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BOOK OF ABSTRACTS

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Dr Bandara Ekanayake - Editor-in-Chief
Dr Manitheepan Kandiah
Dr Dinesh Weerasinghe
Dr Kaushila Thilakasiri
Dr Shajanie Udumullage
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Message from the Chief Editor

It is with great pride and professional satisfaction that we present the **Abstract Book of the Annual Academic Congress 2025**, organized by the Sri Lanka College of Emergency Physicians.

This year's congress stands as a true testament to the academic curiosity, clinical dedication, and scholarly commitment of our medical community. We received an exceptional number of submissions from across the country—and beyond—including original research, clinical audits, case series, case reports, and quality improvement projects. These contributions reflect the evolving breadth and depth of Emergency Medicine, while also highlighting its vital intersections with other medical subspecialties.

Each abstract in this collection represents more than data or findings. It reflects a shared commitment to improving patient outcomes, a constant pursuit of clinical excellence, and a drive to innovate—even in the face of immense operational challenges. From cutting-edge emergency care innovations to real-world quality improvement efforts, the diversity of topics enriches not only our academic discourse but also our daily clinical practice.

As Editor in Chief, I extend my sincere gratitude to all contributors, reviewers, and committee members who worked tirelessly to bring this publication to life. I also congratulate the authors whose work is featured here. Your research is not only commendable, but it also lays the foundation for a more evidence-based and resilient emergency care system in Sri Lanka.

Let this abstract book serve both as a record of achievement and a catalyst for future inquiry. May it inspire collaboration, ignite new ideas, and reaffirm our collective responsibility as clinicians, educators, and researchers to advance the science of Emergency Medicine.

I wish all participants a successful and enriching congress.

Warm regards,
Dr Bandara Ekanayake
Editor-in-Chief – Abstract Book
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Abstracts - Oral Presentations

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OP 01 : Audit : Knowledge About Paracetamol Among Mothers of Children Admitted to the Lady Ridgeway Hospital for Children Preliminary Care Unit.

Madusanka DGM
National hospital Sri Lanka

Background: Paracetamol (PCM) is widely used in pediatric care for its analgesic and antipyretic properties. However, incorrect dosing can lead to inadequate symptom control or potentially dangerous toxicity. Mothers, as primary caregivers, often administer PCM without medical supervision. This audit aimed to evaluate maternal knowledge regarding PCM dosing, awareness of toxicity, and understanding of brand equivalence, among mothers of children admitted to the Pediatric Care Unit at Lady Ridgeway Hospital, Colombo.

Method: A cross-sectional study was conducted over six months (May 1 to October 30) involving 88 mothers of hospitalized children aged from newborn to 13 years. Data were collected using structured questionnaires that assessed demographics, educational background, reasons for hospital admission, weight of children, and maternal knowledge about PCM dosing, toxicity, and brand awareness. Descriptive statistics were used to analyze the results.

Results: Most children were aged 5–12 years, and the average child weight was 20 kg. The mothers' ages ranged from 20 to 50 years, with varied educational levels: 18.2% had completed up to Grade 10, 44.3% had GCE O/L, 29.5% had A/L, and 10.2% were graduates. Common admission causes included fever (25%), asthma exacerbation (16%), and cough (5.7%). Only 42% of mothers believed they gave the correct PCM dose; 58% were unsure or incorrect. Most relied on GP prescriptions (58%), while 21.6% guessed the dose. Just 11.4% knew the toxic dose, and only 23.3% knew the content of a PCM tablet. Additionally, 58% did not recognize that Panadol and PCM are equivalent.

Conclusion: Significant gaps exist in maternal knowledge regarding PCM dosing, toxicity, and brand equivalency. Structured educational interventions and improved communication between healthcare providers and caregivers are essential to ensure safe and effective use of PCM in children.

OP 02: Audit : Audit on the Quality of Inter-Hospital Transfer of Critically Ill Adult Trauma Patients to a Tertiary Trauma Center in Sri Lanka

Senevirathna HMGN[1,4], Goonewardene TDL[2], Jagoda AI[2], Hannadige LM[2], Maduchandra PPDRP[3,4], Udumullage HS[1,4], Karunanayake KPCM[4,5]

[1]Colombo South Teaching Hospital Kalubowila, Post Graduate Institute Of Medicine- University of Colombo, Ministry of Health, [2]National Hospital of Sri Lanka Colombo

[3]National Hospital of Sri Lanka Kandy, [4]Ministry of Health Sri Lanka

[5]Lady Ridgeway Hospital for Children

Background : The transfer of critically ill trauma patients between hospitals is a clinically complex and time-sensitive process requiring skilled personnel, good coordination, and uninterrupted physiological support. Trauma patients often need urgent surgical interventions, advanced resuscitation, and immobilization adding to the complexity of safe transport. Despite its importance in trauma care systems, there are limited local data in Sri Lanka evaluating the quality of such transfers. This audit aimed to assess current practices at the National Hospital of Sri Lanka (NHSL), Colombo, and compare them against national and international standards.

Method : A prospective audit of 150 critically ill adult trauma patients transferred to the Accident Service of NHSL was conducted. Data were collected through a structured questionnaire completed by receiving emergency doctors. Domains assessed included communication, monitoring, documentation, escort personnel, and adverse events. Associations were analyzed using Chi-square and Fisher's exact tests.

Results : Adverse events were observed in 42.6% of transfers, with hypotension (13.3%), neurological decline (16.0%), and cardiac arrest (2.0%) as most serious. Pre-transfer communication occurred in only 33.3% of cases ($p<0.05$). A significant association was found between adverse events and the level of training of accompanying staff ($p=0.0056$), with the highest event rate in transfers conducted without clinically trained personnel. 10% of patients were transferred without any monitoring. Incomplete documentation (over 40%), delays in airway management (16.0%), blood transfusion (10.0%), and tranexamic acid administration (21.2%) were noted.

Conclusion : The audit revealed critical gaps in inter-hospital trauma transfers, particularly in communication, documentation, and staffing. Structured transfer protocols, standardized documentation, and mandatory presence of appropriately trained personnel are essential. A re-audit following these interventions is recommended to evaluate impact and sustainability.

OP 03: Risk factors and predictors of Severe Leptospirosis in Kalutara District, Sri Lanka

Amaratunga Heshan[1], Samarajeewa Ganaja
[1]Post Graduate Institute of Medicine - University of Colombo

Background : Leptospirosis is a considerable public health concern in Sri Lanka. Kalutara District is one hot spot for this zoonotic disease with cumulative incidence of 99-113 cases per 100 000. Risk factors and predictors of this disease are poorly understood in the national context. Our objective was to assess the risk factors and predictors for development of severe leptospirosis in patients admitted to Kalutara District General Hospital (DGH).

Method : A retrospective observational case-control study was carried out at the DGH, Kalutara with 142 patients who were clinically suspected of having leptospirosis from December 2021 to April 2022. Consecutive sampling technique was used. Cases and controls were patients with severe and mild leptospirosis respectively. The Bed Head Tickets were used to extract the needed data, and necessary information was extracted from the patients using an interviewer administered questionnaire and a data collection form.

Results : There were 142 patients with 37.3% cases and 62.7% controls in the two groups with 3 deaths (fatality rate 2.1% case). Risk factors profoundly associated with the disease were smoking, alcoholism. Positive predictors of severe disease identified in our study were, difficulty in breathing, cough, oliguria, icterus, R/upper quadrant pain, oxygen saturation <92%, bleeding manifestations, signs of encephalopathy, thrombocytopenia, neutrophilia, anaemia, hypoalbuminemia, hyperbilirubinemia, increased serum creatinine and prolonged INR. Lack of awareness and delay in admission to the hospital were significantly correlated with the severity of the disease.

Conclusion : The findings of our study revealed smoking, alcoholism as risk factors and difficulty in breathing, cough, oliguria, icterus, R/upper quadrant pain, oxygen saturation <92%, bleeding manifestations, signs of encephalopathy, thrombocytopenia, neutrophilia, anaemia, hypoalbuminemia, hyperbilirubinemia, increased serum creatinine and prolonged INR as predictors of severe leptospirosis disease in Kalutara DS division.

OP 04 : Comparison of the Efficiency of the Sri Lankan Triage Index versus Emergency Severity Index for A&E admissions, District General Hospital Matara.

Rifnas JM[1,2], Arachchige DSS[1,2], Anandika BHK[2,3], Daladawaththa J [1,2], Lokuliyanage HMAU[2,4], Weerarathne TK[1,2], Gunasekara BDRC[2,6]

[1]District General Hospital Matara
[2]Ministry of health
[3]Base hospital Kamburupitiya
[4]District Hospital Akurassa
[5]District General Hospital Matara
[6]Post Graduate Institute of Medicine, Colombo

Background: Evaluating the performance of the Sri Lankan Triage Scale in comparison to established standards is essential for optimizing patient safety, resource management efficiency and accurate prioritization within the Sri Lankan healthcare system.

Objectives: To compare the efficiency of the Sri Lankan Triage Index (SLTI) versus the Emergency Severity Index (ESI) for Accident and Emergency (A&E) admissions.

Methods: An institutional- based, cross-sectional study was conducted on patients aged over 14 years(n=426). Using systematic sampling, data on triage categories and patient demographics were collected through a pre -tested interviewer administered questionnaire and a data extraction sheet. Each subject was assessed using both indexes on A&E admission. The agreement between the Emergency Severity index and the Sri Lankan Triage Index was assessed by using the kappa coefficient with its 95% confidence interval.

Results: Out of the 365 patients (response rate = 85.6%), 57% (n=237 were males. The mean age of the sample was 53.81 (SD=20.31). Fifty four percent (n=197) had life-threatening presentations. The majority of the patients were categorized in the category 2 (29.3%, n=107) and 4 (37%, n=135) in SLTI. However, in ESI 47.9% (n= 175) were category 2 and 31.8% (n=116) category 3. There was significant inter-rater variability between the two indexes (Light`s Kappa= 0.319, p < 0.001). Moreover, category 1 (p <0.001), category 2 (p <0.001), and category 4 (p <0.001) were significantly different in the two indexes.

Conclusions: SLTI under-triage category 1, 2 and 4 compared to the ESI. Identification of th percentage of under-triage is essential in assessing the performance of the triage scale and can adopt novel criteria for triage in the Sri Lankan A&E set up.

Keywords: Triage, Emergency, Sri Lanka, ESI

OP 05 : Research : Increasing incidence of STEMI in younger Adults : A Hospital Based Observational Study at Teaching Hospital Anuradapura

***Kumaradasa LN*[1]**
***Weerasinghe GD* [1]**
[1]*Teaching hospital Anuradapura*

Background: Myocardial infarction (MI), particularly ST-elevation Myocardial Infarction (STEMI), is the leading cause of cardiovascular deaths globally. Recent trends show a shift in the demographic profile, with a growing number of younger individuals being affected. This study aims to evaluate age, gender, and treatment patterns in STEMI cases.

Method: This retrospective observational study analyzed hospital records from Anuradhapura Teaching Hospital for patients admitted to the Emergency Treatment Unit (ETU) with STEMI between January 2024 and May 2025. Data were categorized by month of admission, age group (below or above 45 years), gender, and treatment type (Percutaneous Coronary Intervention [PCI] or thrombolysis). Descriptive statistics were applied to summarize patterns.

Results: A total of 489 patients were admitted in 2024, and 179 up to May 2025. January recorded the highest number of admissions in both years, indicating a potential seasonal trend. In 2024, 14% of patients were below 45 years, increasing to 17% in 2025. The average age of STEMI onset decreased from 66 years in 2024 to 55 years in 2025, showing a rise in younger adult cases. Patients under 35 accounted for 2.45% in 2024 and 1.12% in 2025.
In 2024, 31.7% of patients received PCI; this increased to 49.4% in 2025, while thrombolysis use declined to 50.6%, indicating a shift toward advanced interventional treatment.

Conclusion: This study reveals a rising trend of STEMI in younger adults, with a significant drop in average age of onset. The increasing use of PCI reflects evolving clinical practice and improved access to care. Seasonal spikes in January suggest lifestyle or environmental influences. These findings highlight the need for early prevention, youth-focused public awareness, and sustained investment in cardiac care infrastructure.

OP 06 : Research : Correlation and validation of right-sided electrocardiogram findings with 2-dimensional echocardiography findings in ST-elevated inferior wall myocardial infarction (IWMI) patients presenting to the emergency department – a prospective observational study.

Saif MD[1], Verma A[1], Jaiswal[1], Gupta S[1], Lal M[1]
[1]Max Superspeciality Hospital, Patparganj, New Delhi

Background and Aims : Inferior wall myocardial infarction (IWMI) accounts for 40–50% of STEMI cases, with right ventricular infarction (RVMI) occurring frequently in proximal right coronary artery occlusion. Despite its prognostic significance, RVMI often remains undiagnosed due to limitations of the standard 12-lead ECG. This study evaluates the correlation between right-sided ECG (V4R–V6R) and 2D echocardiography (2D Echo) for detecting RV involvement in IWMI.

Patients and Methods : This prospective observational study included 141 IWMI patients at a tertiary care emergency department. Standard and right-sided ECGs were performed on admission, followed by a 2D Echo for RV assessment. Diagnostic accuracy (sensitivity, specificity, PPV, NPV, AUC) was calculated using SPSS v21, with Chi-square/McNemar tests for correlations.

Results : The mean age was 59.57 ± 12.26 years (78.01% male). ST elevation in V4R–V6R occurred in 50.35% of cases, while 2D Echo confirmed RVMI in 28.37%. Right-sided ECG showed 87.5% sensitivity, 64.2% specificity, 50.72% PPV, 92.42% NPV, and AUC 0.76 ($p = 0.001$). Mechanical ventilation was required in 64.54%, with 11.35% in-hospital mortality.

Conclusion : Right-sided ECG, particularly V4R ST elevation, strongly predicts RVMI in IWMI. Incorporating right-sided ECG into emergency protocols enhances early diagnosis and clinical decision-making, potentially improving outcomes.

OP 07 : Audit : "Researching the Research Interest" - An audit on involvement of Research among Emergency Medicine Trainees in Sri Lanka

Mudithakumara N[1], Ekanayake EMSB[2]
[1]Post Graduate institute of Medicine - University of Colombo
[2]Lady Ridgeway Hospital for Children

Background : Research is a cornerstone of evidence-based medical practice, in the basis of improvement in patient care, healthcare systems, and professional development. The extent of involvement in Emergency Medicine research and the challenges of the Em trainees facing in research is a less discussed area.

Method : This audit investigated the research interests, engagement and challenges of EM trainees (1st to 4th year) in Sri Lanka through a self-administered questionnaire (n=45). Data was collected on research involvement, presentation & publication history, research courses & basic knowledge in different stages of research, specific research interests, and perceived areas needing support, challenges & expectations, and analyzed using MS EXCEL.

Results : The results highlight a significant latent interest in research among EM trainees, with the majority expressing a strong desire to contribute to the evidence base. 27% have never done an audit, case report, research previously; and among those who have published 44% have published case report, around 12% & 14% have been involved with clinical audits and researches respectively. The knowledge & skills in most of the areas (study design, statistical analysis, and scientific writing, even among those who had completed some research courses) require improvements as the trainees self-evaluate themselves and hopeful to get assistance. The audit also pinpoints critical areas where trainees require assistance including dedicated mentorship, access to statistical resources, protected time within the demanding clinical schedules, and research funding.

Conclusion : The trainees involvement and interest in EM research is an area lacking evidence of. Despite this enthusiasm, a noticeable gap exists between interest and tangible research output, among the majority. These findings underscore the need for targeted interventions and enhanced support to nurture and establish a robust “Emergency Medicine Research Culture” and cultivate the habit of research among the EM trainees in Sri Lanka.

OP 08 : Case series : " Moving with no beating heart":- CPR-Induced Consciousness in Middle-Aged Women with VT Cardiac Arrest Post-Myocardial Infarction: A Case Series

Mudithakumara N[1,2], Wijayarathna WMCJB[1]
[1]National Hospital Galle
[2]Post Graduate institute of Medicine - University of Colombo

Background: Cardiopulmonary resuscitation (CPR) induced consciousness (CIC), also known as CPR-induced awareness is a rarely describes phenomenon of some level of purposeful movements in patients undergoing high-quality chest compressions (who have not returned to spontaneous circulation). CIC is an increasingly recognized phenomenon, where the awareness or purposeful movements disappear when the chest compressions stopped. While its precise mechanisms are not fully understood, it is hypothesized to involve cerebral perfusion during high-quality chest compressions. This case series presents three unique instances of CIC occurring in middle-aged Sri Lankan women experiencing ventricular tachycardia (VT) cardiac arrest, likely secondary to acute myocardial infarction (MI).

Clinical Cases: We present three cases of previously healthy, middle-aged women (aged 52, 55, and 62 years) who presented to the Emergency Department with sudden collapse and confirmed VT cardiac arrest. The immediate history was significantly severe ischaemic type chest pain, suggesting acute myocardial infarction as the underlying cause in all three with other reversible causes of cardiac arrest have been excluded. During active chest compressions, all patients exhibited clear signs of consciousness, including opening eyes, attempting to grasp with hands & fingers, purposeful upper limb and lower limb movements and head movements despite ongoing cardiac arrest. These movements were typically terminated with ceasing of CPR for rhythm check. This transient consciousness prompted adjustments in resuscitation strategy to minimize patient distress.

Conclusion: CPR induced consciousness in these three cases, particularly in VT cardiac arrest likely due to MI, offers valuable evidence in a resource limited context. This reinforces the rare but impactful phenomenon and the importance of recognizing CIC during resuscitation, especially when reversible causes of cardiac arrest like acute MI is present. Critical balance between effective resuscitation & patient comfort and consideration of analgesia/ sedation should be considered and warrants further research.

OP 09 : Research : Emergency Care services at Accident and Emergency Treatment Unit of Teaching Hospital Jaffna; A single-centre Descriptive cross-sectional study

Manoharan P[1], Manitheepan K[1], Elango R[1], Mathangi P[1], Mathievaanan S[1]

[1]Accident and Emergency Treatment Unit, Teaching Hospital Jaffna

Introduction : This is a retrospective cross-sectional survey of the patient population who received emergency care services at the Accident and Emergency Treatment Unit of TH Jaffna. This is the largest institution in Northern Province with all the specialities, including Accident and Emergency care. This retrospective data analysis aims to assess the pattern of patient presentation, emergency services provided and adherence to national policy.

Methodology : This is a retrospective cross-sectional study conducted over a year using the patient registration records of the A&E in this hospital. All A&E registered patients were included in this survey. Approval was obtained from the director to use this data for this analysis. Statistical analysis was done using SPSS.

Results : The Accident and Emergency Treatment Unit (A & E) managed 25,817 patients (mean: 2,151/month), with January recording the highest volume. Within A & E, the treatment area attended to 17,276 patients, the resuscitation area 6,874, and the surgical area 1,725. Poisoning and trauma-related cases included 348 drug overdoses, 85 Yellow Oleander poisonings, 254 chemical poisonings, and 344 polytrauma patients, with peak occurrences in April, September, and August. There were 209 reported deaths (peak in April) and 7,964 discharges. Admissions to special care units comprised 494 to the Coronary Care Unit, 95 to the neurosurgical unit, 10 to the Premature Baby Unit, 308 to MICU, 87 to ATICU, and 146 to the Dialysis Unit. Critical interventions included 536 cardiopulmonary resuscitations, 330 intubations, and 1,358 cases of non-invasive ventilation. Thrombolytic therapy was administered in 272 myocardial infarction cases and 41 acute strokes.

Conclusion : A& E unit has significantly contributed to the emergency care for the acutely ill patients and involved in appropriate disposal according to the clinical need. Significant percentage of patients were discharged from A & E according to the EM Policy and contributed to reduce the bed crisis, shorter hospital stay and overall patient flow.

OP 10 : What's New in cardiac arrest Resuscitative Science?

Borah P
Marengo Asia Super Specialty Hospital, Gurgaon, India

Background : Cardiac arrest remains a major cause of global mortality and neurologic disability. Over the past decade, resuscitative science has evolved from protocol-driven algorithms to physiology-guided, precision interventions. This shift reflects growing evidence supporting targeted metrics, smarter technology integration, and individualized decision-making.

Methods : This review synthesizes key findings from high-impact trials and guidelines, including PARAMEDIC-2, ALPS, PART, AIRWAYS-2, ARREST, and TTM2. It integrates updated recommendations from the AHA 2020 Guidelines, observational studies, and emerging innovations in airway management, hemodynamic monitoring, pharmacologic interventions, mechanical circulatory support, and community response systems.

Results : High-quality CPR remains foundational, with diastolic blood pressure >20 mmHg associated with improved ROSC and neurologic outcomes. Early defibrillation, real-time feedback devices, and ultrasound-guided resuscitation enhance clinical effectiveness. Supraglottic airways outperform endotracheal intubation in many out-of-hospital cardiac arrests. Epinephrine increases ROSC but higher cumulative doses are linked to worse long-term neurologic outcomes. Dual sequential defibrillation and stellate ganglion block show promise in refractory VF. Extracorporeal CPR (ECPR) using VA-ECMO improves survival in young, shockable, and reversible arrests if initiated within 30 minutes. The TTM2 trial supports temperature control through fever prevention rather than aggressive hypothermia. Neuroprognostication now emphasizes multimodal assessment after 72 hours, including biomarkers, EEG, and imaging. Community innovations—such as drone-delivered AEDs, VR/AR CPR training, telecommunicator CPR, and AI-driven predictive tools—are reshaping systems of care.

Conclusion : Resuscitation is no longer "one size fits all." Incorporating hemodynamic goals, smarter airway strategies, early ECPR, advanced diagnostics, and public access technology can significantly improve survival and long-term neurologic outcomes in cardiac arrest patients.

OP 11 : **Evaluating the Barriers Among the Healthcare Professionals in Emergency Treatment Units (ETU) and Accident and Emergency (A&E) Departments in the Government Healthcare Institutions in Batticaloa district:**

Rajeswaran Rajavarman
Faculty of Health-Care Sciences, Eastern University Sri Lanka

Background: Accident and Emergency (A&E) Departments and Emergency Treatment Units (ETU) are critical frontline services in government healthcare institutions, providing urgent care to patients with acute conditions.

Objective/ Methods: This study evaluates the main barriers faced by healthcare professionals - physicians, medical officers, and nurses in these settings across Batticaloa district, Sri Lanka, using a descriptive quantitative survey.

Results: The major challenges identified include inadequate staffing (88%), administrative difficulties (78.3%), and shortages of medical supplies (77.2%). Other significant barriers are poor infrastructure, limited training and professional development, communication gaps among staff, and non-compliance by patients. Over half of the surveyed professionals (58.7%) frequently encounter these obstacles. Communication breakdowns are more prevalent in base and district hospitals than teaching hospital ($p < 0.05$), with 43.3% of staff reporting a significant impact on emergency care delivery. Teamwork effectiveness is also lower in these hospitals compared to teaching hospital ($p < 0.05$). Six domains of workplace stressors were analysed: work environment, management, job demands, work relationships, and interactions with patients or their companions. Job demands (mean = 2.671) and work environment (mean = 2.668) are the most stressful domains, while work relationships (mean = 2.14) are least impactful. Assessments of anxiety and depression revealed that 22.8% of participants were in the borderline abnormal and abnormal ranges for anxiety, while for depression, 45.7% were borderline abnormal and 14.1% abnormal. Anxiety levels were significantly related to hospital type, professional role, and communication issues; depression correlated with hospital, designation, and teamwork ($p < 0.05$). Nursing officers are the most vulnerable group, followed by relief house officers.

