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ABSTRACTS

SIMCON 2026 Colombo

A Decade of Inspiration
A Future of Innovation

Oral and Poster Presentations at the

10TH ANNUAL CONGRESS

SRI LANKA COLLEGE OF INTERNAL MEDICINE

05TH - 07TH NOVEMBER 2026 | SHANGRI-LA COLOMBO, SRI LANKA

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MESSAGE FROM THE PRESIDENT



It is my privilege and pleasure to welcome you to SIMCON 2026, the 10th Annual Academic Congress of the Sri Lanka College of Internal Medicine (SLCIM). This year, our congress embodies the theme "A Decade of Inspiration, A Future of Innovation," celebrating ten years of dedication to advancing internal medicine while embracing a future of scientific excellence, meaningful innovation and compassionate patient care. Our theme reflects our commitment to building upon the achievements of the past decade and exploring new ways of thinking, learning and delivering healthcare, guided by evidence, ethics and humanity.

The congress is conducted in association with several prestigious professional organisations and academic institutions, including the American College of Physicians, Royal College of Physicians of Edinburgh, Mayo Clinic, International Society of Internal Medicine, Association of Physicians of India, Association of Physicians of Bangladesh and Society of Internal Medicine of Nepal, together with other regional and national professional bodies. These partnerships provide an important platform for sharing expertise, strengthening academic relationships and fostering future collaborations in education and research.

Our comprehensive scientific programme encompasses contemporary advances and emerging challenges across internal medicine, with particular emphasis on translating scientific evidence into everyday clinical practice. The diverse pre-congress workshops, ranging from artificial intelligence and research methodology to advanced clinical skills, diagnostic reasoning, humane care and preventive medicine, further reflect our commitment to purposeful innovation.

Our free paper sessions, including oral and poster presentations, together with online case presentations, provide essential platforms for academics, clinicians and researchers to showcase their scientific work, exchange ideas and stimulate discussions that contribute to advancing medical knowledge and improving patient care. The online case presentations have further expanded opportunities for young clinicians to share their clinical experiences and demonstrate their diagnostic reasoning and decision-making skills.

We have received an enthusiastic response to our call for abstracts this year, reflecting the vibrant research community dedicated to advancing internal medicine. I extend my sincere gratitude to Dr Suranga Manilgama, Joint Editor-in-Chief of the Asian Journal of Internal Medicine, together with the Editorial Board and external reviewers, for their meticulous efforts in reviewing and organising these submissions. Their dedication has been invaluable in ensuring that high-quality scientific contributions are presented at SIMCON 2026.

I am grateful to the distinguished judging panels for the oral, poster and online case presentation sessions for their valuable time and expertise in selecting the best among the scientific presentations. My heartfelt thanks also go to the organising committees, whose tireless efforts and commitment have been instrumental in making these academic activities possible.

I would like to extend my special appreciation to Dr Madhusha Liyanage, Scientific Copy Editor, and Dr Shashi Karunarathna, Assistant Editor of the Asian Journal of Internal Medicine, for their invaluable contributions to the scientific copy-editing, meticulous preparation and compilation of this supplementary abstract book. Their dedication, attention to detail and commitment to excellence have been instrumental in bringing together this publication and presenting the scientific contributions of our researchers in a manner befitting the high standards of SIMCON 2026.

I am especially grateful to all researchers who have entrusted us with their valuable scientific work. Your dedication, enthusiasm and commitment to advancing medical knowledge are truly inspiring. I warmly congratulate the winners of the best oral, poster and case presentations. Your scientific curiosity, perseverance and innovative thinking set a high standard and serve as an inspiration to the next generation of physicians.

To all participants, speakers, researchers and contributors, thank you for your invaluable contributions to SIMCON 2026. As we celebrate this remarkable milestone in our College's journey, let us carry forward the inspiration of the past decade into a future of meaningful innovation, scientific excellence and compassionate care, making a lasting difference in the lives of our patients and the communities we serve.

With warm regards,

Dr N. Madhuwanthi Hettiarachchi
President – 2026
Sri Lanka College of Internal Medicine

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MESSAGE FROM THE EDITORS

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It is our pleasure to present the Abstract Book of SIMCON 2026, the Annual Academic Sessions of the Sri Lanka College of Internal Medicine, held from 5th to 7th November 2026.

This year, we received an impressive 145 submissions—52 original research abstracts and 93 case reports. The strong response reflects the growing enthusiasm for research, clinical inquiry and academic engagement among physicians and trainees across the country. It is particularly encouraging to see questions arising from everyday clinical practice being developed into research, while unusual and challenging clinical encounters are shared with the wider medical community.

Following a careful and independent review process, the best submissions were selected for presentation at SIMCON 2026 in three categories: oral research presentations, poster presentations and case presentations. These sessions provide a valuable platform to showcase high-quality work, encourage scientific discussion and recognise excellence in clinical research and scholarship.

The preparation of an abstract programme of this scale is very much a collective effort. We extend our sincere appreciation to all our abstract reviewers and judges for generously contributing their time and expertise and for ensuring a fair and rigorous assessment process.

Our special thanks go to Dr Shashi Karunarathna, Assistant Editor, Dr Nishadi Perera and Dr Pamuditha Madanayake for their dedicated coordination of the abstract process, from submission and review through to the final programme. We are equally grateful to all the coordinators and colleagues who supported the online case presentations and the poster and oral research presentation sessions during SIMCON 2026.

We also extend our particular appreciation to Dr Madhusha Liyanage for once again undertaking the meticulous task of compiling and copy-editing the Abstract Book. Her attention to detail, consistency and presentation has contributed greatly to the quality of this publication.

Above all, we thank every author who submitted an abstract. Each submission represents the effort to ask an important question, examine clinical practice more closely, document a valuable observation or contribute new knowledge. We hope that many of these contributions will progress beyond conference presentation to further research, collaboration and full publication.

We hope that the SIMCON 2026 Abstract Book will not only serve as a record of the scientific work presented at this year's conference, but also inspire continued curiosity, collaboration and excellence in internal medicine research in Sri Lanka.

Editors
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OP 001

PRE-ADMISSION ANTIBIOTIC EXPOSURE, SECONDARY INFECTION, AND DENGUE HAEMORRHAGIC FEVER AMONG HOSPITALISED PATIENTS IN SRI LANKA

Lokunarangoda NC[1], Wimalasundera AR[1], Perera MHMTS[2], Perera NT[2], Kothalawala KGD[2], Wettasinghe I[3], Somasiri D[6], Muthugala R[4], Kottegoda C[5], Wijewickrama A[1], Idampitiya D[2], Liyanage NPM[6]

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Introduction: Empirical antibiotic use is common during early undifferentiated febrile illness in dengue-endemic settings, but its relationship with subsequent dengue outcomes remains uncertain.

Objectives: To determine the prevalence of pre-admission antibiotic use and evaluate its associations with dengue haemorrhagic fever (DHF), documented secondary infection, and selected clinical outcomes among hospitalised dengue patients.

Methods: This observational analytical study used pooled, prospectively collected data from patients aged ≥14 years admitted to the National Institute of Infectious Diseases in Sri Lanka with clinically diagnosed or serologically confirmed dengue between June 2023 and January 2026. Documented secondary infection was defined as any clinically diagnosed non-dengue infection, not necessarily laboratory-confirmed. Multivariable logistic regression was used to estimate adjusted odds ratios (aORs) with 95% confidence intervals (CIs), adjusting for age, C-reactive protein (CRP), lowest white blood cell (WBC) count, diabetes mellitus and secondary infection. Sensitivity analyses were performed in serologically confirmed patients.

Results: Among 1,701 patients, 406 (23.9%) had received antibiotics before admission. DHF occurred in 184/406 (45.3%) of antibiotic-exposed vs 448/1,295 (34.6%) of unexposed patients; pre-admission antibiotic use was independently associated with DHF (aOR 1.64, 95% CI 1.29–2.09; $p < 0.001$). Documented secondary infection was also more frequent among antibiotic-exposed patients (63/406 [15.5%] vs 90/1,295 [6.9%]; aOR 2.62, 95% CI 1.85–3.72; $p < 0.001$). Baseline CRP and lowest WBC were comparable between groups. In the serologically confirmed subgroup (n = 740), the association with secondary infection persisted (aOR 1.75, 95% CI 1.06–2.88; $p = 0.027$), whereas that with DHF was attenuated and non-significant (aOR 1.32, 95% CI 0.94–1.86; $p = 0.11$). Secondary infection was associated with longer fever duration and hospital stay.

Conclusion: Pre-admission antibiotic use was common and consistently associated with documented secondary infection. The DHF association was not robust to serological restriction; given possible confounding by indication, neither association should be interpreted as causal. These findings support diagnostic reassessment and antimicrobial stewardship after dengue confirmation when bacterial infection is not supported.

Keywords: dengue; dengue haemorrhagic fever; antibacterial agents; coinfection; antimicrobial stewardship

OP 002

EPIDEMIOLOGY AND CLINICAL FEATURES OF HYMENOPTERAN (BEES, WASPS AND ANTS) STING ENVENOMING IN GAMPOLA, SRI LANKA

Witharana EWRA[1], Karunaratne WAIP[2], De Silva JPWC[1], Ahamad MAN[1], Rifkan M[1], De Silva A[1], Galahitiyawa HS[1], Fernando KHSNR[1], Senarathne MMYS[1], Wijesooriya A[1], Habaragamuwa HNS[1], Kanchanamala PA[1], Shiwanthini KGM[1], Amarasinghe PGNK[1], Jayasinghe S[3]

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Introduction: Hymenopteran sting envenoming is a neglected medical condition in Sri Lanka, despite causing thousands of hospital admissions and an estimated 15–30 deaths annually. However, its epidemiological and clinical characteristics remain poorly documented.

Objectives: To describe and analyse the demographic, epidemiological, and clinical features of hymenopteran sting envenoming in Gampola, Sri Lanka, and to identify the offending hymenopteran species.

Methods: An ethically approved prospective observational study was conducted among consenting patients presenting to Base Hospital Gampola (1 March 2025–31 August 2026) following hymenopteran stings. Demographic, epidemiological, and clinical data were collected using a structured questionnaire. Offending insects were collected and identified to species level. When specimens were unavailable, identification was based on unprompted selection by victims from a collection of reference specimens and photographs.

Results: Ninety-seven patients were included (mean age 54.7 years, range 15–84 years; 56 males). Ninety-one offending insects were identified: *Apis dorsata* (F: Apidae), *Vespa tropica* (F: Vespidae), and *Myopopone castania* (F: Formicidae). All stings occurred during daytime, with 80 (82.4%) patients presenting within two hours. Thirty patients (30.9%) were stung while working in tea plantations. Twenty-nine (29.9%) experienced more than 100 stings, with potential mass-stinging events. Common clinical manifestations included local pain (100%), swelling (87.6%), facial puffiness (50.5%), and nausea/vomiting (40.2%). Nineteen patients (19.6%) developed anaphylaxis and were treated with adrenaline. Twenty-two patients (22.7%), all following *Apis dorsata* stings, developed Kounis syndrome. Neutrophil leucocytosis, elevated alanine aminotransferase, and elevated aspartate aminotransferase were observed in 35 (36.1%), 32 (33.0%), and 32 (33.0%) patients, respectively. No deaths were recorded among the patients.

Conclusion: Hymenopteran sting envenoming in Gampola was predominantly associated with daytime outdoor activities, particularly tea plantation work. *Apis dorsata* was the predominant offending species and was associated with anaphylaxis, neutrophil leucocytosis, elevated liver enzymes and Kounis syndrome. Awareness of these clinical complications and early recognition and management are essential to reduce morbidity associated with hymenopteran stings in Sri Lanka.

Keywords: Hymenoptera; insect bites and stings; anaphylaxis; Kounis syndrome

OP 003

GRACE SCORE AND POST-DISCHARGE MORTALITY FOLLOWING NSTEMI IN A MULTICENTRE SRI LANKAN REGISTRY

Manilgama SR[1,2,3], Nugara VA[3], Jayasinghe K[3,4], Hettiarachchi NM[3,5], Ralapanawa U[3,5], Gunasekara HRP[3,6], De Zoysa W[3,7], Matthias AT[1,2,3], Mettananda C[3,8], Jayasundara AJMK[3,8], Jegathesan N[3,9], Premawardana N[3,10], Seneviratne MP[3,11], Veerasuthen T[3,12], Bandusiri RP[3,13], Mayurathan P[3,14], Hewage ND[1], Lekamwasam S[3,7]

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Introduction: Risk stratification following non-ST-elevation myocardial infarction (NSTEMI) may help identify patients requiring closer follow-up. We examined the association between baseline Global Registry of Acute Coronary Events (GRACE) score and post-discharge mortality in a multicentre Sri Lankan registry.

Methods: The registry included 878 patients admitted with NSTEMI to 13 secondary and tertiary care hospitals. Baseline data included demographic characteristics, comorbidities, and GRACE and Thrombolysis in Myocardial Infarction (TIMI) risk scores. Follow-up information was obtained through telephone interviews and clinic visits. Multivariable logistic regression examined factors associated with post-discharge mortality, with GRACE score incorporated into a sensitivity model.

Results: Mean age was 65.4 ± 11.9 years, and 56.9% were male. Follow-up information was available for 564 patients, with a median follow-up of 340 days (interquartile range [IQR] 307–367). There were 121 deaths (21.5%), of which 78 (64.4%) were classified as cardiac. In the sensitivity model, higher baseline GRACE score was independently associated with mortality (adjusted odds ratio (aOR) 1.02 per point; 95% CI 1.01–1.03; p = 0.003). In the main multivariable analysis, age (aOR 1.05 per year; 95% CI 1.02–1.08; p = 0.002) and acute pulmonary oedema during admission (aOR 2.22; 95% CI 1.12–4.41; p = 0.023) were associated with mortality.

Conclusion: Higher baseline GRACE score was associated with post-discharge mortality following NSTEMI. This finding supports further evaluation of GRACE-based risk stratification in Sri Lankan practice. Assessment of discrimination, calibration, and comparative performance against TIMI is needed before drawing conclusions about predictive accuracy.

Keywords: non-ST elevated myocardial infarction; GRACE score; risk assessment

OP 004

THROMBOPOIETIC RESPONSE BEFORE AND AFTER PLASMA LEAKAGE IN DENGUE: A PROSPECTIVE COMPARATIVE STUDY

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Introduction: In dengue the immature platelet fraction (IPF) is interpreted as a marker of marrow thrombopoiesis. Since it is expressed as a percentage of the total circulating platelet count, it also rises when the circulating platelet pool contracts.

Objectives: To determine whether thrombopoiesis differs, before radiologically apparent leakage and at equivalent platelet counts, between patients who do and do not subsequently leak.

Methods: A single-centre observational cohort study of adults with non-structural protein 1 (NS1)-confirmed dengue was carried out. IPF and platelet count were measured at three clinical events, not days of illness. In dengue haemorrhagic fever (DHF), pre-leakage, 24–36 h into leakage and 24–48 h after the leakage phase were compared against admission, first count < 100 × 10^9/L and nadir of patients with dengue fever (DF). Absolute immature platelet count and IPF-to-platelet ratio were derived.

Results: Seventy of 96 patients were analysed (22 DHF, 48 DF). Baseline platelet counts were comparable in DHF and DF (median 120 versus 126.5 × 10^9/L; p = 0.34). At baseline (pre-leakage in DHF, admission in DF) IPF was higher in DHF (10.30% versus 8.30%; p = 0.0015; area under the curve (AUC) 0.738, 95% confidence interval (CI) 0.620–0.856). The difference persisted after platelet-count adjustment (+24.3%; p = 0.0082) and against DF samples at the same platelet count (+2.20 percentage points; p = 0.0002). Serially, absolute immature platelet count fell in DHF and rose in DF (−5.25 versus +1.24 × 10^9/L; p = 0.0004), while IPF% rose more steeply in DHF (+11.15 versus +7.70 percentage points; p = 0.0009).

Conclusion: In this small cohort, DHF patients showed higher IPF even before radiologically apparent leakage, at comparable platelet counts of DF; thereafter absolute immature platelet count fell while IPF% rose among DHF. Whether this reflects peripheral consumption, marrow involvement or immature platelets contributing to leakage is undetermined. These hypothesis-generating findings need confirmation in larger cohorts with day-of-illness sampling.

Keywords: dengue; thrombopoiesis; immature platelet fraction; plasma leakage; thrombocytopenia

OP 005

HEALTH-RELATED QUALITY OF LIFE AMONG ADULTS RECEIVING ANTI-TUBERCULOSIS TREATMENT AT A CHEST CLINIC IN SRI LANKA: A PROSPECTIVE COMPARATIVE STUDY

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Introduction: Tuberculosis (TB) impairs physical, mental, social and economic well-being even when microbiological cure is achieved. Local data on patient-reported health-related quality of life (HRQoL) during treatment are limited.

Objectives: To assess HRQoL among adults receiving anti-tuberculosis treatment, evaluate change during treatment, and explore associated sociodemographic and clinical factors.

Methods: A prospective observational study with a non-TB comparison group was conducted at Colombo South Chest Clinic. Adults with pulmonary or selected extrapulmonary TB were assessed at treatment initiation, 2 months and 6 months; controls were assessed once. HRQoL was measured using the 36-item Short Form Health Survey (SF-36), generating eight domain scores (0–100) and physical (PCS) and mental (MCS) component scores. Changes over time were analysed using repeated-measures analysis of variance, and associations using univariable analysis of variance ($p < 0.05$).

Results: Of 277 participants, 139 had TB and 138 did not; 124 and 118 TB patients completed 2- and 6-month follow-up. TB patients had more smokers (56.1% vs 21.7%), more comorbidity (74.8% vs 53.6%) and lower mean monthly income (all $p < 0.001$). At initiation, all SF-36 domains were lower in TB patients, with mean overall HRQoL 34.3 ± 2.3 vs 74.7 ± 3.3 in controls ($p < 0.001$). Physical functioning was the lowest domain (29.1 ± 3.0). HRQoL improved to 43.9 ± 4.9 at 2 months and 62.5 ± 3.0 at 6 months ($p < 0.001$), but remained below controls. PCS increased from 33.7 to 53.5 and MCS from 35.0 to 52.8 (both $p < 0.001$). Age ($p = 0.045$), marital status ($p = 0.049$) and comorbidity ($p = 0.006$) were associated with baseline HRQoL, and sex ($p = 0.008$) and smoking ($p = 0.002$) with end-of-treatment HRQoL. Income and the perceived economic crisis showed no significant association.

Conclusion: HRQoL was markedly impaired at TB treatment initiation and improved significantly during therapy, but residual deficits persisted at completion. Routine TB care should incorporate HRQoL assessment, physical rehabilitation, psychosocial support, smoking cessation and comorbidity management.

Keywords: quality of life; tuberculosis; antitubercular agents; SF-36

OP 006

CLINICAL PROFILE AND FACTORS ASSOCIATED WITH SEVERE OUTCOMES IN HOSPITALISED ACUTE PYELONEPHRITIS: A MULTICENTRE SRI LANKAN STUDY

Manilgama SR[1,2,3], Hewage ND[1], Jayasinghe K[3,4], Narangoda E[3,5], Fonseka CL[3,6], Gunasekara HRP[3,7], Hettiarachchi NM[3,8], Mayurathan P[3,9], Premawardana N[3,10], Jegathesan N[3,11], Kumarihamy P[3,12], Perera N[1,2,3], Handagala DMNR[1], Wellappuli WADY[1]

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Introduction: Acute pyelonephritis (APN) is a potentially life-threatening infection, with early recognition of patients at risk of severe disease essential for timely escalation of care. We evaluated the clinical profile, microbiological characteristics, treatment patterns and predictors of severe outcomes among hospitalised patients with APN in Sri Lanka.

Methods: A multicentre observational study included 443 patients aged ≥14 years hospitalised with clinically and/or radiologically diagnosed APN. Demographic, clinical, laboratory, microbiological, treatment and outcome data were analysed. Severe outcome was defined as septic shock, acute kidney injury requiring renal replacement therapy, renal/perinephric abscess, or emphysematous pyelonephritis. Factors associated with severe illness were evaluated using multivariable binary logistic regression.

Results: Median age was 57 years (interquartile range (IQR) 44–66); 72.7% were female and 62.2% had diabetes mellitus. Median peak C-reactive protein (CRP) was 182.7 mg/L (IQR 110.0–265.4). Significant bacteriuria was detected in 23.2% of available urine cultures, while bacteraemia occurred in 16.4% of patients with blood cultures. Empirical cephalosporins and carbapenems were used in 31.4% and 18.1%, respectively; only 14.0% received antimicrobial therapy tailored to susceptibility results at any stage. Septic shock occurred in 5.9%, renal abscess in 2.3%, emphysematous pyelonephritis in 1.6%, and dialysis-requiring acute kidney injury in 1.4%; in-hospital mortality was 0.7%. In multivariable analysis, higher peak CRP (adjusted odds ratio [aOR] 1.002 per mg/L; 95% confidence interval (CI) 1.001–1.003; p = 0.008) and bacteraemia (aOR 2.245; 95% CI 1.074–4.693; p = 0.032) were independently associated with severe illness, whereas age, diabetes and chronic kidney disease were not.

Conclusion: Among hospitalised Sri Lankan patients with APN, severe outcomes were independently associated with greater inflammatory burden and bacteraemia rather than baseline metabolic comorbidity. Early blood cultures and close assessment of inflammatory response may improve risk stratification and identify patients requiring intensified monitoring.

Keywords: pyelonephritis; risk factors; bacteraemia; C-reactive protein

OP 007

INPATIENT PRESCRIBING PRACTICES FOR COMMON INFECTIOUS DISEASES IN SRI LANKA: A MULTICENTRE SURVEY

Mendis SA[1], Pathirana RM[1], Liyanage PLGC[1], Fonseka CL[2], Jayasekera K[3], Piyasiri DLB[3], Dikmadugoda N[4], Jayasinghe IK[5], Premawardana N[6], Gnanapragash N[7], Higgoda RA[8], Jayasekara P[9]

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Introduction: Rational inpatient prescribing for common infectious diseases is critical for optimising clinical outcomes and mitigating antimicrobial resistance, especially in low and middle-income countries.

Objectives: To evaluate inpatient prescribing practices, assessing empirical treatment choices, adherence to the 2024 National Antibiotic Guidelines (NAG), diagnostic culture utilisation, and broad-spectrum antibiotic exposure in Sri Lanka.

