Sri Lanka College of
Sexual Health and HIV Medicine

PROCEEDINGS

of the

31st ANNUAL SCIENTIFIC SESSIONS

2026

In Collaboration with

British HIV Association

29th to 31st October
ITC Ratnadipa, Colombo
Sri Lanka

BRIDGING
TO
TOMORROW

SRI LANKA COLLEGE OF SEXUAL HEALTH AND HIV MEDICINE

Proceedings of the 31st Annual Scientific Sessions 2026

Bridging to Tomorrow

"Advancing Sexual Health and HIV Medicine Through Collaboration and Innovation"

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Message from the Chief Guest



It is a great pleasure to convey my warm greetings to the Sri Lanka College of Sexual Health and HIV Medicine on the publication of its magazine under the inspiring theme, "Bridging to Tomorrow."

Sexual health and HIV medicine remain vital components of a comprehensive, equitable, and compassionate healthcare system. As we advance towards a healthier Sri Lanka, our responsibility extends beyond the treatment of diseases to prevention, early diagnosis, education, counselling, and the protection of every individual's dignity and rights.

The theme "Bridging to Tomorrow" reminds us of the importance of connecting scientific knowledge with clinical practice, research with innovation, and healthcare services with the needs of our communities. It also highlights the need to bridge gaps in access to sexual health services, eliminate stigma and discrimination, and ensure that no individual is left behind because of fear, misinformation, or social barriers.

As the Ministry of Health, we recognize the invaluable contribution of healthcare professionals, researchers, and public health practitioners in strengthening sexual health services and advancing our national response to HIV. Collaboration among professional organisations, government institutions, communities, and international partners is essential to achieving sustainable progress.

Dr Hansaka Wijemuni
Deputy Minister of Health and Mass Media

Message from the Guest of Honour



It is my great honour to be joining you in Colombo as Guest of Honour at the Annual Conference of the Sri Lanka College of Sexual Health and HIV Medicine 2026. Since 1995, BHIVA has been committed to providing excellent care for people living with and affected by HIV in the UK. We serve as a national advisory body and platform on all aspects of HIV care, contributing to international, national, and local committees. We know that progress depends on collaboration across borders and disciplines and that the challenges we face, from early diagnosis and equitable access to treatment and prevention to tackling stigma, are shared ones. I commend SLCoSHH for its leadership in advancing sexual health and HIV medicine in Sri Lanka, and I hope this conference will be stimulating and productive and will strengthen the bonds between our two organisations. On behalf of BHIVA, I extend warm greetings to all delegates and participants, and every good wish for a successful meeting and for our ongoing partnership.

Dr Tristan J Barber
MA MD FRCP FRCP (Edin.) Dip GUM Dip HIV Med.
Chair, British HIV Association (BHIVA)

Address by the special Guest



It is a pleasure to extend my warm greetings to the Sri Lanka College of Sexual Health and HIV Medicine on the occasion of its 31st Annual Scientific Sessions, held under the theme "Bridging to Tomorrow: Advancing Sexual Health and HIV Medicine through Collaboration and Innovation."

Sri Lanka has much to be proud of in its response to HIV, sexually transmitted infections (STIs) and viral hepatitis. The country's low HIV prevalence, its validated achievement in eliminating mother-to-child transmission of HIV and syphilis, and its continued progress in hepatitis B prevention and control with the shift towards elimination of vertical transmission reflect sustained national commitment and the dedication of the Ministry of Health, the National STD/AIDS Control Programme, health professionals, communities and partners.

I commend Sri Lanka for advancing Triple Elimination of mother-to-child transmission of HIV, syphilis and hepatitis B, including the expansion of routine antenatal hepatitis B screening from 1 June 2026. This important step builds on these achievements and demonstrates the country's continued commitment to protecting mothers and children and progressing towards elimination of all three infections. These achievements provide a strong foundation, but they must be sustained through continued investment, effective surveillance and equitable access to quality services. Continued vigilance will be essential to sustain post-elimination gains in preventing mother-to-child transmission of HIV and syphilis.

The epidemiology of HIV and STIs continues to evolve. Reaching populations underserved by existing services, earlier detection of HIV so as to reduce risks of advanced HIV disease, identifying new or emerging transmission and behavioural patterns, addressing stigma and discrimination, and ensuring timely access to prevention, testing, diagnosis, treatment and care remain essential.

I welcome Sri Lanka's continued efforts to expand innovative approaches such as HCV and HIV self-testing, post- and pre-exposure prophylaxis (PEP and PrEP), differentiated service delivery and long-acting HIV prevention options. These approaches offer important opportunities to expand choice and improve access. Their impact, however, depends on making these options accessible, acceptable and affordable to the people who need them, while ensuring informed choice, confidentiality and quality of care.

While important progress has been made, reductions in HIV-related mortality have remained relatively static. Approximately 25%–30% of newly detected cases present with a low CD4 count, underscoring the need for earlier diagnosis and timely linkage to treatment and care. Intensified efforts to identify and reach these individuals therefore remain critical.

I commend the College for developing a scientific programme that addresses many of these emerging priorities, including evolving HIV epidemiology, long-acting PrEP, HIV drug resistance, STIs, viral hepatitis, vertical transmission, substance use and integrated approaches to prevention and care. The exchange of scientific evidence and clinical experience from diverse settings is vital to translating advances in research and global best

practices into approaches that are appropriate to Sri Lanka's context and contribute meaningfully towards achieving national and global targets.

I particularly welcome the strong international collaboration represented at these Scientific Sessions, including the partnership with the British HIV Association (BHIVA) and contributions from WHO and other international experts and institutions. Such professional and technical networks are invaluable for sharing knowledge, strengthening clinical and public health practice, supporting innovation and connecting Sri Lanka with advances in global science. Equally important is the leadership and meaningful participation of communities, including people living with HIV and populations affected by these epidemics, in shaping services that respond to their needs and uphold their rights and dignity.

As the global health financing environment evolves, strong national ownership, sustainable domestic financing, resilient health systems and effective partnerships will become increasingly important. International cooperation can contribute not only resources, but also technical expertise, innovation and enduring professional networks. These efforts must complement national priorities and help ensure that essential prevention, testing, treatment and care services remain accessible and sustainable.

WHO remains committed to working alongside the Ministry of Health, the National STD/AIDS Control Programme, the College, communities and other partners to translate global evidence and innovation into effective, equitable and people-centred services. Together, we must continue to build on Sri Lanka's achievements, address persistent gaps and advance towards the global goals of ending AIDS as a public health threat and accelerating progress against viral hepatitis and STIs.

I congratulate the President, Council and members of the College on the 31st Annual Scientific Sessions and wish all participants fruitful deliberations, meaningful collaboration and a successful conference.

Dr Rajesh Sambhajirao Pandav
WHO Representative to Sri Lanka

Message from the President

Sri Lanka College of Sexual Health and HIV Medicine



As President of the College, I am honoured to lead our professional college at a time when sexual health and HIV medicine are evolving rapidly, bringing both new opportunities and challenges. Our theme, **"Bridging to Tomorrow: Advancing Sexual Health and HIV Medicine through Collaboration and Innovation,"** reflects our commitment to move forward together while building on the strong foundations created by those who have shaped our specialty.

Sri Lanka has made significant progress in HIV and STI prevention, diagnosis and treatment, prevention of mother-to-child transmission, and the integration of hepatitis and sexual health services. However, changing patterns of HIV and STI transmission, antimicrobial resistance, emerging substance-use-related risks, stigma, and the need to reach young and underserved populations remind us that important challenges remain.

Our responsibility extends beyond the management of HIV and sexually transmitted infections. We must promote a holistic approach to sexual health encompassing sexual wellbeing, reproductive health, contraception, fertility, sexual dysfunction, adolescent health, hepatitis, HPV and cancer prevention, and the needs of diverse and vulnerable populations. Care must remain confidential, respectful, evidence-based and centered on the individual.

The future requires us to embrace innovation, including long-acting HIV prevention, self-testing, molecular and point-of-care diagnostics, digital health, telemedicine and responsible applications of artificial intelligence. At the same time, innovation must mean developing better models of care, bringing services closer to communities, reducing barriers to access and ensuring that scientific advances benefit those who need them most.

As a college, we have a responsibility to strengthen professional education, promote high-quality research, support the next generation of specialists, contribute to national guidelines and policy, and foster collaboration locally and internationally

This vision can only be achieved through strong partnerships with the Ministry of Health, national programmes, universities, professional colleges, international organizations, development partners, civil society, communities and the private sector. As President of the Sri Lanka College of Sexual Health and HIV Medicine, my vision is for a college that leads with clinical excellence, scientific integrity, collaboration, innovation and compassion, while preparing our profession to meet the sexual health challenges of tomorrow.

Dr Nimali Jayasuriya
President
Sri Lanka College of Sexual Health and HIV Medicine

Message from the Honorary Secretary

Sri Lanka College of Sexual Health and HIV Medicine



It is my great pleasure to welcome you all to the 31st Annual Scientific Sessions of the Sri Lanka College of Sexual Health and HIV Medicine.

This year, our sessions are held under the theme, **"Bridging to Tomorrow: Advancing Sexual Health and HIV Medicine through Collaboration and Innovation."** This theme reflects the importance of working together, sharing knowledge, and finding new ways to address the challenges we face in sexual health and HIV medicine.

We are delighted to bring together distinguished local and international experts for this important academic event. Our collaboration with the British HIV Association (BHIVA) is a valuable step towards strengthening international partnerships and creating more opportunities for learning and sharing experiences. I hope the scientific programme and pre-congress activities will provide everyone with useful knowledge, fresh perspectives, and inspiration for their future work.

Organizing an event of this scale requires the support and commitment of many people. I would like to express my sincere gratitude to our College President, the Council, the Organizing Committee, and all members who have worked hard to make these sessions a success. I am also deeply grateful to our distinguished local and international faculty, speakers from the World Health Organization (WHO), our collaborating partner, the British HIV Association (BHIVA), and all our sponsors and supporters for their valuable contributions.

Most importantly, I hope these sessions will encourage us to build stronger professional relationships, learn from one another, and work together to improve sexual health and HIV services in Sri Lanka.

As we look to the future, let us continue to embrace collaboration and innovation in our shared efforts to provide accessible, equitable, and compassionate care to all.

I wish you all an enjoyable and rewarding academic experience at the 31st Annual Academic Sessions.

Thank you.

Dr Nisansala Madapatha
Secretary
Sri Lanka College of Sexual Health and HIV Medicine

PROGRAMME OVERVIEW

29th October 2026	30th October 2026	31st October 2026
New OPD Auditorium, NHSL	ITC Ratnadipa, Colombo	ITC Ratnadipa, Colombo
Time: 09:10 AM - 10:30 AM	Time: 08.00 AM -10.30 AM	Time: 08.00 AM -10.45 AM
Pre-Congress Session Evolving HIV Epidemiology and Integrated Strategies for Epidemic Response **Session I**	**Main Congress** **Symposium I** HIV Drug Resistance: Molecular Insights, Transmission Networks, and Contemporary therapeutic challenges	**Free Papers**
	Time: 10:50 AM – 12:50 PM	Time: 11:00 AM - 12.40 PM
	Symposium II HIV Beyond Viral Suppression: Navigating Complex Comorbidities and Integrated Management	**Symposium V** Ending Vertical Transmission and Beyond: Integrated Strategies for Maternal and Pediatric HIV Management
Time: 10:50 AM -12:10PM	Time: 02:00 PM - 03:40 PM	Time 1.30 PM - 3:30 PM
Evolving HIV Epidemiology and Integrated Strategies for Epidemic Response **Session II**	**Symposium III** Integrated Perspectives on STIs: Clinical, Preventive, and Emerging Challenges	**Symposium VI** Collaborative HIV/ STI Prevention Actions: Global Guidance and Multifactorial Health
	Time: 03.50 PM - 05.00PM	Time 3.50 PM – 4.00 PM
	Symposium IV Bridging Clinical Care and Public Health: Managing Hepatitis B and C	**Overseas faculty meeting**
Time 6.45 PM onwards		Time 7.30 PM – 12.00 MN
Inauguration Ceramony Venue: ITC Ratnadipa, Colombo (by invitation)		**Fellowship Dinner and Keynote speech** Venue: ITC Ratnadipa, Colombo

Pre Congress Session

Thursday 29th October 2026 at New OPD Auditorium, NHSL

Evolving HIV Epidemiology and Integrated Strategies for Epidemic Response

Symposium I

Chairpersons: Dr Nimali Jayasuriya and Dr Prageeth Premadasa

09:10 – 09:30 AM	**Adapting HIV Prevention to Meet Changing Population Needs, Lessons from Thailand** *Dr Cheewanan Lertpiriyasuwat (Senior Expert in Preventive Medicine) (WHO)*
09:30 – 09:50 AM	**Hidden Epidemics and Blind Spots: Are We Missing HIV Transmission in Sri Lanka** *Dr Geethani Samaraweera (Consultant Venereologist)*
09:50 – 10:10 AM	**HIV Micro-Epidemics within Low-Prevalence Settings** *Dr Po-Lin Chan (Regional Advisor, Hepatitis/HIV/STIs) (WHO)*
10:10 – 10:30 AM	**Panel Discussion (Moderated by the Chairpersons)**
10:30 – 10:50 AM	**Tea**

Symposium II

Chairpersons: Dr Kokilanthi Dharmaratne and Dr Vino Dharmakulasinghe

10:50-11:10 AM	**Surveillance of Emerging HIV Transmission** *Dr KAM Ariyaratne (Consultant Venereologist)*
11:10 – 11:30 AM	**HIV Epidemic in the MSM; Strategies of Management** *Dr Manik Kholi (Specialist in Sexual Health and HIV)*
11:30 – 11:50 AM	**Long-Acting PrEP as a Transformative Strategy Toward Ending AIDS** *Dr Fiona Cresswell (Clinical Associate Professor and Honorary Consultant in HIV and Sexual Health)*
11:50 – 12:10 PM	**Panel Discussion (Moderated by the Chairpersons)**
12.10 PM onwards	**Lunch**

INAUGURAL CEREMONY
The 31st Annual Scientific Sessions 2026

Thursday, 29th October 2026 at 6.45 PM
At ITC Ratnadipa, Colombo

Welcome Address
Dr Nimali Jayasuriya
President, Sri Lanka College of Sexual Health and HIV Medicine

Presidential Address
Dr Nimali Jayasuriya

Address by Special Guest
Dr Rajesh Sambhajirao Pandav
WHO Representative to Sri Lanka

Address by Guest of Honour
Dr Tristan Barber
Consultant Physician Specializing in HIV medicine
Chair of the British HIV Association
Editor-in-Chief- Journal of HIV Research and Clinical Practice.