Conclusion: The study highlights the urgent need for targeted interventions, continuous professional development, and better resource allocation to improve emergency care in Batticaloa district.

OP 12: Audit Report: ED Door to Departure Time for STEMI Patients at Emergency Treatment Unit - National Hospital of Sri Lanka

SAA Jagadeesh[1,2], RU Gayathrie[2], I De Lanerolle[2]

[1] Post Graduate Institute of Medicine

[2] National Hospital of Sri Lanka

Background: Timely reperfusion is critical in ST-elevation myocardial infarction (STEMI) management. European Society of Cardiology (ESC) 2023 guidelines recommend ≤60 minutes for door to balloon time and ≤45 minutes for emergency department (ED) door-to-departure to cath lab (D2D) time for primary percutaneous coronary intervention (PCI). This audit evaluated D2D performance which is actionable at ETU setup. Audit carried out at Emergency Treatment Unit (ETU) of the National Hospital of Sri Lanka (NHSL).

Methods: A retrospective analysis of consecutive admissions of 180 confirmed STEMI patients over 3 months (April to June 2025) was conducted. Data included demographics, timestamps (arrival [T1] to ED departure [T5]), and treatment modality. Primary outcomes assessed D2D compliance with ESC targets (≤45 minutes) for PCI cases.

Results: Thrombolysis (TNK) was the predominant treatment (62%, n=111), while 38% (n=69) underwent primary PCI. Only 26% of PCI patients met the ≤45minute D2D target. Median D2D time was 65 minutes (IQR:45–110), significantly exceeding ESC standards. Delays were pronounced during night shifts (median 90 vs. 55 minutes daytime; Δ35 min), in older adults (≥60 years: 80 vs. 55 min in <60 years), and females (90 vs. 60 min in males). Monthly trends showed worsening delays (June compliance: 19% vs. April: 30%).

Conclusion: D2D times for STEMI-PCI at NHSL ETU fall critically short of ESC 2023 targets, with only one quarter of patients (26%) meeting the ≤45minute benchmark. Systemic delays disproportionately affect older, female, and night-shift patients. These gaps highlight urgent needs for protocol standardization, nurse-initiated ECG pathways and staff training in atypical presentation recognition. Immediate interventions targeting workflow optimization are recommended to align with international standards and improve reperfusion timelines.

OP 13 : Audit : Clinical audit of critical time windows related to ST elevation myocardial infarction (STEMI) patients presented to an Emergency Department (ED) in a teaching hospital of Sri Lanka, with limited Percutaneous Coronary Intervention (PCI) facilities.

Fernando TNMS
Ministry of Health Sri Lanka

Background : STEMI is a time critical medical emergency. Delaying in diagnosis of STEMI and specific management will lead to negative outcome in patients and increases mortality and morbidity. Conducting a simple audit would help to Identify delays of diagnosis and specific management of STEMI. This Audit was conducted in a Teaching hospital of Sri Lanka which has limited PCI facilities.
The main Objective is to assess whether this ED provide time critical standard care for STEMI patients. Other objective is to improve the care providing to STEMI patients presenting to the ED of this teaching hospital.

Method : 2017 ESC Guidelines for the management of acute myocardial infarction in patients presenting with ST-segment elevation has been used as the standards care.
Data was collected in mid-2021 retrospectively from the bed head tickets (BHT) and STEMI registry maintaining in the ED. All the STEMI patients presented within a three-month period included to the audit. First Medical Contact (FMC) to ECG time, ECG to reperfusion decision, modality of reperfusion, and reperfusion decision to thrombolysis administered time extracted from the BHT and STEMI registry. Data was entered and analysis done with SPSS.

Results : 67 STEMI patients included to this Audit. Out of 67 patients, only 15 (22.4%) were received PCI and other 52 (77.6%) received thrombolysis with Tenecteplase. Mean FMC to ECG taken time was 14 minutes with SD of 7.905. Mean time from ECG to thrombolysis decision was 19.9 minutes. After decision has been made as thrombolysis is the reperfusion strategy, Tenecteplase has been given with a mean time of 5 minutes.

Conclusions : Compare to the standards care time windows, our patients received delayed care except time from thrombolysis decision to Tenecteplase administration, which was much better compared to standards care.

OP 14 : Research : Pre-hospital transportation and associated factors among post traumatic patients presenting to an orthopaedic unit, National Hospital Kandy.

Yapa WSPYUS [1,2], Alwis VKIU[3,4]

[1]National Hospital – Kandy

[2]Post Graduate institute of Medicine - University of Colombo

[3]Australian Centre for Health Services Innovation (AusHSI) and

Centre for Healthcare Transformation, Queensland University of Technology (QUT), Australia

[4]Department of Community Medicine, Faculty of Medicine, University of Peradeniya

Background: In trauma management, early prehospital care and mode of transportation play a critical role. This study aimed to assess prehospital modes of transportation and their associated delays, and outcomes among patients presented to an orthopedic unit.

Methods: A cross-sectional observational study was conducted among 151 trauma patients who were admitted to a single orthopaedic unit in National Hospital, Kandy. Data on transport mode, delays (seek, reach, treatment), reasons for delay, mechanism of injury, and management modality were analyzed. Patients were grouped into four transport categories: ambulance, private vehicle, public transport, and three-wheeler. Statistical tests including ANOVA, Kruskal-Wallis test and Chi-square were used to assess associations.

Results: Three-wheelers were the most common mode of transport (59.6%), followed by private vehicles (23.8%), public transport (8.6%), and ambulances (7.9%). The mean seek delay was 1.0 minutes, reach delay 58.0 minutes, and treatment delay 238.4 minutes. Among patients with seek delay ≥1 day, 34.3% mentioned native treatment as the reason. Of patients with treatment delay ≥1 hour, 52.1% connected with interhospital transfer; Among 77 patients who were transferred, 37.7% ultimately received non-operative management. Seek delay was significantly associated with transport mode ($p < 0.001$). However, reach and treatment delays showed no statistical significance.

There was a significant association between transport mode and site of fracture which categorized as upper limb, lower limb and spine ($p = 0.017$). No significant associations were observed between transport mode and either the mechanism of injury or the type of orthopedic management. Only 29 patients received prehospital treatment and 75% of ambulance users received such care compared to 14.3% among other transport modes.

Conclusion: Transport mode associated with early care-seeking behavior and affected site of the body. Significant seeking delays may correlate with native treatment. Reinforcing referral systems and appropriate consultation are necessary for optimizing trauma care.

OP 15 : Research : Knowledge, attitudes, and practices regarding the 1990 prehospital ambulance service among outpatients in teaching hospital, Peradeniya.

Yapa WSPYUS [1,2], Goonathilake YLRP [1], Weeraprameshwara HK[1] , Ratnayake RMGS[1] , Bindusara WANP[1]

[1]Teaching Hospital – Peradeniya

[2]Post Graduate institute of Medicine - University of Colombo

Background: The 1990 prehospital ambulance service in Sri Lanka provides free, prehospital emergency care, but understanding is limited about the public's awareness, trust, and behavioral response to it. This study aimed to evaluate knowledge, attitudes, and practices regarding the 1990 service among patients and visitors attending an outpatient department.

Methods: This descriptive cross-sectional study was conducted with 147 participants, in outpatient department in Teaching Hospital, Peradeniya. Data was collected using a structured questionnaire covering sociodemographic details, knowledge and perception on 1990 service, as well as participants' preferences and practices. Descriptive statistics were used to analyze the data.

Results: The mean age of participants was 39 years, with 67% female and 71% lacking prior first aid training. Awareness of the 1990 ambulance service was high: 90.5% knew it was free, 83% identified the correct provider, 89% understood it provides prehospital care, and 82% knew the emergency dialing number, though only 35% had saved it. Most (96%) rated the service as important, yet only 37% had used it. Age was significantly associated with the perceived importance of the service ($p = 0.044$).

Ambulance arrival within 5–15 minutes was expected by the majority (61%). Myocardial infarction (74.1%) and road traffic accidents (68%) were the most common causes for calling. Disease severity (87%) and distance to hospital (34.7%) influenced decisions to call an ambulance. Hesitation to call was reported by 11.5%, mainly due to uncertainty about arrival time. Notably, 68% of participants felt they were inadequately educated about the service. A majority (90.4%) supported better investment in the service, especially older individuals ($p = 0.053$).

Conclusion: Although awareness and attitudes toward the 1990 service are positive, actual use and preparedness are limited. The findings highlight the need for educational programs focusing on timely access, appropriate use, and benefits of prehospital care to enhance effective service utilization.

OP 16 : Parental Knowledge, Attitudes, and Practices Regarding Pediatric Fever Management at a Tertiary Children's Hospital in Sri Lanka: Implications for Emergency Medicine

Bindusara WANP[1,2], Yapa WSPYUS[1,2], Wickramasingha WMGK[2], Jayathilaka RPDL[1,3]
[1]Sirimavo Bandaranaka Specialised Children's Hospital, Kandy, [2]Post Graduate Institute of Medicine - University of Colombo, [3]Ministry of Health

Background: Fever is one of the most common reasons for pediatric presentations to emergency departments (EDs) worldwide. Many children with fever are discharged directly from the ED based on the assumption that parents understand appropriate fever management. However, parental misconceptions and improper practices, such as under- or overdosing of antipyretics, can lead to repeated ED visits, delayed treatment, or medication-related complications. This study aimed to assess parental knowledge, attitudes, and practices (KAP) regarding pediatric fever management and explore implications for emergency care.

Methods: A cross-sectional survey was conducted among 100 parents accompanying their children to the pediatric ED at Sirimavo Bandaranayake Specialized Children's Hospital, Kandy. The mean age of respondents was 34.2 years (SD 7.4, range 22–56 years). Fifty-nine percent were homemakers, and 41% were employed. The questionnaire assessed parental understanding of fever definition, thermometer use, antibiotic beliefs, paracetamol dosing, and sources of information.

Results: Seventy percent of parents owned a thermometer, but only 60% used it to measure temperature, while 40% relied on touch alone. Thermometer use was higher among employed parents (70%) compared to homemakers (54%), a significant difference (p < 0.05). The most commonly cited fever cut-off values were 37.5°C and 38°C, with 79% correctly identifying the standard threshold. Twenty-five percent believed all fevers require antibiotics, and 20% delayed antipyretic administration until after medical consultation. Only 55% knew the correct paracetamol dose, and 60% administered the appropriate dose based on their child's weight. Seventy percent were aware of the maximum dosing frequency, and 65% knew the minimum interval between doses. Eighty percent recognized paracetamol as the only safe antipyretic in dengue. Doctors were the main source of information for 50% of parents, followed by pharmacists (30%) and package labels (20%). Eighty-five percent knew paracetamol is available over the counter in Sri Lanka.

Conclusions: In the emergency setting, assumptions about parental knowledge of fever management may lead to premature discharge without adequate education, contributing to inappropriate home care and potential return visits. This study highlights significant gaps in parental understanding and practices related to pediatric fever, including antipyretic dosing errors and antibiotic misconceptions. Emergency physicians should incorporate targeted education on safe fever management during ED visits to empower parents, reduce anxiety-driven presentations, and optimize pediatric care outcomes.

OP 17 : Knowledge and awareness on peri-intubation resuscitation of critically ill adult patients among medical officers

Padmadasa NTDR
National Hospital of Sri Lanka, Ministry of Health, Post Graduate institute of Medicine - University of Colombo

Introduction : Intubation is performed on critically ill patients, particularly in Emergency Departments (ED). Peri-intubation resuscitation is a crucial aspect that can prevent associated adverse events related to intubation of a critically ill patient. In a previous study, which is an international multicenter observational study, it was found that a total of 45.2% of patients encountered at least one significant adverse event during peri-intubation. This study aims to determine the knowledge and awareness of peri-intubation resuscitation among medical officers in Sri Lanka.

Method : A cross-sectional descriptive study on registered medical officers working in Emergency Treatment Units (ETU) and Accident and Emergency Units (A&E) in Sri Lanka. The sample size was 92, convenience sampling method was used as the sampling method. Study was done in the National Hospital Sri Lanka (NHSL), District General Hospital Negombo, Base Hospital- Panadura & Homagama. Medical officers were recruited on a volunteer basis for the study. Data collection was done using an approved questionnaire.

Results :
The majority aged 36-45 years (57.4%), with equal gender distribution. The majority (60.6%) had 5 to 10 years of work experience in emergency settings. Of the participants, 19% had good knowledge, 37% had average knowledge, 44% had poor knowledge of peri-intubation resuscitation. In this study it was found that having knowledge on peri- intubation resuscitation was associated with previous work experience in ICU (p=0.023), presence of postgraduate qualifications in critical care (p=0.014) & work experience > 5 years (p=0.022).There is no statistically significant association found between knowledge levels and gender of study participants (P=0.516). Awareness of the need for peri-intubation resuscitation was significantly higher among those with good knowledge on peri intubation resuscitation. ($p = 0.034$). Awareness of drugs used during intubation is associated with knowledge levels, particularly regarding the use of ketamine (88.9% aware vs. 20.0% unaware, $p < 0.001$) and rocuronium (27.8% aware vs. 2.7% unaware, $p = 0.003$).

Conclusion : The findings indicate a concerning gap in knowledge regarding peri-intubation resuscitation practices. This highlights the urgent need for targeted educational interventions to enhance awareness and competency in this critical area of patient care.

Abstracts - Poster Presentations

Annual Academic Congress 2025 - Sri Lanka College of Emergency Physicians (SLCEP)

PP 01: Audit: Point-of-care-ultrasound (POCUS) documentation in the Accident and Emergency Treatment Unit at Teaching Hospital Jaffna; A Clinical Audit

Joachimson AJ[1], Satgunarajah A[1], Gowrinesan Y[2], Manitheepan K[2]

[1] Faculty of Medicine, University of Colombo

[2]Teaching Hospital Jaffna

Introduction and objective: A clinical audit is a quality improvement initiative aimed at enhancing patient care and outcomes by systematically reviewing clinical practices against defined standards and implementing necessary changes. The objective of this audit was to assess the standard and completeness of documentation pertaining to point-of-care ultrasound (POCUS) within the Accident and Emergency Treatment Unit of the Teaching Hospital, Jaffna.

Materials and Method: An audit checklist comprising seven criteria for the documentation of point-of-care ultrasound (POCUS) was adapted from the guidelines established by the Royal College of Emergency Medicine and Royal College of Radiologists. Data were collected retrospectively from the bed head tickets of patients following POCUS examinations performed and documented by the attending doctors. Compliance was assessed by calculating the percentage of records that met each of the specified documentation criteria.

Results: A total of 100% compliance was observed for documentation of patient details, indication for the scan, findings, and appropriate action taken following the scan. However, documentation of a conclusion was present in only 55% of the records, while the inclusion of the doctor's signature and the date and time of the scan were completely absent.

Conclusions: The audit demonstrated full compliance in documenting patient details, scanning indication, findings, and post-scan actions. However, this may partly reflect the fact that patient details and indications were already recorded in the bed head tickets, rather than being separately documented as part of the POCUS entry. In contrast, critical elements such as the scan conclusion, doctor's signature, and date and time were frequently omitted. These gaps highlight the need to reinforce comprehensive and standardized documentation practices for POCUS to ensure accountability, clinical clarity, and optimal patient care.

PP 02 : Case report : Pregnancy, stroke and valvular Atrial Fibrillation: A delicate Emergency Medicine Dilemma

Bindusara WANP[1,2,3,4], Ekanayake E M S B[4]
[1]Sirimavo Bandaranaka, Specialized Children's Hospital Kandy
[2]Post Graduate Institute of Medicine
[3]Ministry of Health
[4]Lady Ridgeway Hospital for Children

Background: Managing acute ischemic stroke with valvular atrial fibrillation (AF) during pregnancy presents complex challenges due to conflicting therapeutic priorities and risks to both mother and fetus. Decisions must balance thromboembolic prevention, hemodynamic stabilization, hemorrhagic complications, and fetal safety, particularly in rheumatic heart disease.

Clinical case: A 37-year-old pregnant woman (30 weeks gestation, P3C2) presented with acute left-sided weakness, dyspnea, and palpitations. Neurological assessment revealed an NIHSS score of 4, while ECG confirmed AF with rapid ventricular response. Non-contrast brain CT was unremarkable. Thrombolysis was withheld due to mild stroke severity. Bedside echocardiography identified severe rheumatic mitral stenosis and pulmonary hypertension, with clinical signs of pulmonary edema without severe hypoxia. Emergency cardioversion was withheld due to the high thromboembolic risk associated with AF and acute stroke, but was kept as an option should critical hemodynamic instability occur. Rate control targeted 120 bpm using intravenous Digoxin and Amiodarone. Pulmonary edema was managed with Frusemide, avoiding non-invasive ventilation to prevent worsening pulmonary hypertension. Anticoagulation was delayed initially due to acute minor stroke, but was initiated early after transesophageal echocardiography (TOE) detected an intra-atrial thrombus.
Repeat TOE in two weeks confirmed thrombus resolution, enabling percutaneous transvenous mitral commissurotomy (PTMC). At 37 weeks, a planned cesarean section was performed after temporary enoxaparin cessation, delivering a healthy neonate.

Conclusion: This case underscores the necessity of multidisciplinary, individualized care in balancing maternal-fetal risks during cardiovascular and neurological emergencies. Key strategies included decision making on arrhythmia management with situational awareness, cautious anticoagulation timing, avoidance of thrombolysis in mild strokes, and staged interventions (PTMC and planned delivery). Such approaches optimize outcomes in high-risk pregnancies with concurrent cardio cerebral pathology.

PP 03: Case report : Depressed Mental Status in a 3-Year-Old Following Accidental Risperidone Ingestion

Jayathilaka DMGL[1], Wijerathne J[2]
[1]National Hospital Galle.

Introduction : Accidental ingestion of medications is a common cause of emergency department presentations in children. Risperidone, an atypical antipsychotic, though frequently used in adult psychiatric conditions, poses serious toxicological risks in pediatric patients even in small amounts. We present the case of a 3-year-old previously healthy female who developed acute neurological and autonomic dysfunction following accidental ingestion of her mother's risperidone tablets.

Case : 3-year-old child was admitted to local hospital with drowsiness, bilateral lower limb weakness, tachycardia, urinary retention, and pinpoint pupils. She was transferred to tertiary care hospital for further evaluation and management.
Initial differentials included possible envenomation, meningoencephalitis, drug toxicity, and head trauma. Despite normal neuroimaging and basic laboratory results, her symptoms progressed, prompting further evaluation. Detailed retrospective history revealed that the child had ingested multiple risperidone tablets, confirmed through prescription verification and tablet identification. Clinical features were consistent with risperidone toxicity, which commonly presents with central nervous system depression, cardiovascular instability, extrapyramidal symptoms, and autonomic disturbances. Of particular interest in this case were the rare findings of urinary retention, hypersalivation, and pinpoint pupils.
Management was primarily supportive, focusing on airway protection, hydration, continuous cardiac monitoring, and neurological observation. Activated charcoal was not administered due to delayed presentation. The child's condition improved with conservative measures, and she was discharged without complications after 48 hours of observation.

Conclusion : This case highlights the significance of considering atypical antipsychotic toxicity in pediatric patients presenting with unexplained depressed mental status and autonomic symptoms. It also underscores the necessity of obtaining thorough collateral histories and emphasizes the importance of preventive strategies to avoid accidental pediatric ingestions at home.

PP 04 : Case report : Fatal Neonatal Presentation of Undiagnosed Aortic Atresia and Left-Sided Diaphragmatic Hernia

Jayathilaka DMGL[1], Wijerathne J[2]
[1]National Hospital Galle.

Introduction : We report a fatal neonatal case involving a rare combination of undiagnosed aortic atresia with duct-dependent systemic circulation and left-sided congenital diaphragmatic hernia (CDH).

Case report: A term neonate (38 weeks' gestation) was transferred to the emergency department (ED) immediately after birth from a nearby private hospital due to severe central cyanosis, respiratory distress, hypotonia, and generalized floppiness. The baby had been delivered by elective caesarean section following an uneventful antenatal period, with a 5-minute Apgar score of 7. Initial resuscitation at the referring hospital led to transient improvement in heart rate and respiratory effort. However, persistent cyanosis, grunting, diminished air entry on the left side, and hepatomegaly upon ED arrival raised suspicion of critical congenital anomalies Further evaluation at the tertiary care center revealed aortic atresia with a small atrial septal defect (ASD), a large patent ductus arteriosus (PDA), and a left-sided CDH causing mediastinal shift. Despite intubation, ventilation, and immediate initiation of prostaglandin E1 infusion to maintain ductal patency, the neonate rapidly deteriorated and suffered a cardiac arrest. Resuscitation efforts were unsuccessful, and the baby was pronounced dead after prolonged attempts. This case highlights the catastrophic outcome when life-threatening congenital anomalies are missed antenatally. Aortic atresia leads to complete dependency on the PDA for systemic circulation, while CDH compromises pulmonary development and cardiac function due to mechanical compression. The combination of these two conditions presents an extreme resuscitation challenge in the immediate postnatal period.

Conclusion : Antenatal detection of aortic atresia and CDH is critical for survival, allowing for planned delivery at tertiary centers equipped for neonatal cardiac and surgical emergencies. Failure to detect such anomalies limits timely intervention and significantly worsens prognosis. This case underscores the importance of improving prenatal screening sensitivity, early recognition, and the need for coordinated multidisciplinary management in suspected high-risk deliveries to optimize neonatal outcomes.

PP 05 : Case report: A Child Presenting with Hypertensive Emergency and Status Epilepticus due to Acute Oxalate Nephropathy Following *Averrhoa bilimbi* Ingestion.

Jayathilaka DMGL[1], Wijerathne J[2]
[1]National Hospital Galle.

Introduction : Averrhoa bilimbi and Averrhoa carambola (star fruit) are tropical fruits from the Oxalidaceae family, both noted for their high oxalic acid content. While nephrotoxicity related to star fruit is well documented, reports of A. bilimbi-induced acute kidney injury (AKI) remain rare. Oxalate nephropathy results from calcium oxalate crystal deposition in renal tubules, causing tubular obstruction and acute injury. We present a pediatric case of AKI following A. bilimbi ingestion, complicated by hypertensive emergency and status epilepticus.

Case Report : A 7-year-old girl was transferred to the Pediatric Intensive Care Unit (PICU) for management of status epilepticus and further evaluation. Prior to transfer, she had received midazolam and levetiracetam. On arrival, her blood pressure was found to be above the 99th percentile. She developed another seizure, treated with phenytoin, and intravenous labetalol started to gradually reduce her blood pressure. Seizures and hypertension were successfully controlled. A non-contrast CT brain scan was unremarkable.
Initial laboratory workup revealed severe AKI, with a serum creatinine of 9.1 mg/dL. Post-streptococcal glomerulonephritis (PSGN) was initially considered, but the absence of preceding infection, hematuria, or abnormal urinalysis made this unlikely. Abdominal ultrasound showed echogenic kidneys with prominent pyramids. Renal biopsy performed the following day demonstrated normal glomeruli with tubular deposition of translucent, fan-shaped crystals birefringent under polarized light, consistent with oxalate nephropathy.
Detailed history revealed habitual ingestion of large amounts of raw A. bilimbi fruit. The final diagnosis was oxalate nephropathy secondary to dietary hyperoxaluria. The patient recovered with supportive care and was discharged with planned nephrology follow-up.

Discussion and Conclusion: This case underscores the potential of A. bilimbi to cause severe oxalate nephropathy in children, leading to critical complications. Clinicians should consider dietary sources of oxalate in unexplained AKI, particularly in endemic areas. Public education about the risks of oxalate-rich fruits is essential.