Methods: A multicentre survey reviewed 588 inpatient records across five tertiary care centres (Anuradhapura, Colombo, Kandy, Galle, Jaffna). Parameters included empirical prescribing, pre-antibiotic culture collection, conversion of route of administration from intravenous (IV)-to-oral, de-escalation, and broad-spectrum antibiotic use. Statistical analysis utilised chi-square and Welch's t-tests ($\alpha = 0.05$).

Results: Empirical prescribing aligned with NAG in 54.1% (n = 318) of cases, varying significantly across facilities ranging from 28.8% in Jaffna to 64.3% in Anuradhapura (median: 59.3%, interquartile range [IQR]: 6.1%). Pre-treatment site-appropriate cultures were submitted in 65.0% of urinary tract infections (UTIs) (urine) and 32.7% of pneumonia cases (sputum). Pre-antibiotic blood cultures were obtained in 17.5% (n = 101) overall, correlating with pneumonia severity (6.6% in mild vs. 30.0% in severe CURB-65;). Culture-guided de-escalation occurred in 12.5% of indicated cases (n = 5), and IV-to-oral step-down in 8.6% (n = 37). Laboratory turnaround (mean 1.5 days) did not correlate with IV duration. Overall broad-spectrum exposure (WHO Watch/Reserve) reached 26.2%, dominated by meropenem (16.2%) and piperacillin-tazobactam (10.4%). Among patients started on Day 1 empirical meropenem, 58.0% (n = 29) lacked documented clinical indication or severity markers, prescribed for mild-to-moderate infections without shock.

Conclusion: Substantial gaps exist in guideline adherence, culture collection, and de-escalation across Sri Lankan tertiary care hospitals. Interventions such as 48–72-hour clinical reviews and carbapenem pre-authorisation are needed to address clinical inertia and defensive prescribing.

Keywords: anti-bacterial agents; drug utilisation; antimicrobial stewardship; guideline adherence; inpatients

OP 008

PLATELET RECOVERY AND CLINICAL OUTCOMES IN PATIENTS WITH SEPSIS-ASSOCIATED THROMBOCYTOPENIA

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Introduction: Sepsis-associated thrombocytopenia is common and associated with adverse clinical outcomes. However, the prognostic value of platelet recovery remains poorly defined.

Objectives: To evaluate the associations of platelet recovery and time to recovery with intensive care unit (ICU) survival in patients with sepsis-associated thrombocytopenia.

Methods: This prospective cohort study included 59 consecutive adults with sepsis-associated thrombocytopenia admitted to the medical ICU of the National Hospital of Sri Lanka over three years. Sepsis-associated thrombocytopenia was identified after exclusion of alternative causes and considering the temporal relationship between the onset of sepsis and the decline in platelet count. Platelet recovery was defined as the first in a rising trend following the nadir. Associations with ICU survival were analysed using Firth penalised logistic regression and receiver operating characteristic (ROC) analysis. A day-7 landmark analysis excluded deaths before day-7 to reduce immortal-time bias.

Results: The median age was 59 years (interquartile range (IQR) 48–65), and 33 (55.9%) were females. Median 24-h Sequential Organ Failure Assessment (SOFA) score was 6 (IQR 4–8). Overall, 43 patients (72.9%) survived. Platelet recovery occurred in 44 patients (74.6%) at a median of 5 days (IQR 4–7), and was associated with higher odds of survival (odds ratio (OR) 11.31, 95% confidence interval (CI) 3.16–46.13; $p < 0.05$). Among those with platelet recovery, survivors recovered earlier than non-survivors (median 5 vs 8 days; $p < 0.05$).

The areas under the curve (AUCs) for recovery timing and status were 0.87 (95% CI 0.78–0.96) and 0.75 (95% CI 0.62–0.88), respectively. Each additional day to recovery was associated with lower odds of survival (OR 0.60, 95% CI 0.37–0.86; $p < 0.05$). Platelet recovery by day 7 was associated with higher survival than later recovery (34/36 [94.4%] vs 4/8 [50.0%]; OR 13.80, 95% CI 2.36–102.5; $p < 0.05$). This association persisted in the landmark analysis (OR 25.71, 95% CI 4.92–264.81; $p < 0.05$).

Conclusion: Earlier platelet recovery was associated with higher ICU survival, with timing providing greater discrimination than recovery status alone. The association persisted after day-7 landmark analysis, but this threshold remains exploratory and requires validation.

Keywords: sepsis; thrombocytopenia; platelet count; intensive care units; survival

OP 009

ADVANCING AGE AND MAJOR ADVERSE CARDIOVASCULAR EVENTS AMONG PATIENTS HOSPITALISED WITH NSTEMI IN SRI LANKA

Manilgama SR[1,2,3], Nugara VA[3], Jayasinghe K[3,4], Hettiarachchi NM[3,5], Ralapanawa U[3,5], Gunasekara HRP[3,6], De Zoysa W[3,7], Matthias AT[1,2,3], Mettananda C[3,8], Jayasundara AJMK[3,8], Jegathesan N[3,9], Premawardana N[3,10], Seneviratne MP[3,11], Veerasuthen T[3,12], Bandusiri RP[3,13], Mayurathan P[3,14], Hewage ND[1], Lekamwasam S[3,7]

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Introduction: Age-related differences in complications following non-ST-elevation myocardial infarction (NSTEMI) may inform inpatient risk assessment. This study examined the association between age and cardiovascular morbidity and mortality in a multicentre Sri Lankan registry.

Methods: We analysed NSTEMI patients admitted to 13 secondary and tertiary care hospitals in Sri Lanka. In-hospital complications were compared across four age categories (≤40, >40–55, >55–65, >65 years) using chi-square tests. Univariable logistic regression evaluated associations between continuous age and complications, reporting odds ratios (OR) per 10-year increase. Multivariable logistic regression assessed the independent association of age with acute pulmonary oedema (APO) and congestive cardiac failure (CCF) after adjusting for sex, diabetes mellitus, hypertension and moderate–severe chronic kidney disease (CKD).

Results: Among 878 patients, mean age was 65.4 ± 11.9 years; 56.9% were male; 52.5% were aged > 65 years. APO and CCF occurred in 27.9% and 14.4%, respectively. APO increased from 15.8% in ≤40 years to 33.1% in >65 years ($p = 0.005$). Each 10-year increase in age was associated with higher odds of APO in univariable analysis (OR 1.31; 95% CI 1.14–1.50; $p < 0.001$), which persisted after adjustment for sex, diabetes, hypertension and moderate–severe CKD (adjusted odds ratio (aOR) 1.32; 95% CI 1.14–1.52; $p < 0.001$). Although CCF increased from 5.3% to 16.0% across the same age groups, its association with continuous age was not significant in either univariable (OR 1.17; 95% CI 0.99–1.39;$p = 0.069$) or multivariable analysis (aOR 1.15; 95% CI 0.97–1.38; $p = 0.112$). Increasing age was associated with higher odds of arrhythmia [(6.6%), OR 1.36; $p = 0.018$] and lower odds of coronary angiography [(3.6%), OR 0.66; $p = 0.005$] in univariable analyses. Cardiogenic shock (3.3%) and in-hospital mortality (1.2%) showed no significant association with age.

Conclusion: Advancing age was independently associated with occurrence of APO among NSTEMI patients, even after adjustment for major cardiovascular comorbidities. In contrast, age was not independently associated with occurrence of CCF.

Keywords: non-ST-elevation myocardial infarction; age; acute pulmonary oedema; congestive cardiac failure; major adverse cardiovascular events

OP 010

PREVALENCE AND ASSOCIATIONS OF HIGH-SENSITIVITY CRP (HSCRP) IN A GROUP OF TREATMENT-NAÏVE SRI LANKAN DYSLIPIDAEMIC PATIENTS

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Introduction: Inflammation is an essential component of atherosclerosis. Studies have shown hsCRP as a predictor of future atherosclerotic cardiovascular disease (ASCVD). The American Heart Association states hsCRP less than 1 mg/L is low risk, 1–3 mg/L is medium risk and over 3 mg/L is high risk. hsCRP testing in primary prevention of ASCVD is a minimally researched area in South Asia.

Objectives: To describe the prevalence of raised hsCRP and factors associated, in treatment-naïve dyslipidaemic patients aged 25 to 50, without clinically evident ASCVD. The association of high hsCRP level with 10-year cardiovascular (CV) risk as calculated using the WHO cardiovascular disease risk laboratory-based charts for Southeast Asia was also examined.

Methods: A descriptive cross-sectional study was carried out in treatment-naïve dyslipidaemic (low-density lipoprotein (LDL) cholesterol > 100 mg/dL) participants without clinically evident ASCVD attending ambulatory care at two tertiary level centres. Those with any chronic inflammatory disease, active infection and malignancy were excluded. Those with raised conventional CRP were also excluded from analysis to ensure other causes of inflammation are not included. This is the interim analysis of 175 participants. Associations were evaluated with chi-square test, Fisher's exact test and Mann–Whitney U test at 5% significance level.

Results: Response rate was 98.3% (172/175), 35 were excluded due to high CRP levels. Median age was 37.3 (SD 4.61). Of the participants 65.7% had raised hsCRP with 58 (41.4%) and 34 (24.3%) with moderate and high hsCRP respectively. Compared to the low hsCRP group, moderate or high group was associated with higher triglycerides ($p < 0.001$), body mass index (BMI) ($p < 0.001$), hypertension ($p = 0.048$), waist circumference ($p = 0.002$) and hip circumference ($p = 0.007$) levels. Age ($p = 0.487$), gender ($p = 0.196$), diabetes mellitus ($p = 0.063$), smoking status ($p = 0.545$), LDL ($p = 0.762$), high-density lipoprotein (HDL) ($p = 0.124$), physical activity ($p = 0.540$), WHO risk level ($p = 0.719$) did not show statistically significant differences between two groups.

Conclusion: Interim evidence shows high prevalence of hsCRP in treatment naïve dyslipidaemics. Raised hsCRP is significantly associated with components of metabolic syndrome.

Keywords: C-reactive protein; dyslipidaemias; atherosclerosis; cardiovascular risk

OP 011

ASSESSMENT OF SLEEP QUALITY AND ITS ASSOCIATION WITH GLYCAEMIC CONTROL IN TYPE 2 DIABETES MELLITUS (T2DM) AT NATIONAL HOSPITAL GALLE, SRI LANKA: A CROSS-SECTIONAL STUDY

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Introduction: Sleep quality and type 2 diabetes mellitus (T2DM) share a multifaceted relationship. Poor sleep quality may adversely affect glucose metabolism by increasing sympathetic activity and altering hormonal actions affecting insulin resistance. Psychological stress is a shared determinant influencing sleep and glycaemic control. Though the influence of poor sleep quality and perceived stress on glycaemic control has been independently studied, interplay between these three factors together has not been assessed.

Objectives: This study aimed to assess the proportion of poor sleep quality among T2DM patients, their perceived stress levels, association of poor sleep quality with glycaemic control and identify predictors of poor sleep quality in T2DM.

Methods: A cross-sectional study was conducted among 400 adults with T2DM at National Hospital Galle from September 2025 to March 2026. Sleep quality, glycaemic control, and perceived stress were assessed using the Pittsburgh Sleep Quality Index (PSQI), glycated haemoglobin (HbA1c)/fasting blood sugar (FBS), and a previously validated Perceived Stress Scale-10 (PSS-10), respectively.

Results: A total of 400 patients with T2DM participated in the study. Mean age was 61.83 years (SD ± 9.76; range 34–89). The majority were female (58.8%). Mean duration of T2DM was 10.46 years (SD ± 6.57; range 1–33). Poor sleep quality (PSQI > 5) was identified in 69.0% and poor glycaemic control in 60.5%. Poor sleep quality and poor glycaemic control were significantly associated (χ^2 = 19.602, p < 0.001; odds ratio [OR] = 2.636, 95% confidence interval [CI] 1.706–4.072). Mean PSQI global scores were higher in poor glycaemic control (9.92 ± 5.07) compared to good glycaemic control (7.04 ± 4.45; t = −5.993, p < 0.001). The PSQI global score strongly correlated with PSS-10 score (r = 0.653, p < 0.001). Logistic regression identified age (aOR = 1.051, 95% CI 1.022–1.082, p = 0.001) and PSS-10 score (aOR = 1.165, 95% CI 1.115–1.218, p < 0.001) as independent predictors of poor sleep quality. Area under the receiver operating characteristic (ROC) curve (AUC) was 0.663, indicating acceptable discriminative ability of PSQI in identifying poor glycaemic control.

Discussion: Poor sleep quality was significantly associated with poor glycaemic control. Higher perceived stress independently predicted poor sleep quality. Although causality cannot be established through this study design, perceived stress, poor sleep quality and poor glycaemic control are interrelated excluding confounders of age, comorbidities and sleep disorders.

Conclusion: Perceived stress is significantly associated with poor sleep quality and results in poor glycaemic control. Further interventional studies are required to assess whether improving stress and sleep quality enhances glycaemic control.

Keywords: sleep quality; type 2 diabetes mellitus; glycaemic control; psychological stress

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PP 001

PREVALENCE OF HYPERTENSION AND ITS ASSOCIATION WITH OBSTRUCTIVE SLEEP APNOEA RISK AMONG ADULTS WITH OBESITY

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Introduction: Obesity increases the risk of hypertension and obstructive sleep apnoea (OSA), both linked to cardiovascular complications. OSA may elevate blood pressure through intermittent hypoxia and sympathetic activation. However, evidence on the association between hypertension and OSA risk among obese Sri Lankan adults remains limited.

Objectives: This study aimed to determine the prevalence of hypertension and its association with OSA risk among obese adults attending the Outpatient Department of National Hospital, Galle, Sri Lanka.

Methods: A cross-sectional study of 392 adults with body mass index (BMI) ≥25 kg/m^2 was conducted at National Hospital, Galle, using convenience sampling. Data were collected via interviewer-administered questionnaires, including the STOP-BANG questionnaire to assess OSA risk.

Results: Among the participants, 66.6% (n = 261) were female and 33.4% (n = 131) were male. Hypertension was present in 55.1% (n = 216) of participants. OSA risk was categorised as high risk (27.0%, n = 106), intermediate risk (33.9%, n = 133), and low risk (39.0%, n = 153). OSA risk and hypertension were significantly associated ($p < 0.001$), with 87.7% (n = 93) of participants at high risk of OSA having hypertension. Increasing BMI was significantly associated with both hypertension ($p < 0.05$) and OSA risk ($p < 0.05$). Among participants with a BMI ≥35 kg/m^2, 69.4% (n = 43) had hypertension and 62.9% (n = 39) were at high risk of OSA. OSA risk was associated with age ($p < 0.05$) and sex ($p < 0.05$); older participants and males had higher risk.

Conclusions: Approximately one-quarter of adults with obesity were at high risk of OSA. Increasing obesity severity was significantly associated with a higher risk of OSA and a greater prevalence of hypertension. Hypertension was strongly associated with high OSA risk, alongside age and male sex. Routine OSA risk screening among obese and hypertensive patients may support early identification and further diagnostic evaluation.

Keywords: hypertension; obstructive sleep apnoea; obesity; STOP-BANG questionnaire

PP 002

MICROVASCULAR COMPLICATION BURDEN AND CARDIOVASCULAR-RISK ASSESSMENT IN TYPE 2 DIABETES: A TERTIARY-CARE AUDIT FROM SRI LANKA

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Introduction: Adults with type 2 diabetes mellitus are at increased risk of cardiovascular disease (CVD) and microvascular complications. Guideline-recommended risk tools were developed in other populations, so their applicability in Sri Lanka depends on eligibility and data availability.

Objectives: To describe documented microvascular complications; assess eligibility and input-data completeness for QRISK3 and SCORE2-Diabetes; and examine the relationship between complication burden and renal and cardiovascular-risk variables.

Methods: This cross-sectional audit included 252 adults with type 2 diabetes mellitus at a tertiary-care hospital in Sri Lanka. Retinopathy, nephropathy, and neuropathy were coded as present or absent, giving a complication count of 0–3. Participants with documented ischaemic heart disease (IHD), cerebrovascular accident (CVA), or peripheral vascular disease (PVD) were excluded from primary-prevention analyses. Eligibility was defined by model age range (QRISK3, 25–84 years; SCORE2-Diabetes, 40–69 years). Input completeness required age, sex, body mass index (BMI), systolic blood pressure, total cholesterol, high-density lipoprotein (HDL) cholesterol, smoking status, and, for SCORE2-Diabetes, glycated haemoglobin (HbA1c), estimated glomerular filtration rate (eGFR), and age at diabetes diagnosis. Missing smoking status was retained as missing. Associations were assessed using Spearman correlation.

Results: Mean age was 60.8 ± 9.6 years. Of 252 participants, 166 had no recorded microvascular complications, 66 had one, 14 had two, and 6 had three; 86 (34.1%) had at least one. Among 224 participants without established CVD, all were eligible for QRISK3 by age and 181 (80.8%) for SCORE2-Diabetes. Median eGFR fell from 93.54 to 48.87 mL/min/1.73 m^2 across complication categories, with an inverse correlation ($r = -0.38$). Associations with age, blood pressure, HbA1c, and cholesterol-to-HDL ratio were weak. Numerical risk scores were not calculated.

Conclusions: Microvascular complications were common and were associated mainly with reduced renal function. Neither QRISK3 nor SCORE2-Diabetes has been validated in Sri Lankans, and data gaps limit their use. Future work should compare them with the validated WHO/ISH SEAR-B charts.

Keywords: type 2 diabetes mellitus; microvascular complications; cardiovascular risk; glomerular filtration rate; clinical audit

PP 003

CARDIOVASCULAR RISK AWARENESS, DIETARY PRACTICES AND PHYSICAL INACTIVITY AMONG HOSPITALISED PATIENTS WITH ESTABLISHED CARDIOVASCULAR DISEASE

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Introduction: Diet and physical activity are central to secondary cardiovascular prevention, but awareness of risk does not necessarily translate into recommended behaviours.

Objectives: To describe dietary practices, physical activity and relevant risk awareness among patients with established cardiovascular disease (CVD).

Methods: A descriptive cross-sectional study was conducted among 396 adults with established CVD admitted to general medical wards 49 and 47B at the National Hospital of Sri Lanka. Dietary practices were assessed using the validated 8-item Starting The Conversation tool; physical activity and risk awareness were assessed using a pre-tested interviewer-administered questionnaire. Data were analysed using Statistical Package for the Social Sciences (SPSS) version 26.0. Variable-specific denominators reflect available data.

Results: Dietary-risk awareness was reported by 74.0% (293/396), while 20.7% (82/396) were classified as having a healthy diet and 52.3% (207/396) consumed two or fewer fruit servings per day. Among 389 participants with valid exercise responses, 28.3% (110/389) reported regular exercise and 71.7% (279/389) reported none. Among 314 participants with valid responses on sedentary-risk awareness, 60.8% (191/314) recognised the cardiovascular risks of inadequate activity. Among 322 participants reporting inadequate activity, 48.1% (155/322) identified lack of motivation as a barrier.

Conclusions: At the group level, risk awareness coexisted with low healthy-diet classification and limited exercise. Secondary-prevention programmes should combine risk communication with individualised behavioural support, practical goal setting, attention to motivational barriers and planned follow-up.

Keywords: cardiovascular disease; lifestyle modification; diet; physical activity; secondary prevention

PP 004

PHYSICAL INACTIVITY, PSYCHOLOGICAL DISTRESS AND QUALITY OF LIFE IN NON-DIALYSIS DEPENDENT CHRONIC KIDNEY DISEASE: IDENTIFYING MODIFIABLE PREDICTORS IN A SRI LANKAN COHORT

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Introduction: Patient-reported outcomes in non-dialysis dependent chronic kidney disease (CKD) are under-studied in South Asia, and modifiable contributors to quality of life (QoL) are unclear.

Objectives: We aimed to describe physical activity, psychological distress and QoL, and to identify modifiable predictors of kidney-targeted QoL in adults with non-dialysis dependent CKD.

Methods: A cross-sectional study at the Nephrology Clinic of Colombo North Teaching Hospital, Ragama, enrolled consecutive consenting adults with CKD stage 3 or higher (estimated glomerular filtration rate [eGFR] < 60 mL/min/1.73 m^2) not on dialysis. Participants completed the International Physical Activity Questionnaire–Short Form (IPAQ-SF), Kidney Disease Quality of Life Short Form (KDQOL-36) and the Sinhala/Tamil-validated Depression Anxiety Stress Scales-21 (DASS-21). Multivariable linear regression for the kidney-targeted KDQOL summary score adjusted for age, sex, stage, anaemia, comorbidity burden, depression, anxiety and log metabolic equivalent of task (MET)-min/week.

Results: A total of 427 patients were enrolled (mean age 62.9 ± 11.6 years; 59.5% male). 45.8% were in the lowest IPAQ activity category. The KDQOL kidney-targeted summary was 70.0 ± 9.3, with the burden subscale lowest (58.3 ± 15.3) and a non-significant trend toward lower scores at more advanced stages ($p = 0.20$). Mild or higher symptoms of stress, anxiety and depression were present in 43.0%, 40.0% and 10.9% of patients, respectively. Of the 427 patients enrolled in the study, 401 (93.9%) had complete data on every variable. In multivariable regression ($n = 401$, $R^2 = 0.23$), higher physical activity ($\beta = 0.63$ per log MET-min/week, $p < 0.001$), absence of anxiety ($\beta = 5.66$, $p < 0.001$) and absence of depressive symptoms ($\beta = 2.82$, $p = 0.04$) independently predicted better QoL, while age, sex, CKD stage, comorbidity burden and anaemia were not independently significant.

Conclusions: Physical inactivity, anxiety and depressive symptoms were the principal modifiable correlates of poorer quality of life in non-dialysis CKD, identifying clear, overlapping targets for routine screening and intervention in this setting.

Keywords: chronic kidney disease; quality of life; physical inactivity; depression; anxiety

PP 005

DIABETES BURDEN, GLYCAEMIC CONTROL, MEDICATION ADHERENCE AND COMPLICATIONS AMONG HOSPITALISED PATIENTS WITH ESTABLISHED CARDIOVASCULAR DISEASE

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Introduction: Diabetes mellitus (DM) is an important determinant of recurrent cardiovascular risk. Glycaemic monitoring, medication adherence and screening for complications are central to secondary prevention.

Objectives: To assess DM burden, glycaemic control, glycated haemoglobin (HbA1c) monitoring, antidiabetic medication adherence, complication screening and documented microvascular complications among hospitalised adults with established cardiovascular disease (CVD).