Address by the Chief Guest
Dr Hansaka Wijemuni
Deputy Minister of Health and Mass Media, Sri Lanka

SLCoSHH Oration 2026 - Dr Iyanthi Abeyewickreme
Senior Consultant Venereologist
Founder Member and Past President Sri Lanka College of Venereologists
Former Regional Advisor HIV, WHO SEARO
Past President, Sri Lanka Medical Association (2016)
Hon. Senior Fellow, Post Graduate Institute of Medicine, University of Colombo, Sri Lanka

Awards
Award of Fellowship
Award of Honorary Fellowship
Award for Best Performance in MD Venereology

Felicitation to Dr K.A.M Ariyaratne

Vote of Thanks
Dr Nisansala Madapatha
Secretary, Sri Lanka College of Sexual Health and HIV Medicine

Reception

Conference Sessions, Day 1

Friday 30th October 2026 at ITC Ratnadipa, Colombo

Symposium I – HIV Drug Resistance: Molecular Insights, Transmission Networks, and Contemporary Therapeutic Challenges

Chairpersons: Dr Iyanthi Abeywickreme and Dr Leelani Rajapaksa

08:00 – 08:30 AM	**Registration**
08:30 – 08:50 AM	**Molecular Mechanisms of ART Resistance** *Dr Tristan Barber (Consultant Physician in HIV Medicine)*
08:50 – 09:10 AM	**Understanding HIV Drug Resistance Networks Through Phylogenetic Analysis** *Dr Jayanthi Elwitigala (Consultant Microbiologist)*
09:10 – 09:30 AM	**HIV Drug Resistance in the Context of PrEP Use: Current Evidence and Future Directions** *Prof Graham P Taylor (Professor of Human Retrovirology)*
09:30 – 09:50 AM	**Role of Long-Acting Antiretrovirals for Patient Management in the Context of Resistance** *Dr Fiona Cresswell (Clinical Associate Professor and Honorary Consultant in HIV and Sexual Health)*
09:50 – 10:10 AM	**ART Multi-Class Resistance and Complex Treatment Failure: Detection, and Management** *Dr Tristan Barber (Consultant Physician in HIV Medicine)*
10:10 – 10.30 AM	**Panel Discussion (Moderated by the Chairpersons)**
10:30 – 10:50 AM	**Morning Tea**

Symposium II –: HIV Beyond Viral Suppression: Navigating Complex Comorbidities and Integrated Management

Chairpersons: Dr Jayadarie Ranatunge and Dr Geethani Samaraweera

10:50 – 11:10 AM	**Metabolic and Endocrine Dysregulation in HIV: Challenges and Clinical Management** *Dr Emily Clarke (Consultant in Genitourinary Medicine and HIV)*
11.10 – 11.30 AM	**Aging with HIV: Geriatric Syndromes and Polypharmacy** *Dr Tristan Barber (Consultant Physician in HIV Medicine)*
11:30 – 11:50 AM	**IRIS in the Era of Rapid ART Initiation** *Dr Fiona Cresswell (Clinical Associate Professor and Honorary Consultant in HIV and Sexual Health)*
11:50 – 12:10 PM	**Identifying and Managing Sexual Dysfunctions in PLHIV** *Dr Prageeth Premadasa (Consultant Venereologist)*
12:10 – 12:30 PM	**Advances in Prevention and Treatment of TB in PLHIV** *Dr Neranjan Dissanayake (Consultant Pulmonologist)*
12:30 – 12:50 PM	**Panel Discussion (Moderated by the Chairpersons)**
12.50 – 02.00 PM	**Lunch**

Conference Sessions, Day 1

Friday 30th October 2026 at ITC Ratnadipa, Colombo

Symposium III – Integrated Perspectives on STIs: Clinical, Preventive, and Emerging Challenges

Chairpersons: Dr Gayani Nanayakkara and Dr Iruka Rajapaksha

02:00 – 02:20 PM	**STIs in the Era of U=U and PrEP: Changing Epidemiology and Clinical Challenges** *Dr Manik Kohli (Specialist in Sexual Health and HIV)*
02:20 – 02.40 PM	**Atypical STI Presentations in Immunocompromised Patients** *Dr Emily Clarke (Consultant in Genitourinary Medicine and HIV)*
02.40 – 03.00 PM	**Emerging Threats in Sexual Health: From Zika, Mpox, and Evolving Herpes Simplex Viruses to Neisseria Meningitidis** *Dr Manik Kohli (Specialist in Sexual Health and HIV)*
03.00 – 03:20 PM	**BHIVA Guideline Update** *Dr Tristan Barber (Consultant Physician in HIV Medicine)*
03.20 – 03.40 PM	**Panel Discussion (Moderated by the Chairpersons)**
03.40 – 03.50 PM	**Evening Tea**

Symposium IV –Bridging Clinical Care and Public Health: Managing Hepatitis B and C

Chairpersons: Dr Umedha Jayasinghe and Dr Waruni Pannala

03.50 – 04:10 PM	**Clinical and Therapeutic Challenges in HIV–HBV/HCV Co-Infection Management** *Dr Ranjababu Kulasegaram (Consultant Physician in HIV/GU Medicine) (virtual)*
04:10 – 04:30 PM	**Managing Acute Liver Failure in Viral Hepatitis** *Dr Hasitha Wijewantha (Consultant Gastroenterologist and Hepatologist)*
04:30 – 04:50 PM	**Micro-Elimination of Hepatitis B and Hepatitis C: Translating Global Targets into Local Success** *Dr Thilanga Ruwanpathirana (Consultant Epidemiologist)*
04.50 – 05.00 PM	**Panel Discussion (Moderated by the Chairpersons)**

Conference Sessions, Day 2

Saturday 31st October 2026 at ITC Ratnadipa, Colombo

Free Papers
Chairpersons:
Dr Priyantha Weerasinghe and Dr Manjula Rajapaksha

08:00 – 08:30 AM	**Registration**
8: 30 - 10:45 AM	**Free Papers** **Poster Presentations**
10:45 – 11:00 AM	**Morning Tea**

Symposium V
Ending Vertical Transmission and Beyond: Integrated Strategies for Maternal and Pediatric HIV Management
Chairpersons: Dr G Weerasinghe and Dr Darshani Wijewickrama

11:00 – 11:20 AM	**Residual Transmission in EMTCT Programs: Why Do Failures Still Occur?** *Dr Leelani Rajapaksha (Consultant Venereologist)*
11:20 – 11:40 AM	**LAI in Pregnancy- Real World Experience** *Prof Graham P Taylor (Professor of Human Retrovirology)*
11:40 – 12:00 PM	**Challenges in the Management of Sexually Transmitted Infections in Children** *Dr Emily Clarke (Consultant in Genitourinary Medicine and HIV)*
12:00 – 12:20 PM	**Optimizing Antiviral Therapy in Children: Paediatric Dosing, Adherence, and Formulation Challenges** *Dr Caroline Foster (Professor of Practice Adolescent Infectious Diseases) (virtual)*
12:20 – 12:40 PM	**Panel Discussion (Moderated by the Chairpersons)**
12:40 – 01:30 PM	**Lunch**

Conference Sessions, Day 2

Saturday 31st October 2026 at ITC Ratnadipa, Colombo

Symposium VI

Collaborative HIV/ STI Prevention Actions: Global Guidance,and Multifactorial Health Challenges

Chairpersons: Dr Shyama Somawardhana and Dr Piyumi Perera

01:30 – 01:50 PM	**From Global Targets to Local Impact: Implementing WHO HIV Prevention Frameworks in Complex Settings** *Dr Cheewanan Lertpiriyasuwat (Senior Expert in Preventive Medicine) (WHO)*
01:50 – 02:10 PM	**Substance Use and HIV: Clinical, Behavioral, and Public Health Intersections** *Dr Sirin Tangcharoensathien (Senior Research Physician) (Virtual) (WHO)*
02:10 – 02:50 PM	**Addressing the Rising Burden of Syphilis and Other STI Panel Discussion Moderated By Dr Po-Lin Chan (Regional Advisor, Hepatitis/HIV/STIs) (WHO)** **Panelists:** ◦ *Dr Emily Clark (Consultant in Genitourinary Medicine and HIV)* ◦ *Dr Mahesh Ratnayake (Consultant Sexual Health Physician)* ◦ *Dr Leelani Rajapaksha (Consultant Venereologist)* ◦ *Dr Cheewanan Lertpiriyasuwat(Senior Expert in Preventive Medicine) (WHO)*
02:50 – 03:10 PM	**Panel Discussion (Moderated by the Chairpersons)**
03:10 – 03:30 PM	**Interactive Quiz**
03:30 – 03:50 PM	**Evening Tea**
03:50 – 04:00 PM	**Overseas Faculty Meeting**

SLCoSHH Oration 2026

Dr Iyanthi Abeyewickreme



Venereology in Sri Lanka has undergone a remarkable transformation, evolving from the traditional management of sexually transmitted infections to a broader, more inclusive approach to sexual health. Dr Iyanthimala Abeywickreme has been at the forefront of this journey, contributing significantly to the development of specialist services, postgraduate training and national STI/HIV control strategies. Her leadership at the National STD/AIDS Control Programme and the World Health Organization reflects a career dedicated to advancing public health and strengthening the national response to HIV and sexually transmitted infections.

In this oration, "Out of the Shadows: The Transformative Journey from Traditional Venereology to the Open Era of Sexual Health in Our Motherland," Dr Abeywickreme reflects on the historical milestones, evolving societal perspectives and professional achievements that have shaped the specialty. The oration offers an opportunity to revisit the past, appreciate the progress made and envision a future in which sexual health is recognised, discussed and addressed with dignity, inclusivity and compassion.

Dr Iyanthi Abeyewickreme
MBBS, Dip Ven, MSc, MD, FSLCV, FCCPSL
Senior Consultant Venereologist
Founder Member and Past President Sri Lanka College of Venereologists
Former Regional Advisor HIV, WHO SEARO
Past President, Sri Lanka Medical Association (2016)
Hon. Senior Fellow, Post Graduate Institute of Medicine, University of Colombo, Sri Lanka
Past President, Colombo Medical School Alumni Association (CoMSAA) 2018/2019

Abstracts of Guest Lectures - Pre-Congress
29th October 2026

Evolving HIV Epidemiology and Integrated Strategies for Epidemic Response
Session- I

Adapting HIV Prevention to Meet Changing Population Needs, Lessons from Thailand

Dr Cheewanan Lertpiriyasuwat (WHO)
Senior Expert in Preventive Medicine



Thailand's national HIV response faces a concentrated epidemic, with an estimated 619,563 people living with HIV, 7,323 new infections, and 8,385 AIDS-related deaths in 2025. Importantly, 44% of all new HIV infections occurred among young people aged 15–24 years, while 44% occurred among men who have sex with men. This shifting epidemic highlights the accessibility limitations of traditional, hospital-based service models and necessitates a systemic shift toward agile, people-centered HIV prevention strategies.

To address evolving population needs, Thailand established a multifaceted "Ecosystem of Choice" designed to decentralize health services and expand access to HIV prevention. Key interventions include scaling up biomedical prevention options, such as PrEP and HIV self-testing, which are fully integrated into and reimbursed under Universal Health Coverage (UHC). Innovative delivery channels, including Community-Led Health Services (CLHS), pharmacies, and online-to-offline services, have been deployed to reach populations who may face barriers to conventional health services.

Thailand's experience demonstrates six critical enablers: strong community partnerships, technical collaboration, enabling Ministry of Public Health regulations, national strategy and government leadership, service delivery innovations, and sustainable domestic financing through UHC reimbursement.

Hidden Epidemics and Blind Spots: Are We Missing HIV Transmission in Sri Lanka

Dr Geethani Samaraweera (Sri Lanka)
Consultant Venereologist



Despite the availability of comprehensive HIV prevention, testing, and treatment services across Sri Lanka for over three decades, the national epidemic appears to be evolving from a low-level epidemic towards a more concentrated epidemic specially among men who have sex with men. Newly diagnosed HIV infections have increased in recent years. In 2025, 874 new HIV diagnoses were reported nationally, while the estimated number of people living with HIV was approximately 8,700. Estimates also indicate an upward trend in new HIV infections. Although national surveillance provides valuable information on diagnosed infections and recognised key populations, important gaps may remain in identifying undiagnosed and recent infections and transmission occurring outside conventional testing and prevention networks.

This presentation explores potential "hidden epidemics" and blind spots in Sri Lanka's HIV response. While established key populations remain central to prevention efforts, HIV transmission may also occur among individuals who do not identify with traditional risk categories, have multiple or changing sexual networks, or face barriers to accessing sexual health services. Recent infections may remain undiagnosed, particularly during early infection, while individuals with limited engagement with healthcare services may be missed by facility-based testing.

Potential blind spots include individuals outside recognised key populations, partners of people living with HIV, clients of sex workers, people with overlapping sexual networks, people who use drugs,

migrant and mobile populations, and individuals seeking healthcare for conditions where HIV testing is not routinely considered. Stigma, concerns regarding confidentiality, fear of disclosure, perceived low personal risk, and limited awareness may further delay diagnosis.
The presentation will examine whether current surveillance and testing approaches adequately capture these less visible transmission networks. It will highlight the value of triangulating routine surveillance, testing data, behavioural information, molecular epidemiology where available, and community-based and index-partner testing.
A more differentiated HIV response, incorporating provider-initiated testing, community-based and self-testing, partner notification, PrEP, PEP, and targeted risk assessment, may facilitate earlier diagnosis and interruption of transmission chains. Recognising the hidden components of the epidemic is essential to sustaining Sri Lanka's progress towards HIV elimination.

HIV Micro-Epidemics within Low-Prevalence Settings

Dr Po-Lin Chan (WHO)
WHO Regional Advisor Hepatitis/HIV/STI



In many countries with low national HIV prevalence, transmission is not evenly distributed but concentrated within specific populations, geographic areas, and social networks, creating distinct HIV micro-epidemics. National averages can therefore mask disproportionately high burdens among key populations, including men who have sex with men, sex workers, people who inject drugs, transgender people, and their partners, other vulnerable groups, or in geographic areas, whether in urban, peri-urban or rural settings. Increasing evidence shows that HIV transmission is often clustered within localized "hot spots" and high-transmission networks, where barriers to prevention, testing, and treatment persist. As countries move toward epidemic control and the 95-95-95 target by 2030, understanding these micro-epidemics through granular surveillance, geospatial analysis, and population-specific data becomes increasingly important. Identifying, refining strategies and response to localized transmission dynamics enables more precise, equitable, and cost-effective interventions, ensuring that prevention and treatment services reach the populations and places where they are needed most

Session- II

Surveillance of Emerging HIV Transmission

Dr KAM Ariyaratne (Sri Lanka)
Consultant Venereologist



Background: The HIV response has made real progress, but the work is far from finished. In 2025, an estimated 1.2 million people acquired HIV and 570,000 died of HIV-related causes. Declines in new infections are slowing and funding is shrinking, so dependable routine surveillance matters more than ever.
Objective: To summarize the latest guidance on strengthening national HIV surveillance and to consider what it means for everyday clinical practice.
Key content: The guidance brings case definitions into line. Adults and children aged 18 months or older are diagnosed with a three-test sequential algorithm, with no tiebreakers. Younger infants need nucleic acid testing on two separate specimens. Advanced HIV disease (AHD) means a CD4 count ≤200 cells/mm^3 or WHO clinical stage 3 or 4, and it covers every child under five unless they are stable on ART. A minimum dataset and a set of priority AHD indicators track CD4 testing, co-trimoxazole prophylaxis, cryptococcal antigen screening and ART initiation. Together with TB/HIV collaborative surveillance, they make gaps along the testing and treatment cascade easier to see. Deaths are captured more reliably through civil registration linkage and ICD-11 coding, which helps stop people who have died from being recorded as lost to follow-up. Moving to person-centered digital systems relies on unique

identifiers, interoperability and firm confidentiality protections. Key population status should be recorded only when people can be protected from harm.
Conclusions: Physicians shape the quality of surveillance data through everyday practice. That means confirming diagnoses properly, ordering baseline CD4 tests, screening early for opportunistic infections and keeping careful records. Case-based digital surveillance and other programmatic data can reveal emerging transmission clusters and programme gaps early, helping the response stay on course toward global targets of ending AIDS.
Keywords: HIV surveillance; advanced HIV disease; case definitions; cryptococcal infection; tuberculosis; HIV mortality; drug resistance; key populations

HIV epidemic in the MSM; strategies of management

Dr Manik Kholi (United Kingdom)
Specialist in Sexual Health and HIV



Across many settings, HIV epidemics are increasingly concentrated among men who have sex with men (MSM), and a growing number of countries now aim to end transmission within the coming decade. Achieving this depends less on any single tool than on how a range of prevention and care strategies are combined, tailored and delivered to the communities who carry the greatest burden. England, which for the sixth consecutive year has met the UNAIDS 95-95-95 targets, offers an instructive case in what such a combination looks like, and where it still falls short. Whilst diagnoses among white MSM fell by 11% between 2020 and 2024, they rose by 50% among ethnic minority MSM over the same period, who now account for two in five new diagnoses in this group.
Using England's surveillance data and the HIV Action Plan for England 2025-2030, the strategies of management for the epidemic in MSM are examined across five priorities: prevent, test, treat, thrive and collaborate. On prevention, headline high HIV pre-exposure prophylaxis (PrEP) uptake does not necessarily reflect uptake across all MSM sub-populations, and community pharmacy and online pathways may reach those the clinic-based model misses. On testing, there has been expansion of emergency-department opt-out screening and online self-sampling, alongside national campaigns. On treatment, U=U and initiation remain important, with a renewed focus on retention and re-engagement of patients in care. Finally, tackling stigma and inequalities, providing holistic care, and working in partnership with community organisations are key. These strategies have driven real progress, with new diagnoses among MSM continuing to fall. However, MSM are not a homogenous group, and a one size fits all response will not close these gaps.

Long-Acting PrEP as a Transformative Strategy toward Ending AIDS

Dr Fiona Cresswell (United Kingdom)
Clinical Associate Professor and Honorary Consultant in HIV and Sexual Health



This presentation will discuss the prevention portfolio including existing long-acting products and those in the development pipeline. The importance of choice will be considered as well as the trade-offs of various prevention methods. Pivotal long-acting PrEP studies will be discussed and efficacy results presented, with a focus on lenacapavir. The ongoing implementation science research and need for scale to impact the epidemic will be highlighted, including reaching adolescent girls and young women.