PP 06 : Case report : Fatal Cardiac Tamponade Following Thrombolysis for Inferior STEMI: A Case Report of Emergency Pericardiocentesis During Cardiac Arrest

Weerasinghe DSE [1,2]
[1]*National Hospital of Sri Lanka*
[2]*Post Graduate institute of Medicine - University of Colombo*

Background : The most severe potential complications of acute ST-elevation myocardial infarction (STEMI) involve tearing or rupture of acutely infarcted myocardial tissue. The clinical characteristics of these complications differ and depend on the site of rupture, which may involve the free wall of either ventricle, the interventricular septum, or the papillary muscles. Post infarction ventricular free-wall rupture is a rare mechanical complication. As an often-catastrophic event, death typically ensues within minutes due to sudden massive hemopericardium resulting in cardiac tamponade. Cardiac Rupture is associated with high in-hospital mortality. Cardiac rupture usually occurs withing first week after Acute Myocardial Infraction, especially withing the first 24 hours and 3-5 days. Early recognition is vital, and may allow for pericardial drainage and open surgical repair as the only emergent life-saving procedure.

Case Report : A 69-year-old female with diabetes presented with nine hours of severe ischemic chest pain was diagnosed to have an Inferior STEMI. She was clinically stable, other than high blood pressure (164/90 mmHg). Tests confirmed she was having an acute inferior STEMI. Her chest pain continued following thrombolysis with Tenceteplase, and went into a cardiac arrest following a ventricular Tachycardia within 1 hour of post thrombolysis. During cardio-pulmonary resuscitation, a large cardiac tamponade was identified in the Point-of-care ultrasound, and an urgent pericardiocentesis was performed while continuing the resuscitation, 60 ml of blood aspiration from the pericardial sac. However, the patient didn't return to spontaneous circulation, and succumbed death.

Conclusion: Cardiac tamponade caused by myocardial free-wall rupture after thrombolysis is a rare but life threatening complication of Acute Myocardial Infraction. Immediate recognition and treatment, including pericardiocentesis, are crucial, though they may not always result in survival.

PP 07: Case report : Pneumothorax to Cardiac Arrest: A Case of Penetrating Chest Trauma Requiring Clamshell Thoracotomy

Weerasinghe DSE
National Hospital of Sri Lanka, Post Graduate institute of Medicine - University of Colombo

Background: Gunshot wounds to the chest are medical emergencies that can lead to rapid deterioration due to internal bleeding, pneumothorax, or direct injury to vital organs. Early recognition and timely intervention are critical to improving outcomes in such trauma cases.

Clinical Case: A 43-year-old previously healthy Sri Lankan male was admitted to a trauma center of a tertiary care unit, after sustaining multiple gunshot wounds. The patient was conscious with a respiratory rate of 32/min and SpO2 (90%) improved with non-rebreathing mask with 15L oxygen. He had poor chest-expansion and reduced breath sounds on the L/chest, Point-of-care ultrasound evidence of a L/pneumothorax, and immediate finger thoracostomy was performed. There was no external catastrophic bleeding despite visible gunshot wounds to the left chest and pelvis. Hemodynamically, the patient was unstable with a blood pressure of 93/60 mmHg and a heart rate of 136 bpm.
Suddenly, the patient went into a cardiac arrest and given the trajectory of one of the bullets towards the heart, a clamshell thoracotomy was performed with open cardiac massage along with activating ATLS cardiac arrest protocol. Arterial blood gas showed severe metabolic acidosis (pH 6.86, lactate 10, HCO_3^- 2.7, BE -29). Massive transfusion protocol activated, intravenous Tranexamic 1g, and NaHCO3 100ml were administered. The repeat POCUS was normal, and the suspected source of bleeding was L/lung hilum.
Despite aggressive resuscitation efforts, including transient return of spontaneous circulation, the patient remained in an unstable rhythm and was declared dead after an hour of intervention post-thoracotomy.

Conclusion: This case highlights the rapid and fatal course of penetrating chest trauma involving vital thoracic structures. Even with timely diagnosis, thoracostomy, thoracotomy, and full trauma resuscitation, the outcome can be poor due to massive internal bleeding and associated metabolic derangements.

PP 08: Audit : Audit on Documentation of Nasogastric Tube Placement and Confirmation in the ICU, Colombo North Teaching Hospital, Sri Lanka

Madusanka DGM
National hospital Sri Lanka

Background : Nasogastric (NG) tube insertion is a common ICU procedure, but improper placement can cause serious harm, classifying it as a "never event" ; The UK's National Patient Safety Agency (NPSA) recommends confirmation methods such as pH testing (≤5.5) and specific chest X-ray (CXR) findings. Comprehensive documentation, including date, time, tube size, nostril used, and confirmation method, is essential to ensure safety and accountability.

Method: A prospective audit was conducted over three months in the ICU to assess NG tube placement techniques and post-insertion documentation. Data were collected from 39 patient records and observational evidence, focusing on insertion, confirmation methods, and record completeness.

Results: Among the 39 patients (48.7% male, 51.3% female), the most common indication for NG tube insertion was gastric drainage (10.8%). All received Ryle's tubes. For confirmation, 47.4% used auscultation and gastric aspirate, 44.7% used these methods plus CXR, and 7.9% used auscultation alone. No cases employed pH testing. Documentation was completed in only 43.6% of cases. While the date of insertion was always recorded, time was noted in 82.4%, tube size in 11.8%, and type and nostril in just 5.9%. Indications were documented in only 17.6%. In 15.8% of cases, tube position was not checked before feeding.

Conclusion: The audit revealed inconsistent confirmation methods and poor documentation of NG tube placement. The absence of pH testing and incomplete records present potential patient safety risks. Protocol-driven practices and staff education are urgently needed. A follow-up audit will assess the impact of these improvements on documentation and procedural safety.

PP 09 : Case report : Grey Platelet Syndrome and Pregnancy: A Case Report and Literature Review

Madusanka DGM
National hospital Sri Lanka

Background : Grey Platelet Syndrome (GPS) is a rare inherited bleeding disorder characterized by macrothrombocytopenia, platelet dysfunction, and absence of alpha-granules. Patients often present with menorrhagia, easy bruising, and bleeding after minor trauma or surgery. Diagnosis is confirmed by electron microscopy, revealing pale, granule-deficient platelets. GPS is associated with myelofibrosis and splenomegaly and is inherited in an autosomal recessive manner. There are fewer than 100 documented cases globally. Pregnancy in GPS poses a significant bleeding risk, especially during labor and delivery, yet there are no standardized management guidelines.

Clinical Case : A 32-year-old primigravida with a history of GPS was followed through pregnancy at Castle Street Hospital for Women, Colombo. Diagnosed at age 21 after presenting with heavy menstrual bleeding and severe anemia, GPS was confirmed via peripheral smear and electron microscopy. She had a background of myelofibrosis, splenomegaly, and family history of thrombocytopenia. During pregnancy, she developed gestational hypertension and was diagnosed with type 2 diabetes. Her platelet count fluctuated between 15,000–20,000/mm³. At 37+2 weeks, she presented with painless vaginal bleeding. Despite planned induction for vaginal delivery, poor response to platelet transfusion delayed labor. Emergency cesarean section was eventually performed after transfusion of 16 units of apheresis platelets and IV methylprednisolone. A healthy male infant was delivered, with a normal platelet count at birth (197,000/mm³). Postoperative and neonatal care were uneventful. A long-term contraception method was arranged post-delivery.

Conclusion : GPS is extremely rare in pregnancy and presents unique challenges due to bleeding risks and poor response to transfusion. Multidisciplinary management involving obstetrics, hematology, transfusion medicine, and anesthesia is essential. In the absence of guidelines, individualized care, timely transfusion, and careful peripartum planning are critical to achieving favorable maternal and neonatal outcomes.

PP 10 : Case Report: Incidental finding of a Tuberculoma of brain in a 24 year old postpartum woman during postpartum Headache workup in ED – A clinical case report

Achchuthan M

Postgraduate institute of Medicine- University of Colombo, Sri Lanka

Background : Postpartum headaches are frequently attributed to benign causes such as hormonal fluctuations, stress, and sleep deprivation. However, they may occasionally indicate serious underlying conditions, including cerebral venous thrombosis (CVT), space-occupying lesions (SOL), CNS infections or other neurological disorders. Tuberculomas are rare focal lesions resulting from Mycobacterium tuberculosis infection and are noteworthy in postpartum women due to changes in immune function during pregnancy.

Case Presentation : A 24-year-old woman, 23 days postpartum, presented with a 4-day history of progressive, severe generalized headache and drowsiness to ED. The headache was constant, throbbing, and associated with nausea, with no fever, seizures, or visual disturbances and no significant antenatal or postnatal complications. On examination, she had no focal neurological deficits but was persistently drowsy. Given her postpartum status and symptom severity, CVT and SOL were considered.

Investigations : A CT venogram revealed an incidental left parietal lobe mass. MRI and MR venography performed shortly afterward showed a 3.8×2.4×3.5 cm ring-enhancing lesion in the left parietal lobe with significant perilesional edema and a 5 mm midline shift. Venous sinuses were normal. The lesion was initially suspected and reported to be a glioma.

Management and Outcome : A neurosurgery consultation was obtained, and surgery was deferred due to minimal symptoms at that time. Blood tests were largely unremarkable aside from a mildly elevated ESR (46mm/hr). The patient was started on IV dexamethasone and oral levetiracetam. Due to worsening symptoms and increased midline shift on repeat imaging, she underwent urgent craniotomy and excision of the lesion. Intraoperative frozen section identified a tuberculoma. Histopathological and microbiological analysis supported this diagnosis despite negative Mantoux and AFB smears. Postoperatively, the patient was treated with a standard anti-tuberculosis regimen and corticosteroids, along with symptomatic management.

Conclusion : Tuberculomas, though rare, should be considered in postpartum women presenting with severe, unexplained headaches. Early neuroimaging and surgical evaluation are crucial for timely diagnosis. Prompt initiation of anti-tuberculosis therapy can significantly improve prognosis and reduce the risk of neurological complications.

PP 11 : Case report : Adrenal Crisis in a Child with AAA Syndrome Presenting as Hypoglycemia and Altered Sensorium: A Case Report

RAO PS[1], Chikatla T[1] , Oladri P[1] , Ghazi SS[1] , Subhan I[1]
[1]Apollo Hospitals Enterprise Limited , Hyderabad, India

Background : Allgrove Syndrome (AAA Syndrome), is a rare autosomal recessive disorder resulting from a mutation in the AAAS gene located on chromosome 12q13. This gene encodes the ALADIN protein. Allgrove Syndrome typically presents with a classic triad: adrenal insufficiency, alacrima, and achalasia.

Clinical Case : A 4-year-old male child with a known diagnosis of AAA syndrome was brought to the Emergency Department with complaints of drowsiness since morning. No history of recent illness or medication change. On examination, the child was lethargic but hemodynamically stable. Ophthalmological examination revealed the presence of alacrima. Capillary blood glucose was 33 mg/dL (GRBS). Immediate resuscitative measures included administration of 10% dextrose 30 mL IV bolus and hydrocortisone 50 mg IV stat (1-2 mg/Kg). The child's mental status improved post-intervention, and he was admitted for observation and further evaluation. Maintenance fluids with dextrose were initiated, and serial blood glucose monitoring was done. Electrolyte levels remained within normal limits.
As part of routine evaluation for Allgrove's syndrome, upper GI endoscopy was performed to screen for achalasia, which was not found. The child was discharged with reinforcement of adrenal crisis protocols and an emergency steroid plan, which are essential for reducing morbidity.

Conclusion : AAA Syndrome is a rare disorder that requires a high degree of clinical suspicion due to its variable presentation. This case highlights the importance of recognizing hypoglycemia as a potential early manifestation of adrenal insufficiency. Prompt intervention with IV glucose and corticosteroids can be life-saving.
Comprehensive evaluation, including assessment for achalasia and ongoing endocrine monitoring, is essential for appropriate management. Early diagnosis and caregiver education on emergency steroid protocols are crucial in preventing recurrent adrenal crises and improving long-term outcomes in affected children.

PP 12: Audit on Opioid Use and Monitoring in the Accident and Emergency Department (A&E), Colombo South Teaching Hospital.

Sailakshmi Logeeswaran[1], Goonewardene D[1], Liyanage SA[1]
[1]Colombo South Teaching Hospital

Background: Opioids are commonly used for acute pain management in the A&E, but their administration requires careful consideration due to potential adverse effects such as respiratory depression, sedation, and hemodynamic compromise. Strict adherence to prescribing and monitoring for sedation and vitals is essential to ensure patient safety (Herzig et al, 2018). The objective of this audit is to assess compliance with opioid prescribing and monitoring protocols in the A&E, aiming for 100% adherence to safe opioid use practices.

Methods: A retrospective audit was conducted reviewing twenty-four patients' records who were admitted to the A&E, CSTH and discharged from short-stay unit of A&E between 26/05/2025 to 02/06/2025 after receiving opioids either orally or intravenously. Medical records were assessed for both documentation of the clinical indication for opioid administration and appropriate post-administration monitoring, including respiratory rate, sedation level, and blood pressure. Compliance rates were analyzed for each.

Results: Preliminary analysis demonstrated that 100% documentation of indications was present. The compliance with monitoring of vitals was 100% following intravenous administration of opioids, while lacking following oral administration. The significant drawback was noted in the monitoring of **the** sedation score following the administration of opioids.

Conclusion: While documentation of indications was largely satisfactory, monitoring practices of sedation score need improvement. Targeted interventions, including staff education, protocol reinforcement, and implementation of standardized monitoring tools, are recommended. A re-audit is planned to evaluate the effectiveness of these interventions.

PP 13 : Audit : Pain assessment and management: An audit of practice at a tertiary hospital

Perera WPWS
Post Graduate Institute of Medicine

Background : Acute postoperative pain resulting from tissue injury is a common and unpleasant experience for most patients. Effective management, which includes recognition and assessment, enhances patient satisfaction and facilitates smoother recovery. Due to subjective variation in pain perception, recognizing and assessing pain is crucial for tailoring the most appropriate management plan. This audit evaluates post-operative pain management with a focus on assessment and patient satisfaction.

Methods : This audit was conducted in obstetric and gynecological wards of a government-funded tertiary academic institution in the Western Province of Sri Lanka. Forty-three female patients from wards, who underwent gynecological surgeries or cesarean sections between January and March 2023, were randomly selected. Data were collected retrospectively through interviews and clinical notes and analyzed using Excel. Variables assessed included age, pain assessments, pain assessors, assessment tools, and pain management plans.

Results : Of the 43 patients, 15 underwent cesarean sections and 28 gynecological surgeries, with a mean age of 36.7 years. Prior to surgery, 29 patients (67%) were pain-free; only 3 of the 14 in pain had a documented plan. Postoperatively, pain was assessed inconsistently, and no standard tool was universally used. Despite this, all patients had documented management plans. NSAIDs were administered to 88%, Paracetamol to 60% (only 27% regularly), and opioids to 40% (only 21% received). Only 7 patients (16%) were satisfied with pain control.
Pain perception varies and requires individualized management. Lack of standardized assessment and underuse of validated tools contributed to suboptimal pain control. Staff concerns about opioid use also influenced outcomes.

Conclusion : Acute postoperative pain is often inadequately managed. Employing the RAT approach (Recognize, Assess, Treat), validated assessment tools, and regular reassessment can improve outcomes. Multimodal, patient-centered strategies and timely referrals are essential to optimize pain relief and enhance recovery.

PP 14 : Case series: Simultaneous presentation of coronary ischemia and cerebral ischemia with acute limb ischemia: a case series

Wahalawatte YR[1], Vithana SMP[1] , Rathnayaka JB[2] , Samarasinghe B[2]
[1]Post Graduate Institute of Medicine
[2]Teaching Hospital Peradeniya

Background: Simultaneous acute ischemic stroke, myocardial infarction, and acute limb ischemia represent a rare but potentially fatal constellation of thrombotic events with limited evidence-based guidelines available for management. Atrial fibrillation, structural heart disease, and thrombotic predisposition can all contribute to this catastrophic presentation. The following case series illustrates two patients who presented with acute limb ischemia alongside evidence of myocardial or cerebral ischemia.

Cases:
Case 1: A 50-year-old woman with diabetes, hypertension, and dyslipidemia presented with sudden-onset left chest and left arm pain for four hours, accompanied by sweating, nausea, and arm numbness. Examination revealed an irregular tachycardia (160 bpm), absent left arm pulses, and significant inter-arm blood pressure disparity. SpO_2 was undetectable in the left arm. Her left arm showed Rutherford IIa acute limb ischemia. ECG showed atrial fibrillation with RVR, and bedside echocardiography demonstrated Baso septal regional wall motion abnormalities with EF 45–50%. Troponin I was significantly elevated. CT angiogram revealed thrombosis in the left axillary artery without aortic dissection. She underwent successful embolectomy after rate and blood pressure control. She was anticoagulated and discharged on a direct oral anticoagulant.

Case 2: An 83-year-old woman with ischemic cardiomyopathy (EF 25–30%) presented with acute right arm pain and numbness. Examination showed absent distal pulses and motor-sensory impairment (Rutherford IIb). ECG showed chronic LBBB. Duplex imaging confirmed brachial artery thrombosis. IV heparin was initiated, but before surgery, she became unresponsive with signs suggestive of brainstem stroke. The CT brain showed a hyperdense basilar artery. With no interventional options available and a poor prognosis, care was redirected to palliation.

Conclusion: These cases highlight the devastating potential of simultaneous thromboembolic events. A cardiac source of emboli is likely in both. Due to the lack of clear guidelines, individualized, rapid multidisciplinary decision-making is essential. Early recognition and coordinated care can be life and limb-saving

PP 15 : Case report: The ticking venom: a multisystem storm in a delayed Russell's viper bite: a case report

Wahalawatte YR[1], Hettiarchchi NM[2], Kulasinghe A[2]
[1]Post Graduate Institute of Medicine - University of Colombo
[2]Teaching Hospital, Peradeniya

Background: Russell's viper (Daboia russelii) envenomation is notorious for its complex systemic effects, including neurotoxicity, coagulopathy, nephrotoxicity and thrombotic microangiopathy. Delay in receiving antivenom therapy increases the risk of complications and limits therapeutic efficacy. This case highlights the intricate challenges in managing delayed multisystem manifestations of envenomation.

Case: 67-year-old previously healthy man sustained a snakebite on his right leg, believed to be from a Russell's viper. He initially sought treatment from a native healer and presented to a tertiary hospital 24 hours post-bite. He reported abdominal pain and inability to open his eyes. Examination revealed near-complete bilateral ptosis, ophthalmoplegia, and localized right hypochondrial tenderness without bulbar or respiratory muscle involvement. The bite site was inflamed but non-necrotic.
Laboratory evaluation revealed thrombocytopenia (30×10^9/L), coagulopathy (INR unclottable), hematuria, elevated troponin I (6128 pg/ml), creatine kinase (1120 U/L), and LDH (971 U/L). Peripheral smear showed microangiopathic hemolytic anemia (MAHA). ECG showed sinus bradycardia; bedside echocardiogram was initially unremarkable. After toxicology consultation, 20 vials of antivenom were administered without adverse reactions. Fluid management was carefully titrated using IVC variability and urine output. Fresh frozen plasma was given to correct coagulopathy. His neurological status deteriorated with evolving right-sided weakness; CT brain revealed bilateral temporoparietal infarctions with hemorrhagic transformation. Due to ongoing coagulopathy, antiplatelets and statins were initially withheld. Supportive care, physiotherapy, and multidisciplinary input led to gradual recovery. By day five, platelet counts normalized, ptosis resolved, mobility improved, and he was safely discharged.

Conclusion: This case underscores the complexity of delayed Russell's viper bite with multiorgan involvement—neurotoxicity, myocardial injury, thrombotic microangiopathy, and cerebrovascular complications. Despite uncertain antivenom efficacy in delayed presentations, it was administered based on expert consensus. Judicious fluid management, FFP use, physiotherapy, and multidisciplinary care were pivotal to recovery. Public education on early hospital presentation is vital to improving outcomes.

PP 16 : Audit : Knowledge and practical skills about Defibrillator usage among Nursing Staffs in Northern province; An audit

Gowrinesan Y[1], Kugathsan V[2], Sharanya N[2], Janaha R[2], Manitheepan K[2]
[1]Post Graduate Institute of Medicine - University of Colombo,
[2] Teaching Hospital Jaffna
[3]Ministry of Health

Background : Defibrillator is one of the vital biomedical equipment in a healthcare set up. Knowledge and operational skills of defibrillators is essential for all healthcare professionals, especially whoever working in acute and emergency care practices.

Objectives : This audit aims to assess the knowledge and operational skills of defibrillation among the nursing staff.

Methodology : This complete audit cycle was conducted among nursing staff working in various hospitals of the Northern Province. The selected participants completed pre- and post-audit structured questionnaires based on international standards, accompanied by a well-structured workshop on defibrillator use. Data were analyzed using SPSS

Results : A total of 47 nursing staff participated in the audit. The majority (66%) had 1–5 years of service, 21.3% had less than one year, and 12.8% had more than five years of experience. Most respondents (80.9%) were from non-A&E departments, while 19.1% were from the A&E unit.
Simulation-based training had low uptake, with only 21.7% having attended such sessions. A substantial 83% expressed the need for more training. Key barriers to defibrillator use included lack of training (70.5%), difficulty recognizing rhythms (11.4%), fear of causing harm (4.5%), and equipment unfamiliarity (4.5%).
According to Wilcoxon Signed Ranks Test, there was a significant improvement ($p < 0.0001$) in operational skills of defibrillator usage among nursing staffs following a structured workshop.

Conclusion : A well-structured workshop on defibrillator usage will improve the knowledge and practical skills

PP 17 : Case report : "Throwing up with a big-thin pump" - An Atypical Presentation of Pediatric Dilated Cardiomyopathy presented with lower retrosternal obstructive sensation in an Adolescent Girl.

Srisana G[1,2] , Mudithakumara N[1,2] , Ranasinghe D[2]
[1]Post Graduate Institute Of Medicine
[2]Lady Ridgeway Hospital for Children

Background:
Pediatric dilated cardiomyopathy (DCM) is a rare but serious myocardial pathology, characterized by weak & dilated myocardium of the ventricles and impaired systolic function. While common presentations include respiratory distress, fatigue, or signs of heart failure; atypical gastrointestinal symptoms alone as a presentation is uncommon and can mislead the diagnosis. This case highlights an unusual case of DCM in an adolescent female, initially presented with intractable vomiting not responding to antiemetics.

Case Presentation:
A 13-year-old girl presents to emergency department (ED) with a 7-day history of persistent vomiting after 15 minutes of every intake of liquid/semisolid/solid with obstructive sensation in the lower retrosternal region.She was pale but hemodynamically stable, other than tachycardia (150bpm) and tachypnea (60bpm)and a mild hepatomegaly. Point-of-care ultrasound revealed EF 20% with no B profile, with confirmatory findings of DCM in 2D Echo. Ultrasound abdomen, abdominal x-rays was negative for abdominal pathology, chest X-ray was normal other than cardiomegaly. sinus tachycardia was in ECG. Laboratory tests revealed metabolic acidosis with respiratory alkalosis with a lactate of 6.4mmol/L, previously undiagnosed iron deficiency anemia with Hb- 7.7g/dL , elevated liver enzymes (ALT-3548 IU/L), and coagulopathy(INR > 5), SCr 129µmol/L & BU 15mmol/L, with no evidence to support infections. There was no past history of exertional symptoms , but a strong family history of sudden cardiac death of maternal aunt at 24 years. Her condition improved in one week with Milrinone, Frusemide infusion, Methylprednisolone, IV Immunoglobulin, Carnitine, Vitamin K, and blood transfusions.