Methods: A descriptive cross-sectional study was conducted among 396 adults with established CVD admitted to general medical wards 49 and 47B at the National Hospital of Sri Lanka. Diabetes status and HbA1c values were obtained from clinical records; monitoring, medication adherence and complication screening were assessed using a pre-tested interviewer-administered questionnaire. Data were analysed using Statistical Package for the Social Sciences (SPSS) version 26.0. Variable-specific denominators reflect available data.

Results: Among 378 participants with valid glycaemic data, 75.4% (285/378) had DM; 8.1% (23/285) were newly diagnosed during the index admission. Among participants with pre-existing DM and available HbA1c data, 66.0% (173/262) did not meet the study target of HbA1c < 7.0%. Regular HbA1c monitoring was reported by 47.3% (123/260). Full medication adherence during the preceding two weeks was reported by 30.5% (80/262), while 69.5% (182/262) reported at least one missed dose; busy schedules or lifestyle constraints were reported by 63.2% (115/182) of the non-adherent subgroup. Complication screening was reported by 56.9% (149/262). Among the selectively documented subgroup, 74.9% (158/211) had microvascular complications.

Conclusions: DM was common among participants with valid glycaemic data, with substantial reported gaps in glycaemic control, HbA1c monitoring, medication adherence and complication screening. The microvascular-complication proportion relates only to the selectively documented subgroup and should not be generalised to all participants with DM. Hospital admission provides an opportunity for medication review, adherence support, complication assessment and coordinated follow-up.

Keywords: cardiovascular disease; diabetes mellitus; glycated haemoglobin; medication adherence; complications

PP 006

PATTERNS OF CARDIOMETABOLIC COMORBIDITY IN NON-DIALYSIS DEPENDENT CHRONIC KIDNEY DISEASE: A CROSS-SECTIONAL STUDY FROM A SRI LANKAN TERTIARY CARE HOSPITAL

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Introduction: Multimorbidity contributes substantially to outcomes in chronic kidney disease (CKD), but its patterns in South Asian non-dialysis populations are poorly characterised.

Objectives: We aimed to describe the prevalence, distribution and combinations of cardiometabolic comorbidities, and the adequacy of blood pressure control, in adults with non-dialysis dependent CKD.

Methods: A cross-sectional study at the Nephrology Clinic of Colombo North Teaching Hospital, Ragama, enrolled consecutive consenting adults with CKD stage 3 or higher (estimated glomerular filtration rate [eGFR] < 60 mL/min/1.73 m^2) not on dialysis. Comorbidities, blood pressure and demographic data were obtained from clinic records and clinic measurements. Comparisons across CKD stages and sexes used chi-square tests and pairwise co-occurrence among patients with two or more comorbidities was tabulated.

Results: A total of 427 patients were enrolled (mean age 62.9 ± 11.6 years; 59.5% male). Hypertension (83.6%), diabetes mellitus (65.8%) and dyslipidaemia (42.6%) were the most common comorbidities, while ischaemic heart disease was present in 19.7%. Multimorbidity (two or more comorbidities) affected 305 patients (71.4%), including 168 (39.3%) with three or more conditions; only 8.0% had no recorded comorbidity. Multimorbidity prevalence rose with advancing stage, from 50.0% at stage 3A to 79.2% at stage 5 ($p < 0.001$). Among 137 patients with exactly two comorbidities, the diabetic-hypertensive combination accounted for 96 (70.1%) and hypertension featured in 94.2% of all dual combinations. Despite recorded antihypertensive use, 50.4% had clinic blood pressure of 140/90 mmHg or higher.

Conclusions: Multimorbidity, dominated by the diabetic-hypertensive phenotype, was the rule rather than the exception in this Sri Lankan pre-dialysis CKD cohort, and increased steadily with advancing CKD stage. Half of all patients had uncontrolled hypertension at the clinic. Integrated cardiometabolic management, with a particular focus on blood pressure control, should be emphasized in this setting.

Keywords: chronic kidney disease; multimorbidity; hypertension; diabetes mellitus; dyslipidaemia

PP 007

LIPID-MANAGEMENT GAPS IN SECONDARY PREVENTION: LDL-C TARGET ATTAINMENT AND STATIN USE AMONG HOSPITALISED PATIENTS WITH CARDIOVASCULAR DISEASE

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Introduction: Dyslipidaemia is a major modifiable risk factor for recurrent cardiovascular events. Effective secondary prevention requires lipid monitoring and appropriate treatment.

Objectives: To describe lipid-risk awareness, previous screening, pre-admission statin use and low-density lipoprotein cholesterol (LDL-C) target attainment, with relevant age, body mass index (BMI) and lifestyle characteristics, among adults with established cardiovascular disease (CVD).

Methods: A descriptive cross-sectional study recruited 400 adults with established CVD admitted to general medical wards 49 and 47B, National Hospital of Sri Lanka; 396 formed the analytic sample. Questionnaire and clinical-record data were summarised using variable-specific denominators. Statin exposure was recorded, but not agent, dose or intensity. No patient-level comparison of statin use with LDL-C or multivariable adjustment was performed.

Results: Among 396 participants with age data, 5.3% (21) were aged < 40, 50.8% (201) 40–60 and 43.9% (174) > 60 years; mean age was 58.7 ± 11.3 years. Among 277 with BMI data, 63.9% (177) had BMI ≥23 kg/m^2. No composite measure of lipid-specific lifestyle modification was collected; 20.7% (82/396) met healthy-diet criteria, 28.3% (110/389) reported regular exercise and 39.5% (85/215) reported previous weight-reduction action. Among 314 valid respondents, 79.0% (248) recognised abnormal cholesterol as a CVD risk factor and 52.5% (165) reported previous lipid screening. Pre-admission statin use was documented in 69.7% (237/340). Among 228 with LDL-C measurements, 52.2% (119) had LDL-C ≥130 mg/dL and 3.9% (9) had LDL-C < 70 mg/dL.

Conclusions: Lipid-risk awareness was relatively high, but screening and LDL-C target attainment were limited. Statin regimen, treatment duration, adherence and other potential confounders were unavailable, and statin-use and LDL-C estimates came from different subsets; therefore, treatment effectiveness cannot be inferred. Better regimen documentation and longitudinal monitoring are needed.

Keywords: cardiovascular disease; dyslipidaemia; LDL-C targets; statins; secondary prevention

PP 008

AUDIT OF MEDICAL OFFICERS' ADHERENCE TO PULMONARY REHABILITATION REFERRAL CRITERIA FOR COPD IN THE MEDICINE DEPARTMENT OF NATIONAL HOSPITAL OF GALLE

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Introduction: Pulmonary rehabilitation (PR) is an important evidence-based intervention for patients with chronic obstructive pulmonary disease (COPD), improving exercise capacity and quality of life while reducing hospital admissions. Despite clear guideline recommendations, referral to PR remains suboptimal, potentially due to inadequate awareness of referral criteria among clinicians.

Objectives: To assess baseline adherence to PR referral criteria among medical officers and determine the effectiveness of an educational intervention in improving appropriate referral decisions.

Methods: A prospective closed-loop clinical audit was conducted among medical officers working in the general medical wards. Baseline data were collected using a self-administered, case-based questionnaire designed to assess the appropriateness of medical officers' referral decisions for PR. The intervention comprised an educational session on PR and the distribution of educational posters displaying the PR referral criteria. A re-audit was conducted three months later. Performance was assessed against a predefined standard of at least 60% appropriate referral decisions. Descriptive statistics were used for data analysis.

Results: The initial audit included 44 medical officers, with an overall appropriate referral decision rate of 38.1%, below the predefined standard. Appropriate referral decisions were made by 36% of non-postgraduate medical officers and 42% of postgraduate trainees. Following the educational intervention, the re-audit included 35 of the original medical officers and demonstrated marked improvement, with the overall appropriate referral decision rate increasing to 66.1%, exceeding the audit standard. Appropriate referral decisions improved to 62% among non-postgraduate medical officers and 74% among postgraduate trainees.

Conclusions: Baseline adherence to PR referral criteria among medical officers was suboptimal. A simple, low-cost educational intervention was associated with a substantial improvement in appropriate referral decisions, enabling the department to exceed the predefined audit standard. Continued educational reinforcement, visual reminders, and periodic re-auditing may help sustain these improvements and promote appropriate referral for PR.

Keywords: chronic obstructive pulmonary disease; pulmonary rehabilitation; clinical audit; referral and consultation; educational intervention

PP 009

PREVALENCE OF CLINICALLY SIGNIFICANT ADVERSE EFFECTS AFTER ONE YEAR OF HIGH-INTENSITY STATIN THERAPY IN PATIENTS ATTENDING A GENERAL MEDICAL CLINIC IN SRI LANKA: A SINGLE-CENTRE STUDY

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Introduction: High-intensity statins are effective in reducing cardiovascular risk by lowering low-density lipoprotein cholesterol (LDL-C). However, they can cause adverse effects, particularly involving the muscles and liver. There is limited information on the prevalence of clinically significant statin-related adverse effects among patients in Sri Lanka.

Objectives: To determine the prevalence of clinically significant muscle and liver adverse effects after one year of high-intensity statin therapy and to identify factors associated with these adverse effects.

Methods: A retrospective observational study was conducted among 292 adult patients attending the Medical Clinic of Sri Jayewardenepura General Hospital, Sri Lanka, who were receiving high-intensity statin therapy (atorvastatin ≥40 mg/day or rosuvastatin ≥20 mg/day). Patients who had received treatment for at least one year or had their statin dose reduced or discontinued within one year due to adverse effects were included. Data were collected using an interviewer-administered questionnaire and clinic records. Demographic and clinical characteristics, statin therapy and adverse effects were assessed. Associations were analysed using appropriate statistical tests and logistic regression.

Results: Clinically significant muscle and liver toxicity were each observed in 2.4% of patients. Age, gender, body mass index (BMI), comorbidities, statin dose, duration of treatment and indication for treatment were not significantly associated with toxicity. Higher baseline aspartate aminotransferase (AST) and alanine aminotransferase (ALT) levels were more commonly seen among patients who developed muscle or liver toxicity. Advanced chronic liver disease was also associated with higher odds of liver toxicity. However, these findings should be interpreted cautiously because of the small number of toxicity events. Regular lipid monitoring and achievement of LDL-C targets were suboptimal.

Conclusions: High-intensity statins were generally well tolerated in this study, with a low prevalence of clinically significant muscle and liver toxicity. Patients with higher baseline liver enzyme levels were more frequently represented among those with toxicity. Better patient education and regular lipid monitoring may help improve LDL-C target achievement and overall lipid management.

Keywords: statins; adverse effects; muscle toxicity; hepatotoxicity; LDL cholesterol

PP 010

ASSESSMENT OF PATIENTS' AWARENESS OF THEIR ILLNESS AND TREATMENT PLAN IN A TERTIARY CARE MEDICAL UNIT IN SRI LANKA

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Introduction: Patients need to understand their illness and treatment to take part in their care and use medicines safely. However, busy wards may limit information provided during admission.

Objectives: To assess patients' knowledge of their illness and treatment plan before and after patient education in a tertiary-care medical unit.

Methods: A before-and-after study included two separate groups of adult inpatients admitted for at least 24 hours. A trained research assistant administered a structured, pretested questionnaire at discharge before (n = 215) and after (n = 200) the intervention. Patients answered open-ended questions on five areas: reason for admission, diagnosis, investigations, medication names, and side effects. Each response was classified using predefined disease-specific criteria as good, partial, or poor and scored 2, 1, or 0. The five scores gave an overall awareness score of 0–10, categorized as low (0–3), moderate (4–7), or high (8–10). Baseline findings were shared with the medical team, and doctors were advised to educate patients about their illness and treatment during ward rounds. Reassessment was conducted after two weeks. Groups were compared using chi-square tests.

Results: Mean age was 51.9 ± 17.8 years before and 45.2 ± 16.4 years after the intervention; 56.7% and 41.0% were male, respectively. High overall awareness was higher post-intervention (15.6% vs 6.0%; $p = 0.005$). Good awareness was higher for reason for admission (54.0% vs 21.4%; $p < 0.001$), diagnosis (63.5% vs 47.4%; $p = 0.003$), and medication names (20.0% vs 10.7%; $p < 0.001$). For investigations, good awareness was lower in the post-intervention group (47.7% vs 63.3%), while partial awareness was higher (48.7% vs 29.8%; $p < 0.001$). Knowledge of medication side effects remained low in both groups ($p = 0.209$).

Conclusions: Awareness was higher in several areas post-intervention. However, as the groups included different patients with different characteristics, these significant differences cannot be attributed to the intervention alone. Poor awareness of medication side effects highlights the need for better patient education.

Keywords: patient education; health knowledge; inpatients; before-and-after study

PP 011

DIABETIC FOOT RISK STRATIFICATION AND ITS ASSOCIATION WITH RENAL AND METABOLIC PARAMETERS: AN AUDIT FROM A TERTIARY-CARE HOSPITAL IN SRI LANKA

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Introduction: Diabetic foot complications are a major cause of morbidity and lower-limb amputation, often driven by overlapping neuropathy, peripheral arterial disease, deformity, and prior ulceration. Renal impairment is closely linked to diabetic vascular disease, but its relationship with foot risk is underexplored in resource-limited settings such as Sri Lanka.

Objectives: To audit diabetic-care documentation at a tertiary-care hospital and examine associations between International Working Group on the Diabetic Foot (IWGDF) foot-risk category and renal and metabolic parameters, including creatinine, estimated glomerular filtration rate (eGFR), glycated haemoglobin (HbA1c), low-density lipoprotein (LDL) cholesterol, triglycerides, blood pressure, and smoking-advice documentation.

Methods: A retrospective audit of 252 adults with diabetes assessed demographic, biochemical, and structured foot-examination data. Foot risk was classified into four IWGDF categories using loss of protective sensation, peripheral arterial disease, deformity, prior ulceration, amputation, and end-stage renal disease. Group differences were assessed using the Kruskal–Wallis test (significance $p < 0.05$).

Results: Mean age was 60.9 ± 9.6 years; 74.2% were female. Retinopathy, nephropathy, and neuropathy were documented in 19.4%, 15.1%, and 9.9% of patients, respectively. Foot-risk distribution was: Category 0, 61.5% (n=155); Category 1, 30.2% (n=76); Category 2, 2.0% (n=5); Category 3, 4.8% (n=12). Current creatinine rose significantly across categories (0.76 to 1.11 mg/dL, $p < 0.001$), while current eGFR fell significantly (93.38 to 63.98 mL/min/1.73 m^2, $p < 0.001$). Baseline creatinine was also significant ($p = 0.010$). HbA1c showed a non-significant upward trend (7.80% to 9.60%, $p = 0.283$). LDL, triglycerides, blood pressure, and smoking-advice documentation showed no significant association.

Conclusions: Higher diabetic foot-risk category was strongly associated with worsening renal function, highlighting a key link between renal impairment and foot vulnerability. Glycaemic trends were clinically notable but not statistically significant, while lipids, blood pressure, and smoking documentation showed no association. These findings support incorporating renal assessment into diabetic foot-risk pathways. Small numbers in higher-risk categories and incomplete documentation limit interpretation, warranting a larger-scale prospective re-audit.

Keywords: diabetes mellitus; diabetic foot; foot-risk stratification; chronic kidney disease; clinical audit

PP 012

MULTIDISCIPLINARY REHABILITATION IN STROKE: INSIGHTS FROM A KNOWLEDGE, ATTITUDES, AND PRACTICES SURVEY AMONG STROKE PATIENTS AT THE NATIONAL HOSPITAL OF SRI LANKA

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Introduction: Rehabilitation after stroke is influenced by access to services, patients' understanding and engagement, as well as physical and psychosocial factors that may affect how patients translate knowledge into practice. No published Sri Lankan study has examined stroke patients' knowledge, attitudes, and practices (KAP), limiting evidence for rehabilitation planning.

Objectives: To describe stroke-related knowledge, attitudes, and practices and their associations with rehabilitation-relevant factors among stroke patients attending the neurology clinics of the National Hospital of Sri Lanka (NHSL).

Methods: A cross-sectional study was conducted among 110 stroke patients attending NHSL neurology clinics, selected through systematic sampling excluding those with cognitive or significant speech impairment and psychiatric conditions; data were collected using a self-developed questionnaire that was content-validated by experts and pre-tested by four trained interviewers. Knowledge (risk factors, symptoms, and management), attitudes (towards treatment, rehabilitation, and prevention), and practices (emergency response, adherence to treatment and rehabilitation, and prevention) scores were dichotomised as 'good' or 'poor' using a 70% cut-off. Associations with rehabilitation-relevant factors were tested using chi-square tests ($p < 0.05$).

Results: Poor knowledge was present in 57.3% of participants and poor practices in 70.0%, while 88.2% held good attitudes. Hemiparesis was associated with good knowledge ($p = 0.003$) but poor practices ($p = 0.019$). Continuing physiotherapy was linked to good knowledge ($p = 0.004$), and access to counselling with good practices ($p = 0.009$). Employment and higher income were associated with good attitudes ($p = 0.024$ and $p = 0.046$, respectively).

Conclusions: Physical disability may represent an important barrier to rehabilitation practices even when stroke-related knowledge is better, highlighting the potential value of occupational therapy and home-modification support. The associations of physiotherapy and counselling support embedding multidisciplinary rehabilitation into routine stroke follow-up. Employment and income associations with attitudes suggest socioeconomic security warrants attention. Together, these findings highlight the importance of integrating multidisciplinary rehabilitation and tailored support into routine stroke follow-up.

Keywords: stroke; stroke rehabilitation; knowledge, attitudes and practices; physiotherapy

PP 013

INPATIENT ANTIBIOTIC PRESCRIBING AMONG HOSPITALISED DENGUE PATIENTS: ASSOCIATIONS WITH DISEASE SEVERITY AND DOCUMENTED SECONDARY INFECTION AT THE NATIONAL INSTITUTE OF INFECTIOUS DISEASES, SRI LANKA

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Introduction: Antibiotics are not routinely indicated for uncomplicated dengue, but inpatient prescribing may occur when clinicians suspect bacterial coinfection, alternative diagnoses, or complications of severe disease. Local data describing these prescribing patterns are limited.

Objectives: To describe inpatient antibiotic use among hospitalised dengue patients and determine whether pre-admission antibiotic exposure, dengue severity, and documented secondary infection were associated with inpatient prescribing.

Methods: We analysed the 2025–2026 cohort of a prospectively collected observational study at the National Institute of Infectious Diseases, Sri Lanka. Inpatient antibiotic administration was recorded separately from documented secondary infection. Logistic regression was used to assess the associations between pre-admission antibiotic exposure and dengue haemorrhagic fever (DHF) with inpatient antibiotic use.

Results: Among 802 patients with prospectively recorded inpatient prescribing data, 125 (15.6%) received antibiotics during hospitalisation. Inpatient antibiotic use did not differ significantly between patients with and without pre-admission antibiotic exposure (37/212 [17.5%] vs 88/590 [14.9%]; p = 0.445). After adjustment, pre-admission antibiotic exposure was not associated with inpatient antibiotic use (adjusted odds ratio (aOR) 1.16, 95% CI 0.76–1.78; p = 0.483), whereas DHF was associated with higher odds of inpatient antibiotic use (aOR 1.91, 95% CI 1.29–2.81; p = 0.001). Among 91 patients with documented secondary infection, 77 (84.6%) received inpatient antibiotics. Conversely, 48/711 (6.8%) patients without documented secondary infection received antibiotics empirically or prophylactically, accounting for 38.4% of all inpatient antibiotic recipients. This pattern suggests that inpatient treatment decisions were made independently of outpatient prescribing.

Conclusions: Inpatient antibiotic prescribing in dengue was associated with disease severity rather than prior outpatient antibiotic exposure. Most patients with documented secondary infection received antibiotics, but over one-third of inpatient antibiotic recipients had no documented secondary infection. These findings support clearer documentation of indications, targeted empirical therapy, and early review of antimicrobial therapy once dengue is diagnosed.

Keywords: dengue; severe dengue; anti-bacterial agents; antimicrobial stewardship; coinfection

PP 014

INAPPROPRIATE POLYPHARMACY AND ITS ASSOCIATED FACTORS IN OLDER ADULTS ATTENDING THE MEDICAL CLINICS AT NATIONAL HOSPITAL GALLE

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Introduction: Inappropriate polypharmacy, commonly defined as five or more medications with one or more lacking clear clinical indication, is prevalent among older adults due to the high burden of chronic diseases. It is associated with adverse drug events, interactions, increased healthcare utilisation, functional decline, poor compliance, and reduced quality of life. Identifying associated factors is essential for rational prescribing, improved medication compliance, and better health outcomes.

Objectives: The study aimed to estimate the prevalence of inappropriate polypharmacy and its associated factors in older adults attending medical clinics at a tertiary care hospital.

Methods: A cross-sectional study of 360 older adults (>65 years) with non-communicable diseases attending National Hospital, Galle, assessed the appropriateness of polypharmacy and its associated factors. Data were collected using an interviewer-administered questionnaire incorporating validated tools: the Morisky Medication Adherence Scale-4, EuroQol-5 Dimension-5 Level (EQ-5D-5L), and Screening Tool of Older Persons' Prescriptions/Screening Tool to Alert to Right Treatment (STOPP/START) criteria, along with patient prescriptions.

Results: Polypharmacy was prevalent in 79.17% of older adults, with inappropriate polypharmacy present in 70.53% of those on polypharmacy. Age, smoking, and multimorbidity were not significantly associated with inappropriate polypharmacy ($p > 0.05$), while female gender ($p < 0.001$) and alcohol consumption ($p < 0.05$) were significant. Medication adherence was not significantly associated with polypharmacy ($p > 0.05$) but was significantly associated with inappropriate polypharmacy ($p < 0.01$). Quality of life was not significantly associated with inappropriate polypharmacy ($p > 0.05$) but was significantly associated with polypharmacy ($p < 0.05$). Omeprazole was the most commonly prescribed inappropriate medication (32.5%), followed by clopidogrel (13.3%) and aspirin (11.7%).

Conclusions: Inappropriate polypharmacy is highly prevalent among older adults attending medical clinics at National Hospital, Galle, and is associated with gender and alcohol consumption. Although polypharmacy and inappropriate polypharmacy were not significantly associated with medication adherence and quality of life, inappropriate prescribing was common, particularly involving proton pump inhibitors and antiplatelets. Regular STOPP/START-based medication reviews, clinician education, and deprescribing strategies are recommended.