Abstracts of Guest Lectures – Main Congress
30th and 31st October 2026

Symposium 1- HIV Drug Resistance: Molecular Insights, Transmission Networks, and Contemporary therapeutic challenges

Molecular Mechanisms of ART Resistance

Dr Tristan Barber (United Kingdom)
Consultant Physician in HIV Medicine



Antiretroviral therapy (ART) has transformed HIV infection from a fatal disease into a manageable chronic condition, yet the emergence of drug resistance remains a persistent threat to long-term treatment success. This talk examines the molecular basis of ART resistance, focusing on how mutations in key viral targets - reverse transcriptase, protease, integrase, and envelope glycoproteins - alter drug binding and enzymatic function while preserving viral fitness. I will discuss the evolutionary pressures driving resistance selection, including suboptimal adherence, pharmacokinetic variability, and pre-existing viral quasispecies diversity, as well as cross-resistance patterns within and across drug classes. Particular attention will be given to emerging resistance mechanisms associated with newer agents, such as integrase strand transfer inhibitors and long-acting formulations. Understanding these molecular pathways is critical for guiding rational drug design, optimising treatment regimens, and informing resistance surveillance strategies to sustain the efficacy of ART worldwide.

Understanding HIV Drug Resistance Networks Through Phylogenetic Analysis

Dr Jayanthi Elwitigala (Sri Lanka)
Consultant Microbiologist



HIV drug resistance occurs when genetic mutations in the virus alter its structure, reducing the binding affinity or efficacy of antiretroviral therapy (ART) drugs. These mutations can be acquired through transmission of drug-resistant HIV from an infected individual to another person.

Phylogenetic analysis is a scientific method used to reconstruct the evolutionary history and relationships among species, populations, genes, or proteins. In HIV , reconstructing genetic relationships between viral sequences taken from different individuals to map transmission pathways and clusters supports understanding HIV drug resistance networking.

Phylogenetic analysis of HIV pol sequences, routinely generated for genotypic resistance testing, offers a powerful complement to conventional surveillance. It enables tracking how drug-resistant strains of HIV-1 spread through populations revealing molecular transmission clusters , rapidly growing networks, onward transmission of resistant variants, and linkages across risk groups and geographic boundaries that contact tracing alone often misses.

For venereology practitioners, integrating phylogenetic insights with resistance data supports earlier regimen optimisation and enables more precise, equitable control of HIV transmission.

HIV Drug Resistance in the Context of PrEP Use: Current Evidence and Future Directions

Prof Graham P Taylor (United Kingdom)
Professor of Human Retrovirology



Pre-exposure prophylaxis (PreP) is considered a major component in the strategy to eliminate HIV but is limited to those who self-identify as being at risk of infection. Oral PreP may be used 'on demand' or regularly whilst LAI provides a 3rd option. The efficacy of PreP has been demonstrated in multiple RCT reducing (44% reduction in iPREX, 62% protection in TDF2) incident infection in people at high risk of HIV. Ensuring that PreP is not started during undiagnosed early HIV infection is essential to minimise undertreatment of HIV infection and consequent 'treatment failure' with emergence of drug resistance associated mutations (DRMs). Oral HIV PreP is susceptible to similar limitations of oral HIV therapy including poor adherence and discontinuation, which in turn provides an opportunity for the emergence of drug resistance associated mutations. High (19.6%) rates M184I/V have been reported in people newly diagnosed with HIV who previously used PreP (compared with 0.8% if no history of PreP (Saini et al HIV Medicine 2026). Long-acting injectable PreP demonstrates further reduction, compared to oral PreP, in new infection (e.g. Hazard Ratio with cabotegravir 0.12 in HPTN084) with low rates of DRMs whilst in Purpose 1 no incident infections were observed in the Lenacapavir arm. Persistence of compound up to 12 months after the last dose has implications for development of DTMs.

Role of Long-Acting Antiretrovirals for patient management in the Context of Resistance

Dr Fiona Cresswell (United Kingdom)
Clinical Associate Professor and Honorary Consultant in HIV and Sexual Health



This talk will refresh us on the basics of what HIV drug resistance is and how does it develop? We will consider why the risk of emergent resistance is actually greater with some long-acting agents. Global resistance data will be reviewed. The existing and pipeline of long-acting HIV treatment agents, and their drug classes, will be presented. Data specifically examining the use of novel agents such as lenacapavir in the management of complex HIV drug resistance will be discussed, including the role of novel agents in salvage regimens.

ART Multi-Class Resistance and Complex Treatment Failure: Detection, and Management

Dr Tristan Barber (United Kingdom)
Consultant Physician in HIV Medicine

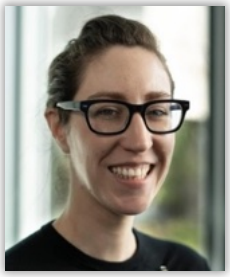


As antiretroviral therapy has expanded globally, an increasing number of people living with HIV now face multi-class drug resistance - a scenario in which the virus harbours mutations conferring reduced susceptibility across two or more antiretroviral drug classes. This talk addresses the clinical and molecular complexity of managing treatment failure in heavily pretreated patients, where resistance patterns, including archived mutations, may complicate regimen selection. I will review current approaches to resistance detection, and the role of proviral DNA sequencing, in patients with suppressed or low-level viremia. The talk will also cover strategies for constructing effective salvage regimens, incorporating newer agents with novel mechanisms of action (such as fostemsavir, and lenacapavir) for people with limited remaining options. Finally, I will discuss the importance of adherence support, therapeutic drug monitoring, and multidisciplinary care in preventing further resistance accumulation. This presentation aims to equip clinicians with a practical framework for navigating one of the most challenging aspects of modern HIV care.

Symposium II- HIV Beyond Viral Suppression: Navigating Complex Comorbidities and Integrated Management

Metabolic and Endocrine Dysregulation in HIV: Challenges and Clinical Management

Dr Emily Clarke (United Kingdom)
Consultant in Genitourinary Medicine and HIV



The success of antiretroviral therapy has transformed HIV infection into a chronic, manageable condition with near-normal life expectancy for many people living with HIV. As this population ages, metabolic and endocrine disorders have emerged as important contributors to morbidity, mortality, and reduced quality of life. These complications arise through a complex interplay between chronic immune activation, persistent inflammation, antiretroviral therapy exposure, ageing, lifestyle factors, and traditional cardiovascular risk factors.

Metabolic disturbances associated with HIV include obesity, insulin resistance, type 2 diabetes mellitus, dyslipidaemia, metabolic syndrome, and metabolic dysfunction-associated steatotic liver disease (MASLD). In parallel, endocrine complications such as osteoporosis, osteopenia, hypogonadism, vitamin D deficiency, and menopausal health issues are increasingly recognised. Together, these conditions contribute substantially to the growing burden of cardiovascular disease, liver disease, frailty, and other non-AIDS comorbidities.

The growing burden of non-communicable disease among people living with HIV has important implications for clinical practice, including in low- and middle-income countries where rates of obesity, diabetes, and cardiovascular disease are also increasing. Effective management requires a proactive approach centred on early identification of risk factors, routine screening, lifestyle modification, optimisation of antiretroviral treatment, and evidence-based management of cardiovascular and metabolic comorbidities.

A multidisciplinary model of care involving HIV physicians, primary care practitioners, endocrinologists, dietitians, nurses, and allied health professionals is increasingly necessary to support healthy ageing and reduce long-term complications. Future developments, including improved cardiovascular risk assessment strategies and emerging therapies for obesity and metabolic disease, may further enhance outcomes.

Understanding the mechanisms, clinical manifestations, and management of metabolic and endocrine dysregulation is essential to delivering comprehensive HIV care in the modern era and ensuring that gains in life expectancy are matched by improvements in long-term health and wellbeing.

Aging with HIV: Geriatric Syndromes and Polypharmacy

Dr Tristan Barber (United Kingdom)
Consultant Physician in HIV Medicine



The success of antiretroviral therapy has transformed HIV into a chronic, manageable condition, resulting in a rapidly growing population of older adults living with HIV. However, this population experiences accelerated and accentuated ageing phenotypes, with higher rates of frailty, falls, cognitive decline, sarcopenia, and multimorbidity compared to age-matched HIV-negative peers. This talk explores the intersection of HIV infection and geriatric syndromes, examining proposed mechanisms including chronic immune activation, persistent inflammation, and cumulative toxicity from long-term antiretroviral exposure. Polypharmacy is a growing clinical challenge, with older people living with HIV often managing five or more medications - raising the risk of drug-drug interactions, adverse effects, and reduced adherence. I will review screening strategies for frailty in this population, clinical approaches to management, including comprehensive geriatric assessment, approaches to antiretroviral and comedication optimisation, and the importance of deprescribing where appropriate. This presentation aims to provide clinicians with practical tools for person-centred HIV care in those with HIV who are older or experiencing premature frailty.

IRIS in the era of rapid ART Initiation

Dr Fiona Cresswell (United Kingdom)
Clinical Associate Professor and Honorary Consultant in HIV and Sexual Health



What do we know about Immune Reconstitution Inflammatory Syndrome – when, how and why does it occur? We will discuss unmasking IRIS and paradoxical IRIS and consider when is the optimum time to start ART? Approaches to reduce the risk of IRIS and the management of IRIS will be considered. Research studies of relevance will be discussed. This is a very clinical session with photos and clinical cases presented.

Identifying and managing sexual dysfunctions in PLHIV

Dr Prageeth Premadasa (Sri Lanka)
Consultant Venereologist



With the success of modern antiretroviral therapy (ART) and progress toward UNAIDS 95-95-95 targets, HIV clinical management has fundamentally evolved. The widespread validation of "Undetectable equals Untransmittable" (U=U) has markedly alleviated transmission anxieties, extended life expectancy, and normalized relationship dynamics, leading to renewed sexual activity among people living with HIV (PLHIV). Nevertheless, achieving virological suppression alone does not equate to optimal well-being, as health-related quality of life is heavily dependent on fulfilling sexual health, which remains widely overlooked. Sexual dysfunctions are disproportionately common in PLHIV, with reported prevalence rates ranging from 53% to 71%, compared to 20% to 30% in seronegative controls. Even among virally suppressed individuals on long-term ART, over 50% report bothersome sexual difficulties. The underlying etiology is complex and multifactorial, involving chronic inflammation, cardiovascular risks, psychological distress (guilt, stigma, altered body image), and medication toxicities. Men living with HIV frequently suffer from erectile dysfunction, ejaculatory dysfunction, and low libido. Furthermore, hypogonadism is highly prevalent and frequently persists despite virological suppression. Standard total testosterone assays can be misleading due to elevated sex hormone–binding globulin (SHBG); therefore, measuring free testosterone is essential for accurate diagnosis. Women living with HIV encounter equally significant challenges, demonstrating high rates of sexual avoidance (84%), communication difficulties (66%), and vaginismus (60%). Despite significant patient interest, sexual health concerns are infrequently discussed during routine clinic visits. Incorporating standardized screening instruments, such as the Brief Sexual Symptom Checklist, into routine practice is crucial to bridging this diagnostic gap. Clinicians must also navigate critical drug-drug interactions: pharmacokinetic boosters (ritonavir and cobicistat) dramatically elevate phosphodiesterase-5 (PDE-5) inhibitor concentrations, necessitating dose adjustments to prevent severe complications like priapism and profound hypotension. Prioritizing routine sexual dysfunction screening, pharmacological vigilance, and localized research is vital to achieving holistic, comprehensive HIV care.

Advances in prevention and treatment of TB in PLHIV

Dr Neranjan Dissanayake (Sri Lanka)
Consultant Pulmonologist



HIV infection deranges the human immune system facilitating the progression of latent tuberculosis to active tuberculosis in PLHIV, who has been previously infected. Furthermore, it significantly increases the risk of developing primary tuberculosis after the initial infection.
The disease Tuberculosis, especially in severely immunocompromised PLHIV is usually disseminated and involves multiple organ systems, with a poorer prognosis than people without HIV.
Other than the significant drug interactions that should come under consideration when treating these patients, anticipating, preventing and

managing Immune Reconstitution Inflammatory Syndrome (IRIS) is paramount to successful treatment outcomes. Hence, an understanding of updated proper effective prevention measures and treatment options will assist in improving morbidity and mortality in these patients, who suffer or are prone to suffer from these dual challenges.

Symposium III- Integrated Perspectives on STIs: Clinical, Preventive, and Emerging Challenges

STIs in the Era of U=U and PrEP: Changing Epidemiology and Clinical Challenges

Dr Manik Kohli (United Kingdom)
Specialist in Sexual Health and HIV)

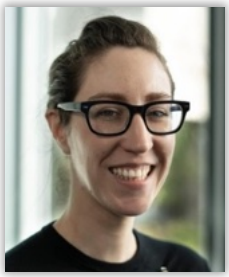


Sexually transmitted infections (STIs) remain common worldwide, and the World Health Organisation (WHO) estimates over 370 million new curable STIs (chlamydia, gonorrhoea, syphilis and trichomoniasis) are diagnosed each year among people aged 15 to 49, many of which are asymptomatic. Since the introduction of PrEP and the undetectable equals untransmittable (U=U) message, studies have demonstrated links with changes in sexual behaviour, including condom use. Concurrently, rates of bacterial sexually transmitted infections (STIs) have risen over recent decades. Across global, European, and United Kingdom surveillance data, we can see a decade-long rise in bacterial STIs which may have now peaked in some places and populations. Recent falls in gonorrhoea and syphilis have been seen, and this may in part be driven by interventions such as doxycycline post-exposure prophylaxis (doxyPEP), however changes in sexual behaviour may also be contributing.

Resurgent syphilis remains a public health challenge, particularly congenital syphilis and complications of neurosyphilis. Cases and outbreaks of multi/extensively drug-resistant *Neisseria gonorrhoeae* and *Shigella* are also of concern, particularly within dense sexual networks of men who have sex with men (MSM). In an era of increasing antimicrobial resistance, new questions are being asked about often we should screen asymptomatic individuals, particularly MSM on PrEP or living with HIV. Whilst rising STIs has been the challenge of the last decade, implementing new interventions and balancing the benefits of frequent testing against the need to preserve antibiotic, may be the challenges of the next one.

Atypical STI Presentations in Immunocompromised Patients

Dr Emily Clarke (United Kingdom)
Consultant in Genitourinary Medicine and HIV



Sexually transmitted infections (STIs) remain a major global public health challenge, but their clinical manifestations are not uniform across patient populations. In individuals with impaired immunity, common sexually transmitted pathogens may produce presentations that differ markedly from classical descriptions, creating significant diagnostic and management challenges. As increasing numbers of people live with HIV, receive immunosuppressive therapies, undergo transplantation or survive malignancy, clinicians are encountering a broader spectrum of atypical STI manifestations in routine practice.

Immune dysfunction can alter host-pathogen interactions, resulting in more extensive disease, unusual lesion morphology, chronic or recurrent infection, treatment failure and dissemination beyond typical anatomical sites. Genital ulcerative diseases may present with giant, destructive or tumour-like lesions, while bacterial and viral infections can mimic inflammatory dermatoses, malignancies or opportunistic infections. The coexistence of multiple sexually transmitted pathogens further complicates diagnosis, particularly in individuals with advanced immune suppression.

Atypical presentations have been described across a wide range of infections, including herpes simplex virus, syphilis, human papillomavirus, lymphogranuloma venereum and mpox. In many cases, these manifestations are associated with delayed diagnosis, increased morbidity and ongoing transmission. Importantly, unusual STI presentations may be the first clinical indication of previously undiagnosed immunodeficiency, providing a critical opportunity for earlier recognition of underlying disease.

Awareness of these clinical patterns is essential for healthcare professionals working in venereology and allied specialties. Comprehensive assessment, appropriate microbiological testing and consideration of co-infection are often required to establish the correct diagnosis. Recognition of clinical features suggestive of immune dysfunction can also facilitate timely investigation for underlying conditions such as HIV infection.

A high index of suspicion is therefore required whenever the severity, morphology, distribution or treatment response of an STI appears inconsistent with expected disease patterns. Improving recognition of atypical presentations has the potential to reduce missed diagnoses, optimise patient outcomes and strengthen STI and HIV control efforts.