Conclusion:
This case highlights the importance of maintaining a high index of suspicion for cardiac causes in children presenting a lower retrosternal obstructive sensation with vomiting , particularly when accompanied by pallor and indicators of end-organ hypoperfusion. Early recognition is crucial to prevent rapid clinical deterioration.

PP 18 : Case Report; A patient with Electrical Storm of the Heart

Perera GWMS
National Hospital of Colombo Sri Lanka, Post Graduate institute of Medicine

Background : Electrical Storm (ES) aka arrhythmic storm aka refractory ventricular tachycardia (VT) or ventricular fibrillation (VF) can be extremely difficult to manage. It is defined as three or more sustained VT/VF with appropriate defibrillator shocks for 24 hours period. The case here is about a patient with ES who survived.

Case Presentation : A 43 years old clerk presented with worsening central chest pain for 2 hours. Electrocardiogram (ECG) showed anterolateral ST segment elevation. He went into sustained VT and we cardioverted 5 times with direct current. Then there was a pause and the patient arrested. Resuscitation was done immediately for 2 and he recovered. Then synchronized cardioversion had to be done for sustained VT for another 7 times. Afterwards patient was stable and we thrombolysed him with tenectaplase. Later he was offered a chance for rescue primary coronary intervention on the same day which was successful. He was discharged to home on day 3 with a follow up plan.

Discussion : ES results from high sympathetic drive to the heart primarily or due to underlying pathologies like Brugada or Early repolarization. Apart from basic resuscitation these patients need special modifications in their management. In them resuscitation has to be prolonged and high energy double down defibrillation with 4 pads can be used. Apart from conventional drugs like amiodarone, magnesium we can use beta blockers like esmolol to suppress sympathetic drive. Extreme measures like stellate ganglion ablation can be used also and at times adrenaline should be avoided.

Conclusion : The ordeal ended happily while stressing the importance of meticulous monitoring and intervention. ES is a thing to anticipate and proact with cardiac ischaemia. It could be challenging yet be managed to discharge a patient to home.

PP 19: Case Report : Fulminant Wasp bite victim

Perera GWMS
Post Graduate Institute of Medicine - University of Colombo, Sri Lanka

Background: Wasp (Vespa tropica) sting could be an overlooked envenomation in a routine medical practice. The index case elaborates how stinging could lead to multi organ failure without overt anaphylactic shock and the importance of instigating Wasp sting Severity Score (WSS) in an Emergency Department (ED) setup as an attempt to prevent catastrophe.

Case presentation: The patient was 59 years old coconut plucker from rural down south of Sri Lanka. He stumbled on a wasp nest on a coconut tree and was stung by more than hundred angry bees. He was brought to the hospital within one hour and active management was done for anaphylaxis although the patient never went into shock. He developed multi organ failure on the first day itself and succumbed on day 07.

Discussion: Wasp sting commonly causes anaphylactic or anaphylactoid reactions by Immunoglobulin E mediated mast cell degranulation. Rarely as in the index patient, it can result in direct tissue injury because of phospholiphase and hyaluronidase and the byproducts created by them. Acetylcholine in the venom causes severe pain via bradykinin and myocardial ischaemia by altering cardiac myocyte substrate preference change. This patient went into renal, respiratory, hepatic, hematological failure from the initial presentation. It was further complicated by high creatine phosphokinase levels and with hemolysis, elevated liver enzymes, and low platelets (HELLP syndrome).

Conclusion: The circumstances surrounding the index case stressed the importance of calculating the Wasp Sting Severity (WSS) score at the initial presentation and prudent use of extra corporeal organ support with the cytoadsorbent therapy not as a last-ditch effort of pulling the dead back. Also, it showed the value of anticipating Kounis' Syndrome when a wasp sting victim presents to an Emergency Department.

PP 20 : Case Report: Hypocalcaemic muscle cramps following spider bite; A Case Report

Srisana G, Manitheepan K
Teaching Hospital Jaffna

Background: Spider bites are common in Sri Lanka and typically present with mild local symptoms. However, certain species such as Poecilotheria fasciata (Ceylon Hunting Spider) may cause significant local and systemic effects. This case report presents a rare manifestation of symptomatic hypocalcaemia following envenomation by P. fasciata, emphasizing the need for clinical awareness.

Case Presentation: A 55-year-old male presented to the Accident and Emergency Unit of Teaching Hospital Jaffna with worsening generalized muscle cramps and body pain, approximately 18 hours after a spider bite to the dorsum of his right foot. The spider was later identified as Poecilotheria fasciata. Initial vital signs were stable, and the bite site was erythematous and swollen. Despite receiving oral and intravenous analgesics, the patient developed severe muscle cramps and carpo-pedal spasm. Suspecting hypocalcaemia, intravenous calcium gluconate was administered, leading to a rapid resolution of symptoms. Laboratory tests confirmed a significantly reduced serum calcium level (0.65 mmol/L), while other parameters remained within normal limits. The patient was observed for 24 hours and discharged symptom-free the following day.

Discussion: The envenomation likely triggered neurotoxic effects mediated by serotonin, histamine, and venom-induced interference with calcium and potassium channels, causing muscular hyperexcitability. Although systemic effects from P. fasciata are rarely reported in Sri Lanka, this case demonstrates the potential for significant neuromuscular involvement. Prompt identification and correction of hypocalcaemia can be life-altering in such cases.

Conclusion: This case highlights a rare but treatable systemic complication of spider envenomation in Sri Lanka. Clinicians should consider electrolyte disturbances, especially hypocalcaemia, in patients presenting with muscle cramps following spider bites. Timely administration of intravenous calcium can result in complete recovery.

PP 21 : Case report : Atypical Cerebellar Manifestations of Carbon Monoxide Poisoning: A Diagnostic Imaging Challenge

Saif MD[1], Verma A[1], Jaiswal S[1], Lal M[1], Gupta S[1]

[1]Max Superspeciality Hospital, Patparganj, New Delhi

Background : Carbon monoxide (CO) poisoning typically manifests with bilateral globus pallidus necrosis and white matter injury on neuroimaging. However, emerging reports describe atypical presentations, including rare cerebellar involvement, which pose diagnostic challenges and may influence therapeutic strategies.

Clinical Case : A 70-year-old female with multiple comorbidities presented with coma (GCS 3) following prolonged CO exposure. Initial evaluation revealed severe metabolic acidosis (pH 7.18, lactate 5.2 mmol/L) and elevated carboxyhemoglobin (28%). Brain MRI at 24 hours demonstrated isolated T2/FLAIR hyperintensity and restricted diffusion in the right cerebellar hemisphere, without classic pallidal involvement. Due to hemodynamic instability, hyperbaric oxygen therapy (HBOT) was deferred, and she was managed with prolonged 100% FiO_2 ventilation and hemodialysis. Neurological recovery followed a sequential pattern—brainstem reflexes returned within 24 hours, followed by cortical function and eventual resolution of anterograde amnesia. At 30-day follow-up, mild residual ataxia (ICARS score 12/100) persisted, correlating with the cerebellar lesion.

Conclusion : This case highlights cerebellar vulnerability in CO poisoning, emphasizing the need for comprehensive MRI evaluation even in the absence of classic findings. The patient's multiphasic recovery, with persistent cerebellar deficits despite global neurological improvement, suggests distinct injury and repair mechanisms in atypical CO toxicity. Early recognition of such variants is critical for prognostication and rehabilitation planning. Clinicians should maintain a high index of suspicion for cerebellar involvement in CO poisoning, particularly in patients with delayed or incomplete recovery.

PP 22 : Case report : Foreign body in the rectum: sexual perversion

Saif MD[1], Verma A[1], Jaiswal S[1], Gupta S[1], Lal M[1]
[1]Max Superspeciality Hospital, Patparganj, New Delhi

Background : Rectal foreign bodies (RFBs) pose significant diagnostic and therapeutic challenges in emergency settings, often requiring a multidisciplinary approach. While most cases result from autoerotic practices, delayed presentation and failed extraction attempts increase the risk of complications such as perforation, bleeding, and infection.

Clinical Case : A 20-year-old male presented with a toilet cleaner brush lodged in the rectum after autoerotic insertion, accompanied by pain and bleeding. Digital rectal exam revealed a circumferential laceration (6-11 o'clock position) and active bleeding. Abdominal radiography confirmed a radiopaque pelvic foreign body. Initial conservative measures (analgesia, Valsalva maneuvers) failed, necessitating surgical intervention. Under anesthesia, exploratory laparotomy was performed, with successful foreign body extraction and creation of a diversion colostomy. The patient recovered well and was discharged with instructions for colostomy care.

Conclusion : This case highlights the importance of prompt imaging, cautious examination, and timely surgical consultation in managing complex RFBs. A stepwise approach—starting with non-invasive techniques and escalating to surgery when needed—optimizes outcomes. Emergency providers should maintain a high suspicion for RFBs in patients with rectal trauma, especially when autoerotic behavior is involved.

PP 23 : Audit : An audit on Non-Invasive Ventilation mask application in Emergency Department

Udeshika P [1], Samarajeewa G[2]
[1]District General Hospital - Embilipitiya
[2]Teaching Hospital - Kalutara

Background: Non-invasive ventilation (NIV) is the application of ventilatory support via a facemask to a spontaneously breathing patient. In ED, NIV is used effectively in initial management of acute exacerbations of chronic obstructive pulmonary disease (COPD), acute cardiogenic pulmonary oedema, acute hypoxemic respiratory failure, pneumonia, and asthma.
This audit was conducted to evaluate the application of Non-Invasive Ventilation (NIV) masks by nursing officers in the Emergency Department (ED) of Teaching Hospital Kalutara, Sri Lanka. The findings indicate a satisfactory level of knowledge among the nursing staff, with areas identified for improvement.

Method: An adult manikin was used. Three sizes of NIV masks with adult tubing and NIV machine were given. Each nursing officer was asked to apply the appropriate size mask and eight points were asked from each regarding application of NIV mask to a patient. Their responses were recorded and analyzed.

Results and Conclusion: The audit revealed that 44% of nursing officers recognized the importance of using the smallest mask for proper fit, while 68% checked the seal before application. However, only 1 out of 25 participants understood the need for slack in the straps to prevent skin pressure issues.
A guideline for NIV mask application has been prepared and displayed in the ED, with plans for three teaching sessions on proper application techniques over the next six months, followed by a re-audit.

PP 24 : Case report : Meningococcal sepsis complicated by peripheral digital gangrene: a case report

Amanda GLS[1], Jansz M[2]

1. *Post Graduate Institute of Medicine, University of Colombo*
2. *Lady Ridgeway Hospital for Children*

Background: Meningococcal disease, caused by Neisseria meningitidis, remains a significant cause of bacterial meningitis and septicemia in infants and young children. While cutaneous manifestations such as petechial or purpuric rashes are common, the development of peripheral digital gangrene is a rare but severe complication, often associated with disseminated intravascular coagulation (DIC) and microvascular thrombosis.

Clinical Case: We report the case of a 3-month-old male infant who presented to the emergency department with a 3-day history of fever and cough. Upon admission, the patient exhibited marked tachypnea (respiratory rate: 76 breaths per minute) but was hemodynamically stable. Notably, a purpuric rash was observed on the lower limbs, accompanied by dry gangrene of the fourth digit of the left hand. Intravenous antibiotic therapy and supportive care were initiated and the patient was promptly transferred to the intensive care unit (ICU). Clinical evaluation and laboratory findings were consistent with meningococcal septicemia complicated by peripheral digital gangrene. During the 17 days of ICU care patient needed ventilator support and inotropic support. Early recognition and management led to clinical improvement.

Conclusions: This case underscores the importance of early identification of meningococcal sepsis and its potential complications. Prompt initiation of empirical antibiotic therapy in the emergency setting is crucial. Clinicians should maintain a high index of suspicion for rare complications such as peripheral gangrene, and management should include careful consideration of vasopressor use and timely anticoagulation when indicated.

PP 25 : Case report: An Unusual First Presentation of G6PD Deficiency in the Emergency Department

Gowrinesan Y[1], Manitheepan K[2,3]
Post Graduate Institute of Medicine - University of Colombo, Sri Lanka
Ministry of Health,
Teaching Hospital Jaffna- Sri Lanka

Background : Glucose-6-phosphate dehydrogenase (G6PD) deficiency is the most prevalent enzymopathy worldwide. This X-linked disorder typically remains clinically silent until the individual is exposed to oxidative stress, which can precipitate acute haemolytic episodes. In the emergency department (ED), the initial presentation may mimic other acute conditions, posing a diagnostic challenge. Timely recognition is crucial to initiate appropriate management and avoid unnecessary interventions.

Clinical Description : A 51-year-old gentleman presented to the ED with a 3-day history of fever, severe arthralgia, and myalgia. On initial examination, he appeared pale and icteric, and was tachypneic and tachycardic, with an SpO_2 of 83% on room air. Given the clinical picture and concurrent epidemic, leptospirosis with pulmonary haemorrhage was initially suspected.
However, the initial ABCDE approach did not improve the clinical parameters, particularly oxygen saturation. Arterial blood gas (ABG) analysis revealed a high P/F ratio and an elevated methemoglobin level of 12%. Point-of-care ultrasound (POCUS) excluded cardiac or pulmonary abnormalities. A peripheral blood smear was performed and aided in reaching the diagnosis of G6PD deficiency complicated by methemoglobinemia, likely triggered by the acute illness.
The patient was managed conservatively with supportive care, including vitamins, folic acid, intravenous fluids, and blood transfusions. He developed acute kidney injury (AKI), likely secondary to hemoglobinuria and hypoperfusion, which was closely monitored throughout the hospital stay. The patient eventually made a full recovery and was discharged from the medical ward.

Conclusion : This case highlights the diagnostic challenge posed by G6PD deficiency, particularly when the initial clinical and biochemical presentation mimics infectious diseases such as leptospirosis. In emergency medicine, where rapid decision-making is essential, such overlap can lead to diagnostic delays or mismanagement. Clinicians must maintain a high index of suspicion for G6PD deficiency in patients presenting with unexplained haemolysis, especially in regions where the condition is prevalent.

PP 26 : Case report : Atypical Use of Tranexamic Acid in Gastrointestinal Bleeding: A Case Report of Undiagnosed Haemophilia B

Herath H M S[1,2,3], Wickramasinghe C[3,4]
[1]National Hospital- Kandy,
[2] Post Graduate Institute of Medicine- University of Colombo,
[3]Ministry of Health
[4]Teaching Hospital - Peradeniya

Background: Haematochezia is one of the presentations of upper GI bleeding. According to the results of HALTIT trial (2013- 2019), the use of Tranexamic acid in GI bleeding does not reduce the death rate and should not be used as a part of acute GI bleeding. In this case we used Tranexamic acid after discussion with the consultant Haematologist.

Case Description: A 30-year-old male patient transferred to T H Peradeniya due to the passage of a large amount of blood per rectum for one day. He had malena for 2 days. No haematemesis, haematuria or any other bleeding manifestation. Fever for 2 days and diffuse abdominal pain. On admission, he complained about chest pain and shortness of breath. He had no significant past medical history, and later he revealed the history of prolonged bleeding after a fall at school, and his brother has a bleeding disorder. On examination, he was very pale with facial puffiness. He was tachypneic with RR of 18/min with clear lungs, SpO2 99% on air. He was in shock with a pulse rate of 120/min, BP90/50mmHg, with cold extremities and CRFT 4 seconds. The abdomen was soft and non-tender. Investigations. FBC, WBC 10.2, RBC 1.4, Hb 4.2g/dl, platelet 204, PT 11.8, INR 1.1, aPTT 51.5 sec. Liver functions, renal functions, CRP, ECG, and POCUS were normal. Standard Upper GI bleeding resuscitation with 3 pints of cross-matched blood, and tranexamic acid 1g IV slow bolus, and factor iX correction with Consultant Haematologist's opinion. Upper and lower GI endoscopies were normal, and Haemophilia B was diagnosed after 3 months.

Conclusion: There are some case presentations which need deviation from the standard guidelines. This case scenario highlights the importance of careful, focused history and a multidisciplinary approach in patient management.

PP 27 : Case report : A Case of Rapid Collapse in a Young Polysubstance User: When Sepsis, Overdose, and Hyperthermia Collide: A Diagnostic and Resuscitative Challenge in the Emergency Department

Udumullage H S
Post graduate Institute of medicine - University of Colombo

Background: Severely ill patients with a history of polysubstance use can present with overlapping toxidromes and complex multisystem involvement. Differentiating between drug-induced syndromes, sepsis, and environmental causes such as heat stroke remains a diagnostic challenge in the Emergency Department (ED), especially when deterioration is rapid and history is limited.

Case Presentation: A 37-year-old male with daily polysubstance use (heroin, methamphetamine, cannabis) presented with a five-day history of fever and cough and was found unresponsive at home on the day of admission. On ED arrival, he was in severe respiratory distress, with an irregular heart rate of 172 bpm (atrial fibrillation), hypotension, fever of 108°F, and GCS 5/15.
Emergency intubation and mechanical ventilation were performed after resuscitation. Though sympathomimetic toxidrome was initially suspected, management also targeted septic shock and NMS/serotonin syndrome. Early investigations showed hyperkalemia, severe metabolic derangements, and early shock. Initial treatment included cooling (external/internal), broad-spectrum antibiotics, electrolyte correction, and inotropic support. ECG showed atrial fibrillation, which reverted to sinus rhythm with aggressive temperature management.
A large volume of coffee-ground aspirate raised concern for upper GI bleeding. Vasopressors were escalated. Despite an initial response, the patient developed worsening hypotension even after uncrossmatched blood transfusion. He was transferred to the ward on portable ventilation while awaiting an ICU bed but died 90 minutes later. Postmortem revealed bilateral bronchopneumonia with pus-filled lungs, no active GI bleed or perforation—suggesting overwhelming sepsis with secondary GI involvement.

Conclusion: This case highlights the diagnostic complexity of managing critically ill patients with polysubstance use. A broad, parallel approach to toxidromes, infections, and metabolic causes is essential. Despite aggressive management and early airway control, fulminant sepsis can lead to poor outcomes.

28 : Case report : A Hidden Threat: Delayed Airway Compromise from Subclavian Artery Injury After Minor Blunt Trauma

Udumullage H S
Post Graduate Institute of Medicine - University of Colombo

Background: Subclavian artery injuries are uncommon, particularly following low-impact blunt trauma, and they usually present early. Delayed vascular bleeding causing airway compromise is extremely rare. This case highlights an unusual presentation of a life-threatening airway issue due to arterial bleeding more than 24 hours after what initially appeared to be a minor accident.

Case Summary: A 71-year-old male presented to the Emergency Department with significant swelling and bluish discolouration over the left chest, neck, and arm. He had fallen off a motorbike the day before at low speed (~20 km/h), sustaining contusions to the left shoulder and arm. He initially self-managed with over-the-counter medications but sought medical care 30 hours later when swelling worsened.
On arrival, he had a hoarse voice, mild breathing difficulty, and visible swelling and discolouration. Despite stable vital signs, the combination of hoarseness, swelling, and upright posture raised concern for airway compromise. He was triaged as a Category 1 case. Elective intubation was successfully performed on the first attempt per Difficult Airway Society guidelines, though the airway was shifted.
Chest X-ray showed tracheal deviation to the right without pneumothorax or hemothorax. A minimally displaced left clavicle fracture was seen. CT angiogram of the neck, chest, and upper limb revealed ongoing arterial bleeding from a branch of the left subclavian artery. Urgent vascular repair was performed, and he was admitted to the ICU postoperatively.

Conclusion: This case is a reminder that not all airway threats are immediate or obvious. Despite a seemingly minor mechanism of injury, a concealed arterial bleed progressed over 24 hours, threatening the airway. Trusting clinical instincts, early airway control, appropriate imaging, and timely surgical intervention were critical to saving the patient's life.

PP 29 : Case report : Not Just Another Wheeze: Vocal Cord Malignancy Masquerading as Refractory Asthma

Udumullage H S
Post graduate Institute of medicine - University of Colombo

Case Report: A 60-year-old male with a recent two-month history of bronchial asthma presented to the Emergency Department (ED) in severe respiratory distress, just nine hours after being discharged for an asthma exacerbation. At discharge, the only residual symptom was persistent hoarseness, which was under outpatient ENT clinic review.
On re-admission, he was breathless with SpO_2 of 79% on room air, respiratory rate 30/min, heart rate 114/min, and BP 146/92 mmHg. He could speak only in single words and had bilateral wheeze on auscultation. Arterial blood gas showed type 2 respiratory failure. Lung ultrasound was unremarkable except for a localized B-profile in the left lower zone. No pneumothorax or effusion was detected.
He received full escalation for status asthmaticus—oxygen, back-to-back bronchodilator nebulization, IV magnesium, IV steroids, salbutamol infusion, and BiPAP. Despite appropriate treatment, the patient did not improve as expected. A persistent, audible wheeze over the neck raised concern for a possible low-pitched, bidirectional stridor, suggesting upper airway involvement.
Urgent ENT consultation and bedside flexible laryngoscopy in the ED revealed a vocal cord mass, highly suspicious for malignancy, causing critical upper airway narrowing. A multidisciplinary decision was made to perform an emergency tracheostomy under local anesthesia with low-dose ketamine.
The procedure led to immediate relief of respiratory distress and stridor. The patient was stabilized and transferred to the ENT ward for further oncological evaluation.

Conclusion: This case highlights the need to reassess presumed asthma exacerbations that fail to respond to standard therapy—especially when associated with voice changes or upper airway sounds. Differential diagnosis often focuses on pneumothorax, co-existing lung disease, or heart failure. However, upper airway obstruction due to malignancy must also be considered. Early recognition and multidisciplinary airway management were critical in saving this patient's life.

PP 30 : Case report : Acute Inflammatory Demyelinating Polyneuropathy Presenting with Bilateral Asymmetrical Facial Nerve Palsy - A Case Report

***Handapangoda H.M.D.Y.T.*[1]**

***Bindusara W.A.N.P.* [1]**

[1]*Post Graduate Institute of Medicine - University of Colombo*

Background: Acute Inflammatory Demyelinating Polyneuropathy is a variant of Guillain-Barré Syndrome usually presenting with ascending weakness and areflexia. Bilateral facial nerve palsy as a presenting feature of AIDP is rare, and asymmetrical involvement is even less common.

Case Presentation: 32 years old male patient presented with bilateral asymmetrical lower motor neuronal type facial nerve palsy, more severe in the left side with lower limb numbness. He has had an upper respiratory tract infection two weeks back and a left sided ear ache since one week followed by left sided facial weakness and numbness. He was treated as left sided Ramsay-Hunt syndrome from a local hospital. He had gradually developed the weakness and numbness in the right side one day prior to the admission. On examination there was bilateral lower motor neurone type facial nerve palsy, more severe in the left side. There was evidence of bilateral asymmetrical sensory polyneuropathy in the lower limbs. Rest of the neurological examination was normal. The initial non contrast CT Brain, and basic laboratory investigations were normal including the inflammatory markers. Patient underwent an urgent nerve conduction study where findings were consistent with demyelinating sensory motor polyneuropathy affecting bilateral upper and lower limbs. The patient was started on intravenous immunoglobulin 25g daily immediately following the nerve conduction study. The weakness gradually improved back to the baseline by the third day of immunoglobulin therapy and the immunoglobulin was continued for 5 days. Patient underwent a routing Contrast Enhanced CT Brain later which was normal.

Conclusion: This is an unusual presentation of AIDP with bilateral asymmetrical facial nerve palsy and isolated sensory involvement of the lower limbs. Early suspicion and diagnosis lead to proper management and complete recovery. Atypical cranial nerve palsies following recent infections should raise a high index of suspicion of AIDP.