Keywords: polypharmacy; inappropriate prescribing; older adults; medication adherence; deprescribing

PP 015

HAEMOSTATIC PROFILE IN LEPTOSPIROSIS-ASSOCIATED COAGULOPATHY: A ROTEM-BASED CROSS-SECTIONAL STUDY

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Introduction: *Leptospira*l haemorrhage is a recognised complication of severe leptospirosis, yet its haemostatic basis remains poorly understood. Thrombocytopenia, platelet dysfunction and clotting-factor abnormalities have been postulated. However, rotational thromboelastometry (ROTEM)-based evidence is limited.

Objectives: To characterise the haemostatic profile among patients with leptospirosis-associated bleeding using conventional coagulation tests and ROTEM.

Methods: We conducted a cross-sectional study among patients with clinically significant leptospirosis-associated bleeding at the medical intensive care unit (ICU) over one year. ROTEM and conventional coagulation studies were analysed descriptively.

Results: Seventeen patients were included. The median age was 56.5 years (range 14–83); 16/17 (94.1%) were male. Pulmonary haemorrhage occurred in 16/17 (94.1%). The median platelet nadir was 29 × 10^9/L (interquartile range [IQR] 17.5–50.5). The median maximum international normalised ratio (INR) was 1.15 (IQR 1.04–1.38) and activated partial thromboplastin time (APTT) was 26.6 s (IQR 24.8–33.3). ROTEM showed normal median INTEM clotting time (CT) and clot formation time (CFT) (194 s [IQR 185–225] and 104 s [IQR 96–187]), with reduced maximum clot firmness (MCF) at 46 mm (IQR 42–56). EXTEM demonstrated mildly prolonged median CT (81 s, IQR 70–117), normal CFT (95 s, IQR 76–165) and reduced A10 (38 mm, IQR 36–43) and MCF (47 mm, IQR 45–61). FIBTEM revealed fibrin-based clot strength with a median A10 of 25.5 mm (IQR 20.5–27.3) and MCF of 30 mm (IQR 24.3–32.5). Maximum lysis was 0% across all assays.

Conclusions: In this cohort, ROTEM demonstrated impaired clot firmness, likely reflecting the marked thrombocytopenia. Clot initiation and fibrin-based clot strength were largely preserved, with minimal fibrinolysis. No major contribution from clotting-factor abnormalities was seen on either ROTEM or conventional coagulation tests. Given that severe haemorrhage was seen at platelet counts higher than those typically associated with spontaneous bleeding, these findings raise the possibility that vascular/endothelial dysfunction contributes to leptospiral haemorrhage beyond systemic coagulopathy alone.

Keywords: leptospirosis; thromboelastography; blood coagulation disorders; thrombocytopenia; haemorrhage

PP 016

IMPACT OF BALANCE AND COGNITIVE TRAINING INTERVENTION ON ADHERENCE TO REHABILITATION PROGRAMME IN OLDER ADULTS RESIDING IN ELDERLY HOMES IN THE GAMPAHA DISTRICT: A QUASI-EXPERIMENTAL STUDY

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Introduction: Falls among older adults are a major public health concern, often leading to functional decline, loss of independence, and reduced quality of life. Poor balance, impaired mobility, fear of falling, and low adherence to rehabilitation programmes further increase the risk of falls, particularly among older adults living in elderly homes.

Objectives: This study aimed to assess the effectiveness of a balance and cognitive training intervention on rehabilitation adherence among older adults living in elderly homes in Gampaha District, Sri Lanka.

Methods: A quasi-experimental study was conducted with pre–post intervention among 40 older adults (aged 65 years and older). Each participant was assigned to a 12-week balance and cognitive training programme, which had three supervised sessions each week. The Montreal Cognitive Assessment (MoCA), Berg Balance Scale (BBS), Timed Up and Go (TUG) test, Falls Efficacy Scale–International (FES-I), Treatment Perception Questionnaire (TPQ), and adherence to rehabilitation were used as outcome measures. Descriptive statistics and inferential statistical tests were used for the data analysis in Statistical Package for the Social Sciences (SPSS) version 26.

Results: Among 40 participants, the intervention significantly improved balance (BBS: 42.13 ± 4.89 to 47.50 ± 3.80; $p < 0.001$), functional mobility (TUG: 14.38 ± 2.47 to 11.98 ± 2.33 s; $p < 0.001$), and reduced fear of falling (FES-I: 34.38 ± 6.91 to 29.58 ± 6.28; $p < 0.001$), with large effect sizes for all outcomes ($r = 0.87–0.88$). Mean rehabilitation adherence was 87.63 ± 9.08%. Multiple regression demonstrated a significant overall model ($F(19,20) = 43.06$, $p < 0.001$; adjusted $R^2 = 0.953$). Gender ($p = 0.005$) and post-intervention fear of falling ($p = 0.049$) were significant independent predictors of adherence.

Conclusions: A combined balance and cognitive training programme is an effective and feasible intervention to increase functional performance and adherence to the rehabilitation process in institutionalized older adults.

Keywords: balance; cognitive training; elderly homes; fear of falling; older adults

PP 017

PREVALENCE OF ISCHAEMIC HEART DISEASE IN PATIENTS WITH AUTOIMMUNE CONNECTIVE TISSUE DISORDERS: A CROSS-SECTIONAL STUDY AT A SRI LANKAN TERTIARY CARE CENTRE

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Introduction: Patients with autoimmune rheumatological diseases have an increased burden of cardiovascular disease due to chronic inflammation, immune mediated vascular injury, traditional risk factors, and treatment-related metabolic effects. Yet local data on ischaemic heart disease (IHD) among Sri Lankan patients with these disorders are limited.

Objectives: To determine the prevalence of IHD among patients with autoimmune rheumatological disorders attending the National Hospital of Sri Lanka (NHSL), and to describe its distribution across different disease subgroups.

Methods: We conducted a descriptive cross-sectional study among 245 patients with connective tissue disorders at the NHSL, Colombo, consisting of patients with systemic lupus erythematosus (SLE), seropositive rheumatoid arthritis (RA), seronegative RA, Sjögren's syndrome (SS), systemic sclerosis (SSc), and mixed connective tissue disorder (MCTD). IHD was defined as having documented evidence of myocardial infarction, coronary revascularization, or a clinical diagnosis by a physician/cardiologist. Descriptive statistics were used to analyse demographic data, disease category, mean age, and IHD status.

Results: The overall mean age of the study population was 56.2 years. IHD was present in 60 patients, giving an overall prevalence of 24.5%. Seronegative RA was the largest subgroup, comprising 120 patients and had the highest absolute burden of IHD with 43 affected patients (38 females). The prevalence of IHD in this group was 35.8%, with a mean age of 62 years. IHD was observed in 11 of 76 patients with seropositive RA, 3 of 28 patients with SLE, 2 of 14 patients with SSc, and 1 of 5 patients with SS. Neither of the two patients with MCTD had IHD (n = 2).

Conclusions: IHD was common in this cohort particularly among seronegative RA patients, a subgroup with a higher mean age than the overall cohort. These findings show that routine cardiovascular risk assessment and integrated preventive care in patients with autoimmune rheumatological diseases are important.

Keywords: ischaemic heart disease; connective tissue diseases; rheumatoid arthritis; systemic lupus erythematosus

PP 018

PREVALENCE AND FACTORS ASSOCIATED WITH LOW VITAMIN D LEVEL AMONG PATIENTS REFERRED TO TWO MEDICAL NUTRITION CLINICS IN THE WESTERN PROVINCE

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Introduction: Vitamin D deficiency is a common public health concern associated with inadequate sun exposure, dietary factors, and underlying medical conditions that affect vitamin D production or metabolism, highlighting the importance of assessing vitamin D levels and their associated factors among patients attending Medical Nutrition clinics.

Objectives: To assess the prevalence and the factors that are associated with low vitamin D level among patients referred to Medical Nutrition clinics in two selected tertiary care hospitals in the Western Province.

Methods: A descriptive cross-sectional study was conducted in two medical nutrition units in the Western Province. Individuals aged over 18 years who were referred to the clinics were included. Patients who underwent bariatric surgery, pregnant women and those receiving chemoradiotherapy were excluded. A total of 391 individuals were recruited through convenience sampling. Data were collected by interviewing patients using a structured questionnaire. Variables were described categorically and compared using the chi-square test.

Results: The mean age of the participants was 47.51 years (SD = 16.20). The mean vitamin D level was 26.41 ng/mL (SD = 12.75), and the majority had levels below 25 ng/mL (n = 225; 57.5%). Regular outdoor physical activity was observed in the majority of the participants (n = 220; 56.3%). The majority consumed milk or yoghurt (n = 359; 91.8%), other dairy products (n = 305; 78.0%), fish (n = 369; 94.4%), and eggs (n = 382; 97.7%). Regular outdoor physical activity was significantly associated with vitamin D levels ($p = 0.014$) along with sun exposure of more than 30 minutes ($p = 0.005$) and daytime sun exposure between 10 a.m. and 3 p.m. ($p = 0.001$). Pathological interference with vitamin D production ($p < 0.001$), use of vitamin D-containing multivitamin supplements ($p < 0.001$), and use of minimum 1000 IU/day vitamin D supplements ($p < 0.001$) were significantly associated with vitamin D levels.

Conclusions: Reduced daytime sun exposure was a significant factor associated with vitamin D deficiency. Promoting healthy lifestyle practices, improving access to vitamin D-rich foods, and validating simple screening tools are recommended to facilitate early identification and prevention of vitamin D deficiency.

Keywords: vitamin D deficiency; sun exposure; dietary habits

PP 019

CONCORDANCE BETWEEN MANUAL METHOD AND AUTOMATED METHODS OF OBTAINING PACKED CELL VOLUME IN DENGUE FEVER PATIENTS TREATED WITH BLOOD OR COLLOID BOLUSES

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Introduction: Dengue fluid therapy is guided by packed cell volume (PCV) change across boluses. Analyser haematocrit (Hct) requires the main laboratory, whereas manual PCV and point-of-care (POC) haemoglobin meters are done on the ward. Whether these methods agree on this change is unknown.

Objectives: To assess agreement between methods in pre- to post-bolus change, and to compare agreement after blood and dextran.

Methods: This prospective method-comparison study included 41 consented adults with severe dengue receiving boluses at the National Institute of Infectious Diseases, Angoda, Sri Lanka. Of 49 bolus episodes, those with paired pre- and post-bolus readings were analysed: PCV–Hct 33 episodes (blood 12, dextran 21); PCV–POC 32 episodes (blood 10, dextran 22). One routine venous sample, drawn from a dedicated cannula in the non-infusion arm 5 minutes before and 20 minutes after each bolus, was tested by microhaematocrit centrifugation, an automated analyser (Mindray BC-6800) and a POC haemoglobin meter (Mission Ultra). Bland–Altman analysis evaluated agreement against a ±3-percentage-point (pp) tolerance, the smallest difference that would change clinical decisions (approximately 1 g/dL haemoglobin).

Results: For change (post- minus pre-bolus), PCV versus analyser Hct showed a mean difference of +0.72 pp but 95% limits of agreement (LoA) of −5.50 to +6.94; 75.8% within ±3 pp. Between the two ward methods, PCV versus POC showed −1.63 pp (LoA −9.51 to +6.25; 56.2% within ±3 pp), although POC moved in the expected direction in 87.5% of boluses. Agreement was numerically closer after blood than dextran (within ±3 pp: PCV–Hct 83% vs 71%; PCV–POC 60% vs 55%), but differences were not significant.

Conclusions: The methods agreed on average, but LoA for bolus-related change exceeded the ±3 pp tolerance. POC tracked the direction but not the magnitude of change, so cannot yet replace manual PCV for ward monitoring. Larger studies are necessary.

Keywords: dengue; haematocrit; point-of-care testing; fluid therapy

PP 020

KNOWLEDGE GAPS IN ASTHMA MANAGEMENT AND THEIR SOCIODEMOGRAPHIC ASSOCIATIONS AMONG ADULT PATIENTS ATTENDING A TERTIARY CHEST CLINIC IN SRI LANKA

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Introduction: Patient understanding of reliever and controller therapy, inhaler technique and triggers is central to asthma control. Sri Lankan data from adult specialist clinics are limited.

Objectives: To assess asthma management knowledge among adult patients attending a tertiary chest clinic, and its associations with sociodemographic characteristics.

Methods: A descriptive cross-sectional study was conducted at the chest clinic, Colombo South Teaching Hospital, from January 2025 to June 2025. Adults aged ≥18 years with physician-diagnosed asthma under clinic follow-up were recruited by consecutive sampling; those declining consent or unable to understand the questionnaire were excluded. An interviewer-administered questionnaire assessed sociodemographic characteristics and 40 knowledge items across ten domains (score 0–40). Group means were compared using one-way analysis of variance ($p < 0.05$).

Results: Among 278 participants (56.8% female), the mean knowledge score was 26.63 (SD 11.24). Symptoms: 94.6% recognised cough and 91.0% wheeze as asthma symptoms, but 65.5% incorrectly considered fever a common symptom. Triggers: 90.6% recognised cold weather, but only 41.0% recognised exercise and 36.3% recognised stress as triggers (59.0% and 63.7%, respectively, did not). Urgent care: 86.3% knew to seek urgent care if symptoms did not improve after reliever use. Only 56.5% knew medication can control asthma, and 51.4% recognised the importance of an action plan. Misconceptions were that salbutamol should be used regularly (54.3%), inhalers cause addiction (68.3%) and reliever-only treatment suffices after discharge (48.6%). Mean scores were lower with older age (> 71 years 13.75 vs 18–35 years 35.29), lower education (no schooling 14.41 vs degree/diploma 36.74), unskilled occupation and lower income (all $p < 0.001$), but did not differ by gender ($p = 0.773$) or ethnicity ($p = 0.484$).

Conclusions: Despite specialist follow-up, important misconceptions regarding controller therapy, reliever overuse, inhaler safety and action plans were common and socially patterned. Repeated, language-appropriate education prioritising older and socioeconomically disadvantaged patients should be integrated into routine care.

Keywords: asthma; reliever and controller therapy

PP 021

SNAKEBITE ENVENOMATION AT A RURAL SRI LANKAN SECONDARY CARE HOSPITAL: A RETROSPECTIVE STUDY

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Introduction: Local epidemiological evidence is essential for optimising the management of snake envenomation in Sri Lanka. This study evaluated the demographic and clinical characteristics, complications, management practices, and outcomes of snakebite patients.

Methods: A retrospective observational study was conducted among patients admitted with snakebite to Base Hospital Medirigiriya, Sri Lanka. Of 100 records initially identified, 86 unique patient records were included following the exclusion of 14 duplicates. Data on demographic characteristics, bite circumstances, clinical manifestations, laboratory findings, treatment modalities, complications, and outcomes were extracted and analysed. Associations between clinical variables and the occurrence of complications were assessed using appropriate statistical tests, with statistical significance defined as $p < 0.05$.

Results: The mean (standard deviation [SD]) age was 42.7 (18) years, with males comprising 54.7% (n = 47) of the cohort. The right foot was the commonest bite site (40.7%). *Hypnale* spp. were the most frequently identified snakes (25.6%), although the offending species remained unidentified in 60.5% of cases. Pain (90.7%) and swelling (59.3%) were the predominant clinical manifestations. Acute kidney injury, coagulopathy, and neurotoxicity occurred in 8.1%, 5.8%, and 4.7% of patients, respectively. Antivenom was administered to 17.4% of patients, while 74.4% received antibiotics. Complications developed in 14% of patients and were significantly associated with male sex ($p = 0.032$). The median time to presentation was 0.45 hours (interquartile range [IQR] 0.25–1.00) and was not associated with complications ($p = 0.82$). Antibiotic use was associated with a longer hospital stay (2.4 days [SD 1.9] vs 1.3 days [SD 1.1]; $p = 0.01$). The mean (SD) duration of hospitalisation was 2.1 (1.8) days, and 95.3% of patients achieved successful discharge.

Conclusions: *Hypnale* spp. were the most frequently identified snakes. Male sex was associated with complications, while antibiotic use was associated with prolonged hospitalisation. Improved snake identification and evidence-based management may enhance patient outcomes.

Keywords: snakebite; snakebite envenomation; *Hypnale*

PP 022

IDENTIFICATION OF POTENTIAL ANTIGENIC EPITOPES IN THE *TOXOPLASMA GONDII* SAG2 GENE USING PCR AMPLIFICATION AND BIOINFORMATICS ANALYSIS

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Introduction: *Toxoplasma gondii* is an important intracellular protozoan parasite capable of causing severe disease in susceptible populations. Surface antigen 2 (SAG2) is a major tachyzoite surface antigen that has potential applications in diagnostic and vaccine research. However, information on antigenic regions of SAG2 in locally obtained samples remains limited.

Objectives: To amplify and sequence a region of the *T. gondii* SAG2 gene and identify potential B-cell epitopes and predicted major histocompatibility complex (MHC)-binding peptides using bioinformatics analysis.

Methods: DNA from a stored B1-positive *T. gondii* sample was amplified by polymerase chain reaction (PCR) targeting a 335-bp SAG2 region. Five complete SAG2 coding sequences from strains RH, ME49, P-Br, KM and CASTELLS were retrieved from GenBank and aligned using SnapGene to identify conserved regions for primer design. Primers were designed using NCBI Primer-BLAST and evaluated with FastPCR. The amplicon was visualised by agarose gel electrophoresis and sequenced, yielding 305 bp of readable sequence. Sequence identity was assessed using BLASTn. The sequence was translated in six reading frames using ExPASy, and Frame 1 was selected based on alignment with the reference SAG2 coding sequence, yielding approximately 101 amino acids. Potential B-cell epitopes and MHC-associated peptides were predicted using the Immune Epitope Database (IEDB).

Results: BepiPred-3.0 predicted two potential linear B-cell epitope regions spanning amino acids 2–83 (82 amino acids; score 0.268) and 88–96 (RSTHRDAIM; score 0.172). Predicted HLA-A02:01-binding peptides, including GFVFFVRAV, KLSCKENVV and ICDYVTEEL, had binding percentile ranks of approximately 1.1–2.6. For HLA-DRB101:01, REKMYFRICDYVTEE and TAAVLCFSARHNQCS had predicted binding percentile ranks of approximately 31–36. These findings represent computational predictions and do not establish experimental binding or immunogenicity.

Conclusions: The analysed SAG2 fragment contained several computationally predicted B-cell epitopes and peptides with predicted MHC binding potential. The findings provide preliminary candidates for further investigation, including experimental assessment of MHC binding and immunogenicity, before considering their diagnostic or vaccine-related applications.

Keywords: *Toxoplasma gondii*; surface antigen 2 (SAG2); b-cell epitopes; major histocompatibility complex; computational biology; polymerase chain reaction

PP 023

HOSPITAL COST OF CARE FOR INFECTIVE ENDOCARDITIS AT A TERTIARY CENTRE IN SRI LANKA: A SINGLE-CENTRE BOTTOM-UP MICRO-COSTING STUDY

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Introduction: Infective endocarditis (IE) requires prolonged intravenous antimicrobial therapy and lengthy inpatient care, yet local data on hospital-incurred cost are scarce.

Objectives: To quantify the cost of an IE admission at a Sri Lankan tertiary centre and identify its principal drivers.

Methods: A retrospective bottom-up micro-costing analysis from the hospital-provider perspective was conducted on 32 IE admissions (2021–2026) at Teaching Hospital, Peradeniya (THP). Costs were built from documented resource use: personnel time by Time-Driven Activity-Based Costing across seven ward-staff roles; antibiotics itemised from actual regimens at MSD 2026 procurement prices; and investigations, echocardiography and imaging priced per item from the Revised Hospital Charges Circular 01-31/2026, with a 30% service charge on drugs and investigations. All items were valued at a single 2026 price base, eliminating temporal price drift. Non-parametric tests were used throughout.

Results: Median THP-incurred cost per admission was Sri Lankan rupees (LKR) 216,057 (interquartile range [IQR] 125,916–335,540). The aggregate cohort spend was LKR 7.23 million. Investigations formed the largest share (40.8%), followed by antibiotics (30.3%) and personnel time (28.9%); nursing alone contributed 50.3% of personnel spend. Cost varied significantly by causative organism (Kruskal–Wallis $p = 0.008$), highest in methicillin-resistant *Staphylococcus aureus* (MRSA) cases (median LKR 386,254, IQR 341,013–400,297) and lowest in viridans streptococcal cases (LKR 51,183, IQR 42,345–95,221), an approximately sevenfold spread. Cost correlated strongly with length of stay (Spearman $\rho = 0.91$, $p < 0.001$).

Conclusions: Investigations, antibiotics and nursing time dominate the hospital cost of IE care, with MRSA a particularly costly stratum. Shortening inpatient antibiotic duration through outpatient parenteral therapy or oral step-down offers the greatest scope to reduce cost.

Keywords: infective endocarditis; hospital costs; cost analysis; micro-costing; length of stay

PP 024

BEYOND SURVIVAL: SYMPTOM BURDEN AND FUNCTIONAL RECOVERY FOLLOWING NSTEMI IN SRI LANKA

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Introduction: Mortality alone does not capture the burden following non-ST-elevation myocardial infarction (NSTEMI). Persistent symptoms, impaired functional recovery, and readmissions are important patient-centred outcomes. We described these outcomes following NSTEMI in a multicentre Sri Lankan registry.

Methods: The registry included 878 patients admitted with NSTEMI to 13 secondary and tertiary care hospitals. Follow-up information was collected through telephone interviews and clinic visits at approximately one year after discharge. Outcomes included survival, recurrent symptoms, hospital readmission, functional recovery, return to daily routines, exercise, and self-reported medication adherence. Percentages were calculated using available responses.

Results: Follow-up information was available for 564 patients at a median of 340 days (interquartile range [IQR] 307–367); 121 (21.5%) had died. Among respondents with available information, recurrent angina or chest discomfort was reported by 43.4% and dyspnoea by 47.3%. Hospital readmission occurred in 165/445 patients (37.1%). Only 40.7% reported recovery to their pre-event functional level, while 57.5% had resumed their daily routines. Regular exercise was reported by 25.0%, although self-reported medication adherence was 93.9%.

Conclusions: Substantial symptom burden, frequent readmissions, and incomplete functional recovery were reported approximately one year after NSTEMI. These findings support incorporating symptom assessment, functional recovery, and rehabilitation needs into post-discharge care. Incomplete follow-up and reliance on self-reported outcomes should be considered when interpreting these findings.