Emerging Threats in Sexual Health: From Zika, Mpox, and Evolving Herpes Simplex Viruses to Neisseria Meningitidis

Dr Manik Kohli ((United Kingdom)
Specialist in Sexual Health and HIV



Many pathogens not typically considered sexually transmitted have emerged as important infections spreading within sexual networks. Evolving viruses and bacteria also present new challenges within sexual health.

Alongside primary mosquito transmission, sexual transmission of Zika virus has been implicated in congenital disease, with prolonged persistence of the virus in semen enabling spread to partners in non-endemic settings. Mpox (clade IIb) caused a global outbreak in 2022, concentrated within sexual networks of men who have sex with men (MSM). Sexually transmitted mpox may present with anogenital lesions and proctitis, and despite vaccination programmes cases linked to sexual transmission are ongoing, including of the more severe clade Ib now detected within MSM sexual networks. Genital herpes is increasingly caused by HSV-1 rather than HSV-2 as sexual practices change; whilst aciclovir resistance is reported among immunocompromised individuals.

Sexual transmission of *Neisseria meningitidis* can lead to symptomatic urogenital infection that is clinically indistinguishable from gonorrhoea, and outbreaks of invasive meningococcal disease have been reported among MSM sexual networks, particularly impacting people living with HIV. A urogenital-specific clade of *N. meningitidis* with gonococcal traits has emerged. High rates of oropharyngeal *N. meningitidis* carriage have been shown among MSM, frequently tetracycline-resistant, raising questions of co-selection as doxycycline post-exposure prophylaxis (doxyPEP) expands.

In the context of interconnected global sexual networks, each pathogen presents unique epidemiolocal and clinical challenges. Active surveillance with rapid public health responses to outbreaks is essential.

BHIVA Guideline Update

Dr Tristan Barber (United Kingdom)
Consultant Physician in HIV Medicine



This talk provides a practical update on three key British HIV Association (BHIVA) guidelines relevant to routine clinical practice. I will summarise the current, published guidance on the Management of HIV in Pregnancy and the Postpartum Period, including the expanded recommendations on infant feeding and the two-pathway approach to postnatal prophylaxis for low- and high-risk infants. I will then turn to two guidelines out for consultation before being finalised: the updated guidelines on the Routine Investigation and Monitoring of Adults Living with HIV, and the BHIVA Vaccination guidelines. For each, I will outline the anticipated scope of changes, highlighting areas likely to affect day-to-day monitoring and immunisation practice.

Symposium IV- Bridging Clinical Care and Public Health: Managing Hepatitis B and C

Clinical and Therapeutic Challenges in HIV–HBV/HCV Co-Infection Management

Dr Ranjababu Kulasegaram (United Kingdom)
Consultant Physician in HIV/GU Medicine



HIV co-infection with hepatitis B virus (HBV) and/or hepatitis C virus (HCV) represents a major clinical challenge because of complex interactions between viral infections, accelerated liver disease progression, drug toxicity, and potential drug interactions. People with HIV–HBV or HIV–HCV co-infection have an increased risk of chronic liver disease, cirrhosis, hepatocellular carcinoma, and liver-related mortality compared with those infected with HBV or HCV alone. Effective management requires early diagnosis, comprehensive assessment of liver disease, vaccination and preventive strategies, and appropriate selection of antiretroviral and antiviral therapies.

In HIV/HCV coinfection, direct-acting antivirals (DAAs) have transformed treatment, achieving high rates of sustained virological response. However, drug–drug interactions between DAAs and antiretroviral agents, advanced liver disease, prior treatment exposure and the risk of HCV reinfection remain important considerations. Patients with current or previous HBV infection undergoing DAA therapy also require assessment and appropriate management of HBV reactivation risk.

Management of HIV/HBV coinfection requires antiretroviral therapy with effective activity against both viruses, while avoiding regimens that provide inadequate HBV suppression and may promote antiviral resistance.

HBV–HDV infection remains an important clinical challenge, with potential for rapid progression of liver disease. Improved case identification, routine consideration of HDV testing in people with HBV, appropriate staging and access to specialist therapies are important components of management. Greater awareness and integrated HBV–HDV pathways may facilitate earlier diagnosis and improve clinical care.

HDV infection remains a major driver of progressive liver disease in individuals with HBV, with coinfection and superinfection posing distinct diagnostic and therapeutic challenges. Accurate identification requires appropriate serological and virological assessment, including HDV RNA quantification, alongside systematic evaluation of liver fibrosis and disease activity. Contemporary management requires an integrated approach to HBV suppression, HDV-directed therapy and surveillance for hepatic complications.

Managing Acute Liver failure in Viral Hepatitis

Dr Hasitha Wijewantha (Sri Lanka)
Consultant Gastroenterologist and Hepatologist



Acute liver failure (ALF) is a life-threatening condition characterised by acute deterioration of liver function, coagulopathy (INR ≥1.5) and hepatic encephalopathy in individuals without pre-existing liver disease. Viral hepatitis remains the leading cause of ALF in the Asia-Pacific region.

Hepatitis A, B and E are important causes of virus-associated ALF, while hepatitis D and non-hepatotropic viruses, including herpes simplex virus (HSV), Epstein–Barr virus, Cytomegalovirus and dengue virus, may also be implicated. Viral hepatitis commonly presents with a prodromal illness characterised by fever, malaise, anorexia, nausea and myalgia, followed by jaundice and markedly elevated aminotransferases. Diagnosis requires targeted serological and molecular investigations.

ALF due to Hepatitis A and E generally has a better prognosis except in pregnant women and immunocompromised individuals. Hepatitis B-associated ALF may result from acute infection or reactivation of previously unrecognised infection; hepatitis B surface antigen and viral DNA may be low or undetectable in some cases of acute liver failure, potentially leading to misclassification as indeterminate ALF. Hepatitis B reactivation is associated with a poorer prognosis than newly acquired infection. HSV

hepatitis warrants particular attention because of its high mortality and frequently unsuspected presentation
Management requires intensive care, comprehensive aetiological investigation, neurological monitoring, infection surveillance, metabolic and nutritional support, and treatment of multi-organ dysfunction. Intravenous N-acetylcysteine may improve transplant-free survival in early-stage non-acetaminophen-related ALF. Empirical intravenous aciclovir should be considered in ALF of unknown aetiology while awaiting HSV PCR results. Early antiviral therapy may be appropriate in hepatitis B-associated ALF, although evidence supporting survival benefit remains limited. Early referral to a liver transplant centre is crucial. Prognostic tools, including the King's College Criteria, MELD score and Clichy criteria, support risk assessment but should complement clinical judgement.
Successful management of viral hepatitis-associated ALF depends on early diagnosis, prompt supportive and aetiology-directed treatment, careful prognostication and timely liver transplantation assessment.

Micro-Elimination of Hepatitis B and Hepatitis C: Translating Global Targets into Local Success

Dr Thilanga Ruwanpathirana (Sri Lanka)
Consultant Epidemiologist



Background: The World Health Organization (WHO) aims to eliminate hepatitis B (HBV) and hepatitis C (HCV) as public health threats by 2030. The global targets include a 90% reduction in new chronic HBV infections, an 80% reduction in HCV incidence, and a 65% reduction in hepatitis-related mortality compared with 2015. WHO validation criteria include HBV-related mortality of ≤4 per 100,000 population, HCV incidence of ≤5 per 100,000, HCV-related mortality of ≤2 per 100,000, and hepatitis B surface antigen (HBsAg) prevalence of ≤0.1% among children under five years. Programme targets include ≥90% coverage of hepatitis B vaccination, ≥90% diagnosis of people living with HBV/HCV, and ≥80% treatment coverage among eligible people.
Local context: Sri Lanka has achieved substantial progress in HBV prevention and was recognised by WHO in 2025 for achieving the hepatitis B control goal, supported by sustained high childhood immunisation coverage. This provides a strong foundation for progressing towards elimination. However, achieving the broader elimination criteria requires identification and management of existing infections, particularly among adults, and strengthening HCV case detection, linkage to care and treatment.
Approach: Micro-elimination can translate these global targets into measurable local outcomes by focusing on defined populations or geographic areas. Priority interventions include mapping disease burden and service gaps, targeted testing and confirmation, effective linkage to care, treatment initiation and monitoring of outcomes. Priority populations may include pregnant women, household contacts, people receiving haemodialysis, blood donors and other groups identified through surveillance.
Conclusion: Sri Lanka's strong HBV prevention platform makes substantial progress towards elimination feasible. However, achieving the full HBV and HCV elimination criteria by 2030 will depend on closing gaps in adult diagnosis, treatment, surveillance and outcome measurement. Micro-elimination provides a practical strategy to identify these gaps, concentrate resources and demonstrate measurable progress from national targets to local success.

Symposium V- Ending Vertical Transmission and Beyond: Integrated Strategies for Maternal and Pediatric HIV Management

Residual Transmission in EMTCT Programs: Why Do Failures Still Occur?

Dr Leelani Rajapaksha (Sri Lanka)
Consultant Venereologist



EMTCT of HIV and syphilis program in Sri Lanka was validated by the WHO in 2019 and the services were maintained satisfactorily over the years. WHO certified the maintenance of quality services for EMTCT of HIV and syphilis in 2022 and 2025. This was based on the satisfactory impact and process indicators for the period. The Country Report for Validation of dual elimination in 2019 and the Maintenance of Services Report in 2022, shows that the impact indicators for the years 2017 to 2021 remained <5% of MTCT rate of HIV with <50 cases with congenital syphilis or paediatric HIV per 100,000 live births. During these years the process indicators; ANC coverage, syphilis/HIV testing coverage and syphilis/HIV treatment coverage remained >95%.

However, in the year 2023, syphilis treatment coverage was 93.6%. This was due to the increase of congenital syphilis cases based on the global case definition for congenital syphilis. These included babies born to pregnant women with syphilis who had inadequate treatment during pregnancy including non-penicillin treatment due to penicillin sensitivity. Three babies had mothers who were newly infected with syphilis in late pregnancy.

In the year 2021 and 2022 each, one baby with paediatric HIV was identified as mothers who were negative for HIV in early pregnancy got infected during late stage of pregnancy. Detection of one baby with paediatric HIV per year increased the mother to child transmission rate to 5.9% and 5.3% for the years 2021 and 2022 respectively. HIV treatment coverage declined to 94.1% in 2021 and 94.7% in 2022.

Sri Lanka is due to submit the country report on maintenance of EMTCT of HIV and syphilis services in 2027. It is a challenge to maintain impact and process indicators with the increasing HIV and syphilis infections in the country. Recent increase of HIV and syphilis identified among pregnant female sex workers, addicted to drugs is a grave concern. Compliance to treatment and follow up is minimal among drug user population increasing the risk for MTCT of HIV and syphilis. This will reverse the achievements attained over the years in the dual elimination program.

LAI in Pregnancy- Real world experience

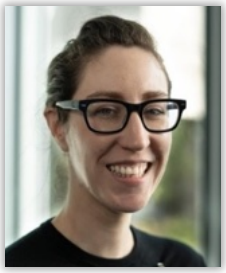
Prof Graham P Taylor ((United Kingdom)
Professor of Human Retrovirology



Data on the safety, efficacy and even the pharmacokinetics of antiretroviral therapy (ART) in pregnant and lactating women is generally delayed 6 – 8 years following licensing. Long-acting injectable ART (LAI) is unusual as data are emerging from its use in both people living with HIV and those using LAI to prevent HIV infection. Whilst in the former, therapy may be offered both for convenience to people who have successfully managed to fully suppress HIV with oral ART and to those who have struggled to swallow tablets for whom LAI may represent a final opportunity to achieve virological control. To date, LAI appears to be safe in pregnancy but consideration should be given to the dosing interval of Cabotegravir/rilpivirine. There is an extensive pipeline of LAI for which new data will be required. Reporting all exposures to the antiretroviral pregnancy register is key to determining the safety of LAI.

Challenges in the Management of Sexually Transmitted Infections in Children

Dr Emily Clarke (United Kingdom)
Consultant in Genitourinary Medicine and HIV



Sexually transmitted infections (STIs) in children present some of the most complex challenges encountered in sexual health practice. Unlike adult STI management, the diagnosis of an STI in a child has implications that extend far beyond treatment of infection, frequently raising concerns regarding child sexual abuse, child sexual exploitation, safeguarding, forensic evidence collection, and long-term psychosocial wellbeing. Clinicians must balance the need for accurate diagnosis and timely treatment with careful assessment of acquisition pathways, preservation of evidence, and protection of the child from further harm.

The management of STIs in children requires consideration of multiple potential routes of transmission, including vertical, non-sexual, and sexual acquisition. The significance of an STI varies according to the child's age, developmental stage, infecting organism, and clinical context. Diagnostic uncertainty can further complicate management, particularly in low-prevalence paediatric populations where the consequences of false-positive or incorrectly interpreted results may be profound. Distinguishing congenital, perinatally acquired, and sexually acquired infections may be challenging, particularly for infections such as chlamydia, herpes simplex virus, human papillomavirus, syphilis, and HIV.

A child presenting with a possible sexually acquired infection requires more than microbiological diagnosis and treatment. Effective management depends on trauma-informed assessment, multidisciplinary collaboration, and timely safeguarding interventions. Sexual health clinicians, paediatricians, forensic specialists, child protection authorities, law enforcement agencies, and psychosocial support services all have important roles in ensuring that children receive appropriate medical care while protecting their safety and wellbeing.

Particular challenges in resource-constrained settings include limited access to specialist services, stigma associated with sexual health and abuse, variations in diagnostic capacity, and the need for effective coordination between multiple agencies. Strengthening referral pathways, improving access to specialist expertise, and supporting multidisciplinary child-centred care are essential components of improving outcomes for vulnerable children and young people affected by STIs.

Optimizing Antiviral Therapy in Children: Paediatric Dosing, Adherence, and Formulation Challenges

Dr Caroline Foster (United Kingdom)
Professor of Practice Adolescent Infectious Diseases



An estimated 11 million children have been born with HIV since the early years of the epidemic and despite vertical transmission being preventable, a further 93,000 children acquired HIV in 2025, the majority perinatally and during breast/chest feeding. There is a median of 8 years between the adult licencing of a new antiretroviral agent and the first published pharmacokinetic data in infants resulting in children born with HIV being exposed to older less potent and more toxic drugs than their parents. This factor, combined with issues of early infant diagnosis, palatability of liquid/dispersible formulations, care giver dependence and the impact of adolescence on adherence to antiretroviral therapy has resulted in an unacceptable age discrimination in the HIV care cascade. In 2024, 74% of adults aged 15 years and older living with HIV had suppressed viral loads, compared to just 47% of children aged 0–14 years. Recent improvements including the inclusion of adolescents within adult phase 3 trials, dosing for dolutegravir in infancy, the development of dispersible fixed dose paediatric combination therapy and emerging data on long acting injectable therapy in children aim to address this gap.

Symposium VI- Collaborative HIV/ STI Prevention Actions: Global Guidance,and Multifactorial Health Challenges

From Global Targets to Local Impact: Implementing WHO HIV Prevention Frameworks in Complex Settings

Dr Cheewanan Lertpiriyasuwat (WHO)
Senior Expert in Preventive Medicine



Achieving the global target of ending AIDS by 2030 requires bridging high-level policies with local implementation in complex settings. While global mandates—such as the UNAIDS 2030 targets and the WHO Combination Prevention Framework—set strategic directions, key populations continue to face structural and social barriers within traditional healthcare systems. Differentiated Service Delivery (DSD) helps bridge this gap by simplifying decentralizing, de-medicalizing, and integrating care.

Thailand operationalized DSD by institutionalizing Community-Led Health Services (CLHS). Through Ministry of Public Health regulations and Section 3 of the National Health Security Act, Thailand established a seven-step roadmap to accredit civil society organizations (CSOs) and certify community health workers (CHWs) to deliver comprehensive HIV/STI services.

By mid-2026, Thailand had accredited 116 organizations and certified more than 1,200 CHWs within the formal health system. This public–community partnership has demonstrated substantial impact. For example, the CLHS model contributed approximately 66% of all national PrEP initiations and achieved an 84% early diagnosis rate (CD4 ≥200 cells/mm^3), compared with 55% nationwide. Thailand's experience demonstrates that transitioning from donor reliance to domestic social contracting under Universal Health Coverage (UHC) provides a pathway toward the financial sustainability of CLHS.

Substance Use and HIV: Clinical, Behavioral, and Public Health Intersections

Dr Sirin Tangcharoensathien (WHO)
Senior Research Physician



Sexualized substance use, particularly methamphetamine use before or during sexual activity among gay and bisexual men, has become an increasingly important topic in the context of HIV, STIs, sexual well-being, and mental health. In addition to its association with increased risk of HIV and other sexually transmitted infections, substance use in sexual settings is closely linked to sexual pleasure, cultural practices, and social connection. However, stigma surrounding both substance use and sexuality can create barriers to accessing appropriate, person-centered health services. It may contribute to risks being addressed without fully understanding the underlying needs and motivations.