PP 31 : Case report : Atypical Presentation of Pituitary Apoplexy Following Minor Head Trauma: A Case Report

Handapangoda H.M.D.Y.T.
Post Graduate Institute of Medicine - University of Colombo

Background: Pituitary apoplexy is a rare, potentially life-threatening condition typically presenting with sudden onset severe headache, visual impairment and altered mental status. It may occasionally present atypically, especially in elderly population. It can be the initial presentation of a pituitary macroadenoma. This is a case of pituitary apoplexy presenting with unilateral partial visual loss following a trivial head trauma without the classical symptoms.

Case Presentation: A 65-year-old female patient presented following an accidental fall from the level ground with a head impact. Her only complaint following the fall was acute blurring of vision in the right eye. There were no features suggestive of a significant traumatic brain injury. The patient was haemodynamically stable, conscious, and rational. The patient already had cataract in her left eye. Proper assessment of vision was not practical with blaring of vision. The right pupil was reactive to light. A non-contrast CT scan of the brain revealed a suprasellar mass suggestive of a pituitary macroadenoma with internal hyperdensity, compatible with possibilities of haemorrhage or calcification. Urgent neurosurgical referral was made and the patient was transferred to the neurosurgical unit. The patient was referred to the endocrinology team thereafter. The endocrinology team initiated steroid therapy after obtaining baseline cortisol levels. MRI performed on the following day confirmed the diagnosis of pituitary macroadenoma with apoplexy. The patient underwent transsphenoidal resection of the macroadenoma with post operative ICU observation. There was no significant improvement of vision following surgery.

Conclusion: This case illustrates an atypical presentation of pituitary apoplexy which is isolated unilateral visual loss without headache or neurological signs. The precipitating factor is minor head trauma. A higher level of suspicion should be maintained on elderly patients presenting with isolated unrelated neurological manifestations even following minor trauma. Imaging in such patients will aid proper diagnosis.

PP 32: Case report : Expanding Hematoma and Airway Compromise After Penetrating Neck Trauma: A Rare Case of Isolated Muscle Bleeding Without Major Vascular Injury

Senevirathna HMGN[1,2], Udumullage HS[1,2]
[1]Colombo South Teaching Hospital Kalubowila
[2]Post Graduate institute of Medicine - University of Colombo

Background: Penetrating neck trauma (PNT) is a life-threatening emergency that warrants urgent evaluation and intervention due to the vital structures condensed within the cervical region. The development of an expanding hematoma in such cases typically suggests major vascular injury. However, isolated muscular bleeding without major vascular bleeding causing airway compromise is a rare but important diagnosis that need time critical interventions. Although the major vascular injuries causing air way compromisation is a common occurrence, the literature is sparse about the isolated muscular bleeding causing hematomas that can cause a threatened airway.

Case Presentation: We report a case of a 72-year-old male with no prior comorbidities who presented following a penetrating neck injury caused by a falling tree branch. On arrival, he demonstrated difficulty in phonation and swallowing, with a rapidly expanding and tense hematoma on the right side zone 2 of the neck causing leftward tracheal deviation. Airway compromise was imminent. Emergency intubation was performed using a modified rapid sequence technique, and urgent surgical exploration was carried out under general anesthesia. Surprisingly, no major vascular injury was identified; the hematoma was due to isolated muscular bleeding. Post-operative recovery was uneventful, and the patient was discharged after ICU observation.

Conclusion: This case highlights the diagnostic challenge with uncommon etiology and airway risk associated with expanding cervical hematomas in penetrating neck trauma. While major vascular injury is the presumed etiology in such scenarios, isolated muscle hemorrhage can cause similar mass effects and airway compromise. Prompt airway management, surgical exploration, and multidisciplinary coordination are crucial even when vascular injuries are absent.

PP 33 : Case report : Intrathecal Hemorrhage in Severe Preeclampsia Causing Spinal Cord Compression: A Rare Neurological Emergency in a Concealed Pregnancy

Senevirathna HMGN[1,2], Prematthilaka NTK[1]

[1]Colombo South Teaching Hospital Kalubowila

[2]Post Graduate institute of Medicine - University of Colombo

Background: Neurological complications of severe preeclampsia reported commonly are cerebral, with conditions such as seizures and posterior reversible encephalopathy syndrome (PRES) being well recognized. However, spinal cord involvement is rare in the literature. Intrathecal hemorrhage causing spinal cord compression in this context is scarcely reported and may be overlooked, especially in the setting of a concealed pregnancy. Early recognition is critical to avoid permanent neurological deficits.

Clinical Case: A 38-year-old woman presented to the emergency department with acute bilateral lower limb weakness and abdominal distension. She denied pregnancy; however, point-of-care ultrasound confirmed a concealed intrauterine fetus at 34 weeks gestation. Her blood pressure was 200/110 mmHg with 3+ proteinuria, consistent with severe preeclampsia. She also complained of blurred vision, and a non-contrast CT brain demonstrated findings consistent with PRES. On neurological examination, she had flaccid paralysis of both lower limbs (power 0/5) with a sensory level at T6. Following hemodynamic stabilization with intravenous antihypertensives and magnesium sulfate, she underwent emergency cesarean section. MRI of the spine revealed intrathecal hemorrhagic content causing spinal cord compression. Laminectomy was done and patient demonstrated gradual neurological recovery post-operatively.

Conclusion: This case represents an exceptionally rare dual neurological complication of severe preeclampsia, involving both PRES and spinal intrathecal hemorrhage leading to cord compression. The concealed nature of the pregnancy may lead to delayed diagnosis and definitive care highlighting the diagnostic complexity in emergency settings. Emergency physicians should maintain a high index of suspicion for preeclampsia and its complications in women of reproductive age presenting with hypertensive crises as early recognition and timely neurosurgical interventions are essential to improve neurological outcomes preventing permanent disability.

PP 34 : Case Report : Pneumothorax following Brachial Plexus block in a Female Undergoing PHILOS Plating: A Rare but Serious Complication

Madhawa JKG[1], Amarasinghe PK[1,2], Janson KD[1,2], Gnanasekeram R[1,2], Mahalekame R[1,2]
[1]National Hospital of Sri Lanka
[2]Ministry of Health

Background: Regional anaesthesia techniques, such as ultrasound-guided brachial plexus blocks, are increasingly preferred for upper limb surgeries due to their efficacy and favourable safety profile. However, complications, though uncommon, can be potentially life-threatening. We report a rare case of pneumothorax following an ultrasound-guided brachial plexus block in an elderly hypertensive patient.

Clinical Case: A 67-year-old hypertensive female sustained a left-sided proximal humerus fracture following a mechanical fall. Six days post-injury, she underwent open reduction and internal fixation with PHILOS plating under an ultrasound-guided supraclavicular brachial plexus block. The intraoperative period was uneventful, and she was transferred to the ward postoperatively. On postoperative day one night, she developed mild shortness of breath. Oxygen saturation on room air was 94%, and clinical examination revealed reduced air entry on the left hemithorax. Chest radiograph demonstrated a left-sided pneumothorax, suspected to be secondary to inadvertent pleural breach during the regional block. An intercostal chest drain was inserted promptly with subsequent clinical and radiological improvement. The patient recovered fully and was discharged in stable condition.
While pneumothorax is a known risk of supraclavicular blocks, its incidence has significantly decreased with ultrasound guidance. However, this case highlights that complications can still occur despite image guidance. Delayed respiratory symptoms in postoperative patients receiving regional anaesthesia warrant prompt evaluation. Since such blocks are often used for day-case surgeries, missed detection during brief monitoring periods can be life-threatening, emphasizing the importance of vigilant postoperative observation even in ultrasound-guided procedures.

Conclusion: This case highlights the rare occurrence of a pneumothorax following a brachial plexus block despite ultrasound guidance. It emphasizes the importance of postoperative vigilance, especially in elderly patients with comorbidities. Early recognition and timely chest tube insertion remain critical in ensuring favourable outcomes.

PP 35 : Case report : Case report on Aslanger Pattern; a pivotal diagnosis

Senadheera JS[1,2], Vijayabandara S[1]
[1]National Hospital of Galle
[2]Post Graduate Institute of Medicine- University of Colombo

Background : Acute Coronary Syndrome (ACS) is a wide diagnostic spectrum of conditions resulting from the occlusion of coronary arteries causing myocardial ischemia or infarction. Patients can present acute symptoms and signs, with the absence or presence of ECG changes and elevation of cardiac biomarkers. This can be categorized into ST Elevation Myocardial Infarction (STEMI) or Non-ST Elevation Acute Coronary Syndrome (NSTEMI-ACS), depending on ECG changes and elevation of cardiac biomarkers. It is imperative to identify the aforementioned categories accurately as the applicable management vary significantly depending on the condition. Patients with STEMI warrant immediate reperfusion therapy whereas patients with a working diagnosis of NSTEMI-ACS may receive immediate invasive strategies based on their high-risk features.
Aslanger et al first articulated the description of Aslanger pattern in 2020. This pattern failed to meet the electrocardiographic criteria for STEMI as specified in the 4th universal definition of myocardial infarction. However, patients with Aslanger pattern have been observed to have high incidence of coronary artery critical stenosis and recorded mortality within one year, similar to inferior STEMI.

Clinical case : A 50-year-old male, known patient with diabetes and hypertension, presented with a complaint of intermittent chest tightness for 3 days. Upon admission, left sided chest tightness had prevailed for 2 hours with radiation to left arm. Associated autonomic symptoms were absent. ECG was suggestive of Aslanger pattern and was non-dynamic. His high sensitive cardiac troponin was 2,980 ng/L and subsequent angiography revealed 80% occlusion of left anterior descending artery (LAD), 95% occlusion of left circumflex artery (LCX) and non-dominant small caliber right coronary artery. He had undergone PCI to LCX and had an uneventful recovery.

Conclusion : Importance of recognizing ECG patterns suggestive of occlusive ACS other than STEMI and NSTEMI in clinical practice is highlighted here to improve diagnosis and outcome.

PP 36 : Case report : Boerhaave Syndrome in an Elderly Female with Ischaemic Heart Disease: A Case Report

Vishnukanthan J[1], Ariyaratne D [2], Weranja TGK [1], Dissanayake GP [1]
[1]Postgraduate Institute of Medicine, University of Colombo
[2]Colombo South Teaching Hospital

Background : Boerhaave syndrome is a spontaneous, full-thickness rupture of the oesophagus, usually caused by a sudden increase in intra-oesophageal pressure following vomiting. Though rare, it is a life-threatening condition with high mortality if diagnosis and treatment are delayed. In elderly patients with comorbidities such as ischaemic heart disease, managing Boerhaave syndrome presents additional challenges, particularly when surgery carries high risk.

Clinical Case : A 76-year-old female with a background of ischaemic heart disease, on regular antiplatelet and statin therapy, presented with multiple episodes of haematemesis and chest pain. On arrival, she was febrile (38.5°C), hypotensive (BP 90/60 mmHg), and tachycardic (HR 110 bpm). Subcutaneous emphysema was noted over the neck and chest wall.
Due to persistent bleeding and clinical instability, urgent upper gastrointestinal endoscopy was performed. A longitudinal tear was identified in the distal oesophagus, consistent with a spontaneous perforation (Boerhaave syndrome). In view of her poor surgical fitness, a decision was made to manage her conservatively. A self-expanding metallic oesophageal stent was placed endoscopically to seal the perforation. She was commenced on intravenous broad-spectrum antibiotics, parenteral nutrition, and oxygen therapy.
A few days into her hospital stay, she developed a productive cough, hypoxia, and fever. Chest radiograph showed left lower lobe consolidation, suggestive of a lower respiratory tract infection, likely due to aspiration. She was treated with targeted antibiotics based on sputum culture, alongside chest physiotherapy, with gradual clinical improvement.
The oesophageal stent was removed after six weeks. She was discharged in stable condition with outpatient follow-up arranged.

Conclusion : Boerhaave syndrome should be considered in elderly patients presenting with haematemesis and chest pain. In poor surgical candidates, endoscopic stenting is an effective alternative. Early recognition and management of complications such as respiratory infections are key to improving outcomes.

PP 37 : Case report : Isolated Testicular Tuberculosis in a 45-Year-Old Male Presenting with a Testicular Lump: A Case Report

Vishnukanthan J[1], Ariyaratne D[2], Weranja TGK[1], Dissanayake GP[1]
[1]Postgraduate Institute of Medicine - University of Colombo
[2]Colombo South Teaching Hospital

Background: Testicular tuberculosis (TB) is a rare manifestation of extrapulmonary TB, accounting for less than 5% of genitourinary TB cases. It often mimics more common scrotal pathologies such as testicular malignancy or epididymo-orchitis, making diagnosis challenging. The disease typically results from haematogenous or lymphatic spread or direct extension from the epididymis. Awareness and early consideration are essential, especially in TB-endemic regions, to avoid delayed diagnosis and unnecessary surgery.

Clinical Case: A 45-year-old previously healthy male presented with a one-month history of a painless, gradually enlarging lump in the left testis. There were no constitutional symptoms or history of TB exposure. Physical examination revealed a firm, non-tender mass in the left testis, with no inguinal lymphadenopathy or systemic signs.

Diagnostic Evaluation: Laboratory tests showed an elevated erythrocyte sedimentation rate (ESR) of 100 mm/hr. Tumor markers, including alpha-fetoprotein (AFP), beta-human chorionic gonadotropin (β-HCG), and lactate dehydrogenase (LDH), were within normal limits. Scrotal ultrasonography revealed a well-defined hypoechoic lesion within the left testis, raising suspicion for malignancy.
Due to diagnostic uncertainty, testicular exploration was performed. Intraoperatively, a firm lesion was noted near the epididymis without evidence of abscess or necrosis. Biopsy of the lesion revealed granulomatous inflammation with central caseous necrosis, consistent with tuberculosis. Ziehl-Neelsen staining was negative for acid-fast bacilli.

Treatment and Follow-up: The patient was started on standard anti-tuberculous therapy: isoniazid, rifampin, pyrazinamide, and ethambutol for two months, followed by isoniazid and rifampin for four months. He showed clinical improvement and is being followed up.

Conclusion: Testicular tuberculosis, though rare, should be considered in the differential diagnosis of testicular masses, especially in endemic areas. Histopathology plays a vital role in diagnosis when imaging is inconclusive. Early recognition and appropriate treatment can prevent complications such as infertility or systemic spread.

PP 38 : Epidemiological profile of road traffic accidents and injury patterns sustained amongst victims presenting to National Hospital of Sri Lanka.

Kodikara K A A E
Post Graduate Institute of Medicine

Introduction: Road traffic accidents (RTAs) were a significant global public health concern, and understanding their epidemiology was essential for developing effective prevention strategies. This study aimed to identify the epidemiological factors and injury patterns sustained due to RTAs among victims who presented to the Accident and Orthopaedic Service (AOS) unit of the National Hospital of Sri Lanka (NHSL).

Methods: A descriptive cross-sectional study was conducted from the 1st of October to the 1st of December 2023 using questionnaires administered to road traffic accident (RTA) victims admitted to the Accident Ward of the National Hospital of Sri Lanka (NHSL), until a total sample size of 464 was reached. Medical records were reviewed to obtain data on trauma assessments and pre-existing medical conditions. Information on demographics, injury patterns, injury severity, and outcomes was collected and analyzed. The study examined variables such as age, gender, educational level, marital status, occupation, and monthly income to assess their association with injury severity. For the categorization of injury severity, the Injury Severity Score (ISS) system validated by Bolorunduro et al. was used. An ISS score of 9–15 was considered moderate, 16–24 as severe, and 25 or greater as very severe.

Results: The study included 464 RTA victims. Fractures were the most common injury (31.5%), followed by cut/open injuries (26.7%), blunt trauma (23.3%), and penetrating trauma (23.3%). The age group 20–30 years had the highest incidence of moderate (50.7%) and severe injuries (42.4%), while very severe injuries peaked in the 50–60 age group (38.6%). Males experienced greater injury severity, with 75.9% categorized as severe and 87% as very severe ($p=0.002$). Victims with higher education levels (>A/L) had lower injury severity ($p=0.036$). Married individuals were more likely to sustain severe (64.6%) and very severe injuries (65.3%). Occupation and monthly income also significantly influenced injury severity, with labourers and individuals earning over Rs. 30,000 experiencing higher levels of severity ($p<0.001$).

Conclusion: This study highlighted the high prevalence of severe injuries among RTA victims, particularly young males and those from lower socioeconomic backgrounds. The findings underscored the need for targeted interventions, including stricter enforcement of traffic laws, public awareness campaigns, and improvements in road infrastructure and emergency medical services, to reduce the incidence and severity of RTAs in Sri Lanka.

PP 39 : Case report : Sinus bradycardia as a rare manifestation in a paediatric patient with Leptospirosis.

Kobbegala KGRLA[1], Thathsarani THBS[2]
[1]Post graduate institute of Medicine
[2]Ministry of Health BH-Thambuttegama

Background : Leptospirosis is a zoonotic infection caused by Leptospira bacteria, typically acquired through exposure to water or soil contaminated with the urine of infected animals. It commonly presents with renal, hepatic, and pulmonary involvement.

Case Presentation : We report the case of a 9-year-old boy who was admitted to the Paediatric Ward of Peradeniya Teaching Hospital with a 3-day history of fever, arthralgia, and myalgia, followed by reduced urine output. On admission, his vital signs were stable (BP 110/70 mmHg, PR 120 bpm). Laboratory investigations revealed an elevated CRP (313 mg/L), serum lactate of 0.5 mmol/L, and a rising creatinine level (from 228 to 435 µmol/L). Leptospirosis IgM antibodies were positive, confirmed by a rapid chromatographic immunoassay. A diagnosis of leptospirosis complicated by acute kidney injury (pRIFLE-F) was made, and the patient was treated with intravenous Meropenem. On day 3 of admission, he developed sinus bradycardia (minimum heart rate of 45 bpm) and hypotension (88/55 mmHg). Troponin I, as well as serum electrolytes including calcium and magnesium, were within normal limits. A 2D echocardiogram performed on days 4 and 5 showed normal findings. Hypotension responded to a noradrenaline infusion, which was tapered off within 72 hours, but bradycardia persisted for another 2 days. Follow-up Holter monitoring was normal.

Conclusion : Although tachycardia is a typical finding in leptospirosis, bradycardia can rarely occur in the paediatric population. Possible mechanisms include autonomic dysfunction and transient myocardial conduction disturbances due to the accumulation of uremic toxins.

PP 40 : Case report : Near fatal asthma exacerbation accompanied by carbon dioxide narcosis

Wijerathna KMPP, Srimaalee MGJ
District General Hospital – Embilipitiya

Introduction

Seizures, while not a frequent manifestation of carbon dioxide narcosis, can indicate late-stage decompensation, impending respiratory arrest, and worsening cerebral edema. The presence of coexisting conditions such as hypoxia may further elevate the risk of seizure activity. Therefore, it is imperative to carefully manage hypercapnia and hypoxia in patients with chronic lung pathologies.

Case Report

This report presents the case of a 54-year-old male patient with a known history of bronchial asthma (BA) and a potential component of chronic obstructive pulmonary disease (COPD). The patient presented to the Accident & Emergency (A&E) unit with a one-day history of acute shortness of breath and wheezing, which deteriorated rapidly over a span of 20 minutes. Initial clinical evaluation demonstrated features consistent with a near-fatal asthma exacerbation. During the assessment, the patient developed a generalized tonic-clonic seizure, which was managed with intravenous midazolam. Then BIPAP was started aiming to washout CO 2 . After one hour of initial treatment, the patient had a significant clinical improvement and transferred to the medical ward for continuation of management. Following two days of inpatient treatment, the patient was successfully discharged with a plan for follow-up.

Conclusion

This case demonstrates the importance of early recognition of CO 2 narcosis in asthma and timely intervention with BIPAP can always save lives in A&E unit.

PP 41 : Case report : Paradoxical Vocal Cord Motion: A Hidden cause of post-extubation stridor and a diagnostic pitfall in the emergency setting

Kadugath KMKP[1], Arulmoli J[2], Wijesinghe WJS[3]
[1]National Hospital of Sri Lanka
[2]Post Graduate Institute of Medicine - University of Jaffna
[3]National Hospital of Sri Lanka

Background : Paradoxical Vocal Cord Motion (PVCM), also referred to as Vocal Cord Dysfunction (VCD), is a functional airway disorder that can closely mimic both upper and occasionally lower airway obstruction. It is often considered a form of conversion disorder and is characterized by inappropriate adduction of vocal cords during inspiration and occasionally during early expiration, resulting in inspiratory stridor and respiratory distress.
Under normal physiology, the true vocal cords abduct during inspiration and adduct during expiration. In PVCM, this motion is paradoxical, leading to symptoms that may simulate upper airway obstruction, anaphylaxis, or even asthma. Patients typically present with stridor and voice changes and occasionally wheezing that are unresponsive to standard medical therapies. This condition poses a diagnostic challenge and confusion particularly in the emergency or postoperative setting, due to its ability to mimic life-threatening airway pathology. This frequently results in unnecessary pharmacological interventions and airway instrumentation, both of which may contribute to iatrogenic morbidity.

Clinical Case : We report the case of a 57-year-old female who developed acute post-extubation stridor following a total thyroidectomy. Despite appropriate medical management, her symptoms persisted. Flexible fiberoptic laryngoscopy revealed paradoxical vocal cord motion, confirming the diagnosis. The patient was subsequently reintubated due to persistent respiratory distress and hypoxia, which required continuous oxygen therapy and speech therapy was arranged following the discharge of the patient.

Conclusion : PVCM should be considered in the differential diagnosis of unexplained stridor or wheezing that is unresponsive to conventional treatment, particularly in postoperative patients or those with recurrent emergency department visits with unresolving wheezing. Awareness of this condition among Emergency Physicians, Anesthesiologists, and Intensivists is crucial to avoid misdiagnosis and prevent unnecessary interventions.

PP 42 : Research : The Cost and Consequences of Inappropriate Admissions: A Study at the Surgical Professorial Unit, Wayamba University.

Jayasooriya K[1], Abeysinghe AHMGB[1], Pathirana NPNB[1]

[1]Department of Surgery, Faculty of Medicine, Wayamba University of Sri Lanka

Background: Inappropriate hospital admissions (IA), defined as admissions where patients could receive the same care at a lower technological level, have a global prevalence of 7% to 70%. IA increases costs and reduces healthcare efficiency, adding strain to Sri Lanka's free healthcare system. This study examines IA prevalence, causes, and policy implications.

Objectives: To assess IA prevalence at the Surgical Professorial Unit, Teaching Hospital-Kurunegala, focusing on clinical appropriateness of admissions, required care levels, and economic burden.

Methodology: A descriptive cross-sectional study was done at the Professorial Surgical Unit, Teaching Hospital Kurunegala. Consecutive sampling included all casualty admissions, excluding non-casualty elective cases. The "Appropriateness Evaluation Protocol" evaluated the admission appropriateness via bed head ticket review, clinical management, and economic impact. Ethical approvals were obtained.

Results: In one month, 268 patients were recruited (150 males [56%],119 females [44%]). Most admissions occurred between 12PM and 12AM through the emergency treatment unit. IA accounted for 44.4%(n=119), mainly ureteric colic (30.25%), mild head injury (23.52%), and road traffic accidents (11.76%). Of IA cases, 33.33% stayed under 24 hours and 66.67% stayed 24–48 hours. Appropriate admissions mostly included cellulitis (18.79%) and RTAs (12.75%). IV fluids and medications were given in 30.22% and 46.27% of cases, respectively, with surgeries in 22.39%. IV antibiotics were the main reason for appropriate admissions.