Keywords: non-ST-elevation myocardial infarction; patient readmission; recovery of function; survival

PP 025

ACUTE *SALMONELLA* GASTROENTERITIS: EPIDEMIOLOGY, CLINICAL PRESENTATION, AVAILABILITY AND CLINICAL UTILITY OF STOOL CULTURE RESULTS IN A TERTIARY CARE HOSPITAL, SOUTHERN SRI LANKA

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Introduction: Acute gastroenteritis (AGE) is commonly managed across hospital wards, where stool cultures are frequently requested. However, their diagnostic yield and turnaround time are often underappreciated by clinicians.

Objectives: To update the epidemiology, clinical profile, and laboratory characteristics of *Salmonella*-associated AGE.

Methods: A retrospective review of 2,157 stool culture worksheets processed between January 2024 and December 2025 was conducted. Data on positive cultures, clinical information and hospital stay were obtained from archived records. Patient locations during three consecutive peak months were mapped.

Results: Of the 2,157 cultures performed, 114 (5.3%) yielded clinically significant pathogens, of which 107 (93.9%) were positive for *Salmonella* spp. Salmonellosis peaked during August–September 2024 and August–December 2025, largely coinciding with school holidays. Cases increased from 32 in 2024 to 75 in 2025.

Females (68/107, 64%) and patients aged > 60 years (44/107, 41%) predominated. Clinical presentations included watery diarrhoea (94/107, 88%), fever (63/107, 59%), vomiting (36/107, 34%), and rarely, dysentery (5/107, 5%).

Mean turnaround time for issuing a positive *Salmonella* report was 3.8 days (range, 2–6). Among 67 patients with available hospital stay data, 36 (54%) were discharged by day 3 and 43 (64%) were discharged before culture reports were available. Blood cultures yielded the same *Salmonella* in two patients; ruptured appendicitis and splenic abscess occurred in one each.

All isolates were susceptible to chloramphenicol and ceftriaxone, while only 61% (65/107) were susceptible to ciprofloxacin. Twelve patients received no antibiotics. The mortality rate was 2/107 (1.9%).

Conclusions: *Salmonella* predominated among positive stool cultures, particularly affecting elderly patients. Seasonal peaks and geographical mapping may facilitate targeted public health interventions. Despite most patients with available data being discharged before culture results, stool culture remains valuable for surveillance, antimicrobial susceptibility testing, and detecting infections associated with serious complications.

Keywords: *Salmonella* infections; gastroenteritis; stool culture; antimicrobial susceptibility testing

PP 026

CLINICAL CHARACTERISTICS AND POSTOPERATIVE OUTCOMES OF NON-FUNCTIONING PITUITARY ADENOMAS: A RETROSPECTIVE STUDY AT A TERTIARY CARE HOSPITAL

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Introduction: Non-functioning pituitary adenomas (NFPAs) commonly present with mass effects and pituitary hormone dysfunction. Assessment of tumour characteristics, pituitary function and postoperative complications is essential for long-term management.

Objectives: To assess tumour characteristics, pituitary function, surgical management, postoperative complications and follow-up outcomes among patients with NFPA.

Methods: This retrospective study included 134 patients diagnosed with NFPA at the National Hospital of Sri Lanka from 1 March to 31 August 2026. Clinical, imaging, surgical and follow-up data collected from the clinic book were analysed using descriptive statistics.

Results: The mean age was 52.4 ± 13.0 years, and 59.7% were female. Visual symptoms (85.8%) and headache (64.2%) were the predominant presentations; 3.0% were detected incidentally. Mean tumour diameter was 3.07 ± 1.21 cm (range, 0.9–7.6 cm); 82.1% were macroadenomas and 17.2% were giant adenomas. Suprasellar extension, optic chiasm compression and cavernous sinus invasion occurred in 61.8%, 75.6% and 48.9%, respectively, among patients with available imaging. hypothalamic–pituitary–adrenal (HPA) axis dysfunction occurred in 99.3%, thyroid dysfunction in 52.2%, gonadal dysfunction in 17.9% and growth hormone (GH) dysfunction in 3.7%. Among patients with pituitary hormone deficiencies, 18.7% had isolated deficiency, 58.2% had multiple deficiencies, and 23.1% had panhypopituitarism. Transsphenoidal surgery was performed in 94.8%, transcranial surgery in 5.2%, and 28.4% required repeat surgery. Postoperative diabetes insipidus (DI) occurred in 19.4%; of these, 52% had transient and 48% persistent DI. syndrome of inappropriate antidiuretic hormone secretion (SIADH) occurred in 3.0%. Postoperative magnetic resonance imaging (MRI) was available for 97.0%; residual tumour and recurrence were reported in 73.8% and 65.9%, respectively. Follow-up data were available for 95.5%, while 4.5% were lost to follow-up. Mean follow-up duration was 5.2 ± 3.3 years.

Conclusions: NFPAs were frequently large and associated with pituitary dysfunction and postoperative complications. The high reported recurrence rate should be interpreted cautiously, as the study period was limited to six months. Structured long-term radiological and endocrine surveillance is essential for optimal management.

Keywords: pituitary neoplasms; non-functioning pituitary adenoma; hypopituitarism; postoperative complications; neoplasm recurrence

PP 027

PREVALENCE, ASSOCIATIONS AND CARDIOVASCULAR RISK OF LEAN VS NON-LEAN METABOLIC DYSFUNCTION-ASSOCIATED STEATOTIC LIVER DISEASE IN SRI LANKA: A MULTICENTRE STUDY

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Introduction: Lean metabolic dysfunction-associated steatotic liver disease (MASLD) is increasingly observed in Sri Lanka and is believed to behave differently from non-lean MASLD. Identifying the associated factors and their cardiovascular risks is important for the prevention and management of the MASLD-related burden. However, there is no data on the prevalence, association and cardiovascular risk of lean MASLD among Sri Lankans.

Therefore, we assessed prevalence, associations and cardiovascular risk in a sample of lean vs non-lean MASLD patients in Sri Lanka.

Methods: We conducted a multicentre cross-sectional study of all adults with diagnosed MASLD attending selected outpatient medical clinics covering nine provinces from 1 to 30 June 2026. Data on demographics and anthropometry were obtained, and investigations were extracted from medical records. Liver fibrosis risk was calculated using the Fibrosis-4 (FIB-4) equation with aspartate aminotransferase (AST), alanine aminotransferase (ALT) and platelet count, and cardiovascular risk was estimated using the World Health Organization (WHO) risk charts with total cholesterol. Individuals without the necessary documented blood investigations were excluded. Lean MASLD was defined as body mass index (BMI) < 23 kg/m^2. High risk of SF was defined as a FIB-4 score > 1.3 in those aged ≤65 years and > 2.0 in those aged > 65 years. High 10-year cardiovascular disease (CVD) risk was defined as a WHO score ≥20. Associations of lean vs non-lean MASLD were compared using logistic regression and chi-square tests.

Results: Of 648 MASLD patients (female 59.7%; mean age 54 ± 12.9 years) studied, 125 (19.3%) had lean MASLD. The prevalence of SF was 5.2% vs 4.8% (p = 0.794) and of high CVD risk 31.9% vs 32.5% (p = 0.915) among non-lean vs lean MASLD, respectively. Lean MASLD was associated with current smoking (odds ratio [OR] 2.32, p = 0.012) and having controlled systolic blood pressure (OR 1.67, p = 0.033), but not with the FIB-4 score (p = 0.639) or CVD risk (p = 0.645).

Conclusions: Nearly 20% of MASLD patients in Sri Lanka were lean. Patients with lean, compared with non-lean, MASLD did not differ in fibrosis or CVD risk.

Keywords: metabolic dysfunction-associated steatotic liver disease; lean phenotype; liver fibrosis; cardiovascular risk; fibrosis-4 index

PP 028

ADRENAL CRISIS PREVENTION IN PATIENTS RECEIVING HYDROCORTISONE: A CLINICAL AUDIT OF PATIENT EDUCATION AND SAFETY MEASURES AT A TERTIARY ENDOCRINE CLINIC

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Introduction: Patients receiving hydrocortisone require education on sick-day rules, stress dosing and emergency management to prevent adrenal crisis. This first-cycle clinical audit evaluated documentation of these preventive measures.

Objectives: To assess documentation of adrenal crisis prevention education and safety measures among patients receiving hydrocortisone at the Endocrine Clinic, National Hospital of Sri Lanka.

Methods: This first-cycle audit included 40 patients receiving hydrocortisone who attended the Endocrine Clinic at a tertiary care centre between 15 August and 15 September 2026. All eligible patients attending during the study period were included. Documentation of sick-day rules, stress-dosing advice, emergency hydrocortisone injection education, adrenal crisis education and steroid-alert card provision was assessed using clinic books. Audit criteria were based on the Endocrine Society Clinical Practice Guideline on Primary Adrenal Insufficiency (2016), supplemented by Society for Endocrinology guidance on adrenal crisis prevention and emergency management. The proposed audit target was 100% documentation of each applicable education component.

Results: The mean age was 53.6 ± 12.6 years (range 22–82), and 52.5% were male. The most common diagnosis was non-functioning pituitary adenoma (65%), followed by acromegaly (12.5%), primary adrenal insufficiency (12.5%), macroprolactinoma (5%), craniopharyngioma (2.5%) and meningioma (2.5%). Sick-day rules were documented in 1 patient (2.5%), while stress-dosing advice was documented in none. Emergency hydrocortisone injection education was documented in 5 patients (12.5%), adrenal crisis education in 15 (37.5%), and steroid-alert cards in 16 (40%). Four patients (10%) had a documented history of adrenal crisis, and 6 (15%) had previous hospital admissions.

Conclusions: Substantial gaps were identified in documentation of adrenal crisis prevention measures. The absence of documentation does not necessarily indicate that education was not provided. Planned interventions include documenting education on the front page of clinic records and issuing steroid-alert cards. A second audit cycle will be conducted after six months to evaluate improvements in documentation and patient safety measures.

Keywords: adrenal insufficiency; adrenal crisis; patient education safety measures

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Case Presentations (CP)

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SRI LANKA COLLEGE OF INTERNAL MEDICINE

CP 001

LITHIUM-ASSOCIATED DRESS: AN UNUSUAL CULPRIT WITH ATYPICAL CLINICAL FEATURES

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Introduction: Drug reaction with eosinophilia and systemic symptoms (DRESS) is a severe drug hypersensitivity syndrome characterised by fever, rash, lymphadenopathy, haematological abnormalities and internal-organ involvement. Lithium is an unusual and rarely reported culprit, making diagnosis challenging when atypical features overlap with other severe cutaneous adverse reactions.

Case presentation: A 23-year-old woman with bipolar affective disorder presented with high-grade fever, generalised pruritic maculopapular rash, arthralgia and constitutional symptoms 14 days after lithium initiation. The eruption initially involved the face and trunk and rapidly progressed within 24 hours to the limbs, with oral mucosal involvement and dusky-purpuric changes. Examination revealed generalised lymphadenopathy and hepatosplenomegaly. Investigations demonstrated marked leucocytosis, peaking at 63 × 10^9/L, with mild eosinophilia (absolute eosinophil count 0.74–0.81 × 10^9/L) and significant hepatic involvement (aspartate aminotransferase (AST) 721 U/L, alanine aminotransferase (ALT) 491 U/L). Renal function and urinalysis were normal. HIV, Venereal Disease Research Laboratory (VDRL), Epstein–Barr virus (EBV) and cytomegalovirus (CMV) testing were negative, and tuberculosis was excluded. Blood picture showed no abnormal cells, triglycerides were normal, and contrast-enhanced computed tomography (CECT) of the neck, chest, abdomen and pelvis showed no evidence of malignancy. Skin biopsy supported DRESS. She was treated with systemic corticosteroids following withdrawal of the suspected offending drug.

Discussion: The diagnosis was challenging because of the short latency following lithium initiation, mild eosinophilia, rapid progression and prominent mucosal involvement, raising concern for Stevens–Johnson syndrome/toxic epidermal necrolysis (SJS/TEN). Marked leukocytosis also prompted consideration of infection, inflammatory disease, haematological malignancy and haemophagocytic lymphohistiocytosis (HLH); extensive evaluation did not support these alternatives.

Conclusion: This case highlights DRESS associated with an unusual culprit drug and demonstrates the importance of integrating drug chronology, clinical phenotype, organ involvement and systematic exclusion of mimics. Diagnostic scoring systems should support rather than replace clinical judgement in atypical presentations.

Keywords: lithium; DRESS; drug hypersensitivity syndrome; bipolar disorder; adverse drug reaction

CP 002

RARE ASSOCIATION OF CONCURRENT MELIOIDOSIS AND MUCORMYCOSIS IN A PATIENT WITH DIABETES MELLITUS

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Introduction: Melioidosis and mucormycosis are severe infections associated with poorly controlled diabetes mellitus, but their concurrent occurrence is exceptionally rare and presents a major diagnostic and therapeutic challenge, particularly in resource-limited settings.

Case presentation: A 49-year-old woman with poorly controlled type 2 diabetes mellitus presented with prolonged fever, weight loss, respiratory symptoms, multiple hepatosplenic lesions, and a progressive necrotising nasal ulcer. Imaging demonstrated pulmonary nodules and consolidation, mediastinal lymphadenopathy, and multiple hepatic and splenic lesions. The overlapping clinical and radiological features mimicked disseminated malignancy, resulting in significant diagnostic uncertainty. Blood culture isolated *Burkholderia pseudomallei*, while direct microscopy of tissue from the nasal lesion demonstrated fungal filaments consistent with mucormycosis, confirming concurrent melioidosis and mucormycosis. She was treated with intravenous meropenem followed by oral cotrimoxazole, liposomal amphotericin B, optimisation of glycaemic control, and multidisciplinary care. She showed progressive clinical and radiological improvement, with clearance of bacteraemia and resolution of the hepatosplenic abscesses.

Conclusion: This case highlights the importance of considering concurrent melioidosis and mucormycosis in patients with poorly controlled diabetes presenting with multisystem disease. Early recognition, appropriate microbiological and pathological investigations, targeted therapy, and multidisciplinary management can facilitate successful outcomes even in resource-limited settings.

Keywords: melioidosis; *Burkholderia pseudomallei*; diabetes mellitus; hepatosplenic abscesses; mucormycosis; coinfection

CP 003

OVERDRAINAGE-INDUCED INTRACRANIAL HYPOTENSION AND FROIN'S SYNDROME FOLLOWING VENTRICULOPERITONEAL SHUNTING: A DIAGNOSTIC CHALLENGE

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Introduction: Ventriculoperitoneal (VP) shunt overdrainage can lead to severe intracranial hypotension, but secondary spinal fluid stasis mimicking Froin's syndrome is exceptionally rare. Diagnosing this dual pathology in encephalopathic patients poses a significant clinical challenge due to overlapping symptoms.

Case presentation: A 59-year-old woman with diabetes, hypertension, and a 1-year history of dementia underwent VP shunting for suspected normal pressure hydrocephalus. Within one month post-operatively, she developed a progressively deteriorating level of consciousness (Glasgow Coma Scale [GCS] 9/15) without fever, photophobia, or meningism. Investigations ruled out active central nervous system (CNS) infection, metabolic encephalopathies, toxin exposure, and shunt-site infection. Lumbar puncture revealed markedly elevated cerebrospinal fluid (CSF) protein, xanthochromia, normal white blood cell (WBC) count, and normal glucose; pyogenic, tuberculous, and fungal cultures were negative. Electroencephalography (EEG) showed no epileptiform activity. Neuroimaging (brain and spine magnetic resonance imaging [MRI]) demonstrated bilateral subdural effusions, diffuse pachymeningeal enhancement, and cauda equina nerve root clumping, confirming severe intracranial hypotension secondary to over-shunting along with features of Froin's syndrome.

Discussion: Froin's syndrome classically arises from spinal canal occlusion causing CSF stagnation, high protein, and xanthochromia. In this patient, CSF hyperviscosity and secondary spinal stasis occurred alongside severe intracranial hypotension from VP shunt overdrainage. The patient's obtundation created diagnostic ambiguity, as persistent low GCS was initially attributed to CNS infection or metabolic causes. Identifying pachymeningeal enhancement and cauda equina clumping on MRI was key to establishing the dual aetiology.

Conclusion: This case highlights a rare combination of post-shunt intracranial hypotension and Froin's syndrome. VP shunt clamping led to rapid, dramatic GCS recovery and successful rehabilitation, demonstrating that timely recognition of shunt overdrainage can reverse severe, unexplained neurological deterioration.

Keywords: ventriculoperitoneal (VP) shunt overdrainage; intracranial hypotension; Froin's syndrome

CP 004

RARE ISOLATED BASAL VEIN OF ROSENTHAL THROMBOSIS CAUSING THALAMIC HAEMORRHAGE DURING INTENSIVE-PHASE ANTI-TUBERCULOUS THERAPY

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Introduction: Cerebral venous thrombosis is an uncommon cause of stroke. Deep cerebral venous thrombosis can cause deep intracerebral haemorrhage, while isolated basal vein of Rosenthal (BVR) is exceptionally rare. Tuberculosis (TB) is an under-recognised prothrombotic condition.

Case presentation: A 23-year-old Sri Lankan man with extrapulmonary pleural tuberculosis, receiving intensive-phase anti-tuberculous therapy for 14 days, presented with acute right-sided upper and lower limb numbness. He had no history of hypertension, bleeding disorders or other conventional vascular risk factors. Full blood count, coagulation profile, inflammatory markers, renal functions, liver functions and electrolytes were normal. Acquired thrombophilia and autoimmune screening, including phospholipid antibodies, was unremarkable, and cardiac evaluation was normal. Non-contrast computed tomography (CT) of the brain demonstrated an isolated left thalamic haemorrhage. Computed tomography angiography excluded an arterial pathology, while CT venography demonstrated isolated thrombosis of the left BVR. He was treated with therapeutic anticoagulation while continuing anti-tuberculous therapy, with close neurological monitoring. He showed gradual clinical improvement without haemorrhagic progression.

Discussion: This case highlights deep cerebral venous thrombosis as an unusual cause of thalamic haemorrhage. Tuberculosis-associated systemic inflammation and hypercoagulability may promote thrombosis through endothelial activation and other prothrombotic mechanisms. Treatment-related immune responses, including possible TB-associated immune reconstitution inflammatory syndrome, may have contributed. Rifampicin-containing regimens have also been associated with thromboembolic events, although an independent causal effect remains uncertain. Thus, thrombosis in this patient was likely multifactorial.

Conclusion: Deep cerebral venous thrombosis should be considered in young patients presenting with deep intracerebral haemorrhage, particularly without conventional risk factors. Isolated BVR thrombosis is a rare cause of thalamic haemorrhage, and prompt venographic imaging can facilitate diagnosis and guide appropriate anticoagulation.

Keywords: isolated basal vein of Rosenthal thrombosis; thalamic haemorrhage; tuberculosis; intracranial thrombosis

CP 005

A CASE REPORT OF A 14-YEAR-OLD WITH INTRACTABLE VOMITING – SEROPOSITIVE AREA POSTREMA SYNDROME

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Introduction: Area postrema syndrome (APS) is an important clinical manifestation of neuromyelitis optica spectrum disorder (NMOSD). It involves the area postrema, a chemoreceptor trigger zone located in the dorsal medulla. It is a very rare disorder in adolescents and can mimic common gastrointestinal diseases.

Case presentation: A 14-year-old Sri Lankan girl presented with a two-month history of intractable vomiting, persistent hiccups, epigastric pain, regurgitation and an unintentional weight loss of 4 kg. Her symptoms did not respond to conventional antiemetic therapy. She was initially managed as gastroenteritis. She was later managed as gastroesophageal reflux disease with hiatus hernia following an upper GI endoscopy. On examination, she was dehydrated and had horizontal jerky nystagmus, cerebellar ataxia and a positive Romberg's sign. Magnetic resonance imaging (MRI) of the brain showed a region of abnormally high T2-weighted/fluid-attenuated inversion recovery (FLAIR) signal noted in dorsal lower medulla and area postrema, extending to the cervicomedullary junction. Cerebrospinal fluid analysis, visual evoked potentials and electroencephalography (EEG) were normal. Serum aquaporin-4 immunoglobulin G (AQP4-IgG) was positive, confirming seropositive NMOSD.

Initially she was treated with methylprednisolone pulses, which were later converted to oral prednisolone. Her symptoms completely resolved within one week. Mycophenolate mofetil was commenced with steroid tapering. A repeat MRI of the brain performed two months later revealed partial interval improvement with early gliosis in the abnormal areas of the lower medulla oblongata and craniovertebral junction, with no new lesions.

Discussion: APS may be the initial manifestation of NMOSD and can be mistaken for common gastrointestinal diseases. MRI brain demonstrating area postrema involvement and AQP4-IgG testing are key features for establishing the diagnosis.

Conclusion: This case highlights the importance of suspecting APS in patients with unexplained vomiting and initiating treatment early to prevent future relapses such as optic neuritis or myelitis.

Keywords: area postrema syndrome; neuromyelitis optica spectrum disorder; intractable vomiting; persistent hiccups; adolescent

CP 006

SENSORY GANGLIONOPATHY AND DISTAL RENAL TUBULAR ACIDOSIS PRECEDING SICCA SYMPTOMS IN PRIMARY SJÖGREN SYNDROME

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Introduction: Primary Sjögren syndrome (pSS) is a systemic autoimmune disease characterised by exocrine gland dysfunction and diverse extraglandular manifestations. Neurological and renal involvement may occasionally precede the characteristic sicca syndrome. We report the unusual co-occurrence of sensory ganglionopathy and distal renal tubular acidosis (dRTA), with sicca symptoms emerging only years after the onset of neurological disease.

Case presentation: A 42-year-old Sri Lankan woman with recurrent nephrolithiasis presented with an eight-year history of progressive imbalance and recurrent falls, worse in darkness. Xerostomia and xerophthalmia had developed only three months before presentation. Examination revealed loss of proprioception and vibration sense with patchy loss of pain and temperature sensation. Motor function and the rest of the neurological examination were normal. Neurophysiological studies confirmed a sensory ganglionopathy. Investigations revealed hypokalaemia, normal-anion-gap metabolic acidosis (K^+ 3.0 mmol/L, pH 7.20, HCO_3^- 14 mmol/L) with an inappropriately high urinary pH of 5.6, consistent with dRTA. X-ray of the kidneys, ureters and bladder (KUB) revealed nephrocalcinosis and staghorn calculi. Serum creatinine was normal. Positive antinuclear and anti-SSA antibodies, Schirmer's test and minor salivary-gland histology confirmed pSS. Treatment with corticosteroids, intravenous immunoglobulin and rituximab produced only modest neurological improvement; dRTA was treated with sodium bicarbonate and potassium supplements.