This session will explore sexualized substance use from clinical, behavioral, and public health perspectives. We will discuss how stigma, enabling environments, and drug policy affect health outcomes and health care services for people who use drugs.

We will share insights from co-developing service delivery models through community consultation and highlight the importance of community-led health services. We will also present a comprehensive harm reduction package: a four-pronged approach that includes substance use literacy, sexual and mental health services, legal consultation, and social and family support.

Finally, the session will reflect on lessons that extend beyond the public health sector, emphasizing other relevant stakeholder engagement, cross-sector collaboration, and the importance of involving communities in designing sustainable and comprehensive service packages for harm reduction.

Take-home message: Effective responses to sexualized substance use require active community involvement and cross-sector collaboration to develop comprehensive, person-centered harm reduction services. Addressing stigma and legal barriers is essential, and decriminalization can help create a safer environment and improve access to healthcare and harm reduction services for people who use.

Oral Presentations: Free Paper Session
31st October 2026

OP-01

Knowledge, Attitudes and Practices on Sexually Transmitted Infections and HIV among Transgender Persons attending Selected Sexual Health Clinics in Colombo.

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Introduction: Transgender individuals are recognised as a key population with an increased risk of HIV and sexually transmitted infections worldwide. In Sri Lanka, they have also been identified as one of the most at-risk populations for HIV/STI. Local evidence regarding their sociodemographic characteristics, knowledge, attitudes, and practices related to HIV/STIs is limited. This study aimed to generate evidence to strengthen targeted sexual health interventions.
Objective: To describe socio-demographic characteristics, knowledge, attitudes, and practices related to HIV/AIDS and STIs among transgender individuals attending selected sexual health clinics in Colombo, Sri Lanka.
Methods: A clinic-based descriptive cross-sectional study was conducted among 186 transgender individuals attending selected sexual health clinics in Colombo, Sri Lanka. Participants were selected using stratified probability-proportionate random sampling. Data were collected using a pre-tested, structured, self-administered questionnaire and analysed using SPSS version 22. Knowledge, attitude, and practice scores were assessed and reported with 95% confidence intervals.
Results: The mean age was 26.8 years (SD = 5.9); 57.5% were trans women and 42.5% trans men. Most were Sinhalese (94.1%), and 42.5% had received A/L or higher education.
The mean knowledge score was 64.9 (95% CI: 62.4–67.4), mean attitude score, 63.4 (95% CI: 59.6–67.1), and mean sexual practice score, 62.5. All had heard of HIV/AIDS; only 34.4% identified the difference; 90.3% knew consistent condom use prevents HIV & most STIs (89.2%). While 38.2% reported previous STI diagnosis, 58.6% knew their HIV status.
Favourable attitudes towards people living with HIV were reported by 74.2%.
At last sex, 90.6% trans women had a male partner;66.7% reported receptive anal sex, and 52.8% did not use condoms. All transmen reported a regular female partner at last sex.
Early sexual debut less than 16 years, reported by 25.8%, while 76.1% reported consenting to first sex.
Conclusions and Recommendations: Despite satisfactory overall knowledge and favourable attitudes, important gaps existed regarding HIV/AIDS, STI prevention, condom use, STI curability, and vaccination. High-risk sexual practices were observed among trans women. Targeted, transgender-inclusive sexual health education, improved condom accessibility, and age-appropriate sexuality education are recommended.
Keywords: Trans gender; Trans men; Trans women; HIV; STIs; Sexual practices; Sri Lanka

OP-02

Prevalence and behavioral risk factors of Human Immunodeficiency Virus, Syphilis infections among Sexually Transmitted Infections clinic attendees in Anuradhapura (2019-2024)

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Introduction: HIV and syphilis remain important sexually transmitted infections (STIs), with transmission influenced by sexual behaviours and related socio-demographic factors. However, cliniclevel evidence on the prevalence of HIV and syphilis and their associated behavioural risk factors among STI clinic attendees remains limited, particularly from longitudinal analyses covering an extended five-year period. This study aimed to provide evidence on the burden and risk profile of these infections among STI clinic attendees.
Objectives: To determine the prevalence of HIV and syphilis and identify socio-demographic and behavioural risk factors associated with infection among STI clinic attendees in Anuradhapura from 2019 to 2024.
Methods: A retrospective cross-sectional study was conducted among 427 randomly selected STI clinic attendees from 4,472 eligible clinic records. Data on socio-demographic characteristics, behavioural risk factors, and laboratory-confirmed HIV and syphilis results were extracted using a structured data extraction instrument. Statistical analyses were performed using SPSS version 22. Descriptive statistics summarized participant characteristics, while Fisher's exact test assessed associations between infection status and selected variables.
Results: The mean age of participants was 34±11 years, and 53.6% (229/427) were female. HIV prevalence was 3.3% (14/427; 95% CI: 1.7–4.9%), syphilis prevalence was 4.4% (19/427; 95% CI: 2.6–6.3%), and HIV–syphilis co-infection prevalence was 1.2% (5/427; 95% CI: 0.5–2.7%). Condom use at the last sexual encounter was reported by only 13% of participants, while 74% reported not using condoms. Male attendees had significantly higher HIV prevalence than females (7.1% vs. 0%; p=0.0000165) and higher syphilis prevalence (8.6% vs. 0.9%; p=0.0000889). Homosexual orientation was significantly associated with HIV (p=0.0021) and syphilis (p=0.00079). Syphilis was also significantly associated with higher educational attainment (p=0.018) and having non-regular sexual partners (p=0.021). Condom use, substance use, previous STI history, and blood exposure were not significantly associated with infection status.
Conclusions: Among STI clinic attendees in Anuradhapura, HIV prevalence was 3.3%, syphilis prevalence was 4.4%, and HIV–syphilis co-infection prevalence was 1.2%. HIV and syphilis were significantly more prevalent among male attendees, while homosexual orientation was associated with both infections. Syphilis was also associated with higher educational attainment and having non-regular sexual partners.

OP-03

Chemsex in Sri Lanka: Stakeholder Perspectives, Service Needs and Programme Priorities

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Introduction: Chemsex, defined as the use of psychoactive substances to facilitate or prolong sexual activity, has important implications for sexual health, HIV/STI prevention, substance-related harms, and psychosocial well-being. Although increasingly recognised globally, chemsex remains under-characterised in Sri Lanka
Objective: To explore stakeholder perspectives on chemsex in Sri Lanka, identify perceived service gaps and needs, and develop priorities for strengthening the national programme response.
Method: A qualitative stakeholder assessment was conducted involving in-depth interviews with six programme professionals and two focus groups involving 30 individuals engaging in chemsex in Colombo and Gampaha. Participants were recruited using purposive sampling. Discussions explored patterns and contexts of chemsex, sexual and other health concerns, barriers to accessing services, and perceived gaps in existing services. Data were analyzed using thematic analysis. Findings were subsequently discussed at a stakeholder workshop involving multiple government and non-government stakeholders to identify and prioritise programme needs. The findings represent stakeholder perspectives and are not intended to estimate the population prevalence of chemsex.
Key Findings: Four major areas of concern emerged: (1) Crystal methamphetamine with polydrug use involving ketamine, GHB/GBL, MDMA, cannabis, and erectile dysfunction medications. (2)Chemsex events organised through private social media platforms and dating applications, with peer networks facilitating participation and drug access. (3)Motivations for engaging in chemsex included enhanced sexual pleasure, prolonged sexual activity, curiosity, peer influence, and increasing drug dependence. (4)Participants identified HIV/STI transmission, needle sharing, overdose, and adverse mental health effects. Major service gaps included stigma, gaps in HIV/STI testing and harm-reduction services, poor intersectoral coordination, limited referral pathways, and restrictive legal frameworks. Stakeholders recommended expanding confidential community-based services, strengthening harm-reduction programmes, improving multisectoral collaboration, reforming drug-related legislation, and increasing public and professional awareness.
Conclusion: Chemsex is an emerging and under-recognised issue requiring greater attention within Sri Lanka's sexual-health and HIV response. Stakeholders identified the need for an integrated, confidential and non-judgemental approach addressing sexualhealth, substance-use and psychosocial needs. Strengthening provider capacity, establishing referral pathways, developing locally relevant guidance, and generating further evidence were identified as key priorities for an effective national programme response

OP-04

Knowledge of HIV Infection, Biomedical and Behavioral Means of Prevention among Nursing Officers at Teaching Hospital, Anuradhapura

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Introduction: Nursing officers play a pivotal role in HIV prevention, infection control, and patient care. Adequate knowledge of HIV infection and current biomedical and behavioural prevention strategies is essential for reducing transmission, promoting evidence-based practice, and improving patient outcomes.
Objective: To assess knowledge of HIV infection, biomedical and behavioural means of HIV prevention among nursing officers at Teaching Hospital, Anuradhapura, Sri Lanka.
Methods: A descriptive cross-sectional study was conducted among 311 nursing officers recruited using simple random sampling from February to October 2024. Data were collected using a structured, pre-tested, self-administered questionnaire comprising 30 knowledge questions, with 10 questions each on HIV infection, behavioural prevention, and biomedical prevention. Each domain was scored out of 100. Data were analysed using SPSS version 28.
Results: The mean age of participants was 37.3 ± 8.8 years, and 88.7% were female. Most held a nursing diploma (86.2%), while 41.4% were Grade III nursing officers. Mean knowledge scores were 47% (SD 15%) for HIV infection, 68% (SD 20.5%) for behavioural prevention, and 37% (SD 12%) for biomedical prevention. High knowledge was demonstrated regarding the absence of a cure for HIV, target cells, needle sharing as a transmission route, condom use, post-exposure prophylaxis, and condom use among serodiscordant couples. However, substantial misconceptions were seen mother-to-child transmission, high-risk sexual behaviours, prolonged penetrative sexual intercourse as a risk factor, and daily preexposure prophylaxis (PrEP). Knowledge of HIV infection and biomedical prevention was not significantly associated with gender, age, educational status, nursing grade, working unit, or duration of service (all $p>0.05$). Behavioural prevention knowledge was significantly associated with working unit ($p=0.02$), with nurses in medical units achieving the highest mean scores.
Conclusion: Nursing officers demonstrated moderate knowledge of behavioural HIV prevention but inadequate knowledge of HIV infection and biomedical prevention, highlighting important gaps in contemporary HIV prevention. Targeted continuing professional education, particularly on mother-to-child transmission and biomedical prevention strategies, should be strengthened to support evidence-based nursing practice. Regular updates on evolving HIV prevention recommendations, practical training on prevention technologies, and reinforcement of accurate transmission knowledge may improve nurses' preparedness to provide appropriate counselling, prevention services, and stigma-free care effectively.

OP-05

Antiretroviral Drug Resistance Patterns Among People Living with HIV at the Central HIV Clinic, NSACP, Sri Lanka: A Cross-Sectional Study

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Background: Antiretroviral drug resistance contributes to virological failure and may limit future treatment options, challenging the third UNAIDS 95-95-95 target. In Sri Lanka, HIV drug resistance testing is limited by economic and specialized laboratory constraints, highlighting the need to understand local resistance patterns to optimize ART and manage treatment failure.

Objective: To describe the pattern of HIV viral resistance among PLHIV undergoing resistance testing at the Central HIV Clinic, Colombo, Sri Lanka from 2016-2026.
Methods: A retrospective cross-sectional study was conducted among PLHIV receiving care from the central HIV clinic Colombo, who underwent HIV genotyping drug resistance testing at the ICMR-National AIDS research institute Pune, India over 10-years (2016-2026). All 89 individuals who underwent testing, including 43 with confirmed ART resistance were included in the study. Secondary data was collected from clinical records. Data analyzed by SPSS 31.
Results: Among the 89 individuals who underwent testing, 64 (72%) were male, mean age was 49 years. Five (11.6%) were children, 17were MSM, 5FSW, and 3drug user. Median ART exposure was 13-years (IQR 9.5–16). At suspected virological failure, 42 (47.2%) patients had viral loads of >10,000–100,000 copies/ml, while 16 (32.6%) had viral loads >100,000 copies/ml. 7(16.3%) had poor adherence. At resistance testing, CD4-count was >350cells/mm^3 in 35(39%) and <100cells/mm^3 in 17(19.1%). Among those who showed resistance TDF+FTC+EFV was the most common initial regimen (23/43,53.5%), followed by AZT+3TC-based regimens (13/43,30%). Combined NRTI and NNRTI resistance predominated (30/43,69.8%). M184V was the most common NRTI mutation (29/43,67.4%) and K103N the most frequent NNRTI mutation (17/43, 39.5%). Subtype C predominated (25/43,58.1%). ART was modified in 33(76.7%) patients, all of whom (33,100%) achieve d subsequent viral load reduction; 25(75.8%) achieved an undetectable viral load. Eight patients died and two were lost to follow-up.
Conclusion: Dual-class NRTI, NNRTI resistance was most common, with M184V and K103N as the predominant mutations. Most patients had received EFV-based ART, and subtype C predominated. ART modification after resistance testing reduced viral load in most patients, highlighting the need for regular viral load monitoring, timely resistance testing, and individualized ART to sustain viral suppression and preserve future treatment options in Sri Lanka.

OP-06

Prevalence, Severity and Associated Factors of Erectile Dysfunction among Central STD Clinic Attendees, Colombo

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Introduction: Erectile dysfunction (ED) is a common sexual health condition affecting physical, psychological, and interpersonal well-being. Sri Lankan evidence on ED among men attending sexual health services remains limited.
Objective: To determine the prevalence, severity, and associated factors of ED among male attendees of the Central STD and Sexual Health Clinic, Colombo.
Methods: A descriptive cross-sectional study was conducted from May to October 2025 among newly registered male attendees. Sri Lankan males aged ≥18 years were eligible; non-Sri Lankan citizens and individuals with communication difficulties due to psychiatric illness, neurological impairment, or intellectual disability were excluded. Systematic random sampling selected every seventh attendee. Of 364 planned, 358 were enrolled. Data were collected using a pretested, self-administered modified IIEF-derived questionnaire covering sociodemographic, lifestyle, medical and erectile-function characteristics. The questionnaire underwent translation, back-translation, expert review for face and content validity, and pretesting. Five items generated the erectile-function score; an additional relationshipsatisfaction item was analysed separately. Scores ranged from 5–25, with severity categories adapted from IIEF-5/SHIM classification: no ED 22–25, mild 17–21, mild-tomoderate 12–16, moderate 8–11, and severe 5–7. Data were analysed using SPSS 25. Prevalence with 95% CIs was calculated, followed by bivariate and multivariable logistic regression analyses.
Results: Mean age was 35.3 years (SD 10.7; median 34; range 19–77). Overall, 49.2% (176/358; 95% CI 44.0%–54.0%) had ED: 15.4% mild, 7.5% mild-to-moderate, 4.7% moderate and 21.5% severe. Bivariate analysis showed significant associations with older age, education, religion, monthly income, alcohol consumption, high physical activity, diabetes, hypertension and dyslipidaemia; smoking was not significantly associated. Multivariable analysis showed marital status [aOR 0.386, 95% CI 0.216–

0.690], monthly income [aOR 1.681, 95% CI 1.157–2.442], alcohol consumption [aOR 1.895, 95% CI 1.088–3.300] and dyslipidaemia [aOR 3.323, 95% CI 1.396–7.909] remained independently associated with ED.
Conclusion: ED affected approximately half of clinic attendees, with more than one-fifth experiencing severe dysfunction. These findings support recognition of metabolic and cardiovascular disease risks. Assessment of erectile function and modifiable lifestyle and cardiometabolic risk factors within sexual health services may facilitate intervention, referral, and management, improving sexual, psychological, and health outcomes.