Conclusion: IA significantly strain surgical services. The high rate of short stays cases such as ureteric colic and mild head injury indicates the need for dedicated short-stay units. Stricter admission criteria, improved diagnostics, and these units can optimize resource use and healthcare sustainability in Sri Lanka.

PP 43 : Research : Reevaluating the Need for CT Imaging and Admission in Mild Traumatic Brain Injury: A Study at Teaching Hospital Kurunegala

Jayasooriya K[1], Abeysinghe AHMGB[1], Pathirana NPNB[1] , Wijayasuriya WAKR[1]
[1]Department of Surgery, Faculty of Medicine, Wayamba University of Sri Lanka

Background: Traumatic brain injuries represent a major healthcare challenge in Sri Lanka, accounting for 37% of traumatic admissions with significant mortality and morbidity. Mild traumatic brain injuries(mTBI) constitute the majority of cases but frequently undergo unnecessary hospital admissions and CT imaging, leading to resource misallocation, increased costs, and avoidable radiation exposure. The absence of standardized protocols contributes to clinical practice variations and precautionary overtreatment.

Methods: A descriptive cross-sectional study was conducted over one month at the Surgical Professorial Unit, Teaching Hospital Kurunegala. Adult patients aged ≥18 years with mTBI (Glasgow Coma Scale 13-15) were included through consecutive sampling. Data collection utilized structured medical record reviews covering demographics, injury patterns, CT scan indications, admission criteria, and management protocols.
Results: Among 41 mTBI patients studied, the mean age was 36.21 years with a male predominance of 70.73% (n=29) versus 29.27% (n=12) females. Only 29% (n=12) of patients received clinically appropriate hospital admissions, with the majority admitted for secondary injuries and referrals unrelated to mTBI (17%,n=7), while merely 5% (n=2) met NICE admission criteria. Notably, 71% (n=29) represented inappropriate admissions due to 24 hour head injury monitoring that failed to comply with established guidelines. CT imaging was performed in 28% (n=12) of cases, with indications including clinical suspicion of intracranial injury (50%,n=6) and high-risk injury mechanisms (42%, n=5); however, no pathological abnormalities were detected in any scanned patients. Road traffic accidents constituted the predominant etiology, accounting for 49% (n=20) of injuries.

Conclusions: Though majority of severe injuries and pathological cases were admitted to the neurosurgery unit, resulting in most admissions to the surgical unit being neurologically normal patients, this study demonstrates significant deviations from international mTBI management standards, highlighting the need for evidence-based protocols to reduce inappropriate admissions, optimize resource utilization, and improve healthcare efficiency in Sri Lankan hospitals.

PP 44: Case report : Spontaneous Splenic Rupture in a Patient with Hypofibrinogenemia Due to a Benign Splenic Cyst: A Case Report

Jayasooriya K[1], Abeysinghe AHMGB[1] 1, Pathirana NPNB [1], Abeysinghe AHMCD[2] , Wijesekara WADMP[3]

[1]Department of Surgery, Faculty of Medicine, Wayamba University of Sri Lanka

[2]Faculty of Medicine, Rajarata University of Sri Lanka

[3]Teaching hospital, Kurunegala

Background: Congenital fibrinogen disorders, including hypofibrinogenemia (HF), are rare inherited coagulation abnormalities with a prevalence of 1-2 cases per million people globally. These disorders result from quantitative or qualitative fibrinogen defects, leading to impaired hemostasis and increased bleeding tendency. Spontaneous splenic rupture represents a rare but potentially life-threatening complication in patients with HF, often presenting with subtle clinical symptoms that complicate timely diagnosis and management.

Clinical Case: A 30-year-old female with known childhood-diagnosed hypofibrinogenemia presented with two-day history of left-sided upper abdominal pain and urinary symptoms. Initial laboratory investigations revealed severe anemia (hemoglobin 5.21 g/dL) with leukocytosis. Despite blood transfusion, her hemoglobin further decreased to 4.9 g/dL with development of mild abdominal distension. Abdominal ultrasound demonstrated moderate free fluid suggesting intraperitoneal bleeding. Gynecological evaluation excluded ectopic pregnancy with negative beta-HCG and transvaginal ultrasound findings. Contrast-enhanced computed tomography confirmed benign splenic cysts with moderate abdominal and pelvic free fluid, establishing the diagnosis of spontaneous splenic rupture secondary to bleeding from a benign splenic cyst. Conservative management was implemented using 50 units of cryoprecipitate and 5 units of blood transfusion following hematology consultation. The patient's hemoglobin improved to 9.6 g/dL with hemodynamic stabilization (blood pressure 110/80 mmHg, pulse 80 bpm). Surgical intervention was avoided due to high perioperative bleeding risks associated with her coagulation disorder. The patient was discharged after five days with stable condition and scheduled for regular hematological follow-up.

Conclusion : This case demonstrates successful conservative management of spontaneous splenic rupture in hypofibrinogenemia using cryoprecipitate and blood products. It emphasizes the importance of multidisciplinary care, careful risk-benefit assessment regarding surgical intervention, and the potential for favorable outcomes with non-operative management in patients with inherited bleeding disorders, even in life-threatening scenario

PP 45: Perceptions regarding traditional bone setting among patients with fractures in National Hospital of Sri Lanka

Kirushanth S[1], Dias ISU[2,3], Tharmakulasingham N[1], Nawarathnam C[1]
[1]Postgraduate Institute of Medicine, University of Colombo
[2]Ministry of Health
[3]National Hospital of Sri Lanka

Background : Many developing countries, especially in Asia, Africa and South America, have an integrated approach to management of fractures where both traditional bone setting (TBS) and conventional care co-exist. In Sri Lanka, traditional bone setting appears to be a popular mode of treatment of fractures.

Methods : A descriptive cross-sectional study was carried out using a semi-structured questionnaire to gather information from 100 patients with fractures treated at orthopaedic surgery clinics, orthopaedic surgery wards and accident service ward at National Hospital of Sri Lanka (NHSL). Consecutive sampling method was utilized. Data was analysed using SPSS version 30 and results presented in the form of means, percentages and tables.

Results : Majority of the respondents (27%) were in the 60-69 age group, with a mean age of 52.67 years. Most respondents (50%) sought TBS treatment for chronic pain. The main reasons for seeking TBS were cost and accessibility. 15 respondents (15%) had experienced complications following TBS treatment, the most common being exacerbation of pain (40%). The reason for almost all respondents to seek formal healthcare for orthopaedic ailments was the availability of sophisticated imaging (98%). 50% were undecided regarding the skills of traditional bone setters when compared to orthodox practitioners. Majority (50%) believed that orthodox care is more effective in pain and wound management, while half the respondents (65%) believed that orthodox care is not associated with a higher cost when compared to TBS services.

Conclusion : Our study highlights the continued reliance in traditional bone setting for orthopaedic issues including fractures, contributed by factors such as accessibility, cost and cultural beliefs. Our findings emphasize the importance of formal healthcare, mostly with regards to its advanced diagnostics. We suggest that a greater linkage between traditional bone setting and orthodox medicine will improve the overall outcome when treating orthopaedic issues while reducing the risks.

PP 46 : Case report : Hyperparathyroidism's Rare Reveal: Young Adult with Recurrent Pancreatitis

Kirushanth S[1], Dias ISU[2], Perera BL[2], Tharmakulasingham N[1]

1. *Postgraduate Institute of Medicine, University of Colombo*
2. *National Hospital of Sri Lanka*

Background: Acute pancreatitis is a common condition with significant morbidity and mortality if not treated properly. While the most common causes are gallstones and alcohol, there are rarer causes such as primary hyperparathyroidism. Today most patients with primary hyperparathyroidism are asymptomatic. And symptomatic patients present with bone disease and renal manifestations. Yet they can still present with acute pancreatitis, mostly in advanced disease. Infrequently, it can be the first presentation of primary hyperparathyroidism as depicted in our case. A high index of suspicion can prevent it from progressing into chronic pancreatitis.

Clinical Case: We herein report a case of a 20-year-old male presenting with epigastric abdominal pain and vomiting, which is relieved by bending forward. On examination, the patient was in pain but hemodynamically stable with a soft abdomen. Initial investigations found elevated serum amylase levels and imaging also confirmed the acute pancreatitis. However, initial aetiology screening was normal. Further investigations revealed hypercalcemia. A diagnosis of primary hyperparathyroidism and parathyroid adenoma was made based on an elevated parathyroid hormone level and USS neck showing a left inferior parathyroid adenoma. Technetium-99m methoxy-isobutyl-isonitrile scintigraphy was used to localize the parathyroid adenoma. The patient underwent left lower parathyroidectomy. After the surgery, he had a normal parathyroid hormone level with no further episodes of acute pancreatitis.

Conclusion: Acute pancreatitis is a rare presentation of primary hyperparathyroidism. Primary hyperparathyroidism should be suspected in patients with acute pancreatitis with no common etiologies. Diagnosis is important since parathyroidectomy is a definitive treatment method which can prevent progression into chronic pancreatitis.

PP 47 : Case report : Neuroleptic malignancy syndrome secondry to Clozapine poisoning with concurrent infection.

Tharuka LNH[1,2]
[1]National Hospital of Sri Lanka
[2]Post Graduate Institute of Medicine - University of Colombo

Background: Neuroleptic Malignant Syndrome (NMS) is a life-threatening adverse effect, especially associated with typical antipsychotics. Clozapine, an atypical antipsychotic, has the lowest
risk of causing NMS, with a reported global incidence of approximately 0.02%. The blockade of D2 dopamine receptors in the brain and spinal cord leads to the classic features of NMS such as hypothalamic dysfunction, extra pyramidal symptoms and sympathetic nervous system dysfunction. Clozapine has less affinity for D2 receptors. However, higher doses of clozapine may still lead to NMS.

Case Report : A 38-year-old male with treatment-resistant schizophrenia on clozapine was found unconscious with empty clozapine blister packs nearby. On admission, he was febrile (39.9°C), drowsy (GCS 14), with BP 110/70 mmHg, PR 115/min, RR 18/min, and SpO_2 95%.
Examination revealed neck stiffness, photophobia, limb rigidity, and bilateral coarse crepitations. Clozapine overdose with aspiration pneumonia and meningitis was suspected.
Diagnostic Evaluation Initial investigations showed, WBC 10.13×10^9/L, Neutrophils 8.7 $\times 10^9$/L,CRP 205.5 mg/L, Procalcitonin 1.33 ng/mL, Chest X-ray -infiltrates. Empirical IV antibiotics were started. Lumbar puncture showed no evidence of meningitis. Fever persisted despite antibiotics. On day 2, serum CPK was 3067 IU/L. With clinical features of hyperthermia, rigidity, altered mental status, and sweating, a diagnosis of NMS was made. Antibiotics were adjusted for aspiration pneumonia, and supportive therapy with fluids, paracetamol, diazepam, and thiamine was given.

Conclusion : This patient presented with suspected clozapine overdose complicated by aspiration pneumonia and possible meningitis, highlighting diagnostic complexity and multi-system involvement. A high index of suspicion is crucial when features like hyperthermia, rigidity, and altered mental status are present. In this case, markedly elevated CPK supported the diagnosis of NMS despite raised procalcitonin and CRP. Early recognition and prompt treatment are key to reducing morbidity and improving outcomes.

PP 48: Audit: attitudes, practices and knowledge related to gastric lavage in the management of drug overdose or acute poisoning among Medical officers attached to Emergency Departments in Sri Lanka.

Hannadige LM
National Hospital of Sri Lanka

Background: Gastric lavage was widely practised as a means of gastric decontamination. This study was conducted to describe attitudes, practices, knowledge and their associated factors related to gastric lavage in the management of drug overdose or acute poisoning among medical officers attached to Emergency Departments (A&E / ETU/ PCU) in Sri Lanka.

Method: A hospital-based descriptive cross-sectional study was conducted from January to March 2023. A self-administered questionnaire was developed and validated using the modified Delphi technique.

Results: Sample size was 197 and mean age was 40.56 years. The mean years at the Emergency Department was 4.62 years. Regarding knowledge on gastric lavage, 79% had good knowledge. Regarding monitoring the vital parameters during the procedure, 56.8% (n=109) had agreed with the practice. The majority (67.9%) had agreed that gastric lavage is a stressful procedure to perform and monitor. Significant associations were found between knowledge level and practice of obtaining patient consent ($P<0.001$), appropriate timing of gastric lavage ($P=0.006$), using normal saline for gastric lavage ($P=0.003$), and monitoring vital parameters during the procedure ($P=0.003$). There were significant associations between knowledge level and the following attitudes: gastric avoid medicolegal issues ($P=0.041$), gastric lavage should be performed even if the patient refuses and the knowledge level ($P<0.001$).

Conclusion: This study highlights the knowledge gaps in medical officers in emergency units regarding gastric lavage in acute poisoning. Conducting educational programmes to update the medical officers regarding current guidelines on practising gastric lavage is recommended.

PP 49 : Case report : Prinso poisoning in a pregnant young woman with Bernard Souliers Syndrome

Mallawarachchi MU

National Hospital Galle

Background: Sri Lanka has the highest suicide rate in South-East Asia, with rural areas commonly seeing deliberate ingestion of household products. Prinso detergent, despite being banned, is frequently used due to its low cost and accessibility. It contains Potassium permanganate and Oxalic acid, both corrosive and potentially life-threatening, causing complications like hypocalcemia, haemorrhagic gastritis, acute kidney injury, shock, and ARDS. Literature on Prinso poisoning during pregnancy is scarce, with limited data on fetal outcomes. Bernard-Soulier Syndrome, a rare inherited bleeding disorder, complicates such cases further. This report highlights a rare case of Prinso poisoning in a pregnant woman with Bernard- Soulier Syndrome.

Case Report: A 34-year-old pregnant woman (G3P3C2) at 24 weeks' gestation with Bernard-Soulier syndrome presented to TH Karapitiya following deliberate ingestion of Prinso (potassium permanganate and calcium oxalate) in a suicidal attempt. She developed burning epigastric pain, haematemesis, haematuria, and oliguria. Viable pregnancy was confirmed. The bedside test for Methaemoglobinemia was negative. POCUS scan suggested features of fluid overload.

Initial management included activated charcoal, gastric lavage, IV fluids, Bicarbonate, Calcium gluconate, KCl, and antiemetics. Investigations showed AKI with metabolic acidosis, anaemia (Hb 6 g/dL), severe thrombocytopenia (Plt $3x10^3$), hypocalcemia, and elevated CRP. Despite fluid resuscitation, she progressed to oliguric AKI and underwent haemodialysis and Leucoreduced RBC transfusions. By Day 3, she developed respiratory distress and haemoptysis, initially treated as acute pulmonary oedema. Her condition worsened with fever and productive cough; cultures confirmed MRSA pneumonia and sepsis despite improved renal functions. She developed ARDS, required inotropes, IV antibiotics (Piperacillin-Tazobactam, Ceftriaxone), antivirals, tranexamic acid, and mechanical ventilation following a hypoxic cardiac arrest needing ICU care. After some meticulous care at ICU, her renal and respiratory functions improved, and bleeding manifestations resolved. She was discharged from ICU on Day 21 and home by Week 4 with viable pregnancy after psychiatric evaluation and support. At 38 weeks, she had an uncomplicated normal vaginal delivery of a healthy baby.

Conclusion: This case report presents a rare instance of Prinso poisoning in a pregnant patient with Bernard-Soulier Syndrome. The poisoning led to complications such as acute kidney injury needing haemodialysis, hypocalcemia, erosive hemorrhagic gastritis, and bleeding, worsened by the platelet disorder. The patient experienced hypoxic cardiac arrest due to ARDS, LRTI, and septic shock, requiring further intensive support. Although the fetus remained viable, both lives were at risk. Improved regulation and public education on such toxic substances are urgently needed.

PP 50 : Case Report : PCC vs FFP in Combined Venom- and Warfarin-Induced Coagulopathy: A Case Report of a Russell's Viper Bite in a Patient with Severe Valvular Heart Disease.

Herath MHMSD
Ministry of Health, Sri Lanka

Background: Snakebite is a significant medical emergency in Sri Lanka. Russell's viper, one of the deadly venomous snakes, causes venom-induced consumptive coagulopathy (VICC) as a complication of envenomation. Management becomes more complex in patients on anticoagulation, where standard treatment with fresh frozen plasma (FFP) may exacerbate underlying cardiac conditions. This case highlights the clinical challenge of coagulopathy reversal in a patient with severe mitral stenosis and aortic regurgitation on warfarin therapy.

Clinical Case: A 40-year-old female with known severe valvular heart disease and chronic atrial fibrillation on warfarin (INR >3) presented with a suspected Russell's viper bite to the right ankle. Clinical signs included local swelling, active bleeding, drowsiness, and prolonged clotting times. Antivenom therapy (30 vials) was administered promptly. ROTEM confirmed VICC with fibrinogen deficiency. Although clotting factor replacement with FFP and cryoprecipitate was advised, concerns over fluid overload in the context of heart failure led to a recommendation for prothrombin complex concentrate (PCC). However, due to unavailability, FFP was administered. The patient deteriorated rapidly with respiratory failure, haematuria, vaginal bleeding, and neurological decline. Despite prompt resuscitation at intensive care unit, she died with heart failure exacerbation.

Conclusion: This case demonstrates the lethal synergy of VICC and warfarin-induced coagulopathy in a patient with compromised cardiac function. Standard FFP therapy, though widely used, may be inappropriate in volume-sensitive patients. PCC provides a faster, low-volume alternative with fewer complications and should be prioritized in similar high-risk cases. The outcome underscores the importance of individualized treatment strategies and the need for broader availability of PCC in emergency settings, especially where pre-existing comorbidities limit conventional therapy.

PP 51 : Case reports : Challenging Emergency Management of Life-Threatening Deep Perineal Laceration with Complex Pelvic Fracture

Kumarasinghe MN[1,2,3], Karunarathne D[1,2]
[1]National Hospital of Sri Lanka
[2]Ministry of Health
[3]Post Graduate Institute of Medicine - University of Colombo

Background : Managing severe pelvic haemorrhage in patients with complex pelvic fractures and deep perineal lacerations remains highly challenging. Literature supports bilateral internal iliac artery ligation combined with pre-peritoneal packing as an effective damage control strategy for uncontrolled pelvic bleeding. These injuries carry a high mortality rate, with overall survival around 35%. We report a successful case managed with bilateral internal iliac artery ligation, pre-peritoneal, and perineal wound packing.

Case Presentation: A 24-year-old male, after being run over, was transferred for further management of a complex pelvic injury. Initial interventions at the referring centre included emergency laparotomy, diverting loop colostomy, deep perineal wound packing, suprapubic catheter placement, and massive blood transfusion. On arrival, the patient was intubated, tachycardic, but normotensive. Ongoing pelvic bleeding necessitated activation of the massive transfusion protocol and urgent re-laparotomy.
Intraoperatively, the patient had a deep perineal laceration with severe crush injury involving the anal sphincter, pelvic floor, and bulbourethra. A complex pelvic fracture and retroperitoneal non-expanding hematoma were noted without rectal perforation. An external fixator was applied, the loop colostomy was converted to an end colostomy, and intra-peritoneal, pre-peritoneal, and perineal packing were performed.
Due to continued bleeding, re-laparotomy was undertaken within two hours, and bilateral internal iliac artery ligation with repacking was performed. Coagulopathy was corrected using ROTEM-guided transfusion, and bleeding was controlled. Packs were removed after 48 hours. The patient required 15 days of ICU care before transfer to the ward, with ongoing perineal wound management using vacuum-assisted dressing.

Conclusion: Bilateral internal iliac artery ligation with pre-peritoneal and perineal packing is an effective damage control strategy in life-threatening pelvic hemorrhage. Rapid decision-making and timely intervention maximize its potential benefit.

PP 52 : Case report : Pulmonary contusion in a child – An atypical fireworks-related injury

Perera MAS
Lady Ridgeway Hospital

Background: A surge in fireworks-related injuries is common in festive seasons. Mostly being burns and amputations involving hands and injuries to the eyes, head and neck. However, life-threatening chest injuries due to regular commercially available fireworks are very sparsely reported. We present a case of a child with a significant pulmonary contusion caused by an ordinary skyrocket on Sinhala New Year Day of 2025.

Case: An 8-year-old boy was presented to the Paediatric Emergency Department following a skyrocket impact and blast on his right chest. He was complaining of pain and a cavitated wound on his right upper chest with a mild increase in work of breathing and blood-stained sputum on admission. His Saturation was 90% on air and was breathing at 32 breaths per minute, with diffused rales and crepitations on both lungs. He promptly responded to Oxygen therapy with a facemask and nebulization with salbutamol. Open and closed pneumothorax were excluded clinically and with lung ultrasound. Subsequent chest imaging with HRCT revealed a significant unilateral pulmonary contusion which gave rise to his symptoms. His Pulmonary contusion was managed conservatively with graded oxygen therapy, and his wound was managed surgically and child was discharged in 3 days and had an uneventful recovery.

Conclusion: Acute lung injury such as blast lung is frequently reported due to shock waves of major explosions. However, a usual firework has the capacity to elicit such an injury in a child. Hence clinicians should be especially vigilant when managing fireworks-related burn injuries to the chest. Government authorities must revise legislation regulations, and establish standardization and monitoring procedures for the fireworks industry to ensure this leisure activity is safe for society rather than a social hazard.

PP 53 : Case report : Emergency Department Clamshell Thoracotomy for a Blunt Thoracic Injury

Kumarasinghe MN[1,2], Karunarathne D[1], Ruwanpathirana K G[1], Afdhaal F[1]
[1]National Hospital of Sri Lanka
[2]Post Graduate Institute of Medicine, University of Colombo

Background : Clamshell thoracotomy, or bilateral anterolateral thoracotomy, is an uncommon emergency department procedure, primarily performed for penetrating thoracic injuries. Its use in blunt thoracic trauma with witnessed cardiac arrest and signs of life is rare. Survival rates are approximately 10–35% for penetrating injuries and 1–2% for blunt trauma. The procedure involves bilateral thoracotomies through the fifth intercostal spaces and transverse sternotomy, providing excellent exposure of both hemi-thoraces, heart, pericardium, lungs, and great vessels. It allows open cardiac massage, relief of tamponade, hilar or descending aortic clamping, and temporary haemorrhage control until definitive surgical care is available.

Case Presentation : A 15-year-old girl presented to the resuscitation room after a fall from the fifth floor, with right-sided blunt chest trauma and hypovolemic shock. A right-sided chest drain was inserted, releasing a massive hemothorax, and fluid resuscitation was initiated. During resuscitation, the patient developed cardiac arrest, unresponsive to 20 minutes of CPR. A clamshell thoracotomy was performed. Open cardiac massage was initiated. The right atrium was cannulated with a large-bore cannula, and massive transfusion was commenced directly. Sinus rhythm was restored within minutes. Active bleeding from the right thorax was identified. The right hemithorax was packed, and the patient was transferred to the operating theatre. Intraoperative findings included multiple posterior rib fractures, intercostal vessel bleeding, a complete azygos vein tear, and right lung parenchymal injury. Unfortunately, the patient succumbed intraoperatively.

Conclusion : Emergency clamshell thoracotomy is a potentially life-saving intervention in select blunt trauma cases, enabling temporary hemodynamic recovery and allowing definitive surgical repair. Rapid decision-making and surgical preparation is crucial to maximize its potential benefits.

PP 54 : Case report: "Red Flags After the Gym: A Case Report of Exercise Induced Rhabdomyolysis in a Healthy Young Man.