Discussion: Sensory ganglionopathy and dRTA are uncommon extraglandular manifestations of pSS, and their coexistence is rarely reported. Sensory ganglionopathy and dRTA preceding sicca symptoms by eight years was a striking feature in this patient. The limited neurological recovery despite immunotherapy may reflect irreversible dorsal-root-ganglion neuronal loss following longstanding disease.

Conclusion: Primary Sjögren syndrome should be considered in otherwise unexplained sensory ganglionopathy or dRTA, even in the absence of sicca symptoms, especially if they co-exist. Earlier recognition of this systemic phenotype may permit treatment before irreversible neurological or renal complications develop.

Keywords: Sjögren syndrome; sensory ganglionopathy; distal renal tubular acidosis; nephrocalcinosis

CP 007

SYPHILITIC CHOLANGIOPATHY IN ADVANCED HIV INFECTION: A REVERSIBLE CAUSE OF CHOLESTATIC JAUNDICE WITHOUT CUTANEOUS MANIFESTATIONS

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Introduction: Cholestatic liver disease in advanced HIV infection has a broad differential, including opportunistic infections, malignancy, drug-induced liver injury and HIV-associated cholangiopathy. Syphilitic hepatobiliary disease is uncommon and may occur without characteristic mucocutaneous manifestations, creating a diagnostic challenge.

Case presentation: A 35-year-old previously healthy man presented with a 3-week history of intermittent fever, night sweats, watery diarrhoea, right upper-quadrant pain, progressive jaundice, dark urine and pruritus. Examination revealed icterus and tender hepatomegaly, without mucocutaneous lesions, genital lesions or lymphadenopathy. Biochemistry demonstrated a predominantly cholestatic pattern, with progressive conjugated hyperbilirubinaemia, elevated alkaline phosphatase and gamma-glutamyl transferase, relatively modest transaminase elevations and preserved synthetic function. Ultrasonography showed mild intrahepatic biliary dilatation without common bile duct dilatation, while contrast-enhanced computed tomography (CT) demonstrated no significant biliary obstruction or mass lesion. Advanced HIV infection was newly diagnosed (CD4 74 cells/µL; HIV RNA 9.08 million copies/mL). Extensive investigations excluded opportunistic and other infectious causes, including *Cryptosporidium*, Microsporidia, cytomegalovirus (CMV), Epstein–Barr virus (EBV), *Mycobacterium avium* complex (MAC), tuberculosis and viral hepatitis. Syphilis serology was reactive (*Treponema pallidum* particle agglutination (TPPA) positive, Venereal Disease Research Laboratory (VDRL) 1:4). Following intramuscular benzathine penicillin G 2.4 million units, he demonstrated rapid clinical improvement with progressive resolution of jaundice and normalisation of liver biochemistry, even before starting antiretroviral therapy.

Discussion: Syphilitic hepatobiliary disease may manifest as cholestatic hepatitis or cholangiopathy without classical secondary syphilis manifestations. In advanced HIV infection, it can closely mimic HIV-associated cholangiopathy. The compatible clinical phenotype, reactive serology, exclusion of alternative causes and prompt response to penicillin supported syphilitic cholangiopathy as the most likely diagnosis.

Conclusion: Syphilitic cholangiopathy should be considered in unexplained cholestatic liver disease in advanced HIV infection, even without cutaneous manifestations, as timely recognition and penicillin therapy may lead to substantial clinical and biochemical recovery.

Keywords: syphilitic hepatobiliary disease; HIV; syphilis; cholestasis; cholangiopathy

CP 008

RARE PRESENTATION OF SEVERE SERONEGATIVE BICKERSTAFF BRAINSTEM ENCEPHALITIS–GUILLAIN-BARRÉ SYNDROME OVERLAP WITH PROLONGED RESPIRATORY FAILURE

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Introduction: Bickerstaff brainstem encephalitis (BBE) and Guillain-Barré syndrome (GBS) are considered part of a continuous immune-mediated spectrum. Clinical overlaps between these disorders occur, and seronegative overlap presentations can pose diagnostic and therapeutic challenges.

Case presentation: A 59-year-old man presented with a three-week history of progressive gait unsteadiness, followed by dysarthria and dysphagia. Examination revealed marked ataxia, bilateral lower motor neuron facial nerve palsy, left-sided lateral rectus palsy, bulbar dysfunction with palatal palsy, generalised areflexia and symmetrical, predominantly proximal lower limb weakness. He was initially fully conscious and oriented but developed a confusional state on day 3 of admission and, later that day, progressive respiratory failure requiring endotracheal intubation. The following day, he developed seizures; however, magnetic resonance imaging of the brain showed no abnormalities except chronic small-vessel ischaemic changes. Nerve conduction studies demonstrated a predominantly motor demyelinating peripheral neuropathy consistent with a GBS variant. Cerebrospinal fluid assessment showed elevated protein (88 mg/dL) with mild pleocytosis, indicating albuminocytologic dissociation. An antiganglioside antibody panel, including anti-GQ1b, was negative. He was treated with intravenous immunoglobulin, followed by plasma exchange. Despite treatment, he required a tracheostomy 14 days after treatment commenced because of persistent neuromuscular weakness; however, his level of consciousness improved.

Discussion: Ataxia, ophthalmoplegia, impaired consciousness, seizures and bilateral symmetrical proximal areflexic weakness, together with electrophysiological evidence of demyelinating neuropathy, clinically support a BBE-GBS overlap syndrome. Persistent motor weakness despite sequential immunotherapy may reflect the severity of the underlying peripheral nerve involvement, possible critical illness neuromyopathy and the consequences of delayed presentation.

Conclusion: Early clinical recognition of the BBE-GBS overlap phenotype is paramount, and the absence of characteristic magnetic resonance imaging features or anti-GQ1b positivity does not exclude the diagnosis. The limited neurological recovery despite sequential immunotherapies emphasises the potential for severe and prolonged disability if treatment is delayed.

Keywords: Bickerstaff brainstem encephalitis; Guillain-Barré syndrome; BBE-GBS overlap phenotype

CP 009

A TROPICAL DIAGNOSTIC DILEMMA: FULMINANT MENINGOCOCCAEMIA MIMICKING DENGUE AND LEPTOSPIROSIS

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Introduction: Fulminant meningococcaemia is a rapidly progressive manifestation of invasive meningococcal disease, with diverse presentations including sepsis and multiorgan dysfunction. In tropical settings, overlapping features may lead to diagnostic bias towards more prevalent infections. We report a case of meningococcaemia masquerading as dengue fever and severe leptospirosis.

Case presentation: A healthy 22-year-old man presented with an acute febrile illness, severe myalgia, and altered behaviour. He was febrile, tachycardic, borderline hypotensive, with a Glasgow Coma Scale of 13/15, without focal neurological signs or meningism. Investigations showed marked leucopenia, progressive thrombocytopenia, moderately raised C-reactive protein (CRP), gallbladder wall oedema, minimal hepatorenal fluid, direct hyperbilirubinaemia, coagulopathy and acute kidney injury. The leucopenia subsequently evolved into neutrophilic leucocytosis with a disproportionately marked rise in CRP. He rapidly deteriorated with myocardial injury, progressive lactic acidosis and decompensated septic shock. Dynamic ST-segment changes, elevated troponin I and echocardiographic findings were suggestive of myocarditis. Muddy water exposure, conjunctival suffusions and multiorgan involvement in an endemic region shifted consideration towards Weil's disease, and he was managed with intravenous ceftriaxone 2 g twice daily empirically and intensive care organ support. An early maculopapular rash evolved into purpura fulminans and blood cultures obtained on day 4 grew *Neisseria meningitidis* on day 6. Dengue and leptospirosis IgM were negative, while a single acute-phase leptospirosis microscopic agglutination titre was non-diagnostic. He went on to make an uncomplicated recovery.

Discussion: Early leucopenia, thrombocytopenia and ultrasonographic features of plasma leakage suggested dengue, whereas conjunctival suffusion, myalgia, marked neutrophilic inflammation, hepatorenal involvement and epidemiological factors favoured leptospirosis. Subsequent development of purpura fulminans provided an important clue to a culture-confirmed invasive meningococcaemia.

Conclusion: Meningococcal sepsis should remain an important differential diagnosis in rapidly deteriorating tropical febrile illness, despite apparently characteristic epidemiological and clinical features. Early microbiological investigation is essential to minimise diagnostic anchoring and enable timely, targeted treatment.

Keywords: meningococcaemia; *Neisseria meningitidis*; purpura fulminans; dengue; leptospirosis

CP 010

AN UNUSUAL CASE OF DELAYED RECOVERY FOLLOWING SEPSIS-ASSOCIATED ENCEPHALOPATHY

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Introduction: Sepsis-associated encephalopathy (SAE) is defined as diffuse cerebral dysfunction occurring with systemic infection without direct central nervous system (CNS) infection. This is a rare case of delayed recovery following SAE and highlights the important diagnostic and therapeutic interventions.

Case presentation: A 47-year-old woman with diabetes mellitus presented with fever and right-sided loin pain. Diagnosis of right-sided pyelonephritis complicated by acute kidney injury was made and she was commenced on intravenous antibiotics and fluid resuscitation. From the third day of the illness, she developed progressive, intermittent confusional state and impairments in short-term memory, visuospatial orientation and executive functions. Acute kidney injury resolved completely by the 8th day (documented peak blood urea nitrogen (BUN) 45 mg/dL, serum creatinine 3.4 mg/dL). No features of severe renal impairment were noted excluding the possibility of uraemic encephalopathy. There was no evidence of severe hepatic dysfunction, electrolyte abnormalities, significant hypoglycaemia or hyperglycaemia, cardiocerebral syndrome or cerebral hypoperfusion that could account for cerebral dysfunction. Partial improvement was noted in neurocognitive profile despite resolution of systemic infection. Two interval (day 10 and day 26) cerebrospinal fluid (CSF) analyses were normal. First electroencephalography (EEG) (day 16) revealed diffuse slow cortical waves. Magnetic resonance imaging (MRI) of the brain revealed no abnormalities. Following structured cognitive, visual rehabilitation and occupational therapy, the patient demonstrated substantial clinical improvement towards the 4th week, though some residual cognitive deficits persisted. EEG performed on day 26 showed no abnormalities.

Discussion: By definition, SAE improves with the resolution of the infection. Here, although the observed constellation of neurocognitive symptoms was compatible with SAE, there was a significant delay in the recovery, which warranted further exclusion of other causes of encephalopathy. This clinical profile is better explained by post-sepsis brain dysfunction or neurocognitive sequelae of SAE.

Conclusion: Early recognition, mobilisation, structured cognitive rehabilitation and supportive treatment have been shown to prevent long-term neurocognitive sequelae. Diagnosing this condition in the appropriate clinical context may also prevent unnecessary in-depth work-up for autoimmune and rarer conditions.

Keywords: sepsis-associated encephalopathy; post-sepsis cerebral dysfunction; encephalopathy; cognitive dysfunction; rehabilitation

CP 011

DISSEMINATED MUCORMYCOSIS WITH CEREBRAL, SPINAL AND PULMONARY INVOLVEMENT IN A PATIENT WITH TYPE 1 DIABETES MELLITUS

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Introduction: Disseminated mucormycosis is an aggressive, opportunistic fungal infection predominantly affecting immunocompromised states such as uncontrolled diabetes mellitus (DM). It is associated with substantial morbidity and mortality.

Case presentation: A 22-year-old woman with type 1 DM presented with a one-week history of fever and productive cough, followed by altered level of consciousness and bilateral lower-limb weakness. Neurological examination elicited bilateral lower-motor-neuron-type weakness of the lower limbs. Investigations revealed diabetic ketoacidosis. Magnetic resonance imaging of the brain and whole spine demonstrated a right parietal cerebral abscess (3.9 × 3.7 × 4.6 cm) and an epidural abscess (L3 to S1) with cauda equina syndrome. Contrast-enhanced computed tomography revealed a cavitary consolidation in the left lower lobe of the lung. She underwent right parietal hemicraniotomy and L2–L4 laminectomy with evacuation of cerebral and epidural abscesses and spinal cord decompression. Histopathological examination of cerebral and pulmonary specimens demonstrated broad, aseptate fungal hyphae consistent with mucormycosis. Cerebrospinal fluid (CSF) analysis showed a lymphocytic cellular response (1024 lymphocytes/mm^3; 426 polymorphs/mm^3), elevated protein (160 mg/dL), and glucose of 194 mg/dL (concurrent random blood glucose, 309 mg/dL). CSF pyogenic culture and cytology were negative. Screening for tuberculosis was negative in cerebral, spinal and pulmonary specimens. Prolonged treatment with intravenous liposomal amphotericin B for eight months yielded complete clinical and radiological resolution. She currently has normal cognitive function and is undergoing neurorehabilitation for residual weakness.

Discussion: Mucormycosis may occur as rhino-orbital-cerebral, pulmonary, cutaneous and gastrointestinal disease. Spinal involvement is exceptionally uncommon. Disseminated disease involving multiple non-contiguous anatomical sites, particularly the central nervous system and spine, has poor prognosis. Successful management requires prompt recognition, aggressive surgical source control and prolonged antifungal therapy.

Conclusion: This case highlights that a high index of suspicion, early radiological assessment, prompt tissue diagnosis and aggressive treatment may achieve favourable outcomes despite disseminated cerebral, spinal and pulmonary disease in mucormycosis.

Keywords: disseminated mucormycosis; type 1 diabetes mellitus; diabetic ketoacidosis; epidural abscess

CP 012

FROM ORAL LESION TO ADRENAL FAILURE: MULTISITE HISTOPLASMOSIS PRESENTING WITH BILATERAL ADRENAL DESTRUCTION

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Introduction: Histoplasmosis, caused by *Histoplasma capsulatum*, is rarely reported in Sri Lanka and may present extrapulmonary, delaying diagnosis. Oral involvement is recognised in disseminated disease and may facilitate early tissue diagnosis. Adrenal involvement commonly causes bilateral enlargement and may cause primary adrenal insufficiency from severe adrenal destruction.

Case presentation: A 62-year-old man with diabetes mellitus developed bilateral palatal lesions in December 2024. Biopsy showed macrophages containing intracellular organisms with halos, highlighted by Grocott methenamine silver (GMS) staining, favouring oral histoplasmosis. Six months of itraconazole produced no significant clinical improvement, prompting prolonged treatment. He subsequently developed recurrent syncope with metabolic abnormalities suggestive of adrenal insufficiency. In January 2026, he presented in a collapsed state with severe hyponatraemia, hyperkalaemia and a low random cortisol level. Hydrocortisone was commenced, followed by fludrocortisone. A subsequent short Synacthen test, performed after converting hydrocortisone to dexamethasone, showed an inadequate cortisol response, confirming primary adrenal insufficiency, although the adrenocorticotropic hormone (ACTH) and thyroid-stimulating hormone (TSH) levels were normal. Imaging revealed bilateral hypoattenuating adrenal masses measuring 3.8 × 3.4 cm and 3.0 × 2.5 cm, and the Mantoux test was negative. As imaging was inconclusive and both tuberculosis and malignancy remained possible, a right adrenalectomy was performed. Histology showed necrotising granulomatous destruction with GMS-positive intracellular organisms and no acid-fast bacilli, confirming adrenal histoplasmosis. He then received two weeks of amphotericin, followed by itraconazole and hormone replacement, and improved clinically.

Discussion: This case highlights a diagnostic dilemma. Disseminated histoplasmosis may develop despite itraconazole, particularly with immunosuppression. Inappropriately normal ACTH may reflect itraconazole-induced central adrenal insufficiency. In endemic settings, bilateral adrenal masses warrant consideration of tuberculosis and biopsy confirmation.

Conclusion: Histoplasmosis should be considered in immunocompromised patients with bilateral adrenal masses, particularly where tuberculosis is also prevalent. Care should be taken when interpreting pituitary-adrenal hormonal assays while on steroid and antifungal therapy. Prompt recognition and treatment of adrenal insufficiency can prevent Addisonian crisis.

Keywords: histoplasmosis; *Histoplasma capsulatum*; adrenal histoplasmosis; adrenal insufficiency

CP 013

SPONTANEOUS SPLENIC RUPTURE IN POST-CRITICAL DENGUE HAEMORRHAGIC FEVER

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Introduction: Dengue haemorrhagic fever (DHF) is characterised by a critical phase marked by plasma leakage. While hepatic complications are expected, spontaneous splenic rupture (SSR) is a rare and potentially fatal complication, occurring in approximately 1.5% of cases. Its diagnosis is highly challenging because its symptoms often mimic routine abdominal pain associated with the critical phase. This report highlights a rare instance of SSR manifesting during the post-critical recovery phase, emphasising the need for sustained clinical vigilance.

Case presentation: A 32-year-old man developed DHF marked by plasma leakage and severe thrombocytopenia. During the recovery phase, on day 7 of illness, despite clinical improvement, including rising platelets and a convalescent rash, he developed severe left upper quadrant pain radiating to his left shoulder (Kehr's sign). Contrast-enhanced computed tomography (CECT) revealed a massive peri-splenic haematoma and haemoperitoneum, indicating a spontaneous splenic rupture. The patient underwent an emergency laparotomy and splenectomy with packed red cell transfusions, leading to uneventful recovery.

Discussion: SSR in DHF results from congestive splenomegaly, severe thrombocytopenia, and coagulopathy, making the splenic capsule highly susceptible to minor mechanical stresses. Crucially, this case demonstrates that SSR can present during the recovery phase when other clinical markers are actively improving. Persistent abdominal pain, Kehr's sign, or a sudden haemoglobin drop should immediately shift the differential diagnosis toward visceral rupture. While non-operative management is generally preferred for haemodynamically stable patients to avoid severe surgical bleeding, this patient's extensive haemoperitoneum necessitated prompt surgical intervention.

Conclusion: Clinicians must suspect SSR in DHF patients presenting with persistent abdominal pain, even during the recovery phase. Prompt radiological evaluation and timely intervention remain crucial to reducing mortality while carefully balancing surgical versus non-operative management.

Keywords: dengue haemorrhagic fever; spontaneous splenic rupture; splenectomy; haemoperitoneum

CP 014

WHEN THE BRAINSTEM MEETS THE PERIPHERAL NERVE: CONUNDRUM OF BICKERSTAFF BRAINSTEM ENCEPHALITIS–GUILLAIN-BARRÉ SYNDROME OVERLAP FOLLOWING SUSPECTED LEPTOSPIROSIS

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Introduction: Bickerstaff brainstem encephalitis (BBE) is a rare post-infectious immune-mediated neurological disorder within the anti-GQ1b antibody spectrum, characterised by ophthalmoplegia, ataxia and impaired consciousness. Although BBE may overlap with Guillain-Barré syndrome (GBS), BBE-GBS overlap following leptospirosis is exceptionally uncommon, and poses a significant diagnostic challenge.

Case presentation: A 57-year-old man with a history of chronic alcohol use presented with fever, myalgia, and conjunctival suffusion, and was managed for leptospirosis, given the compatible presentation. By day 7, he developed an acute neurological syndrome with bilateral partial ptosis, complete ophthalmoplegia, gait ataxia, generalised hyporeflexia and progressive confusion. The brain magnetic resonance imaging was normal, cerebrospinal fluid showed elevated protein with minimal pleocytosis, electroencephalogram demonstrated diffuse slowing, and nerve conduction studies revealed F-wave abnormalities. While the presentation raised the possibility of alternative syndromes like Wernicke's encephalopathy and *Listeria* rhombencephalitis, treatment with antibiotics, high-dose thiamine and intravenous methylprednisolone showed no neurological improvement. Given the combination of brainstem dysfunction, peripheral neuropathy and supportive neurophysiology, intravenous immunoglobulin was initiated, suspecting BBE-GBS overlap. The response was striking, with complete neurological recovery. Although confirmatory antibody testing was delayed due to resource constraints, the subsequent finding of substantially elevated anti-GM1, despite negative anti-GQ1b IgG antibodies, provided additional immunological support for a GBS-spectrum disorder, while the diagnosis of BBE remained primarily clinical.

Discussion: The case highlights the protean presentation and the diagnostic complexity of BBE-GBS overlap, where simultaneous central and peripheral involvement can obscure a unifying diagnosis. When definitive biomarkers are unavailable or inconclusive, the diagnosis hinges on the convergence of clinical acumen, supportive investigations, and systematic exclusion of competing mimics.

Conclusion: Recognising the clinical spectrum of BBE-GBS overlap is crucial, particularly when the conventional diagnostic markers are negative. Early clinical recognition and timely immunotherapy are decisive in achieving neurological recovery.

Keywords: Bickerstaff brainstem encephalitis; Guillain-Barré syndrome; anti-GM1; leptospirosis

CP 015

PSEUDO-BEHÇET SYNDROME: A RARE MULTISYSTEMIC PRESENTATION OF CUTANEOUS TUBERCULOSIS

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Introduction: Behçet disease is a multisystem inflammatory disorder characterised by recurrent oral and genital ulcers, ocular inflammation, skin lesions, and musculoskeletal manifestations. Tuberculosis (TB), particularly extrapulmonary TB, can mimic systemic inflammatory and vasculitic disorders. Recognising these infectious mimics is crucial before initiating immunosuppressive therapy.

Case presentation: A previously healthy 16-year-old male presented with a three-month history of recurrent bilateral, painless, non-pruritic red eyes. One month later, he developed asymmetrical oligoarthritis with significant morning stiffness. He also experienced recurrent oral ulcers and subsequently developed painless nodular lesions with punched-out areas over the knuckles, dorsum of the hands, forearms, and extensor surfaces of the elbows. He reported low-grade fever, anorexia, and weight loss. There was no genital ulceration, photosensitivity, alopecia, axial involvement, gastrointestinal symptoms, or respiratory symptoms suggestive of pulmonary TB. Examination revealed anterior uveitis, healing oral ulcers, and multiple nodular skin lesions. Erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP) were markedly elevated (96 mm/h and 102 mg/L), while antinuclear antibody (ANA), rheumatoid factor and pathergy testing were negative. Skin biopsy demonstrated granulomatous inflammation with caseous necrosis, and tuberculosis polymerase chain reaction (TB-PCR) from the skin lesion was weakly positive. A diagnosis of cutaneous-extrapulmonary TB was made. He was started on anti-tuberculous therapy (ATT) and recovered successfully.