OP-07

Respondent-Driven Sampling in Sri Lanka; Applications and Methodological Reporting: A Scoping Review

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Introduction: Respondent-driven sampling (RDS), developed by Douglas D. Heckathorn in 1997, is a network-based sampling approach designed to recruit hard-to-reach populations. RDS is a chain-referral method starts with initial seeds who recruit peers using a defined number of coupons. Recruitment progresses through successive waves, generating a network of study subjects. Key RDS diagnostics include recruitment waves, homophily, convergence and bottleneck effects. Although RDS has increasingly been used in Sri Lanka, its applications and methodological reporting have not been systematically mapped.
Objective: To map the evidence on the use of RDS in Sri Lanka and describe the populations studied, applications and methodological reporting.
Methods: A scoping review was conducted using Joanna Briggs Institute methodology from inception to 1 September 2026 and reported according to PRISMA-ScR. Peer-reviewed and grey literature were searched in Google, Google Scholar, PubMed, Sri Lanka Journals Online, and ResearchGate. Synonyms and related terms for "RDS" and "Sri Lanka" were used with an English-language restriction. Eligible studies were independently charted by two authors. Data included population, setting, sample size, seeds, coupons, network size, waves, convergence, bottlenecks, and RDS estimates. Duplicates and irrelevant articles were manually removed.
Results: Eleven records met the review criteria. RDS was applied among several hard-to-reach populations, including FSW, MSM, PWUD, transgender women and beach boys. Sample sizes ranged from approximately 225 to 1,180 participants. Reported seed numbers ranged from 3 to 13, with two or three recruitment coupons. Recruitment chains extended to eight or nine waves in several studies. The three-city FSW survey demonstrated convergence for most or all examined indicators and reported homophily across cities. The Galle beach-boy study reached eight waves and achieved convergence across all five examined variables. However, several studies provided limited information on waves, homophily, convergence or bottleneck effects. Multiple publications originated from shared RDS datasets.
Conclusion: RDS is an important strategy for accessing hard-to-reach populations in Sri Lanka. However, reporting of core methodological parameters remains inconsistent. Future studies should systematically report seed selection, coupon numbers, recruitment waves, network size, homophily, convergence, bottlenecks, estimators and weighting procedures. Standardized reporting would improve transparency, comparability and confidence in RDS derived population estimates.

OP-08

Addictive Substance Use and Associated Factors Among Men Who Have Sex with Men Receiving Sexual Health services from Selected Clinics, Colombo, Sri Lanka

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Introduction: Substance use is an important public health concern and disproportionately affects marginalized populations. Sexualized substance use may facilitate high-risk sexual behaviours and vulnerability to sexually transmitted infections and HIV. Data on substance use and sexualized drug use among MSM in Sri Lanka remain limited.

Objectives: To describe the sociodemographic characteristics of MSM accessing sexual health services in Colombo; determine the prevalence and patterns of substance use and sexualized drug use; identify commonly used substances; and assess factors associated with substance use and sexualized drug use.

Methods: A clinic-based descriptive cross-sectional study was conducted among 272 MSM attending selected STD, HIV and community PrEP clinics in Colombo. Participants recruited through consecutive sampling, with randomization of clinic days and time windows.

Data were collected using self-administered questionnaire. Descriptive statistics were used to estimate prevalence and patterns of substance use. Associations between substance use, sexualized drug use and selected sociodemographic and behavioural factors were assessed using inferential methods.

Results: Alcohol was the most frequently used substance (71.7%), followed by tobacco (56.3%). Illicit substance use was substantial, with cannabis reported by 31.3% and methamphetamine by 19.9%. Injection drug use was reported by 12.5%. Sexualized drug use was reported by the majority of participants who had used illicit substances. Multiple sexual partners and inconsistent condom use were common. Sexualized drug use was significantly associated with inconsistent condom use ($p=0.001$). Lower educational attainment and lower monthly income were associated with active tobacco, cannabis and methamphetamine use. Younger age and lower income were associated with injecting drug use. No sociodemographic factors were significantly associated with sexualized drug use.

Discussion: The findings demonstrate overlap between substance use and sexual health risk among MSM accessing services in Colombo. The association between sexualized drug use and inconsistent condom use suggests that sexualized substance use represents an important context for HIV and STI prevention. Socioeconomic and age-related differences in patterns of substance use further support the need for targeted interventions.

Conclusion: Integrating routine screening for substance use and sexualized drug use into MSM sexual health services and tailored harm-reduction, may strengthen the sexual health response for MSM in Sri Lanka.

Poster Presentations- Research

PPR- 01

Prevalence of HIV, Syphilis, and the Biological False-Positivity Rate of Syphilis Serology Among Pregnant Women Attending MOH Clinics in Anuradhapura District 2025

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Introduction: Elimination of mother-to-child transmission (EMTCT) of HIV and syphilis is a major global and national public health priority. Universal antenatal screening enables early diagnosis and treatment, preventing vertical transmission and reducing adverse maternal and neonatal outcomes. The STD Laboratory of the Sexual Health Clinic is the reference laboratory for pregnant women attending MOH clinics in Anuradhapura.
Objectives: To determine the prevalence of HIV, syphilis, and the biological false-positivity rate of Venereal Disease Research Laboratory (VDRL) test among pregnant women attending MOH clinics in Anuradhapura during 2025.
Methods: A descriptive cross-sectional laboratory-based study was conducted at the STD clinic Laboratory. Blood samples collected from antenatal mothers attending 218 antenatal clinics across the 22 Medical Officer of Health (MOH) areas during 2025 were transported and screened for HIV using the HIV-1/2 Ag/Ab Combo Rapid Diagnostic Test (Determine™) and for syphilis using the VDRL test (Lorne VDRL Stabilized Kit). All VDRL-reactive samples were confirmed using the Treponema pallidum Particle Agglutination (TPPA) assay (SERODIA®-TP.PA). Biological false positivity was defined as a VDRL-reactive, TPPA-nonreactive result. Data were analyzed using descriptive statistics.
Results: A total of 10,778 antenatal blood samples were screened in 2025. According to the Electronic Information Management System (EIMS) in the MCH care, 11,084 pregnant women attended as actual number for screening while the estimated number of pregnant women was 10,200. Of the actual number, 9,720 (87.7%) were screened before 12 weeks of gestation and 1,364 (12.3%) after the first trimester. A record mismatch of 296 (2.7%) was observed between EIMS and STD laboratory records. No HIV-positive pregnant women were identified (prevalence 0%). Twenty-eight samples (0.26%; 2.6 per 1,000) were VDRL reactive. Six samples were confirmed positive by TPPA, giving a syphilis prevalence of 0.056% (0.56 per 1,000). The remaining 22 samples were biological false-positive VDRL reactions, giving a biological false-positivity rate of 0.20%: 2 per 1000.
Conclusion: The prevalence of HIV and syphilis among antenatal mothers in Anuradhapura District was 0% and 0.06% (0.6 per 1,000) respectively, indicating a low disease burden. The biological false-positive VDRL rate was 0.2%; 2 per 1000 and importantly, 78.6% of VDRL reactions are false positive.

PPR-02

Determinants and Treatment Outcomes of Hepatitis B and C Among Attendees of the Central Sexually Transmitted Disease (STD) Clinic, Colombo, Sri Lanka, 2024–2026

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Background: Hepatitis B virus (HBV) and hepatitis C virus (HCV) remain important public health concerns with distinct transmission patterns and treatment pathways. In Sri Lanka, patients were traditionally managed in tertiary hospitals by gastroenterologists; however, with decentralization, STD clinics now play an increasing role in HBV and HCV management. Evaluating epidemiological patterns and treatment outcomes is essential to improve service delivery.
Methods: A cross-sectional study was conducted using records of confirmed HBV (n=44) and HCV (n=63) patients registered at the Central STD Clinic, Colombo, between 2024 and 2026. Data were extracted from clinic registers, laboratory reports and the electronic information management system.

Sociodemographic characteristics, risk factors, treatment cascade indicators, and comparative associations were analyzed.
Results: Among 107 patients, 91.6% were male, with a mean age of 35.85±11.7 years. Most were Sinhala (68.2%), followed by Muslim (26.2%). Muslim patients represented a higher proportion of HCV cases (36.5%) than the overall cohort (26.2%) and HBV cohort (11.4%). Overall, 56.1% reported methamphetamine or heroin use and 37.9% reported cannabis use. Methamphetamine/heroin use was significantly higher among HCV than HBV patients (79.4% vs. 22.7%). Injecting drug use (IDU) was strongly associated with HCV (74.6%) compared with HBV (11.4%) ($p<0.0001$). Tattooing was also more common among HCV patients (41.3% vs. 15.4%; $p=0.0258$). HBV cases showed higher prevalence of sexual risk indicators, including same-sex sexual contact (45.5% vs. 23.8%; $p=0.0205$) and a higher median annual sexual partner (2 vs. 1; $p=0.0001$). HIV co-infection occurred in 22.7% of HBV and 11.1% of HCV cases. Treatment was initiated in 70.5% of HBV patients; among non-initiators, 69.2% had no treatment indication and 30.8% defaulted. For HCV, 82.5% initiated direct-acting antiviral therapy, 64.7% completed treatment, and 75.7% achieved sustained virological response. Treatment default was associated with injecting drug use and prisoners ($p<0.05$).
Conclusion: HBV and HCV demonstrated distinct epidemiological patterns, with HCV cases strongly associated with IDU, while HBV cases had higher prevalence of risky sexual behaviors. Viral hepatitis elimination efforts require more than stand-alone clinical care and should adopt a patient-centered, integrated approach addressing mental health, substance use, STI prevention, sexual health, and social services.

PPR-03

Profile of Patients Referred to Medicolegal Assessment Following Alleged Sexual Abuse in 2025: a Retrospective Study at the Sexual Health Clinic, Anuradhapura

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Introduction: Sexual abuse is an important medico-legal and public health concern in Sri Lanka, with physical, psychological, sexual, and social consequences. The National STD/AIDS Control Programme provides sexual health and medico-legal services for individuals referred through judicial and legal pathways. Understanding the characteristics of such referrals is important for strengthening clinical services, safeguarding vulnerable populations, and planning preventive and psychosocial interventions.
Objective: To describe the characteristics of patients referred for medico-legal assessment following alleged sexual abuse to the sexual health clinic, Anuradhapura, during 2025.
Methods: A retrospective descriptive study was conducted among all 138 patients referred for medicolegal assessment following alleged sexual abuse from January to December 2025. Data were extracted using a data extraction sheet, and analyzed using SPSS.
Results: Patients age ranged from 11–83 years, with a mean age of 17.3 ± 9.7 years, median 15 years. . Approximately 39% were aged 15 years. Most were female (136, 97.8%), never married (130, 93.5%), and students (120, 86.3%). Lower-secondary education was reported in 102 (73.4%). Divisional secretariat area of the victim was documented only in 25 cases (18%) referrals. Most referrals were from Judicial Medical Officers (129, 92.8%). The interval from alleged incident to referral was unavailable in 52 cases; among 86 cases with data, it ranged from one day to 10 years. Twenty-one (24.4%) were referred within 72 hours, while 54 (62.8%) were referred after one month. Almost all were identified as victims (137,
99.3%). Alleged perpetrators were predominantly boyfriends (71, 51.4%) or other known persons (43, 31.2%). Genital examination was performed in 128 (92.8%) cases, with no genital or extragenital injuries documented. Sexual penetration was the commonest alleged offence (88, 63.8%), followed by elopement with a boyfriend (33, 23.9%). All tested negative for HIV and syphilis. Most had no identifiable STI (123, 89.1%). The perpetrator–victim age gap was available in 45 cases, ranging from 0–35 years (mean 6.93 ± 6.97)

PPR-04

Prevalence of HIV and TPPA Positivity Among Outpatient Attendees at the Anuradhapura Sexual Health Clinic in 2025

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Introduction: Sexually transmitted infections (STIs), including HIV and syphilis, remain important public health concerns requiring accessible testing, early diagnosis, and timely treatment. Sexual health services provide opportunities for infection detection among individuals seeking outpatient testing. This study assessed HIV and TPPA positivity among patients attending the Anuradhapura Sexual Health Clinic during 2025.
Objective: To determine the prevalence of HIV and TPPA positivity among newly attending clients undergoing outpatient testing at the Anuradhapura Sexual Health Clinic in 2025.
Methods: A retrospective descriptive study was conducted among 412 consecutive newly attending clients undergoing outpatient testing at the Sexual Health Clinic, Anuradhapura, in 2025. Data were extracted from the national Electronic Information Management System (EIMS), exported to Microsoft Excel, and analyzed using SPSS version 22. All clients underwent HIV and syphilis testing. HIV testing was performed using the HIV-1/2 Ag/Ab Combo Rapid Diagnostic Test (Determine™). Syphilis testing included the Venereal Disease Research Laboratory (VDRL) test (Lorne VDRL Stabilized Kit) and *Treponema pallidum* particle agglutination (TPPA) assay (SERODIA®-TP.PA). Categorical variables were summarized as frequencies and percentages, while age was summarized using the mean, standard deviation, median, and range.
Results: Among 412 clients attended for outpatient testing, 256 (62.1%) were male, 153 (37.1%) female, and sex was unrecorded for 3 (0.7%). Age was available for 403; mean age was 35.2 years (SD 13.1), median 32 years, and range 6–73 years. Of the total, 191 (46.4%) were married and living with their spouse, 56 (13.6%) single/never married, 4 (1.0%) living together, and 1 (0.2%) separated; marital status was unrecorded for 159 (38.6%). Three (0.73%) clients were HIV-positive and 409 (99.27%) HIV-negative. Eight (1.94%) had reactive VDRL results: R2 (n=2), R4 (n=1), R16 (n=1), R64 (n=2), and WR0 (n=2). TPPA was positive in 4 (0.97%) clients (2+), while 408 (99.03%) were negative.
Conclusion: Among clients attended for outpatient testing, HIV positivity was 0.73%, TPPA positivity 0.97%, and VDRL reactivity 1.94%. Routine HIV and syphilis testing in sexual health services supports early detection and timely linkage to treatment, partner services, and prevention interventions.

PPR-05

Cervical Chlamydia Trachomatis and Neisseria Gonorrhoeae PCR Positivity Among Selected Group of Female Spa Service Providers in City of Anuradhapura: A Cross-Sectional record-based Study

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Background: Female spa service providers (FSSP) may experience occupational and structural vulnerabilities that increase their risk of exposure to sexually transmitted infections (STIs), including asymptomatic infections. Spa-based sexual services are increasingly recognised as a potential setting for sexual risk behaviours. However, local data on the prevalence of curable STIs, particularly cervical *Chlamydia trachomatis* (CT) and *Neisseria gonorrhoeae* (NG), among FSSP are limited.
Objective: To determine the prevalence of cervical CT and NG PCR positivity among selected group of female spa service providers working in spas in the Anuradhapura city area.
Methods: A descriptive cross-sectional study was conducted among FSSPs invited for STD screening from 40 registered spas within Anuradhapura city. All FSSPs who attended during March–October 2024 were included. Patient records were used for data collection. Endocervical swab specimens were collected and sent for CT/NG PCR testing using the Xpert® CT/NG assay. Data were extracted from clinic records and analysed using Microsoft Excel.
Results: A total of 65 FSSP were included. The mean age among 63 participants with available age data was 32.3 years (SD 8.4), with a median age of 30 years (IQR 27.0–38.5). Uppersecondary education (Grades

10–11) was reported by 36/65 (55.4%) participants. Twenty-six (40.0%) were divorced, separated or widowed, while 25 (38.5%) were married. Most participants were asymptomatic at presentation (61/65; 93.8%). Among 62 participants with valid PCR results, 15 were CT-positive (24.2%; 95% CI 15.2%–36.2%), one was NG-positive (1.6%; 95% CI 0.3%–8.6%), and one had CT/NG coinfection (1.6%). Treatment was documented in 60% (9/15) of CT-positive participants and the single NG-positive participant.
Conclusion: Among FSSP with valid PCR results, cervical CT positivity was 24.2% (15/62; 95% CI 15.2%–36.2%), indicating a substantial burden of CT infection, despite 93.8% (61/65) being asymptomatic at presentation. NG positivity was 1.6% (1/62; 95% CI 0.3%–8.6%), with CT/NG coinfection detected in 1.6% (1/62). However linkage-to-treatment rete was 60% (9/15). These findings highlight the importance of proactive STI screening among FSSP, particularly for asymptomatic CT infection. Prevention interventions need to be strengthened among the spa settings. Larger, representative studies are needed to obtain more precise prevalence estimates.