Deshapriya DMPW, Kamal DVK
National Hospital Kandy, Sri Lanka

Introduction: Exercise-induced rhabdomyolysis (EIR) is a potentially life-threatening condition characterized by skeletal muscle breakdown and release of intracellular contents into the bloodstream. It commonly occurs in unconditioned individuals engaging in intense physical activity, especially in the presence of contributing factors such as dehydration.

Case Presentation: We report a case of a 26-year-old previously healthy male who presented with red-colored urine and severe bilateral calf pain following two consecutive days of vigorous lower limb workouts after a period of less physical activity . Clinical assessment revealed stable vital signs with marked calf tenderness. Laboratory investigations showed a markedly elevated serum creatine kinase (CK) level of 95,050 U/L , but preserved renal function and normal acid-base and electrolyte status. Urinalysis revealed light red-colored urine, acidic pH with occasional red cells.. Arterial blood gas analysis was within normal limits.

Management and Outcome: The patient was admitted to a high dependency unit and managed with aggressive intravenous fluid therapy and forced diuresis to maintain adequate urine output. Pain was controlled with oral analgesics. He remained clinically stable throughout his hospital stay without developing acute kidney injury or significant metabolic derangements. CK levels progressively decreased, and he was discharged on day five with complete resolution of symptoms.

Conclusion: This case highlights the importance of early recognition and aggressive fluid resuscitation in managing severe exercise-induced rhabdomyolysis, particularly in unconditioned individuals. Despite extremely elevated CK levels, timely fluid resuscitation and vigilant monitoring prevented complications, underscoring the critical role of prevention through patient education on gradual exercise progression and adequate hydration.

PP 55 : Case report : Suicidal attempt by swallowing Formetrol and Budesonide DPI capsules

Mallawarachchi MU[1,2], Wijegunawardena I[1]
1.National Hospital of Sri Lanka
2. Post graduate institute of Medicine- University of Colombo

Background: Formeterol, a long-acting β2 agonist, and budesonide, a corticosteroid, are commonly used to manage asthma and COPD. While generally safe, serious adverse effects like arrhythmias, hypokalemia, hyperglycemia, and metabolic acidosis can occur, especially with overdose. Suicidal ideation has been associated with their combination, though oral toxicity data is limited. This case reports a rare instance of deliberate ingestion of 18 DPI capsules containing both drugs in Sri Lanka, resulting in tachycardia, prolonged QT, electrolyte imbalance, and metabolic acidosis. Despite the prevalence of self-harm in Sri Lanka, this unusual presentation of DPI poisoning warrants documentation to expand current literature on systemic toxicity from inhaler misuse.

Case Report: A 45-year-old woman presented to the ETU at NHSL three hours after deliberately ingesting 18 DPI capsules of formoterol/budesonide (12 µg/400 µg) for self-harm. She was restless, febrile (100°F), tachycardic (120 bpm), and tachypneic, with no other significant systemic symptoms. ECG showed sinus tachycardia, widespread ST depressions, and borderline QT prolongation (QTc 447 ms). VBG revealed compensated metabolic acidosis with elevated lactate (6.7), hypokalemia (K^+ 2.8), hyponatremia (Na^+ 129), and hyperglycemia (glucose 264). POCUS was unremarkable. Management included IV fluids, IV potassium and IV magnesium supplementation, considering risk for arrhythmias, and supportive medications like antiemetics and PPI. After four hours, the patient's heart rate improved, QT normalized, and lactate decreased. Persistent hypokalemia required ongoing correction. She remained hemodynamically stable, with normalized ECG and electrolytes prior to discharge. She was monitored for two days and received psychiatric support on request. The case highlights beta-agonist toxicity with metabolic complications following DPI ingestion, emphasizing the importance of recognizing such rare but potentially serious presentations.

Conclusion: This case was unique because the DPI capsules (subtherapeutic minimal dose) were taken orally, which caused life threatening cardiac (tachycardia and long QTc) and systemic metabolic effects (lactic acidosis, hyperglycemia and Hypokalemia). The literature only reports one case of oral intoxication from the inhaler form of formoterol and Budesonide, leaving us with limited knowledge on the topic.

PP 56: Case report : The Missing Piece: Esophageal Foreign Body Presenting as Recurrent Unstable Atrial Fibrillation

Haseena MHF[1,2] , Ethulgama SB[1]
[1]National Hospital Kandy
[2] Post Graduate institute of Medicine - University of Colombo

Background : Impacted esophageal foreign bodies are not an uncommon presentation in the emergency department. However, this case describes an unusual presentation where an esophageal foreign body ,impacted at the level of aortic constriction ,triggered hemodynamically unstable tachy-arrhythmia. This case emphasizes the importance of maintaining a broad differential diagnosis, the importance of point of care imaging, and the significance of early multidisciplinary involvement in acute care settings.

Diagnostic Evaluation : A 64-year-old previously healthy male was brought to the Emergency Treatment Unit after being found unresponsive at home. He was drowsy (AVPU: P), with SpO_2 of 84%, cold extremities, hypotensive (BP 72/50 mmHg), and irregularly irregular narrow complex tachycardia—atrial fibrillation with a rapid ventricular rate of 160 bpm. Patient was previously unevaluated ,no significant medical or drug history was found.
Bedside ultrasonography was uneventful . Patients complains of persistent chest discomfort warranted a chest X-ray, which revealed a radiopaque foreign body in the mid-esophagus.

Treatment : Initial synchronized cardioversion at 200 J restored sinus rhythm with transient improvement. Two further episodes of unstable atrial fibrillation occurred within 45 minutes, requiring repeat cardioversion and initiation of an amiodarone infusion. After hemodynamic stabilization and imaging, ENT input was taken.With the indication of urgent endoscopy a partially impacted denture revealed at the mid oesophagus level,likely aspirated during sleep.

Follow-Up : The denture was retrieved endoscopically. Esophageal erosions were noted, and the patient was kept nil per oral. Repeat endoscopy confirmed mucosal healing. He remained stable without recurrence or instability and was discharged uneventfully.

Conclusion : This case emphasizes the importance of considering atypical causes in new-onset arrhythmias. A structured approach, anatomical guidance, and timely multidisciplinary coordination with imaging proved success.

PP 57 : Case report : Case of methaemoglobinaemia

Naleen Dharmarathne, Hurry Rupert
Royal Derby Hospital, University Hospitals of Derby and Burton, United Kingdom

Background: Methaemoglobinaemia usually presents with central cyanosis and is a rare cause of hypoxia that's unresponsive to oxygen. Amongst acquired causes, recreational drug use is a common culprit. This case describes a 36-year-old male who collapsed after ingesting recreational drugs called poppers (alkyl nitrite) and inhaling monkey dust (synthetic psychoactive). Despite treatment with intravenous methylene blue, he died in the ICU.

Clinical Case: Diagnostic Evaluation: A 36-year-old male with no prior medical history, suffered a witnessed collapse after consuming poppers and inhaling monkey dust. Upon arrival at the emergency department, he had a GCS of 3, central cyanosis, SpO_2 of 83% on 15 L of oxygen, a heart rate of 139 bpm and a blood pressure of 106/70 mmHg.
Rapid sequence intubation was performed, but he had multiple PEA arrests before achieving ROSC. His initial arterial blood gas analysis showed a pH of 7.3, lactate of 15.5 mmol/L, bicarbonate of 10.9 mmol/L, PCO_2 of 2.6 kPa, PO_2 of 31.5 kPa, and methaemoglobin levels exceeding 30%. His blood appeared thick and chocolate brown.

Treatment: He received IV methylene blue 180 mg (2 mg/kg) with an additional dose during further PEA arrests. His methaemoglobin levels dropped to 2.1%. Despite intensive care, his EEG revealed moderate cerebral dysfunction and he died on day 8.

Conclusion: Recreational drug use, especially alkyl nitrites, should be suspected in oxygen-resistant hypoxemia. Since some centres do not routinely measure methaemoglobin, early suspicion is vital to initiate the anti-dote. There is often a discrepancy between SpO2 and SaO2 in the ABG, as was seen in this case. 30% is the maximum methaemoglobin value that can be recorded in our analyser, but clinical presentation suggests that the actual levels may be higher. Although responsive to Methylene blue, patient likely died due to secondary complications.

PP 58 : Case report : A Rare Case of Small Bowel Herniation Through a Traumatic Abdominal Wall Defect Following Traditional Wound Repair: A Case Report

N Tharumakulasingham[1], S Kirushanth[1]
[1]Post Graduate institute of Medicine - University of Colombo

Introduction: Traumatic abdominal wall hernias (TAWH) are uncommon and often underdiagnosed injuries following blunt abdominal trauma. We present a rare case of small bowel herniation through a traumatic defect, complicated by traditional wound repair, leading to bowel incarceration and perforation.

Case Presentation: A 48-year-old previously healthy male sustained blunt trauma to the left flank, resulting in a 5 cm skin laceration. The wound was repaired by a traditional medical practitioner. Two days later, he presented to the Accident & Emergency (A&E) department with abdominal pain and vomiting. On examination, he was ill-looking, tachycardic, and had a distended abdomen with guarding. A contrast-enhanced computed tomography (CECT) scan revealed herniation of small bowel loops into the anterior abdominal wall beneath the laceration.
An emergency laparotomy was performed, revealing herniation of a jejunal loop through the abdominal wall defect, with a skin suture puncturing the jejunum. The herniated bowel was successfully reduced, and the jejunal perforation was repaired. The patient had an uneventful recovery and was discharged in stable condition.

Conclusion: This case emphasizes the importance of recognizing TAWH as a possible sequela of blunt trauma, particularly in cases where wound repair is performed without proper assessment of deeper tissue involvement. Traditional wound management techniques can obscure significant internal injuries, delaying appropriate treatment. Clinicians must maintain a high index of suspicion for underlying herniation in patients presenting with post-traumatic abdominal pain. Prompt imaging and surgical intervention are critical in ensuring favorable outcomes.

PP 59 : Case report :Novel Management of Extensive Submucosal Hematoma with Peritoneal Rupture Following Stapled Haemorrhoidectomy: A Case Report Without Faecal Diversion

N Tharumakulasingham, S Kirushanth
Post Graduate institute of Medicine - University of Colombo

Background: Hemorrhoidal disease (HD) is a prevalent condition affecting the anorectal area due to anatomical and pathophysiological changes. Among the surgical treatments available, stapled hemorrhoidectomy is a common and effective technique for removing haemorrhoids that results in minimal post-operative pain. However, like any surgical procedure, it carries some risk of complications.

Case presentation: A 25 year old male patient of Asian background underwent stapled hemorrhoidectomy for grade II hemorrhoidal disease. Subsequently he developed submucosal bleeding as a complication which extended proximally up to rectosigmoid junction. This led to the formation of a tense intramural hematoma with secondary infection, disrupting sigmoid wall and causing intra-abdominal bleeding. This necessitated a laparotomy and led to significant morbidity. This case highlights the importance of recognizing and an ageing submucosal bleeding as a potential complication of stapled hemorrhoidectomy.

Conclusion: Even though stapler hemorrhoidectomy is often considered an easy surgery, we should always be alert regarding life-threatening complications such as intra-abdominal bleeding when there is an insidious nature of the rectal bleeding without an apparent external manifestation.

PP 60 : Case report : Early coronary angiography in distinguishing between the types of Kounis syndrome: A Case of Type II Kounis Syndrome Following Diclofenac Administration

Nanayakakra OIP[1], Soysa WLM[2]
[1]National Hospital of Sri Lanka
[2]Post Graduate Institute of Medicine- University of Colombo

Background : Kounis syndrome is defined as the occurrence of acute coronary syndrome (ACS) in the setting of an allergic or hypersensitivity reaction. It is believed to result from the activation of mast cells and other inflammatory cells, which release vasoactive and pro-inflammatory mediators leading to coronary artery vasospasm, plaque rupture, or even stent thrombosis.

Clinical Case : We report a 50-year-old male patient with a history of percutaneous intervention with three coronary stents inserted who presented with acute coronary syndrome(ACS) following an anaphylactic shock triggered by diclofenac sodium. The patient initially developed anaphylactic shock, which was managed with intramuscular adrenaline. Subsequently, he was managed for ACS and was treated with clopidogrel, atorvastatin, and enoxaparin, without aspirin due to the recent allergic event.
Electrocardiography revealed dynamic changes, and high-sensitivity troponin levels were markedly elevated. Transthoracic echocardiography showed mild hypokinesia of the inferior wall, consistent with ECG findings. Coronary angiography revealed no evidence of stent thrombosis but demonstrated significant atherosclerotic lesions proximal to the left circumflex artery stent (80%) and distal to the right coronary artery stent (50%).
Initially, the patient was suspected to have type 3 Kounis syndrome. However, following the angiogram, the diagnosis was refined to type 2 Kounis syndrome.

Conclusion: This case highlights the importance of early coronary angiography in distinguishing between the types of Kounis syndrome and initiating appropriate management strategies.

PP 61 : Case report : A Rare Case of Severe Lactic Acidosis and DKA Requiring Mechanical Ventilation in patient with type 2 diabetes mellitus- case report

Abeysekara RMNI
National Hospital Kandy

Background: Diabetic ketoacidosis (DKA) is a complication of diabetes mellitus due to insulin insufficiency. DKA is diagnosed by the presence of acidosis, hyperglycemia and hyperketonemia. Lactic acidosis is a common finding in DKA although very severe lactatemia is uncommon. This case report describes the management of a patient with DKA, severe metabolic acidosis and severe lactatemia.

Case presentation: A 65-year-old male known Type 2 DM with poor treatment compliance, presented to the ED with 2 days of epigastric pain, nausea, vomiting, and sudden onset dyspnea. On assessment, he was conscious, tachypneic (RR 30/min), SpO_2 94%, BP 130/80 mmHg, HR 120 bpm, with mild epigastric tenderness. Initial investigations revealed severe high anion gap metabolic acidosis with elevated lactate levels. investigations- PH- 6.65, PCO2-7.5 mmHg, PO2-140 mmHg, HCO3-0.8 mmol/l, Lactate-17.9 mmol/l,anion gap-32.9, blood glucose- 332 mg/dl , urinary ketone bodies -positive, ECG-sinus tachycardia, bedside POCUS/ECHO/ chest x ray-normal. DKA was diagnosed and treatment started with IV fluids and insulin infusion. Intubation was required due to respiratory fatigue. Serial blood gas measurements at the ICU showed gradual resolution of hyperlactatemia with treatment, and metabolic derangement was corrected within 72 hours.He made a full recovery after 5 days of icu stay.

Conclusion: Lactic acidosis(>2 mmol/ l) is a relatively common finding with DKA. but severe lactic acidosis with levels more than 4 mmol/l is rare. Elevated lactate levels in DKA is due to the tissue hypoperfusion secondary to intravascular volume contraction. And severe lactatemia is thought to be due to metabolic derangement and abnormal glucose metabolism. Unlike in other conditions with elevated lactate levels eg. sepsis, patients with DKA and high lactate levels are having a more favorable outcome even with severely elevated lactate levels and acidosis.

PP 62 : Case report : A rare case of transient AV node block due to vagal stimulation precipitated by pharyngotonsillitis- case report

Abeysekara R.M.N.I
National Hospital Kandy

Background: Pharyngotonsillitis is an acute inflammation of the pharynx and tonsils. Common causative agents are viruses (90%) bacterial (10%). Usual presentation is with fever, upper respiratory symptoms and sore throat. This case report describes a rare presentation of acute viral pharyngotonsillitis with transient AV block due vagal stimulation caused by inflamed tonsils.

Case presentation: A 44 year old previously healthy male presented to the ED complaining of sore throat, swallowing difficulty, mild fever for 3 days and sudden onset palpitations and lightheadedness since morning. He denied any chest pain. He is a non smoker and occasional alcohol consumer. His clinical examination was significant for pharyngeal inflammation and tonsillar swelling. His heart rate was 42 bpm and irregular. Rest of the examination was unremarkable.

Initial ECG done at the ED showed a 2:1 AV block with a heart rate of 35 bpm. Basic blood investigations including troponin I, metabolic panel with serum electrolytes were normal. He was treated with IV atropine and transferred to the medical ward for further observation. He was monitored at the ward with serial ECGs ,showed paroxysmal 1st and 2nd degree AV blocks. Treatment was started with azithromycin, dexamethasone and salbutamol. By the 3rd day his ECG showed a sinus rhythm with normal PR interval. Further investigations including 2D echo, Holter study and thyroid profile were normal. After consultation with cardiac electrophysiology team, a diagnosis of transient AV block precipitated by pharyngotonsillitis was made. ECG was in sinus rhythm at post discharge review.

Conclusion: Overstimulation of the vagus nerve caused by pharyngeal and tonsillar infections and inflammation can result in bradycardia with paroxysmal AV node blocks. This case demonstrates the presentation of a transient AV block precipitated by vagal stimulation secondary to pharyngitis. This condition can be treated without pacing and by treating the underlying infection.

PP 63 : Case report : Bilateral Primary Spontaneous Pneumothorax- A Case Report.

Rajapaksha RMSAB
Post Graduate Institute of Medicine – University of Colombo

Background: Primary Spontaneous Pneumothorax is a common clinical presentation to Emergency Departments. However, the incidence of primary spontaneous pneumothorax ranges from as low as 1.4% to 7.6 %. Presentation of bilateral primary spontaneous tension pneumothorax is even rarer. The clinical presentation is variable, ranging from mild dyspnea to tension pneumothorax. Bilateral tension pneumothorax can be defined by the absence of tracheal deviation on Chest Radiograph due to equally collapsed lungs bilaterally with haemodynamic compromise. Immediate decompression is needed bilaterally simultaneously to avoid further deterioration of the patient. This should be followed by advanced imaging and cardiothoracic surgical intervention to prevent similar presentations in future.

Clinical Case: A 34-year-old lady presented to the emergency department with cyanosis and shortness of breath with a background history of worsening exercise tolerance for four days. Her Oxygen Saturation was 85% with supplemental oxygen and had bilaterally reduced air entry. She was haemodynamically unstable with engorged neck veins. Bilateral tension pneumothorax was confirmed with absence of lung sliding bilaterally on point-of-care lung ultrasound scan and bedside chest radiograph with signs of obstructive shock. Simultaneous bilateral needle decompression improved the haemodynamics and oxygen saturation of the patient. This was followed by simultaneous insertion of bilateral chest tubes. High-resolution computed Tomography of the patient confirmed the presence of emphysematous lung disease.

Conclusion: Bilateral tension pneumothorax presentation can vary from the typical presentation of unilateral tension pneumothorax. A high degree of clinical suspicion is needed to exclude bilateral spontaneous pneumothorax when the clinical signs and symptoms are bilateral. Bedside Point of Care Ultrasound Scan can be used to rapidly confirm the clinical diagnosis. This case study illustrates the importance of immediate simultaneous bilateral decompression of bilateral tension pneumothorax to prevent further lung collapse, mediastinal shift and haemodynamic deterioration that can occur with unilateral decompression.

PP 64 : Case report: Angioedema in the Emergency Department: A Tale of Two Aetiologies

S A A Jagadeesh
Post Graduate Institute of Medicine – University of Colombo

Background: Angioedema is a potentially life-threatening condition characterised by sudden, localised oedema of subcutaneous or submucosal tissues. It poses significant diagnostic and therapeutic challenges in emergency settings due to its diverse aetiologies. Prompt identification of the underlying mechanism, histamine mediated or bradykinin mediated, is essential for effective treatment and airway protection.

Case reports: We report two contrasting cases of angioedema presenting to a tertiary emergency department. The first involved a 69-year-old female with isolated significant sudden onset tongue swelling without respiratory depression, haemodynamic instability or urticaria, suggestive of a bradykinin-mediated mechanism. She had been on losartan for five years, and did not respond to initial adrenaline therapy, supporting a diagnosis of angiotensin receptor blocker (ARB)-induced angioedema. Conservative management and ARB withdrawal led to clinical improvement without requiring targeted therapy such as Icatibant or fresh frozen plasma. The second case, a 49-year-old male on losartan, developed rapid-onset lip and tongue swelling, generalised pruritus, and drooling shortly after ingestion of amoxicillin. The presence of itchiness and temporal relationship to amoxicillin favoured a diagnosis of histamine-mediated anaphylaxis. He showed prompt clinical improvement following intramuscular adrenaline and supportive therapy. These cases underscore the importance of differentiating between histamine and bradykinin-mediated angioedema, as they differ markedly in therapeutic responses. While histamine-mediated reactions typically respond well to adrenaline, steroids, and antihistamines, bradykinin-driven angioedema often requires withdrawal of the offending agent and close monitoring, with specific therapies reserved for more severe cases.

Conclusion: Emergency physicians must maintain a high index of suspicion for drug-induced angioedema, especially in patients on ACE inhibitors or ARBs - even on long-term basis, and should be adept at rapid aetiological differentiation to prevent airway compromise and optimise outcomes.

PP 65 : Research : An Evaluation of Artificial Intelligence (AI)-Powered Emergency Department Triage: Cross-Sectional Descriptive Observational Study at a District General Hospital(DGH) Sri Lanka

Illangasinghe SB[1,2], Chandrasena H[3] , Gayan I [4]

[1] National Hospital of Sri Lanka , [2]Post Graduate institute of Medicine - University of Colombo

[3]Epidemiology unit, Ministry of Health Sri Lanka, [4]District General Hospital Horana

Background: Emergency Departments(ED) always have a high volume of patients, which necessitates quick and accurate triage decisions. Recently developed AI-powered Emergency Severity Index (ESI) system by OpenAI (®) have high potential to carry out triage and improve outcomes. However, their effectiveness in resource-limited settings like Sri Lanka hasn't been assessed.

Study Objective: Statistically compare the accuracy of ESI triage decisions made by the AI system with those made by human decision-makers over a 4-week period at DGH Sri Lanka.

Methods: This was an observational, descriptive cross-sectional study conducted over 4 weeks at the Emergency Treatment Unit (ETU) of DGH Horana. All patients were triaged using both AI-powered ESI and human clinical triage methods. Data collected included patient demographics, clinical presentation, ESI triage outcomes, re-triage status, and patient disposition. The two methods were compared to assess concordance, discrepancies, and triage time efficiency.

Results: The AI-powered triage system demonstrated 93% concordance with human triage decisions, mainly in identifying high-risk cases (Levels 1and 2) with 95% accuracy. The AI system showed a slightly faster triage time. However, a 15% over-triage rate was observed in low-risk presentations (Levels 4 and 5). Also noted 17% discrepancies in these level 3 and 4 Triage cases which resulted in unnecessary resource allocations.

Conclusion: The AI- ESI triage system significantly enhances triage accuracy and operational efficiency in high-risk Level 1 and 2 patients in an ETU at DGH Sri Lanka. The AI system's time-saving benefits and strong performance were observed in high-acuity cases. Over-triage in lower-acuity cases was observed, and this requires further refinement. These findings demonstrate AI's potential to enhance emergency department workflows and patient prioritization in resource-limited settings, especially in Level 1 and 2 triage cases.

PP 66 : Case report : Acute Abdomen as a rare case of Lupus Enteritis in Systemic Lupus Erythematosus

Senthuran S[1], Kumanan T[2]

[1]Registrar in Emergency Medicine, Professorial Medical Unit, Teaching Hospital Jaffna.

[2]Professor of Medicine & A&E; Consultant Physician, Professorial Medical Unit, Teaching Hospital Jaffna.

Background: Systemic Lupus Erythematosus (SLE) is a multisystem autoimmune disorder with a broad spectrum of clinical manifestations. Gastrointestinal involvement, particularly lupus enteritis is an uncommon and potentially under-recognized complication, often leading to diagnostic delays.