Discussion: The combination of recurrent oral ulcers, ocular inflammation, skin lesions, and inflammatory oligoarthritis initially suggested Behçet disease or a Behçet-like syndrome. However, the absence of genital ulcers and negative pathergy test, together with caseous necrosis and positive TB-PCR, supported a tuberculous aetiology. Extrapulmonary TB can rarely produce multisystem manifestations and closely mimic inflammatory diseases.

Conclusion: TB should be considered in Behçet-like presentations involving ocular, cutaneous, mucosal, and articular systems, especially in TB-endemic settings. Careful clinical assessment and tissue diagnosis are essential to prevent misdiagnosis and inappropriate immunosuppression.

Keywords: pseudo-Behçet syndrome; cutaneous tuberculosis; Behçet disease; uveitis

CP 016

SYSTEMIC LUPUS ERYTHEMATOSUS ASSOCIATED WITH ACUTE DISSEMINATED ENCEPHALOMYELITIS IN A YOUNG MALE: A RARE CASE REPORT IN SRI LANKA

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Introduction: Acute disseminated encephalomyelitis (ADEM) is an uncommon immune-mediated inflammatory demyelinating disorder of the central nervous system, most often occurring after an infectious illness or vaccination. Its association with systemic lupus erythematosus (SLE) is exceptionally rare, particularly when ADEM is the initial manifestation of SLE in a young male. We report a rare case of neuropsychiatric SLE presenting with ADEM in a previously healthy adolescent.

Case presentation: A 17-year-old previously healthy Sri Lankan man presented with fever, headache, and progressive alteration of consciousness following a recent febrile respiratory illness. Initial clinical assessment favoured meningoencephalitis. However, extensive microbiological investigations, including blood and cerebrospinal fluid cultures, tuberculosis testing, and viral and fungal screening, were unrevealing. Cerebrospinal fluid demonstrated markedly elevated protein with minimal pleocytosis. Brain magnetic resonance imaging (MRI) revealed asymmetric multifocal subcortical T2-weighted/fluid-attenuated inversion recovery (FLAIR) hyperintense lesions with patchy enhancement, highly suggestive of ADEM. Further evaluation prompted by persistent pancytopenia and multisystem abnormalities revealed a markedly elevated erythrocyte sedimentation rate (ESR) with normal C-reactive protein, strongly positive antinuclear antibody (1:2560), markedly elevated anti-double-stranded DNA antibodies (> 150 IU/mL), and hypocomplementaemia. Persistent microscopic haematuria and proteinuria led to renal biopsy, which demonstrated class III focal lupus nephritis. The overall clinical, serological, neurological, and renal findings fulfilled the 2019 European Alliance of Associations for Rheumatology/American College of Rheumatology (EULAR/ACR) classification criteria for SLE, establishing ADEM as an initial neuropsychiatric manifestation of SLE. Following exclusion of active infection, he was treated with intravenous methylprednisolone followed by oral prednisolone, hydroxychloroquine, and tacrolimus. He demonstrated rapid neurological recovery, with improvement in cytopenias and renal abnormalities.

Conclusion: ADEM may rarely be the presenting manifestation of previously undiagnosed SLE, even in the absence of classical lupus features. In patients presenting with acute encephalopathy and characteristic demyelinating lesions, the presence of unexplained cytopenias, hypocomplementaemia, urinary abnormalities, and a disproportionately elevated ESR should prompt evaluation for underlying SLE. Early recognition and timely immunosuppressive therapy can result in excellent neurological and systemic outcomes.

Keywords: acute disseminated encephalomyelitis; systemic lupus erythematosus; neuropsychiatric systemic lupus erythematosus; lupus nephritis

CP 017

VALPROIC ACID-INDUCED ENCEPHALOPATHY: A RARE CAUSE OF METABOLIC ENCEPHALOPATHY IN THE ELDERLY

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Introduction: Valproic acid-induced encephalopathy (VPA-E) can manifest as confusion, worsening seizure control, gastrointestinal symptoms or extrapyramidal features. Though sodium valproate (NVL) has a reasonable safety profile, VPA-E remains a serious adverse effect.

Case presentation: We report a 64-year-old man previously treated with NVL for presumed epilepsy for 25 years presenting with reduced level of consciousness over two weeks which had spontaneously resolved upon defaulting anti-seizure medication (ASM) for a week. He was initially started on NVL for a single episode of syncope without classic features of a seizure and had not undergone cerebral imaging or electroencephalography (EEG). There was no history suggestive of infection, falls or substance abuse. On examination the patient was well oriented with a Glasgow Coma Scale (GCS) of 15/15, normal fundus and normal plantars. He was afebrile with flapping tremors and had no clinical features of meningism or focal neurological signs. Cardiovascular, respiratory and abdominal system examinations were unremarkable.

Investigations revealed normal full blood count, electrocardiogram (ECG), serum electrolytes, liver and renal functions with elevated blood urea nitrogen (48 µmol/L). EEG revealed mild encephalopathy with normal contrast computed tomography (CT) of the brain and elevated arterial ammonia (AA) (55 µmol/L). Ultrasound abdomen, 2D echocardiogram and 24-hour Holter monitoring were unremarkable. Upon confirmation of the clinical diagnosis of VPA-E with elevated AA and normal liver functions the patient was asked to discontinue NVL and reassured.

Discussion: Metabolic encephalopathy was initially suspected in the absence of infection and trauma. Normal liver, renal and electrolyte profiles ruled out other biochemical causes for encephalopathy. Improvement of symptoms upon withholding NVL with elevated AA was strongly supportive of VPA-E. NVL blood levels were not performed due to unavailability.

Conclusion: VPA-E should be strongly suspected in a patient on NVL presenting with worsening confusion, encephalopathy on EEG, normal cerebral imaging and elevated arterial ammonia. ASM should not be initiated without a proper indication.

Keywords: valproic acid-induced encephalopathy; metabolic encephalopathy; sodium valproate; hyperammonaemia

CP 018

LADY WINDERMERE SYNDROME PRESENTING AS ACUTE HYPOXIC RESPIRATORY FAILURE

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Introduction: Lady Windermere syndrome (LWS) is a rare clinical entity characterised by non-tuberculous mycobacterial (NTM) pulmonary disease, typically *Mycobacterium avium* complex (MAC), classically affecting middle-aged and elderly women without underlying structural lung disease. In tuberculosis-endemic regions, diagnosis remains challenging as NTM infections mimic pulmonary tuberculosis or recurrent bacterial pneumonia. Misdiagnosis leads to inappropriate treatment, predisposing patients to recurrent presentations of pneumonia unless managed with targeted therapy.

Case presentation: A 68-year-old woman with poorly controlled type 2 diabetes mellitus presented with acute hypoxic respiratory failure (88% on room air, requiring 8 L/min oxygen) following a two-week history of cough and fever. Chest radiography demonstrated right middle lobe opacification. Further, high-resolution computed tomography (HRCT) of the chest confirmed right middle lobe and lingular lobe bronchiectasis with nodular opacities, a feature of Lady Windermere syndrome. Initial management for community-acquired pneumonia included broad-spectrum antibiotics and macrolide coverage, with gradual clinical improvement and weaning of oxygen. Her sputum was negative for tuberculosis polymerase chain reaction (PCR) and the rapid test for HIV was also negative. Two sputum cultures subsequently yielded MAC. Targeted macrolide-based multidrug therapy yielded rapid clinical improvement and complete resolution of symptoms and sustained clinical improvement during subsequent follow-up.

Discussion: LWS is a clinically rare manifestation arising from anatomical susceptibility of the narrow middle lobe and lingula bronchi, compounded by voluntary cough suppression. MAC pulmonary disease is notoriously difficult to treat, requiring prolonged multidrug regimens. Diagnostic delays frequently lead to repeated, mismanaged acute admissions for recurrent pneumonia. Prompt imaging and mycobacterial cultures are vital for establishing a definitive diagnosis.

Conclusion: This case highlights the clinical rarity of Lady Windermere syndrome, presenting as acute respiratory failure. Clinicians must consider NTM infections in non-resolving or recurrent pneumonia to avoid treatment failure and initiate appropriate, prolonged antimicrobial therapy.

Keywords: Lady Windermere syndrome; *Mycobacterium avium* complex; non-tuberculous mycobacteria; bronchiectasis

CP 019

POSSIBLE SYPHILITIC HEPATITIS AS A MANIFESTATION OF SECONDARY SYPHILIS MIMICKING AUTOIMMUNE HEPATITIS–PRIMARY BILIARY CHOLANGITIS OVERLAP SYNDROME

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Introduction: Syphilitic hepatitis, an uncommon manifestation of secondary syphilis, often presents with a cholestatic pattern of liver injury. It can also mimic other hepatobiliary and autoimmune conditions potentially leading to inappropriate treatment modalities.

Case presentation: A 47-year-old woman presented with high-grade fever followed by progressive jaundice, dark urine, pale stools, and pruritus, preceded by a non-pruritic rash involving the palms and soles and a history of unprotected sexual exposure 2–3 months earlier. Examination revealed deep icterus and a palmoplantar rash in the absence of stigmata of chronic liver disease. Investigations demonstrated a cholestatic pattern of liver injury with elevated inflammatory markers. Positive antinuclear and anti-mitochondrial antibodies with elevated immunoglobulin G (IgG) levels raised concerns for autoimmune hepatitis/primary biliary cholangitis (AIH/PBC) overlap syndrome. However, liver biopsy was inconclusive of either autoimmune or syphilitic hepatitis but showed a predominant cholestatic pattern. Serological testing confirmed syphilis, with a positive Venereal Disease Research Laboratory (VDRL) test and *Treponema pallidum* particle agglutination (TPPA) assay. Clinical and biochemical improvement occurred after antibiotics with complete recovery following a single dose of benzathine penicillin G. Autoimmune markers including antinuclear antibodies, anti-mitochondrial antibodies and immunoglobulin G levels became negative two months after syphilis treatment.

Discussion: Although the cholestatic pattern and liver biopsy findings may suggest AIH/PBC overlap syndrome features, autoimmune markers should be interpreted in conjunction with the clinical context. The subsequent improvement in the clinical condition and the disappearance of the autoimmune abnormalities following antibiotic treatment support their transient nature and suggest an infection-related immunological phenomenon rather than a primary autoimmune liver disease.

Conclusion: Autoimmune markers may be misleading in patients with cholestatic liver injury in the presence of syphilis. Early recognition of syphilitic hepatitis is essential to ensure appropriate treatment and to prevent undue immunosuppression.

Keywords: syphilitic hepatitis; secondary syphilis; autoimmune hepatitis–primary biliary cholangitis overlap syndrome; cholestasis

CP 020

A CASE OF DISSEMINATED MELIOIDOSIS-NEUROMELIOIDOSIS

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Introduction: Melioidosis is a potentially life-threatening infection caused by *Burkholderia pseudomallei*. Its incidence is increasing in Sri Lanka. Neuromelioidosis is a rare manifestation, occurring in fewer than 5% of cases, with high mortality.

Case presentation: A 60-year-old Sri Lankan male with newly diagnosed diabetes mellitus presented with a two-week history of fever, anorexia, arthralgia, myalgia, and a dry cough. Blood and urine cultures and investigations for tuberculosis were negative. Imaging revealed focal areas of pulmonary consolidations with small necrotic areas, multiple liver lesions and right epididymo-orchitis. Multisystem involvement with melioidosis antibody titre of 1:1280 supported the diagnosis of disseminated melioidosis. He was treated with intravenous meropenem for 6 weeks, followed by eradication therapy with cotrimoxazole. He had a good clinical response. However, while on eradication therapy, he defaulted on treatment and developed sudden-onset left-sided weakness. Based on contrast-enhanced computed tomography (CECT) of the brain findings, he was managed for an acute right-sided ischaemic stroke. One month later, he presented with recurrent focal seizures with a painful red eye. Magnetic resonance imaging (MRI) of the brain demonstrated an irregular conglomerate mass consisting of multiple punctate and rim-enhancing nodules in the right cerebral hemisphere. A repeat melioidosis antibody titre had risen to 1:10240. A diagnosis of neuromelioidosis with anterior uveitis was made. A cerebral biopsy was considered but deferred due to the highly vascular nature of the lesion. Intravenous meropenem was restarted, which resulted in significant neurological improvement. Antibody titre dropped to 1:1280 after 8 weeks of treatment.

Discussion: Neuromelioidosis can mimic other neurological disorders, making diagnosis challenging. Tissue diagnosis is not always feasible. Although serological titres are not diagnostic, they may provide supportive evidence, particularly in multisystem involvement.

Conclusion: Early recognition and strict adherence to prolonged antimicrobial therapy are important to prevent relapses.

Keywords: melioidosis; *Burkholderia pseudomallei*; neuromelioidosis; disseminated melioidosis; central nervous system infection

CP 021

BEYOND PRIMARY ALDOSTERONISM: CONCURRENT MILD AUTONOMOUS CORTISOL SECRETION AND MICROPROLACTINOMA IN A YOUNG HYPERTENSIVE

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Introduction: Young adults with hypertension need careful work-up for secondary causes, especially primary aldosteronism (PA). Occasionally, PA coexists with mild autonomous cortisol secretion (MACS) which is defined as biochemical cortisol excess without the physical signs of Cushing syndrome, which increases cardiometabolic risk. Dual secreting adrenal adenoma and a functioning pituitary adenoma rarely coexist and point towards an inherited syndrome. We report an aldosterone-producing adenoma with MACS alongside a microprolactinoma causing secondary hypogonadism.

Case presentation: A 32-year-old man presented with resistant hypertension, newly diagnosed diabetes, sparse body hair, and erectile dysfunction. Examination showed severe target-organ damage: stage IV hypertensive retinopathy and left ventricular hypertrophy. Biochemistry revealed mild hypokalaemic metabolic alkalosis. Saline loading confirmed PA. Laboratory confirmation of serum cortisol excess (overnight dexamethasone suppression test: 238 nmol/L; low-dose dexamethasone suppression test: 293.92 nmol/L) and suppressed adrenocorticotropic hormone (ACTH: 4.37 pg/mL) established concurrent MACS without overt cushingoid features. Abdominal computed tomography (CT) showed a 25.5-mm right adrenal adenoma. Marked hyperprolactinaemia with hypogonadotropic hypogonadism prompted a pituitary magnetic resonance imaging (MRI), which confirmed a microadenoma; other pituitary hormones, including thyroid-stimulating hormone and insulin-like growth factor 1 were normal. He received cabergoline for the prolactinoma and spironolactone for blood pressure control before undergoing laparoscopic right adrenalectomy. Postoperatively, transient hypotension required hydrocortisone, confirming relative adrenal insufficiency from hypothalamic-pituitary-adrenal axis suppression. Within a week, he was normotensive without any medications.

Discussion: Combined aldosterone and cortisol excess likely drove this patient's severe vascular damage and early diabetes. Identifying MACS before surgery was critical; it allowed us to anticipate postoperative adrenal insufficiency and prevent an adrenal crisis. Having both adrenal and pituitary tumours also meant testing for multiple endocrine neoplasia type 1 (MEN1).

Conclusion: Patients with PA should be routinely screened for cortisol autonomy to ensure perioperative safety and reduce cardiometabolic risk, while subtle clinical clues help catch coexisting endocrine tumours early.

Keywords: mild autonomous cortisol secretion; microprolactinoma; aldosterone-producing adenoma; resistant hypertension; primary aldosteronism

CP 022

MCKITTRICK–WHEELOCK SYNDROME PRESENTING WITH HYPERKALAEMIA AND SEVERE ACUTE KIDNEY INJURY: AN UNUSUAL PRESENTATION OF A SIGMOID TUBULOVILLOUS ADENOMA

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Introduction: McKittrick–Wheelock syndrome (MWS) is a rare, potentially life-threatening complication of colorectal villous or tubulovillous adenomas, characterised by secretory diarrhoea, electrolyte disturbances and acute kidney injury (AKI). Typically associated with large rectosigmoid lesions, it commonly causes profound dehydration and hypokalaemia. We report an unusual presentation involving a relatively small sigmoid adenoma, hyperkalaemia and severe AKI.

Case presentation: A 57-year-old Sri Lankan man with hypertension, dyslipidaemia and well-controlled type 2 diabetes mellitus presented with generalised oedema, oliguria and four weeks of profuse watery diarrhoea, occurring approximately ten times daily, including nocturnal episodes. Investigations revealed severe AKI (serum creatinine 978 µmol/L), hyponatraemia, hypochloraemia, hyperkalaemia, metabolic acidosis and subnephrotic-range proteinuria. Inflammatory markers were not elevated, and stool microscopy showed no pus cells. Colonoscopy identified a 3 × 3.5 cm pedunculated polyp in the lower sigmoid colon. Histopathology confirmed a tubulovillous adenoma with high-grade dysplasia. Complete endoscopic polypectomy achieved negative stalk margins. Subsequently, diarrhoea and oedema resolved, with normalisation of renal function, electrolytes and proteinuria.

Discussion: Unlike the typical presentation of MWS with large villous adenomas and hypokalaemia, this patient had a relatively small pedunculated lesion and hyperkalaemia, potentially attributable to impaired renal potassium excretion during severe AKI. Persistent nocturnal watery diarrhoea, absence of inflammatory features and marked renal dysfunction were important diagnostic clues. Resolution following polypectomy strongly supported the diagnosis. The case illustrates that MWS may present with atypical electrolyte disturbances and severe renal complications despite a relatively small adenoma.

Conclusion: McKittrick–Wheelock syndrome should be considered in patients with persistent secretory-type diarrhoea, unexplained electrolyte disturbances and acute kidney injury, even without the classical hypokalaemia or a large rectal mass. Early colonoscopic diagnosis and definitive polypectomy can result in complete recovery.

Keywords: McKittrick–Wheelock syndrome; secretory diarrhoea; acute kidney injury; hyperkalaemia; tubulovillous adenoma; polypectomy

CP 023

SJÖGREN SYNDROME ASSOCIATED WITH BILATERAL HEARING LOSS AND DISTAL RENAL TUBULAR ACIDOSIS

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Introduction: Sjögren syndrome (SS) is a systemic autoimmune disorder with variable extraglandular manifestations. Distal renal tubular acidosis (dRTA) and hearing loss are recognised but uncommon associations of SS and their coexistence as presenting features is seldom described.

Case presentation: A 41-year-old woman presented with a four-day history of bilateral hearing impairment, without significant systemic symptoms. Otoscopy revealed otitis externa sicca, a retracted tympanic membrane and mild middle-ear effusion. Pure-tone audiometry showed bilateral moderate-to-profound mixed hearing loss. Investigations revealed raised erythrocyte sedimentation rate (ESR), normochromic normocytic anaemia and renal impairment. Hypokalaemia, normal anion gap metabolic acidosis and alkaline urine were suggestive of dRTA. Subsequent directed questioning revealed subtle sicca symptoms. Minor salivary gland biopsy revealed multifocal periductal lymphocytic aggregates favouring SS. A strongly positive antinuclear antibody (ANA) (> 1:2560) with nuclear pattern and positive anti-Ro and anti-La antibodies further supported the diagnosis. Anti-dsDNA and rheumatoid factor were negative with low C4 and normal C3. Myringotomy yielded a small amount of fluid. Following intratympanic dexamethasone, hearing thresholds improved at low and mid frequencies although high-frequency loss persisted.

Discussion: This case illustrates an unusual presentation of SS, with bilateral mixed hearing loss and dRTA. The sensorineural component may reflect immune-mediated cochlear injury, microvasculitis and ischaemia of labyrinthine vessels, or neuritis. Conductive hearing loss may have been related to eustachian tube dysfunction secondary to mucosal dryness and middle ear effusions. The audiometry and middle-ear findings with improvement following corticosteroids and myringotomy support the dual pathology. Although sicca symptoms were subtle, this presentation led to uncovering of an underlying SS.

Conclusion: The association of hearing loss and dRTA with SS highlights how atypical extraglandular manifestations may be the first clue to an underlying autoimmune disease. This case highlights the importance of considering SS in patients with otherwise unexplained hearing loss and other extraglandular manifestations.

Keywords: Sjögren syndrome; bilateral hearing loss; distal renal tubular acidosis; middle ear effusion

CP 024

SEVERE LEPTOSPIROSIS LEADING TO TRANSIENT CENTRAL DIABETES INSIPIDUS

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Introduction: Leptospirosis, being the commonest zoonosis in Sri Lanka, has shown diverse neurological manifestations among the other systemic complications. This case describes secondary posterior hypophysitis, a rare neurological complication of severe leptospirosis.

Case presentation: A 39-year-old man presented with high-grade fever and myalgia. Diagnosis of leptospirosis was serologically confirmed. He progressed to a confusional state with deteriorating renal function warranting haemodialysis. Despite resolution of renal function, the patient continued to be confused. Persistent hypernatraemia (> 155 mmol/L) was initially attributed to hypovolaemia, considering the high collapsibility index of the inferior vena cava, and was managed with fluid resuscitation. The patient deteriorated further following fluid resuscitation with worsening hypernatraemia (151 to 164 mmol/L), rising serum osmolarity (318 mOsm/kg to 347 mOsm/kg), persistent polyuria (3.5–4.5 L/day) and low urine osmolarity (264 mOsm/kg). Following the correction of hypernatraemia, a supervised water deprivation test followed by desmopressin challenge demonstrated an increase in urine osmolarity (264 mOsm/kg to 810 mOsm/kg), confirming the diagnosis of central diabetes insipidus (CDI). MRI brain showed symmetrical neurohypophyseal enlargement with contrast enhancement suggestive of posterior hypophysitis. Brainstem lesions and vasculitic changes were not observed. Cerebrospinal fluid analysis did not reveal significant abnormalities. Alongside intravenous antibiotics and supportive renal care, the patient was treated successfully with intranasal desmopressin for 3 weeks. Doses were then tapered off as serum sodium levels returned to baseline along with resolution of polyuria.

Discussion: Though aseptic meningitis occurs in nearly 10–15% of patients with leptospirosis, isolated and reversible involvement of the posterior pituitary with resultant CDI is rarely reported, and secondary vasculitis and immune-mediated damage are implicated in the pathogenesis.

Conclusion: Persistent hypernatraemia, polyuria and inappropriately diluted urine should always be considered important clinical clues for diagnosing CDI.