PPR-06

Long-term Outcomes of Antiretroviral Therapy at the Anuradhapura Sexual Health Clinic: A 20-year Retrospective Cohort Study

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Introduction: Monitoring, retention, mortality, viral-load outcomes and timeliness of antiretroviral therapy (ART) initiation is important for evaluating HIV services. Evidence on long-term ART outcomes at district clinics remains limited. This study assessed patient characteristics, treatment outcomes, viral-load suppression and survival probabilities.
Objective: To describe the long-term outcomes of antiretroviral therapy at the Anuradhapura Sexual Health Clinic.
Methods: A retrospective cohort study was conducted using routinely maintained HIV records. Twenty years of available follow-up data were included, with a data cut-off date of 30 June 2026. All patients who initiated ART at clinic were eligible. Baseline characteristics and outcomes were analyzed using descriptive and time-to-event methods. Person-time was calculated from ART initiation to the recorded outcome or study closure. Kaplan–Meier methods estimated survival and retention-in-care probabilities. Viral suppression was defined as a recent viral load <1,000 copies/ml. The median interval from registration to ART initiation was calculated.
Results: Of 176 records assessed, 136 patients were eligible; 104 (76.5%) were male, 31 (22.8%) female and 1 (0.7%) transgender. At the data cut-off, 99 (72.8%) remained in care, with a mean age of 38.9±11.7 years. Baseline CD4 results were available for 125 (91.9%), with a median of 389 cells/µl (IQR: 190–551); 32 (25.6%) had a CD4 count <200 cells/µl. The median interval from registration to ART initiation was six days during the last three years. Overall, 18 (13.2%) had died, 5 (3.7%) were lost to follow-up and 14 (10.3%) transferred out. The cohort contributed 498.2 person-years of follow-up. Mortality, loss-to-follow-up and transfer-out rates were 3.61, 1.00 and 2.81 per 100 person-years, respectively, with total attrition of 7.43 per 100 person-years. Among 82 patients with recent viral-load results available at cutoff date, 75 (91.5%) were virally suppressed and 68 (82.9%) had viral loads <50 copies/ml. The Kaplan–Meier estimated 10-year survival probability was 84.3% (95% CI: 75.7–90.0%).
Conclusion: The ART cohort demonstrated high viral suppression and increasingly rapid ART initiation after scale up of 7-day or same-day policy. However, incomplete viral-load monitoring, advanced immunosuppression at ART initiation and long-term attrition remain concerns. Earlier diagnosis, systematic viral-load monitoring and strengthened retention support are needed.

PPR-07

Implementation Challenges and Health System Readiness for Long-Acting Injectable Antiretroviral Therapy in Sri Lanka: A CFIR 2.0-Based Implementation Assessment

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Introduction: Sri Lanka has a HIV programme providing antiretroviral therapy (ART) and prevention services. Long-acting injectable antiretroviral therapy (LA-ART) may reduce pill burden and address barriers to oral therapy but requires dosing, delivery, supply-chain management and patient follow-up. Assessing health-system readiness is essential before introduction.
Objective: To assess health-system readiness and identify implementation challenges for LA-ART in Sri Lanka using the Consolidated Framework for Implementation Research (CFIR) 2.0.
Methods: Mixed-methods readiness assessment 46ynthesized evidence from (1) implementation experience from a UK clinic, (2) a review of grey literature on LA-ART implementation in low- and middle-income countries, and (3) assessment of Sri Lanka's HIV care framework and infrastructure. PubMed, MEDLINE and Google Scholar were searched from April 2020 to April 2026, identifying ten eligible studies. Findings were deductively mapped to five CFIR 2.0 domains and constructs. Readiness was scored using a five-point scale (1 = severe gap; 5 = fully ready), target of 4.5/5.0. Scoring was undertaken by the principal investigator, with uncertainties discussed with the co-investigator and resolved by consensus.
Results: Overall readiness was 2.17/5.0, representing a 2.33 gap from the target. Gaps were identified across Innovation Characteristics, Inner Setting, Health Workforce and Implementation Process. Key barriers included high unit costs, limited cold-chain capacity, inadequate clinic space, limited digital appointment and missed-appointment tracking, and increases in demand. Procurement and financing had the lowest readiness score (1.0/5.0; gap 3.5), followed by workforce and task-shifting, digital appointment systems, and demand management (2.0/5.0; gap 2.5 each). Cold-chain and logistics and default tracing scored 3.0/5.0 (gap 1.5).
Conclusion: Sri Lanka has an HIV service platform that could support LA-ART integration; however, readiness gaps remain. Without system adaptation, implementation may increase missed or delayed injections, cold-chain wastage and clinic workload, while delayed dosing could increase the risk of suboptimal antiretroviral exposure and resistance.
Recommendations: A phased approach with health-system strengthening is recommended, including nurse-led injection services, regional cold-chain capacity, automated appointment and reminder systems with appointment tracing, and eligibility and demand triage. Priorities should also include strengthened pharmacovigilance and resistance monitoring, alongside a pilot to assess feasibility and refine service delivery before national scale-up.

PPR-08

Prevalence of Hepatitis B, Hepatitis C, HIV and Treponema pallidum Infection Among Clients of a Drug Rehabilitation Centre, Thaldena: A Retrospective Record-Based Cross-Sectional Study

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Introduction: People who use drugs, particularly those with a history of injecting drug use, are at increased risk of blood-borne and sexually transmitted infections, including hepatitis B virus (HBV), hepatitis C virus (HCV), HIV and *Treponema pallidum* (TP). This study describes the prevalence of these infections and selected behavioural exposures among clients of a drug rehabilitation centre in Thaldena, Badulla District.
Objective: To describe the prevalence of HBV, HCV, HIV and *Treponema pallidum* infection among clients attending the drug rehabilitation centre in Thaldena, Badulla District, from 1 May to 31 July 2026.
Methods: A retrospective record-based cross-sectional study was conducted among 363 clients who were convicted of drug-related offences. Biological samples were collected as part of routine clinic services. Selected sociodemographic and behavioural data were collected by the Sexual Health Clinic,

Badulla. Data from routine registers for 1 May–31 July 2026 were extracted and analysed using Microsoft Excel for descriptive statistics.

Results: The mean age was 30.24 ± 9.36 years (range 19–72). Injecting drug use was reported by 121 (33.3%) clients. Sharing of injecting equipment was reported sometimes by 17 (4.7%), always by 4 (1.1%), and occasionally by 2 (0.6%). Tattooing and body piercing were reported by 235 (64.7%) and 180 (49.7%), respectively. Multiple sexual partners were reported by 124 (34.2%). Never, inconsistent and consistent condom use were reported by 260 (71.6%), 64 (17.6%) and 37 (10.2%), respectively. A history of sexually transmitted disease, homosexual behaviour and sex under the influence of drugs was reported by 20 (5.5%), 53 (14.6%) and 183 (50.4%), respectively. A history of blood transfusion was reported by 21 (5.8%). HCV antibody positivity was 9.3%, while VDRL reactivity was 3.5%; all VDRL-reactive samples were TPPA positive. HIV and HBsAg positivity were 0.05% and 0.03%.

Conclusion: HCV antibody positivity and *Treponema pallidum* infection were identified among clients, alongside commonly reported behavioural exposures associated with blood-borne and sexually transmitted infections. The findings support integrating routine infection screening with drug rehabilitation services, including linkage to treatment and prevention services, harm-reduction interventions, and education on safer injecting and sexual practices.

PPR-09

Population Size Estimation of Transgender and Related Populations in Sri Lanka: A Scoping Review

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Introduction: Reliable population size estimates are required for health-service planning, resource allocation and assessment of key population programme coverage. Sri Lankan estimates have used changing terminology and population definitions, ranging from 'nachchis' within men who have sex with men to transgender women and broader self-identified transgender populations.

Objective:To map the available evidence on population size estimation of transgender and related populations in Sri Lanka and describe the definitions, methods, geographical coverage and estimates reported.

Methods: This scoping review was conducted according to Joanna Briggs Institute (JBI) methodology from inception to 01/09/2026. The results reported using Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews PRISMA-ScR. Eligible sources included peer-reviewed and grey literature published in English, that reported, population size estimate for transgender persons, transgender women, Nachchis or closely related populations in Sri Lanka. PubMed, Google Scholar, Research Gate and Sri Lanka Journals Online and also local transgender network websites were searched. Derivative words for transgender, population size estimation and Sri Lanka were used in search strategy. Linked sources were identified to prevent double-counting. Data charting was done using a well-structured form by two independent individuals and final correction were done for discrepancies in a discussion.

Results: Six documents published between 2012 and 2021 were included: one peer-reviewed article and five technical, governmental, surveillance or non-governmental reports (grey literature). Methods included geographical mapping, service and unique-object multipliers, modified Delphi consensus and general-population survey projection. A 2013 national mapping study estimated 2,693 Nachchis (range 2,335–3,051). A 2020 multi-method study estimated 2,200 transgender women (plausible range 2,000–3,500). A 2021 national survey projected 1% self-identified transgender adults aged 18–65 years. Substantial variations in operational definitions, age groups, sampling strategies, and geographic coverage were observed.

PPR-10

Microbiological Profile and Direct Gram-stain Findings of High Vaginal Swabs: A Descriptive Analysis of Patients with Vaginal Complaints

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Introduction: High vaginal swabs (HVS) are frequently submitted for microbiological investigation of vaginal discharge, antenatal screening, and other genital complaints. Interpretation of culture findings may be challenging, as potential pathogens, colonizing organisms, and normal vaginal flora may coexist. Direct Gram staining may provide additional information, particularly when culture findings are inconclusive.
Objectives: To describe the age distribution, culture profile, and direct Gram-stain findings of HVS specimens and assess microscopy in selected cultures.
Methods: A retrospective descriptive analysis was performed on HVS cultures using routine media from October 2024 to August 2026 at a laboratory in Galle. Patient age, culture results, and direct Gram-stain findings were analyzed, with particular attention to *Candida* spp., Group B Streptococcus (GBS), *Staphylococcus aureus,* and *Gardnerella vaginalis*. Gram-stain findings included pus cells, lactobacilli, yeasts, and clue cells. Mixed cultures, no-significant pathogen cultures, and no-growth cultures were also evaluated.
Results: Among 336 patients, 233 (69.3%) were aged 21–40 years and 78 (23.2%) were 41–60 years. Yeasts were cultured from 83 specimens, coliforms from 50, GBS from 49, *S. aureus* from 24, and *G. vaginalis* from 15. Mixed cultures occurred in 39 specimens, while 98 yielded no significant pathogen and 31 showed no growth. Overall direct Gram stain demonstrated pus cells in 110 (32.7%), lactobacilli in 100 (29.8%), yeasts in 68 (20.2%), and clue cells in 17 (5.1%). Yeasts were visualized in 62/83 (74.7%) yeast-culture-positive specimens, while clue cells were present in 11/15 (73.3%) *G. vaginalis*-positive specimens. Pus cells occurred in all *Gardnerella*-positive, 46/83 (55.4%) yeast-positive, 17/49 (34.7%) GBS-positive, and 12/24 (50.0%) *S. aureus*-positive specimens. Pus cells were also observed in 30/98 (30.6%) specimens with no significant pathogens and 9/31 (29.0%) with no growth. Lactobacilli were not seen in *Gardnerella*-positive cultures.
Conclusions: Direct microscopy provided useful complementary information to culture, particularly for candidiasis and bacterial vaginosis. Inflammatory cells, despite negative or non-significant cultures, highlight the limitations of routine culture in explaining vaginal symptoms. HVS evaluation should therefore integrate clinical findings with direct microscopy and culture, while access to selective culture media and other appropriate diagnostic methods should be strengthened where feasible.

Poster Presentations- Case Reports

PPC-01

When Vision Reveals More: A Case of Concurrent CMV Retinitis and Cerebellar Tuberculoma as Possible Unmasking IRIS

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Background: Development of immune reconstitution inflammatory syndrome (IRIS) is a likely possibility following commencement of ART in advanced HIV infection. Unmasking IRIS occurs when subclinical opportunistic infections (OIs) become clinically apparent as immune function recovers, particularly when ART is commenced before Ois are ruled out in advanced immunosuppression. Cytomegalovirus (CMV) retinitis and central nervous system tuberculosis can trigger unmasking IRIS, and their concurrent occurrence illustrates the complexity of managing multi-organ IRIS in advanced HIV.
Case presentation: A 29-year-old asymptomatic male was diagnosed with HIV infection and commenced on ART before his baseline CD4 count became available, which was later found to be 39 cells/mm^3. Approximately two weeks later, he developed sudden-onset, painless, progressive blurring of vision in the left eye, without systemic symptoms such as fever or neurological deficit. Fundoscopy revealed retinal whitening with granular fluffy lesions, flame-shaped and blot haemorrhages, producing a classic "bushfire" / "cheese and ketchup" appearance consistent with CMV retinitis. Intravenous ganciclovir was initiated with clinical improvement, followed by oral valganciclovir maintenance therapy. During follow-up, while receiving IV ganciclovir, he developed new-onset ataxia. Subsequent MRI revealed a small ring-enhancing lesion in the cerebellum suggestive of a tuberculoma. Cerebrospinal fluid full report was unremarkable and CSF CMV PCR, TB GeneXpert, EBV PCR, fungal studies and serum cryptococcal antigen and toxoplasma antibodies, were all negative. Despite negative laboratory findings, the radiological appearance and multidisciplinary discussion supported the presumptive diagnosis of cerebellar tuberculoma, and anti-TB therapy was initiated, with subsequent good clinical improvement.
Discussion: This case demonstrates concurrent possible ocular and neurological unmasking IRIS following ART initiation in a patient with advanced immunosuppression. It highlights that the absence of symptoms at HIV diagnosis does not exclude severe immune deficiency. Furthermore, normal cerebrospinal fluid findings despite significant radiological findings emphasize the limitations of laboratory investigations in advanced HIV and the importance of integrating clinical assessment with imaging when establishing a diagnosis.
Conclusion: Clinicians should remain vigilant for unmasking IRIS after rapid ART initiation, even in asymptomatic patients. Advanced immunosuppression may be clinically silent, and atypical presentations with inconclusive investigations require multidisciplinary assessment to facilitate timely diagnosis and optimize outcomes.

PPC-02

Sexsomnia: A Case of Sleep-Related Abnormal Sexual Behaviour Caused by Obstructive Sleep Apnoea

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Introduction: Sexsomnia, or sleep-related abnormal sexual behaviour, is a rare non-rapid eye movement (NREM) parasomnia, characterised by involuntary sexual behaviours during sleep and subsequent amnesia for the event. It is under-recognised because of embarrassment and sensitive

nature of the symptoms. Obstructive sleep apnoea (OSA) may manifest episodes though recurrent sleep fragmentation and incomplete arousals. We report a patient where sexsomnia was the presenting manifestation of an undiagnosed OSA, which resolved completely after continuous positive airway pressure (CPAP) therapy.

Case Presentation: A 54-year-old married man, body mass index of 30 kg/m^2, presented with a six-month history of recurrent sleep-related sexual behaviours, as witnessed by his wife. Episodes occurred once or twice weekly in sleep, during which he initiated sexual contact and attempted intercourse while appearing asleep, with partially closed eyes and minimal responsiveness. When awakened, he briefly regained awareness, before returning to sleep. He had complete amnesia for the events the following morning. His wife also reported loud snoring and witnessed apnoea. The patient complained of excessive daytime sleepiness (Epworth Sleepiness Scale 14/24, (normal <10/24); STOP-Bang score 5/8, (>3/8 indicates high risk for OSA)).

Overnight level I polysomnography revealed moderate OSA (apnoea-hypopnoea index (AHI) 28 events/hour - REM AHI 23 events/hour, NREM AHI 16 events/hour) with a significantly elevated arousal index of 48 events/hour. No abnormal sexual behaviours were recorded during the study. Auto-adjusting CPAP therapy was commenced, and at six-week follow-up snoring, witnessed apnoea and daytime sleepiness had significantly improved. Both patient and his wife reported complete cessation of sleep-related sexual behaviours. CPAP adherence was excellent (>90% nights with >4 hours of use) with a residual AHI of 0.7 events/hour.

Discussion: This case highlights sexsomnia as a manifestation of OSA which resolved completely after effective CPAP therapy. Recognition of this association is crucial because treatment of underlying sleep-disordered breathing, may eliminate abnormal sexual behaviours without pharmacological intervention.

Conclusion; Healthcare professionals working in sexual health should consider sleep disorders when evaluating abnormal nocturnal sexual behaviours and, where appropriate, obtain a collateral history from the bed partner. Increased awareness may facilitate earlier diagnosis, mitigate the psychosocial and relational consequences of untreated sexsomnia.

PPC-03

A Curious Case of Recurrent Urethral Bleeding in an Adolescent Male: Unmasking distal urethral varices

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Introduction: Urethral varices are an uncommon cause of urethral bleeding and may present a diagnostic challenge, particularly in adolescents. Recurrent bleeding with no obvious infective or structural cause should prompt consideration of rare vascular abnormalities. We report a case of recurrent urethral bleeding in an adolescent male subsequently diagnosed with urethral varices and successfully undergoing treatment with laser therapy.