Clinical Case: A 26-year-old female with a known history of Systemic Lupus Erythematosus (SLE), who had been non-compliant with treatment for approximately one year postpartum, initially exhibited nonspecific gastrointestinal symptoms, including recurrent vomiting and profuse diarrhea. There was no associated fever or abdominal pain, and inflammatory markers remained within normal limits. The initial clinical evaluation was consistent with acute gastroenteritis.

Despite conservative management with antiemetics and hydration and following a transient period of clinical improvement lasting two days, she developed severe, poorly localized periumbilical abdominal pain, along with worsening vomiting and diarrhea. This clinical deterioration prompted further diagnostic evaluation using contrast- enhanced computed tomography (CECT) of the abdomen and pelvis. The imaging revealed bowel wall thickening of small bowel loops (likely distal jejunal/proximal ileal) with submucosal edema suggestive of enteritis, mildly dilated proximal bowel loops, and gross ascites.

A provisional diagnosis of lupus enteritis was made. High-dose intravenous methylprednisolone was initiated, resulting in remarkable clinical improvement. The abdominal pain, which had been poorly responsive to intravenous morphine, significantly subsided. Vomiting and diarrhea also gradually resolved.

Conclusion: This case highlights the diagnostic challenges associated with lupus enteritis, particularly in the absence of elevated inflammatory markers. Early consideration of this rare SLE manifestation, especially in patients with abdominal symptoms, is essential to ensure timely and appropriate management.

PP 67 : Case report : Paraplegia as an uncommon initial presentation of Tuberculous Meningitis

Senthuran S[1] , Kumanan T[2]

[1]Registrar in Emergency Medicine, Professorial Medical unit, Teaching Hospital Jaffna.

[2]Professorial Medical unit, Teaching Hospital Jaffna.

Background: Tuberculous meningitis represents a rare but serious manifestation of extrapulmonary tuberculosis, often associated with significant morbidity if not promptly diagnosed and treated.

Clinical Case: We report the case of a previously healthy patient who presented with a 4-day history of fever accompanied by chills and rigors, acute urinary retention with overflow incontinence and constipation. He also experienced gait instability leading to an attempted fall, along with numbness in both lower limbs. There was no weakness in the upper limbs or face, and he reported no back or neck pain, headache, or respiratory symptoms. Laboratory investigations revealed moderately elevated inflammatory markers. Magnetic Resonance Imaging (MRI) of the spine demonstrated diffuse leptomeningeal enhancement throughout the entire spinal cord, raising suspicion of central nervous system involvement. Although all routine tuberculosis screening tests returned negative results, the Mantoux test was positive, showing a 16 mm induration. Based on clinical and radiological findings, a provisional diagnosis of TB meningitis was made. The patient was commenced on standard antituberculosis therapy (ATT) in combination with intravenous Dexamethasone. Remarkable clinical improvement was noted within five days of treatment initiation.

Conclusion: This case underscores the importance of considering TB meningitis in patients with neurological deficits and meningeal enhancement on imaging, even in the absence of confirmatory laboratory tests. Early empirical initiation of ATT, guided by clinical judgement and radiological evidence, can be life-saving and may lead to rapid neurological recovery.

PP 68 : Case report : A Case of Posterior Reversible Encephalopathy Syndrome in Eclampsia

***Ariyawansha TI*[1,2]**
[1]*National Hospital Kandy*
[2]*Post Graduate Institute of Medicine- University of Colombo*

Background: Posterior reversible encephalopathy syndrome (PRES) is relatively uncommon disease characterized by acute neurological symptoms and vasogenic cerebral oedema, most commonly involving the posterior parietal and occipital lobes.

Clinical presentation: A 36-year-old woman in her seventh pregnancy presented at 32 weeks of POA with acute severe headache, blindness, vomiting, and two episodes of convulsions. Her blood pressure was 180/116 mmHg, GCS score was 12, and she had brisk tendon reflexes. Urine dipstick test for protein was positive (two plus). NCCT brain showed subcortical hypoattenuation in bilateral parieto-occipital lobes, consistent with PRES. She was treated with antihypertensives and intravenous magnesium sulphate boluses to control the convulsions. The pregnancy was terminated by emergency cesarean section, and both the mother and the baby survived.

Conclusion: This case highlights the importance of early diagnosis of PRES and the importance of a multidisciplinary approach in managing PRES to prevent possible complications. Early intervention leads to better outcomes.

PP 69 : Case report: A rare case of acute pancreatitis associated with pre-eclampsia in a pregnant woman

***Ariyawansha TI*[1,2]**
[1]*National Hospital Kandy*
[2]*Post Graduate Institute of Medicine- University of Colombo*

Background: Acute pancreatitis is the acute inflammation of the pancreatic tissue. Sometimes it involves surrounding tissue and distal organs. Acute pancreatitis is diagnosed based on revised Atlanta criteria, which include characteristic abdominal pain, serum amylase or lipase levels elevated to more than three times the upper limit of normal and imaging findings. The diagnosis is made when two out of three criteria are present. Pre-eclampsia is defined as the presence of new-onset hypertension (above 140 mmHg systolic or & 90 mmHg diastolic) after 20 weeks of pregnancy combined with proteinuria or maternal organ dysfunction or uteroplacental insufficiency. Co-existence of both conditions during pregnancy is rare and carries a higher mortality.

Case presentation: A 20-year-old lady in her 1 st pregnancy presented with severe epigastric pain, nausea and vomiting at 35 weeks of gestation. Upon examination, she had blood pressure of 150/100 mmHg, severe epigastric tenderness and a urine dipstick for protein at 2+. Serum amylase level was 1246 U/L. USS of the abdomen revealed features of acute pancreatitis, and there were no gallstones. Diagnosis of acute pancreatitis and pre-eclampsia was made.

Management: Moderately aggressive fluid resuscitation (1.5ml/ kg) was started with regular monitoring of fluid status. Oral antihypertensives were given to control blood pressure. Later, intravenous Magnesium Sulphate was started, and an Emergency cesarean section was done due to the development of severe pre-eclampsia.

Conclusion: The Mainstay of management of acute pancreatitis is early aggressive fluid resuscitation. Although this case highlights the importance of moderate fluid resuscitation to prevent volume-related complications in acute pancreatitis in a patient with pre-eclampsia.

PP 70 : Triage Categorization in Emergency Departments using Ensemble Learning

Thasitha Thangarasa[1], Kumara BTGS[2], Manitheepan K[3]

[1]Department of Computing and Information Systems, Faculty of Computing, Sabaragamuwa University, Sri Lanka, [2]Department of Software Engineering, Faculty of Computing, Sabaragamuwa University, Sri Lanka, [3]Teaching Hospital Jaffna

Background : Triage in Emergency Departments (EDs) is a crucial step in prioritizing patient care based on clinical urgency. In Sri Lanka, EDs face significant challenges including overcrowding, limited resources, and inconsistencies in manual triage processes. These issues often compromise timely and appropriate patient care. An advanced triage prediction model using ensemble learning was developed in this study to address these challenges.

Methodology : Primary data were collected from the Accident and Emergency Treatment Unit at the Teaching Hospital, Jaffna, including vital signs such as heart rate, blood pressure, respiratory rate, and oxygen saturation. After data cleaning and normalization, the dataset was split into training and testing subsets. Several classification algorithms were applied, including Logistic Regression (LR), Decision Tree (DT), K-Nearest Neighbors (KNN), Naive Bayes (NB), Support Vector Machine (SVM), and Light Gradient Boosting Machine (LightGBM). Ensemble techniques, including Voting and Stacking Classifiers, were implemented to improve model performance. The final model used a Stacking Classifier with LightGBM as the meta-learner. Model performance was evaluated using accuracy, precision, recall, and F1 score.

Results : Among the individual classifiers, the SVM showed highest accuracy that is 0.86 . However, the Stacking Classifier outperformed all individual models, achieving the highest overall performance with a score of 0.91 across all evaluation metrics. This ensemble approach reduces inconsistencies in manual triage, minimizes delays, improves resource allocation and ensures more accurate patient prioritization in emergency care settings.

Conclusion : The study demonstrates that Ensemble Learning can significantly enhance triage prediction accuracy, reduce inconsistencies in manual assessment, and support timely patient prioritization in EDs. The model's high performance highlights its potential for integration into real-time clinical workflows. Future work will focus on expand datasets and explore real-time implementation for clinical use.

PP 71: Case report: Atrial fibrillation following low-voltage electrocution: a case report

Wickremasinghe WVR [1]
Gamage RSP[1]
[1]*DGH Nuwara Eliya*

Background: Electrocution, whether from high or low voltage, can cause life-threatening injuries, particularly cardiac complications such as arrhythmias and myocardial injury. While sinus tachycardia and premature ventricular complexes become the most common arrhythmias recognized, atrial fibrillation (AF) is rarely reported, especially after low-voltage exposure.

Clinical Case: A 38-year-old male with no prior health issues presented to the emergency department (ED) after a low-voltage (230V) electrocution while operating a printing machine. He complained of palpitations and right upper limb pain following the event. His cardiovascular examination revealed an irregularly irregular pulse at 140-150 bpm and a blood pressure of 133/73 mmHg. No signs of heart failure or ischemia were noted. The entry and exit wounds were absent and other systems examination was unremarkable. The 12-lead ECG showed AF without ischemic changes. Cardiac biomarkers, electrolytes, and renal functions were normal. He neither had a past history of palpitations nor other identifiable causes for AF. Despite initial treatment with IV amiodarone 300g bolus, chemical cardioversion failed. Synchronized electrical cardioversion at 150J restored the sinus rhythm. IV amiodarone infusion, IV hydration with crystalloids and continuous cardiac monitoring were continued for the next 24 hours. The patient remained stable and asymptomatic, with a normal echocardiogram the next day. No complications like rhabdomyolysis occurred. He was discharged on day three, and reviewed two weeks later, where he remained asymptomatic with a normal ECG.

Conclusion: Low-voltage electrocution can precipitate arrhythmias, including rare cases of Atrial fibrillation. Timely ECG assessment and continuous cardiac monitoring are crucial for early detection and management.

PP 72 : Case report : Managing the Unknown: The Life-Saving Role of Clinical Judgment in Ethylene Glycol Poisoning During Early Pregnancy

Wickremasinghe WVR
District General Hospital, Nuwara Eliya

Introduction: Ethylene glycol poisoning is a medical emergency requiring prompt recognition and intervention. In resource-limited settings where toxicology testing and specific antidotes are unavailable, clinical judgment becomes critical—particularly during pregnancy, when outcomes affect both mother and fetus.

Clinical Case: A 23-year-old woman was brought to the emergency department after being found unconscious at home. She had no significant medical history and had been well the previous evening. On arrival, she was tachycardic (144 bpm), hypotensive (BP 100/60 mmHg), with deep rapid breathing and a GCS of 9/15. She was afebrile, and physical examination was otherwise unremarkable.
Initial venous blood gas revealed profound high anion gap metabolic acidosis (pH 6.5, undetectable bicarbonate, lactate 16 mmol/L). Blood glucose was normal, ketones were negative, and routine labs were within normal limits. Urine β-hCG test became positive, and transabdominal ultrasound newly identified a viable 6-week intrauterine pregnancy. CT brain was normal. Toxicology and osmolality testing were unavailable.
A toxic ingestion was suspected. Supportive IV fluids were started, and the patient was transferred to the ICU. CRRT was initiated for acidosis management and presumed toxin removal. Ten hours later, family produced an empty ethylene glycol (brake fluid) bottle, confirming the diagnosis. With fomepizole and IV ethanol unavailable, 40% oral ethanol was administered via nasogastric tube. The patient regained consciousness the next day, reporting intentional ingestion following a domestic dispute. She was diagnosed with morbid jealousy disorder and transferred to psychiatric care. The pregnancy remained viable; fetal outcomes are pending.

Conclusion: This case highlights the life-saving role of clinical judgment in toxic ingestions where diagnostics are limited. Timely CRRT and supportive care, initiated based on clinical suspicion, were likely life-saving for both mother and fetus. It also reinforces the importance of routine pregnancy testing in all women of reproductive age

PP 73 : Case report : A rare case of an adult acute epiglottitis diagnosed with x-rays and managed without airway interventions.

Yapa W. S. P. Y. U. S. [1,2]
[1]*National Hospital – Kandy*
[2]*Post Graduate Institute of Medicine - University of Colombo*

Background: Acute epiglottitis is a rare disease encountered in the adult population. Although it is an airway-threatening condition in the paediatric population, among adults, the need for airway interventions is less frequent. The causes of adult acute epiglottitis are commonly bacterial infections, Inhalational injury and trauma. This is a rare case of adult acute epiglottitis diagnosed in the emergency department with x-ray imaging, which was managed without airway interventions.

Clinical Case: A 68-year-old male presented with sore throat, difficulty in speaking, odynophagia and muffled voice that progressed over one day with fever. No history of headache, neck pains or chest pains. He didn't have a history of respiratory tract infection, neck trauma, or exposure to steam inhalation. He was a diabetic patient with poor glycaemic control.
On examination, he was found to have a tachycardia of 108 bpm and blood pressure of 100/70. He was having a hoarse voice, but no drooling or stridor on examination. Neck movements were normal, though tender left side cervical lymphadenopathy was noted. No respiratory distress was observed on admission. With these findings X-ray of the neck was performed, which revealed a thumbprint sign indicating acute epiglottitis. Laboratory studies showed neutrophilic leukocytosis.
Intravenous Ceftriaxone was started and the patient was observed for deterioration. Flexible Fibro-optic laryngoscopic examination of the throat was done, which confirmed the diagnosis. The patient was closely observed in the ward and managed without airway interventions. His blood culture was negative, and the patient was treated with antibiotics for ten-day duration along with blood sugar control. Discharged without complications.

Conclusion: Though acute epiglottitis is rare in adults, with rising trends of the incidence, x-ray imaging can be a crucial screening tool in adults for the diagnosis. With close observations, adult acute epiglottitis may be managed without airway interventions.

PP 74 : Case report : A Case Report on Management of Epi-peritoneal haematoma in a Patient on warfarin

Mendis WPM
District General Hospital, Embilipitiya.

Background: Warfarin is the most commonly used oral anticoagulant in Sri Lanka. Bleeding and severe haemorrhage are significant adverse effects associated with warfarin treatment. Therefore, confirmation of true indication for commencement of warfarin, proper patient and family education throughout warfarin treatment, and routine INR monitoring is mandatory. Warfarin acts via cytochrome P450 pathway and antibiotics which are capable of modulating this pathway may results in supratherapeutic or sub-therapeutic values of INR.

Clinical case: In this case Mrs;Z 65 years old, diagnosed patient with Hypertension, hypothyroidism, OS- ASD with Left to right shunt, moderate pulmonary hypertension and persistent atrial fibrillation. She is on warfarin 3.5mg daily with good drug compliance with effective INR levels 2-3, presented to ED with abdominal pain for 2days duration with faintishness. She has a preceding history of cough and fever which led to intake of antibiotics 5days ago. She is diagnosed to have large epi-peritoneal haematoma with haemodynamic instability with supratherapeutic INR. Therefore, patient was managed as major bleeding manifestation following warfarin intake, where immediate INR reversal obtained via administration of IV vitamin K and IV FFP and IV 4 factor PCC. All three modalities were used under the guidance of consultant Haematologist in order to overcome logistic barriers and to achieve immediate INR reversal. Epi-peritoneal haematoma diagnosed with the help of USS and follow-up USS showed resolving haematoma. Haematoma was managed conservatively. She made a successful recovery.

Conclusion: If warfarin reversal is required, the method chosen for reversal depends on clinical seriousness of bleeding and balance against the thrombotic risk of a temporary cessation of anticoagulation. Factors that require consideration include the indication for warfarin, the seriousness of bleeding, the speed and completeness of reversal required. For epi-peritoneal haematoma conservative methods should be applied and surgery should be avoided as much as possible.

PP 75 : Case report : A Hidden Crisis in Shock: Sepsis inducing Adrenal crisis in a patient with Empty Sella Syndrome

Wickramasingha WMGK[1,2], Hemachandra RMSS[3,4]
[1]Sirimavo Bandaranaike Specialized Children's Hospital,
[2]Post Graduate institute of Medicine - University of Colombo
[3]Ministry of Health,
[4]National Hospital Kandy

Background : Adrenal crisis is a life-threatening emergency resulting from insufficient cortisol, often triggered by physiological stresses in patients with adrenal insufficiency. It may present with shock unresponsive to fluids and vasopressors in the background of sepsis.

Clinical case : A 54-year-old woman presented to the emergency department with reduced responsiveness following two days of diarrhea. She was in shock and blood gas revealed metabolic acidosis, lactemia, hyponatremia and mild hyperkalemia. The treatment for septic shock was initiated with IV Ceftriaxone, IV metronidazole after obtaining blood for culture and simultaneous fluid resuscitation. As she remained hypotensive, IV noradrenaline was initiated, but the response was inadequate. Point-of-care ultrasound was inconclusive.
While planning for second vasopressor, her husband provided a medical emergency card revealing a diagnosis of panhypopituitarism due to Empty Sella Syndrome, for which she was on glucocorticoid replacement. Adrenal crisis precipitated by sepsis was suspected. She was treated with IV hydrocortisone 100mg followed by 200mg in 5%dextrose infusion, leading to rapid hemodynamic improvement. Lab investigations showed neutrophil leukocytosis with normal hemoglobin and CRP of 198. She was admitted to the medical ward under endocrinology care.

Conclusion : When a known patient with adrenal insufficiency is coming to emergency department with undifferentiated shock with background sepsis, adrenal crisis must be considered. Failure to recognize this can delay life-saving steroid administration. Early administration of IV hydrocortisone and fluid resuscitation is critical in reversing shock and improving outcomes. This case highlights the subtle presentation and potentially fatal course of adrenal crisis, particularly when overlapped by sepsis and the importance of adherence to "sick day rules" and carrying medical emergency card which help to early identification of adrenal crisis in emergency department. Also this case points out that standard management at the correct time in suspicious adrenal crisis provides significant improvement in the overall patient outcome.

PP 76 : Case report : A Subtle onset with a Rapid Turn: A Case of AMAN type Guillain-Barré Syndrome in a Child

Wickramasingha WMGK[1,2], Abewardana LS[1,2]
[1]Sirimavo Bandaranaike Specialized Children's Hospital
[2]Post Graduate institute of Medicine - University of Colombo

Background : Guillain-Barré syndrome (GBS) is an acute polyneuropathy characterized by immune-mediated peripheral nerve myelin sheath or axon destruction. It is usually preceded by a minor viral or bacterial illness. The nonspecific presenting symptoms in the pediatric population make it a diagnostic challenge especially in emergency setting.

Clinical case : A 4 ½ year old previously healthy girl admitted to emergency department with non specific symptoms of bilateral lower limb pain, myalgia following a recent upper respiratory tract infection. Initial assessment was unremarkable except for mild dehydration. Once she was admitted to the pediatric ward, the detailed neurology examination revealed pain on moving bilateral lower limbs leading to reduced power (4/5). Other than that, rest of the neurology was normal which prompted viral myositis as the provisional diagnosis. Within next 24 hours she complained of worsening lower limb pain, difficulty in swallowing and coughing, raising clinical suspicion of GBS. Urgent neurology opinion was taken and the nerve conduction studies revealed AMAN type GBS. She was immediately transferred to ICU where she received IV immunoglobulin, plasma exchange and other supportive care. During ICU stay her respiratory functions rapidly deteriorated which needed ventilatory support for 7 days. Later she showed significant improvement with standard treatment and had a rapid recovery.

Conclusion : This case highlights the diagnostic complexity of pediatric GBS, especially in its early phase when classic neurological signs may be absent. Subtle yet significant symptoms like limb pain must provoke the clinicians to suspect early GBS in children. And also this case elaborates the classic course (rapidly progressive weakness, respiratory failure, and good recovery) of AMAN variant of GBS which is more common in children. And this case signifies the importance of early recognition and timely initiation of immunomodulatory therapy, which can be life-saving and significantly improve patient outcomes.

PP 77 : Case report : A pressured response: navigating anaphylaxis in the hypertensive patient: a case report

Wahalawatte YR[1,2], Jayathilake NK[2]

[1]Postgraduate Institute of Medicine—University of Colombo

[2]National Hospital Kandy

Background:

Anaphylaxis is a life-threatening condition requires prompt administration of adrenaline. However, in patients presenting with concurrent severe hypertension, this treatment poses a clinical dilemma, as adrenaline can further raise blood pressure and precipitate complications. Managing such cases requires careful risk-benefit analysis and individualized treatment strategies.

Case:

A 28-year-old female with systemic lupus erythematosus and antiphospholipid syndrome was being treated for lupus nephritis and on renal replacement therapy. The patient was undergoing evaluation for dyspnea. Pulmonary embolism was suspected, and a CT pulmonary angiogram was performed. Her blood pressure was 150/70 mmHg before the procedure. Within minutes of the contrast administration, she developed acute respiratory distress with oxygen saturation dropping to 87% despite a patent airway. On examination, she was tachypneic (RR 36/min), tachycardic (PR 118 bpm), and severely hypertensive (BP 190/110 mmHg). Postural blood pressure was not evaluated because of her distress. Diffuse bilateral rhonchi were noted on auscultation. The patient was visibly agitated. No rash, urticaria were present. Contrast-induced anaphylaxis was suspected. Due to the markedly elevated blood pressure, giving standard intramuscular adrenaline (0.5 mL of 1:1000) was questioned initially. A reduced intramuscular dose of adrenaline (0.3 mL of 1:1000) was cautiously given, followed by close monitoring. No further blood pressure elevation occurred. A second 0.3 mL dose was administered five minutes later as her symptoms were persisting. She achieved rapid symptom resolution. She was additionally treated with nebulized adrenaline, salbutamol and intravenous hydrocortisone. Her oxygen saturation normalized over the next hour, and she remained hemodynamically stable during observation.

Conclusion:

Hypertension can be an associated feature of anaphylaxis (Hypertensive anaphylaxis). Moreover, Anaphylaxis can be present with comorbid hypertension. This case highlights the importance of adjustment of standard anaphylaxis protocols with close monitoring. Clinicians should be aware of such atypical responses and tailor treatment to balance efficacy with safety.

PP 78 : Audit : Effectiveness of Short Stay Unit in District General Hospital Embilipitiya

Samaradiwakara RKNS[1,2]
[1]District General Hospital Embilipitiya
[2]Postgraduate Institute of Medicine Sri Lanka

Background : This audit evaluates the effectiveness of the Short Stay Unit (SSU) at the District General Hospital, Embilipitiya, in terms of emergency department (ED) efficiency enhancement, patient outcomes improvement, and reduction of inpatient admission rates. The SSU introduced as a strategic intervention to manage patients requiring short-term care. However, the performance and effectiveness had not been formally assessed prior to this audit.

Methodology: A retrospective audit was conducted covering the period from 1st November 2024 to 29th February 2025, analyzing approximately 200-300 SSU admissions. Data were collected from admission/discharge records, patient medical files, and the hospital information system. Discharge rates, readmission rates, reasons for SSU admission, and the impact on overall hospital admission rates were the major considered metrics.
This audit revealed a significant increase in discharge rates from 19.18% to 33.76% before SSU implementation to post-implementation, with readmission rates remaining below 1%.
Additionally, the hospital admission rate decreased from 80.80% to 66.22%. Gastroesophageal reflux disease, musculoskeletal chest pain, and upper respiratory tract infections were the common reasons for SSU admission.

Conclusion: These findings suggest that the SSU has positively impacted patient flow and ED efficiency while reducing unnecessary inpatient admissions. Following these results, implementation of targeted strategies to reduce readmission rates, optimization of triage protocols to improve screening of patients, and enhancement of staff training to understand discharge patterns are recommended. To understand the effectiveness of these strategies, a follow up audit is planned within one year of the implementation.