Keywords: leptospirosis; secondary posterior hypophysitis; central diabetes insipidus; aseptic meningitis; hypernatraemia; desmopressin

CP 025

LEPTOSPIROSIS-ASSOCIATED IMMUNE-MEDIATED VASCULITIS COMPLICATED BY PERIPHERAL GANGRENE AND MONONEURITIS MULTIPLEX

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Introduction: Leptospirosis is a zoonotic infection with a broad clinical spectrum, ranging from self-limiting febrile illness to severe multiorgan dysfunction. Peripheral gangrene and vasculitic neuropathy are rare complications. We report a case of severe leptospirosis complicated by multiorgan dysfunction with rare immune-mediated leucocytoclastic vasculitis, peripheral gangrene and mononeuritis.

Case presentation: A 47-year-old man, a manual labourer from Pettah, Colombo, presented with a four-day history of fever, marked myalgia, arthralgia, jaundice, dark-coloured urine, oliguria and progressive dyspnoea without haemoptysis. He developed multi organ dysfunction requiring intensive care admission, mechanical ventilation and inotropic support. After 10 days, he improved clinically, was extubated and transferred to the ward. Despite resolution of systemic symptoms and improving organ functions, he developed painful, bilateral symmetrical blackish discolouration of the lower limbs with reduced sensation. A palpable, non-blanching erythematous rash appeared over both lower limbs. Over the following days, similar discolouration developed over the fingertips, accompanied by right radial nerve palsy. Initial *Leptospira* microscopic agglutination testing (MAT) was negative; however, subsequent convalescent MAT titre was > 1:10,000 significantly positive. Skin biopsy demonstrated leucocytoclastic vasculitis. Antinuclear antibody (ANA), antineutrophil cytoplasmic antibody (ANCA) and secondary vasculitic screening were negative. A diagnosis of leptospirosis-associated immune-mediated vasculitis with peripheral gangrene and mononeuritis multiplex was made. He received intravenous methylprednisolone 500 mg three times daily for three days, followed by oral prednisolone, intravenous cyclophosphamide and plasma exchange. The vasculitic rash improved, with no further progression of peripheral ischaemia, although right radial nerve palsy persisted.

Discussion: The development of vasculitic lesions, symmetrical peripheral gangrene and neuropathy during recovery, supported by histology and a markedly positive convalescent MAT, suggests an immune-mediated mechanism. Vasculitic nerve ischaemia may cause irreversible neurological deficits.

Conclusion: Leptospirosis may rarely cause immune-mediated vasculitis with peripheral gangrene and mononeuritis. Early recognition and immunosuppression may prevent progression and further tissue loss.

Keywords: leptospirosis-associated immune-mediated vasculitis; peripheral gangrene; mononeuritis multiplex; leucocytoclastic vasculitis

CP 026

PAPULAR PRURITIC ERUPTION AND *SALMONELLA* CHOLERAESUIS BACTERAEMIA REVEALING ADVANCED HIV INFECTION

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Introduction: Papular pruritic eruption (PPE) is a common cutaneous manifestation and may be the initial presentation of HIV-associated immunosuppression, although it is frequently under-recognised. Invasive non-typhoidal *Salmonella* (iNTS) infection is a strongly associated opportunistic infection in advanced HIV. We report a case of a Sri Lankan man who initially presented with PPE and was subsequently diagnosed with advanced HIV infection, complicated by *Salmonella* Choleraesuis bacteraemia.

Case presentation: A 27-year-old previously healthy man presented with high-grade fever, myalgia, and arthralgia for three days. He reported a 10-month history of a pruritic papular eruption that had failed to respond to topical corticosteroids and ultraviolet B (UVB) phototherapy. He was initially managed for possible viral/dengue infection, with resolution of fever and thrombocytopenia within four days. However, fever recurred two days later, and blood cultures yielded *Salmonella* Choleraesuis. Given the persistence of fever despite appropriate antimicrobial therapy and the well-established association between iNTS infection and advanced HIV infection, HIV testing was performed and was positive, with a CD4 count of 24 cells/µL. Repeat skin biopsy findings were consistent with HIV-associated PPE. Although the patient initially denied such exposure, he subsequently disclosed a history of high-risk sexual exposure.

Discussion: Invasive NTS infection in advanced HIV commonly manifests as bacteraemia without gastrointestinal symptoms. *S.* Choleraesuis is a relatively uncommon NTS serovar associated with invasive disease in immunocompromised hosts. In this case, the combination of refractory PPE and invasive *S.* Choleraesuis bacteraemia provided complementary clinical clues to previously unrecognised advanced HIV infection.

Conclusion: To our knowledge, this represents the first reported case of *Salmonella* Choleraesuis bacteraemia in Sri Lanka. This case highlights the importance of recognising PPE and iNTS infection as sentinel manifestations of advanced HIV, particularly in socially conservative populations where the patient may not be forthcoming with a significant sexual history due to social stigma.

Keywords: non-typhoidal *Salmonella*; *Salmonella* Choleraesuis; papular pruritic eruption; HIV infection; bacteraemia

CP 027

A RARE PRESENTATION OF UNILATERAL PAPILLOEDEMA IN EXTENSIVE CEREBRAL VENOUS SINUS THROMBOSIS

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Introduction: Papilloedema is usually bilateral and is a manifestation of raised intracranial pressure (ICP). Unilateral papilloedema is rare and has been described in conditions such as Foster Kennedy syndrome, but is seldom reported in cerebral venous sinus thrombosis (CVST). This can pose a diagnostic challenge. We report a rare case of unilateral papilloedema associated with extensive CVST.

Case presentation: A 37-year-old man with a history of chronic right otitis media presented with a one-week history of occipital headache, worsening with coughing and straining. Visual acuity and colour vision were preserved bilaterally. Fundus examination demonstrated optic disc oedema in the left eye with a normal right optic disc. Optical coherence tomography showed a preserved right optic disc contour and increased retinal nerve fibre layer thickness in the left eye, with complete cup obliteration. Visual evoked potentials were normal. Computed tomography (CT) and magnetic resonance (MR) venography revealed extensive CVST involving the right transverse sinus, straight sinus, and superior sagittal sinus, with radiological features of raised ICP. He was treated with anti-oedema measures and anticoagulation with enoxaparin, followed by a direct oral anticoagulant. Clinical improvement was noted during follow-up, and serial fundus examinations are ongoing. Chronic otitis media was considered a possible precipitating factor, with thrombophilia screening pending.

Discussion: Unilateral optic disc swelling in the setting of extensive CVST is an unusual finding. Other possibilities of unilateral optic disc swelling were considered and excluded such as optic neuritis and anterior ischaemic optic neuropathy. The asymmetric retinal nerve fibre layer thickening may reflect differences in optic nerve sheath pressure transmission, individual variations in venous drainage, or asymmetric susceptibility to raised ICP.

Conclusion: This case highlights the importance of fundus examination in patients presenting with headache. Unilateral papilloedema should not exclude raised ICP and should prompt appropriate neuroimaging and evaluation for intracranial hypertension, similar to bilateral papilloedema.

Keywords: cerebral venous sinus thrombosis; papilloedema; intracranial hypertension; otitis media

CP 028

FOLLICULAR LYMPHOMA PRESENTING WITH SKELETAL INVOLVEMENT AND GRANULOMATOUS REACTION INITIALLY DIAGNOSED AS TUBERCULOUS SPONDYLODISCITIS

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Introduction: Follicular lymphoma typically presents with painless lymphadenopathy and an indolent course. Atypical presentations with granulomatous reaction on histology create diagnostic difficulty in tuberculosis-endemic settings.

Case presentation: A 53-year-old man developed backache, leg weakness and constitutional symptoms. Contrast-enhanced computerised tomography and magnetic resonance imaging showed destructive lesions at L1–L4 levels with widespread lymphadenopathy. Vertebral tissue histology showed histiocytic collection with a giant cell reaction. Smear for acid-fast bacilli, mycobacterial culture and polymerase chain reaction (PCR) for tuberculosis were negative on both vertebral tissue and bronchoalveolar lavage specimens. Human immunodeficiency virus testing was negative. Anti-tuberculosis therapy (ATT) was commenced empirically, with transient symptomatic improvement. Seven months later he presented with bilateral leg oedema, exertional dyspnoea, cachexia, generalised lymphadenopathy and bilateral pleural effusions. Pleural fluid and lymph node mycobacterial studies, including PCR, were negative. Axillary lymph node excision biopsy showed complete effacement of nodal architecture by closely packed, non-polarised follicles composed predominantly of centrocyte-like lymphoid cells consistent with follicular lymphoma, WHO grade 1, CD20+/CD10+/BCL2-, with hyaline-vascular Castleman-like features. Human herpesvirus 8 (HHV-8) testing was unavailable. He was commenced on rituximab-cyclophosphamide-doxorubicin-vincristine-prednisolone (R-CHOP) chemotherapy but subsequently died during further treatment.

Discussion: Granulomatous inflammation is not specific for tuberculosis and may accompany lymphoma through tumour-associated immune activation, obscuring the underlying diagnosis. In our patient, histiocytic collection with giant cell reaction and vertebral destruction in an endemic setting supported empirical ATT, whereas absent microbiological confirmation, generalised lymphadenopathy and lack of sustained clinical improvement warranted re-evaluation with lymph node biopsy. However, coexisting tuberculosis or another cause of a giant cell reaction cannot be definitively ruled out.

Conclusion: Granulomatous inflammation alone is insufficient to diagnose tuberculosis. Lymphoma should be considered an important differential diagnosis in granulomatous disease with destructive skeletal lesions and generalised lymphadenopathy when there is failure to improve with empirical ATT, and biopsy/re-biopsy of the most accessible representative site is recommended.

Keywords: follicular lymphoma; granulomatous inflammation; spondylodiscitis; tuberculosis; diagnostic errors

CP 029

MANTLE CELL LYMPHOMA WITH PROSTATIC INVOLVEMENT MIMICKING PRIMARY PROSTATE MALIGNANCY

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Introduction: Primary lymphoma of the prostate accounts for less than 0.1% of prostatic malignancies, while secondary prostatic involvement by lymphoma is also rare. Mantle cell lymphoma (MCL), an uncommon, mature B-cell non-Hodgkin lymphoma, rarely infiltrates the prostate and may mimic adenocarcinoma.

Case presentation: A previously well 79-year-old man presented with lower urinary tract and constitutional symptoms of six months' duration. Examination revealed cachexia, pallor, generalised lymphadenopathy, moderate splenomegaly and a firm, nodular, asymmetrical prostate on digital rectal examination. Investigations demonstrated pancytopenia, an erythrocyte sedimentation rate of 70 mm/h and a prostate-specific antigen (PSA) level of 18.5 ng/mL. Peripheral blood film revealed normochromic anaemia with a leucoerythroblastic picture. Bone marrow and lymph node biopsies confirmed low-grade B-cell lymphoma, consistent with stage IV disease. Prostatic histopathology unexpectedly demonstrated secondary lymphomatous infiltration, with relatively preserved background prostatic parenchyma. Immunohistochemistry revealed tumour cell positivity for CD20 and cyclin D1, a Ki-67 proliferation index of 70%, and negative pan-cytokeratin staining, supporting MCL. He received two cycles of bendamustine–rituximab chemotherapy and remains clinically stable.

Discussion: Prostatic involvement by lymphoma is exceptionally uncommon and may clinically mimic primary prostate adenocarcinoma, particularly in elderly patients presenting with lower urinary tract symptoms, elevated PSA and suspicious digital rectal examination findings. Generalised lymphadenopathy, splenomegaly and pancytopenia were important indicators of disseminated haematological malignancy in this patient. Histological assessment and immunohistochemistry established the diagnosis, distinguishing lymphomatous infiltration from primary prostatic epithelial malignancy. This case also illustrates the potential for elevated PSA to misdirect the initial diagnostic approach.

Conclusion: Secondary prostatic involvement by MCL represents a rare presentation of disseminated lymphoma. Recognition of systemic manifestations and definitive histopathological and immunohistochemical evaluation are essential for accurate diagnosis and appropriate systemic treatment.

Keywords: mantle cell lymphoma; B-cell non-Hodgkin lymphoma; generalised lymphadenopathy; prostatic neoplasms

CP 030

CRYOGLOBULINAEMIA WITH MULTISYSTEM INVOLVEMENT AND PULMONARY TUBERCULOSIS: A DIAGNOSTIC CHALLENGE

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Introduction: Cryoglobulinaemia is a rare systemic disorder with diverse clinical manifestations. Identifying the underlying cause is challenging when the presentation is nonspecific and involves multiple systems. We describe a patient with leucocytoclastic vasculitis and IgM-kappa cryoglobulinaemia associated with pulmonary tuberculosis.

Case presentation: A 49-year-old man with poorly controlled diabetes mellitus complicated by peripheral and autonomic neuropathy, heart failure with reduced ejection fraction and a previous unexplained pericardial effusion presented with a seven-day history of intermittent fever, arthralgia and myalgia. He also had significant unintentional weight loss, anorexia, diarrhoea and proteinuria for 18 months. During admission, he developed bilateral lower-limb oedema and a non-blanching maculopapular rash. Examination additionally revealed marked muscle wasting, bilateral foot drop and sensory loss.

Investigations showed anaemia (haemoglobin 8.4 g/dL), an elevated erythrocyte sedimentation rate (ESR) of 114 mm/h, low complement levels (C3 69.4 mg/dL; C4 6.1 mg/dL), a strongly positive rheumatoid factor (538 IU/mL) and significant proteinuria (urine protein-to-creatinine ratio 2375 mg/g) with normal serum creatinine. Skin biopsy confirmed small-vessel leucocytoclastic vasculitis. Serum cryoglobulins were detected, with IgM-kappa identified by immunofixation. Investigations for plasma-cell disease, amyloidosis, autoimmune disease and viral infections did not identify a cause. Computed tomography (CT) of the chest demonstrated multiple bilateral cavitating and non-cavitating pulmonary nodules with largest in apicoposterior segment of left upper lobe and subpleural nodules with tree-in-bud configuration. Bronchoalveolar lavage was positive for *Mycobacterium tuberculosis* by GeneXpert, and antituberculous treatment was started. He subsequently developed severe sepsis and died.

Discussion: The rash, neuropathy, proteinuria, low complement levels and positive rheumatoid factor prompted testing for cryoglobulins. CT showed pulmonary nodules and tree-in-bud changes, prompting bronchoalveolar lavage that confirmed tuberculosis as possible underlying aetiology.

Conclusion: Cryoglobulinaemia should be considered in patients with unexplained multisystem disease and cutaneous small-vessel vasculitis, particularly when associated with hypocomplementaemia and rheumatoid factor positivity. Tuberculosis should be considered as a possible underlying aetiology in endemic settings.

Keywords: leucocytoclastic vasculitis; cryoglobulinaemia; pulmonary tuberculosis; diabetes mellitus

CP 031

BACLOFEN-INDUCED ENCEPHALOPATHY IN A PATIENT WITH END-STAGE KIDNEY DISEASE ON REGULAR HAEMODIALYSIS WITH CONCURRENT MSSA BACTERAEMIA AND SPONDYLODISCITIS: A DIAGNOSTIC CHALLENGE

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Introduction: Baclofen is a centrally acting muscle relaxant predominantly excreted by the kidneys. Patients with end-stage kidney disease (ESKD) are particularly vulnerable to its accumulation and neurotoxicity.

Case presentation: A patient with ESKD on regular haemodialysis via a permcath presented with severe back pain without focal neurological signs. C-reactive protein (CRP) was elevated at 265 mg/L without fever spikes. Initial blood cultures, urinalysis, lumbosacral radiography and renal ultrasonography were unremarkable. A subsequent blood culture grew methicillin-sensitive *Staphylococcus aureus* (MSSA), and flucloxacillin was commenced. The patient remained haemodynamically stable, with declining CRP. Baclofen 5 mg twice daily was initiated for persistent severe back pain and muscle spasm while awaiting imaging. Magnetic resonance imaging (MRI) demonstrated L4–L5 spondylodiscitis without abscess or collection.

Two days after baclofen initiation, the patient developed reduced consciousness, with a Glasgow Coma Scale (GCS) score of 10/15. There was no neck stiffness, flapping tremor or fluctuating consciousness to suggest meningitis, uraemia or delirium. There was no acute biochemical deterioration to suggest worsening sepsis. Computed tomography (CT) of the brain and cerebrospinal fluid (CSF) examination, including culture, were unremarkable. Electroencephalography (EEG) showed diffuse slowing, while calcium, magnesium, liver enzymes, ammonia and arterial blood gas were normal. Blood urea remained at baseline. Despite three consecutive days of haemodialysis for presumed uraemic encephalopathy, significant improvement was absent. However, following withdrawal of baclofen, GCS gradually improved with continued alternate-day haemodialysis.

Discussion: The temporal relationship between baclofen initiation and neurological deterioration, alongside the absence of evidence for alternative causes, favoured baclofen-induced encephalopathy as a diagnosis of exclusion. The lack of significant improvement during daily haemodialysis while on baclofen further highlighted the importance of recognising and withdrawing the offending medication.

Conclusion: This case highlights the risk of baclofen neurotoxicity, even at low doses, in ESKD. It also highlights the importance of reviewing medication history when evaluating reduced consciousness, particularly when other causes do not adequately explain the clinical deterioration.

Keywords: baclofen-induced encephalopathy; baclofen; spondylodiscitis; end-stage kidney disease; haemodialysis

CP 032

HOFFMANN SYNDROME: A RARE PRESENTATION OF HYPOTHYROID MYOPATHY

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Introduction: Hoffmann syndrome is a rare manifestation of hypothyroidism characterised by proximal muscle weakness, stiffness, and muscle pseudohypertrophy, particularly affecting the calves. Its unusual presentation may delay diagnosis.

Case presentation: A 47-year-old man presented with constipation, cold intolerance, lethargy, fatigue, hoarseness, daytime somnolence, and snoring. He reported progressive weight gain, bilateral calf enlargement, and difficulty climbing stairs. Examination revealed bilateral calf enlargement and proximal muscle weakness (power 4/5) and exaggerated deep tendon reflexes. Investigations showed severe hypothyroidism (thyroid-stimulating hormone (TSH) 119.33 µIU/mL, free thyroxine (FT4) 0.26 ng/dL), elevated creatine kinase (3,851 U/L), serum creatinine of 1.9 mg/dL, and normocytic anaemia (haemoglobin 11.8 g/dL). Electromyography demonstrated myopathic potentials in proximal limb muscles without spontaneous activity supporting a myopathic process. Echocardiography revealed mild pericardial effusion, and pulmonary function testing showed a moderate restrictive ventilatory defect. Following levothyroxine therapy, most hypothyroid symptoms improved; however, calf enlargement persisted at 3-month follow-up.

Discussion: Hoffmann syndrome represents hypothyroid myopathy accompanied by muscle pseudohypertrophy, attributed to muscle fibre changes and interstitial tissue accumulation. Clinical evidence of pseudohypertrophy is essential to distinguish it from hypothyroid myopathy without muscle enlargement. Elevated creatine kinase supports muscle involvement, while electromyography confirms a myopathic process. Muscle responses to thyroid hormone replacement vary between individuals. Although symptoms and biochemical abnormalities may improve relatively early, regression of pseudohypertrophy may be delayed or incomplete. Persistent enlargement despite symptomatic improvement does not necessarily indicate treatment failure, although progression warrants reassessment.

Conclusion: Hoffmann syndrome should be considered in patients with hypothyroidism, proximal muscle weakness, and calf pseudohypertrophy. This case highlights the potential dissociation between symptomatic recovery and resolution of muscle enlargement.

Keywords: Hoffmann syndrome; hypothyroidism; myopathy; proximal muscle weakness; pseudohypertrophy

CP 033

CO-TRIMOXAZOLE HYPERSENSITIVITY MIMICKING HLH IN MELIOIDOSIS ERADICATION THERAPY

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Introduction: Melioidosis, caused by *Burkholderia pseudomallei*, requires a prolonged two-phase antibiotic regimen to prevent relapse, with high-dose co-trimoxazole forming the cornerstone of the eradication phase. Rarely, co-trimoxazole causes severe adverse reactions, including bone marrow suppression, hepatotoxicity, and systemic inflammatory response syndrome (SIRS), that can mimic secondary haemophagocytic lymphohistiocytosis (HLH), creating a diagnostic and therapeutic challenge.

Case presentation: A 16-year-old boy presented with a right inguinal abscess from which *Burkholderia pseudomallei* was isolated. He completed 21 days of intravenous ceftazidime and was discharged afebrile on oral co-trimoxazole eradication therapy. Four days later, he returned with a high-grade fever, painful oral ulcers, diffuse erythematous rash, vomiting, and diarrhoea. Investigations showed bicytopenia (haemoglobin 8.8 g/dL, platelets 55 × 10^9/L, white blood cells 2.51 × 10^9/L), transaminitis (aspartate aminotransferase (AST) 677 U/L, alanine aminotransferase (ALT) 357 U/L), hyperferritinaemia (> 1650 ng/mL), and elevated lactate dehydrogenase (2792 U/L). Haemophagocytosis was noted on the bone marrow aspirate, raising the concern for secondary HLH. However, he fulfilled only 4 of 8 HLH-2024 criteria with the available investigations, and his HScore was low (137). Severe co-trimoxazole-induced hypersensitivity was diagnosed. The drug was withdrawn, and he showed rapid clinical and biochemical recovery without corticosteroids. Eradication therapy was switched to doxycycline.

Discussion: Severe co-trimoxazole hypersensitivity may present with fever, mucositis, cytopaenias, hepatitis, and hyperferritinaemia, mimicking secondary HLH and sepsis. Hyperferritinaemia is a non-specific marker, and the modest elevation here was well below the levels typical of HLH. Structured assessment with the HLH-2024 criteria and HScore made HLH unlikely, and rapid recovery after drug withdrawal without corticosteroids supported a drug-related cause. Drug-triggered hyperinflammation cannot be entirely excluded, and the HScore has been validated mainly in adults.

Conclusion: Severe co-trimoxazole hypersensitivity is an important differential diagnosis of secondary HLH during melioidosis eradication therapy. Prompt drug withdrawal and structured use of HLH diagnostic tools can help avoid unnecessary immunosuppressive treatment.

Keywords: melioidosis; *Burkholderia pseudomallei*; co-trimoxazole; haemophagocytic lymphohistiocytosis; HScore; drug hypersensitivity



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