cardiovascular disorders (21, 28.4%), congenital malformations (15, 20.3%), low birth weight and prematurity (12, 16.2%), and infections (12, 16.2%). Length of hospital stay differed significantly between years ($p=0.003$), with more deaths occurring within 24 hours of admission in 2025 (12, 36.4%). Cause of death was significantly associated with birth weight (Monte Carlo $p<0.001$), gestational age ($p=0.001$) and source of admission (Fisher's exact $p=0.015$); Most deaths due to intrapartum complications, including hypoxic-ischaemic encephalopathy, occurred among transferred neonates (5, 71.4%). Among respiratory and cardiovascular deaths, 15 (71.4%) occurred in neonates in the extremely low birth weight category, while 7 (46.7%) congenital malformation deaths occurred in neonates with normal birth weight. Neonatal mortality declined from 15.01 to 13.01 per 1,000 live births from 2024 to 2025.

Conclusion

Neonatal mortality was predominantly due to early neonatal deaths, with respiratory and cardiovascular disorders, congenital anomalies, and low birth weight and prematurity being the leading causes. The relatively lower contribution of infections is notable. Respiratory and cardiovascular disorders (18, 85.7%) were common among preterm neonates, whereas congenital malformations were common among term neonates (9, 60%).

PP 37 : KNOWLEDGE ON NEWBORN SCREENING TOOLS AMONG POSTNATAL MOTHERS IN SOUTHERN SRI LANKA

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Background

Newborn screening facilitates the early identification of congenital disorders, enabling timely interventions and improving neonatal outcomes. Sri Lanka has implemented screening programs for congenital hypothyroidism, critical congenital heart disease, and hearing impairment, together with routine newborn examinations. This study aimed to assess the knowledge on newborn screening and its associated factors among postnatal mothers attended in selected tertiary care hospitals in Southern Sri Lanka.

Method

A descriptive cross-sectional study was conducted among 408 postnatal mothers using a structured self-administered questionnaire. Overall knowledge regarding newborn screening was assessed using a scoring system and categorized according to quartiles: poor knowledge (<Q1), average knowledge (Q1–Q3), and satisfactory knowledge (>Q3). Associations between maternal factors and knowledge categories were assessed using the Chi-square test with a significance level of 0.05.

Results

The mean age of participants was 29.5 ± 5.4 years. Recognition of conditions detected through newborn screening included congenital heart disease (73.0%), developmental dysplasia of the hip (52.7%), deafness (39.2%), and cataract (31.6%). The heel prick test was correctly identified as a screening method for congenital hypothyroidism by 87.7% of participants. Majority (98.3%) of mothers correctly identified the purpose of newborn screening and recognized that screening should be performed for all hospital-born babies (78.9%). The mean (SD) overall knowledge score was 56.2% (14.5). Overall, 53.7% had average knowledge, 29.2% had poor knowledge, and only 17.2% demonstrated satisfactory knowledge. Higher maternal education at Advanced Level or above ($p=0.003$) and higher household income ($p=0.015$) were significantly associated with satisfactory knowledge, while age ($p=0.713$) and parity ($p=0.100$) showed no significant association.

Conclusion

Although majority of mothers recognized the purpose of newborn screening and the heel prick test, overall knowledge regarding newborn screening was suboptimal, particularly for several screened conditions. Maternal education and socioeconomic status were important determinants of knowledge. Strengthening antenatal and postnatal health education programs may improve maternal awareness and promote greater participation in newborn screening initiatives.

Keywords: Knowledge, Newborn Screening, Postnatal Mothers

PP 38 : WHEN THE CAUDAL MESODERM FAILS - A RARE MULTISYSTEM NEONATAL CHALLENGE

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Introduction

Caudal regression syndrome (CRS) is a rare congenital malformation resulting from abnormal development of the caudal mesoderm. It can involve the spine, genitourinary system, gastrointestinal tract, and lower limbs. Severe forms may resemble sirenomelia and are often associated with maternal diabetes, oligohydramnios, and pulmonary hypoplasia. Early recognition is critical for counseling and management.

Case Report

A 27-year-old primigravida with a 3-year history of primary subfertility, chronic hypertension on nifedipine, and gestational diabetes on metformin delivered a live preterm baby at 34 weeks and 4 days gestation via elective cesarean section. The birth weight was 1.16 kg. Antenatal scans revealed severe oligohydramnios and bilateral absent kidneys. At birth, the neonate required resuscitation and respiratory support. Clinical examination revealed dysmorphic facial features including low-set ears, epicanthic folds, wide-set eyes, and a small chin, with absent external genitalia, imperforate anus, and bilateral congenital talipes of the lower limbs.

Investigations demonstrated dextrocardia and hypoplastic lungs on chest X-ray. Cranial ultrasound was normal. Abdominal ultrasound and KUB confirmed bilateral dysplastic kidneys and absent bladder, with otherwise normal abdominal structures. No cardiac murmur was detected clinically.

Conclusion

This case represents a severe form of CRS with multisystem involvement, including renal agenesis, absent bladder, imperforate anus, lower limb deformities, pulmonary hypoplasia, and facial dysmorphism. It highlights the importance of detailed antenatal assessment, early neonatal resuscitation, and multidisciplinary evaluation. Maternal comorbidities, including diabetes and hypertension, may contribute to the spectrum of anomalies. Recognition of such presentations aids in prognosis determination, family counseling, and planning of supportive care.