Case Report: A 15-year-old male presented to the sexual health clinic, Chilaw with a history of recurrent bleeding from the urethral meatus. The bleeding occurred both spontaneously and following provocation such as rubbing or handling of the penis and had persisted for around a month. There was no associated dysuria, urethral itching, pain or penile swelling. He strongly denied sexual contact. He was a Grade 11 student with a background history of bronchial asthma managed with inhalers. On examination there was bleeding per urethra during milking, and a warty/ vascular like lesion at the meatus. No other abnormality was detected. Initial differential diagnoses included urethritis/urinary tract pathology and a possible urethral or meatal lesion. The clinical findings were not consistent with haematospermia. He received empirical antimicrobial treatment with cefixime and azithromycin to cover urethritis, following which the bleeding temporarily decreased but subsequently persisted. Full blood count was normal. Urinalysis showed moderately increased pus cells and occasional red blood cells. HIV and syphilis screening was negative. Ultrasound examination of the penis and scrotum demonstrated no focal lesion, although urethral pathology could not be excluded. Persistent bleeding

prompted discussion with the genitourinary surgical team, with a urethral vascular malformation or varicosity considered. The patient was subsequently diagnosed with varices at the distal urethra following cystoscopy examination and underwent endoscopic laser ablation by the urological team, with subsequent clinical improvement.
Discussion: Urethral varices are rare causes of recurrent urethral bleeding and may be missed on routine imaging. Persistent unexplained bleeding warrants consideration of vascular abnormalities and specialist evaluation.
Conclusion: Urethral varices should be considered in adolescents with recurrent unexplained urethral bleeding. Early multidisciplinary evaluation can facilitate definitive management. MRI may be required to definitively characterize suspected arteriovenous malformations.

PPC-04

Acute HIV Infection Presenting with New-Onset Seizure in a Young Male: A Case Report

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Introduction: Acute HIV infection, also known as acute retroviral syndrome, occurs shortly after acquisition of Human immunodeficiency virus and represents the period of rapid viral replication before full seroconversion. Clinical manifestations commonly include fever, lymphadenopathy, rash, pharyngitis, and myalgia. However, these symptoms are nonspecific and often misdiagnosed as other viral illnesses.
Neurological complications have been reported in acute HIV infection and may include aseptic meningitis, encephalitis, neuropathies, and rarely seizures. Early neurological involvement is believed to result from viral neuroinvasion and immune activation in the central nervous system.
This report describes a young male diagnosed with acute HIV infection after several negative antigen, antibody tests and who developed a new-onset seizure during the early stage of infection.
Case Report: A 21-year-old male presented with genital warts on 29 January 2026 and was diagnosed with HIV infection following a positive HIV-1/2 enzyme-linked immunosorbent assay, confirmed by three rapid tests. He had tested HIV negative in August 2025. His most probable exposure was unprotected insertive anal intercourse on 22 September 2025; an ELISA one month later was negative. In November, he developed genital warts and, six weeks after exposure, fever, myalgia, and cervical lymphadenopathy. Lymph node biopsy showed reactive lymphadenitis. On 22 December, he developed a generalized tonic-clonic seizure. Computed tomography, Magnetic Resonance Imaging, Electroencephalography, serum electrolytes, and glucose were normal. Lamotrigine was commenced, with no recurrence. A self-HIV test in late December was negative. In January, viral load was 18,900 copies/mL and CD4 count 380 cells/mm^3, increasing to 448 within four days without treatment. He commenced tenofovir disoproxil fumarate, lamivudine, and dolutegravir. Syphilis screening was negative.
Discussion: The temporal relationship between acute retroviral syndrome and seizure suggests possible early HIV-related central nervous system involvement. Although seizures are rare during acute HIV infection, viral neuroinvasion and immune-mediated neuroinflammation may lower the seizure threshold; however, a primary seizure disorder cannot be excluded.
Conclusion: Acute HIV infection may present despite negative window-period tests. Nonspecific systemic symptoms and rare neurological manifestations, including seizures, may occur. High clinical suspicion is essential following recent high-risk exposure.
Key words: HIV- Human Immunodeficiency virus, acute seroconversion illness, HIV neuroinvasion

PPC-05

Giant Idiopathic Esophageal Ulceration in Advanced HIV Infection: A Case Report

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Introduction: Esophageal ulcer is an important complication of advanced HIV infection. They may result from opportunistic infections, malignancies, drug-induced injury, gastroesophageal reflux disease, and nutritional deficiencies. Advanced HIV infection itself may also cause large idiopathic esophageal ulcers.
Case Report: A 32-year-old heterosexual male, who had previously worked abroad, presented with a 5month history of loss of appetite, weight loss, and intermittent dysphagia and odynophagia. He was pale and cachectic. Upper gastrointestinal endoscopy (UGIE) revealed two large deep ulcers in the distal esophagus. Esophageal biopsy showed marked inflammation with no evidence of TB, fungal, viral or malignancy etiology. CECT chest and abdomen demonstrated nonspecific changes. He was confirmed as retroviral positive with a CD4 count of 31 cells/µL and viral load of 222,000 copies/mL. Plasma CMV viral load was 474 IU/mL. Cryptococcal antigen and TB screening were negative. HSV and CMV PCR from ulcers were not performed as there were no preserved specimens.
With profound immunosuppression he was emphatically treated with IV ganciclovir for possible CMV esophagitis which was discontinued subsequently with negative histology and very low CMV viraemia. ART was initiated soon after exclusion of opportunistic infections. Nutrition referral done and follow-up UGIE was planned in 2 months. His symptoms improved dramatically after initiation of ART, and he gained 17 kg over 7 weeks.
Discussion: Common causes of esophageal ulceration among patients presenting with advanced immunosuppression include CMV, Candida, HSV, Mycobacterium avium complex, tuberculosis, and malignancy. Initially patient was emphatically treated for CMV esophagitis but absence of characteristic histology in esophageal biopsy and very low CMV viral load in blood ruled out possibility of CMV esophagitis. After excluding other possible infective etiologies and malignancy possible diagnosis of idiopathic esophageal ulceration due to advanced HIV was made. This was further supported by rapid clinical improvement of his symptoms and weight gain following initiation of ART.
Conclusion: Although rare, idiopathic esophageal ulceration needs to be considered in patients with advanced HIV presenting with dysphagia after excluding infectious and malignant causes. Profound immunosuppression may contribute to ulcer development, and prompt initiation of ART can result in rapid symptomatic improvement and substantial nutritional recovery.

PPC-06

Individualized Timing of Antiretroviral Therapy in Severe Cerebral Toxoplasmosis in Advanced HIV Infection Treated with Recommended-dose Cotrimoxazole: A Case Report

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Introduction: Cerebral toxoplasmosis is a common central nervous system opportunistic infection seen in people with advanced HIV infection. Diagnosis is frequently presumptive, based on clinical features, characteristic neuroimaging, positive Toxoplasma gondii IgG serology, and response to anti-toxoplasma therapy. Although pyrimethamine-based therapy is the preferred treatment, limited availability in resource-constrained settings necessitates alternative regimens such as cotrimoxazole.
Case Report: A 32-year-old carpenter presented with a three-month history of progressive right-sided upper motor neuron weakness, partial seizures, and expressive aphasia. He was confirmed as HIV positive, with a CD4 count of 83 cells/mm^3 and viral load of 289,000 copies/mL. Brain MRI demonstrated multiple ring-enhancing lesions involving both cerebral hemispheres and the left

cerebellum, with extensive perilesional oedema, midline shift, and impending left uncal herniation. Toxoplasma gondii IgG was positive. CMV, TB, and cryptococcal screening were negative. As pyrimethamine and sulfadiazine were unavailable, recommended-dose oral cotrimoxazole (TMP 5mg/kg, SMX 25mg/kg) was initiated twice daily. Follow-up MRI two weeks after commencement of cotrimoxazole demonstrated reduced lesion size, oedema, and reduction of midline shift, with persistent impending herniation. At four weeks, MRI showed further improvement with no new lesions; thus, ART was initiated. Six weeks after acute therapy, cotrimoxazole was continued as maintenance therapy and the patient showed marked clinical improvement and was discharged from the ward.

Discussion: The diagnosis of presumed cerebral toxoplasmosis was supported by advanced HIV infection, positive Toxoplasma serology, characteristic MRI findings, and favourable clinical and radiological response to therapy. Recommended-dose cotrimoxazole is an effective alternative to pyrimethamine-based regimens when not available. Although anti-retroviral therapy (ART) can generally be initiated 2-3 weeks after commencement of toxoplasma treatment, ART was delayed up to 4 weeks to minimize the risk of possible neurological deterioration from immune reconstitution inflammatory syndrome.

Conclusion: Cerebral toxoplasmosis should be considered in people with advanced HIV presenting with focal neurological deficits and multiple brain lesions. This case highlights that recommended-dose cotrimoxazole is an effective alternative when standard therapy is unavailable, resulting in significant clinical and radiological improvement. Prompt diagnosis, appropriate treatment, timely ART initiation, and careful monitoring are essential for optimal outcomes.

PPC-07

Beyond Pneumocystis: A Complex Case of, Tuberculosis, CMV-IRIS and Pleural Fusariosis in Advanced HIV

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Introduction: Advanced HIV infection causes profound immunosuppression, and susceptibility to multiple opportunistic infections (OI). Pneumocystis jirovecii pneumonia (PJP) is one of the commonest OI which may complicate with spontaneous pneumothorax. Although early antiretroviral therapy (ART) improves the outcome, immune reconstitution inflammatory syndrome (IRIS) may unmask occult infections or exacerbate existing infections, creating diagnostic and therapeutic challenges.

Case Presentation: A 37-year-old male recently diagnosed as pleural TB and initiated on anti-TB treatment presented with sudden onset shortness of breath and a right-sided spontaneous pneumothorax, requiring chest-drain insertion. He was subsequently diagnosed with advanced HIV infection, with a CD4 count of 6 cells/µL. Based on clinical and radiological findings, PJP treatment was initiated, resulting in significant improvement over next 2 weeks. ART was subsequently commenced. Three weeks later, he developed fever, dyspnoea, and worsening hypoxia. With marked rise in CMV viraemia from 8550 to 4,750,000 IU/mL and clinical deterioration, unmasking CMV-IRIS was suspected and Intravenous ganciclovir was initiated. Fusarium species, an opportunistic mould was also isolated from his endotracheal tube prompting intravenous voriconazole. He improved significantly over next two weeks and was discharged with a pleural vent for the slowly resolving pneumothorax and persistent bronchopleural fistula.

Discussion: Spontaneous pneumothorax in advanced HIV prompted the consideration of PJP and initiation of treatment resulted in significant improvement in the first two weeks. Previous tuberculosis diagnosed without HIV testing represented a missed opportunity for earlier HIV diagnosis and prevention of progression to profound immunosuppression. Subsequent deterioration following ART initiation, together with marked rise in CMV viraemia, supported suspected unmasking CMV IRIS with improvement following ganciclovir therapy. Concurrent pleural Fusarium infection further increased the complexity and risk of morbidity, and mortality. However timely multidisciplinary intervention contributed to a favourable outcome.

Conclusion: This case highlights the importance of early HIV diagnosis and comprehensive evaluation of OI in advance HIV. Spontaneous pneumothorax may indicate PJP in advanced HIV while clinical deterioration after ART initiation should prompt consideration of IRIS and additional infections requiring timely multidisciplinary management.

PPC-08

Genital Lichen Planus with Coexisting Vitiligo in an Elderly Male: A Case Report

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Introduction: Lichen planus(LP) is a chronic inflammatory mucocutaneous disorder that may involve the genital region and can clinically mimic sexually transmitted diseases(STDs). Vitiligo is an autoimmune disorder characterized by the destruction of melanocytes and may coexist with other dermatological and autoimmune conditions. The coexistence of genital LP and generalized vitiligo is uncommon and may pose diagnostic challenges, particularly in the assessment of genital lesions. We present a case of genital LP associated with generalized vitiligo, highlighting the importance of recognizing inflammatory dermatoses in the differential diagnosis of genital lesions.
Case Report: A 73-year-old widowed-male presented to the STD clinic with a 2–3-week history of hypopigmented penile lesions. He had type-2 diabetes mellitus treated with metformin and recently diagnosed ischemic heart disease.There was no previous history of STIs. Examination revealed scattered hypopigmented patches over the trunk and limbs. Genital examination showed a 2×2cm hypopigmented patch on the glans and a 1×4cm lesion on the dorsal penile shaft. A violaceous, band-like plaque was present over the foreskin, suggestive of LP. Dermatological assessment also suggested vitiligo. Biopsy of the penile lesion confirmed LP. He was treated with topical mometasone, with good clinical improvement. Three months Later he presented with genital warts.
Discussion: Genital LP has variable clinical manifestations and may mimic infectious or other noninfectious conditions, creating diagnostic challenges in STD clinics. Histopathology is valuable when the clinical presentation is atypical or the diagnosis is uncertain. The coexistence of LP and vitiligo may reflect shared autoimmune mechanisms involving T-cellmediated responses against keratinocytes and melanocytes, although the exact relationship remains unclear. Topical corticosteroids are the mainstay of treatment for genital LP. Management should be individualized, with regular follow-up to assess response and monitor for complications.
Conclusion: This case illustrates the coexistence of genital LP and generalized vitiligo in an elderly man. It highlights the importance of considering non-infectious dermatoses in patients presenting to STD clinics, particularly when genital lesions have atypical features. Histopathological confirmation can be valuable in establishing the diagnosis when clinical findings are inconclusive. Appropriate treatment, multidisciplinary care, and regular follow-up are important in the management of patients with coexisting inflammatory dermatoses.

PPC-09

Syphilitic Hepatitis in a HIV HBV Coinfected Patient

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Introduction: Syphilis, caused by *Treponema pallidum* is a multiorgan disease. Hepatic involvement, termed syphilitic hepatitis is a rare complication commonly reported in secondary syphilis. We report a rare case of syphilitic hepatitis in a patient with primary syphilis with HIV HBV coinfection.

Case: A 30-year-old gay man presented to the STD Clinic, Ragama, with a painless preputial ulcer of 2 days' duration. Initial syphilis serology and dark-ground microscopy were negative, but he was newly diagnosed with HIV and started on TDF+3TC+DTG. HBsAg was positive, with elevated AST (161U/L), ALT (406U/L), GGT (139U/L) and marginally elevated ALP (135U/L).
His baseline CD4 count was 628cells/microliter.
Two weeks later, he developed acute hepatitis, with VDRL R16 and positive TPPA, confirming primary syphilis. HBV serology showed total anti-HBc positivity, anti-HBe positivity, negative HBeAg, and an undetectable HBV viral load. Benzathine penicillin was deferred initially due to fever and administered once the fever subsided. At treatment, AST and ALT peaked at 1034 and 1286U/L, respectively. Hepatitis symptoms and transaminases subsequently improved, with gradual normalization over six months. Hepatitis A, C and D were excluded, and abdominal ultrasonography was normal.
Discussion: Syphilitic hepatitis is a diagnosis of exclusion and diagnosis is challenging in HIV coinfection as classic cholestatic pattern of liver injury is not observed in majority.
In our patient, mixed enzyme pattern of liver injury was initially considered to be due to hepatitis B thus, expected to improve with TDF. Rising liver enzymes and development of symptoms of acute hepatitis after initiation of TDF prompted consideration of alternative diagnosis. Viral Hepatitis(A,C,D) and drug induced liver injury were excluded. Ultrasonography excluded structural and obstructive causes. Autoimmune screening was unavailable. Improvement of symptoms as well as liver enzymes following treatment for syphilis, supported the diagnosis of syphilitic hepatitis.
Conclusion: In patients with HIV, elevated transaminases require careful evaluation to identify the underlying cause. Syphilitic hepatitis though rare may mimic HBV flare, drug/substance related hepatotoxicity, opportunistic infections and metabolic causes. Rapid normalization of transaminases following penicillin treatment supports the diagnosis and highlights the need to consider syphilitic hepatitis in unexplained liver injury, regardless of the enzyme pattern.

PPC-10

Not Every Glans Lesion Is an STI: A Recurrent Parameatal Cyst in an Adult Male- A Case report

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Introduction: Parameatal urethral cysts are rare benign lesions arising around the external urethral meatus and are usually asymptomatic. Although they may occur in adults, recurrence after simple needle drainage is uncommon and may be overlooked in patients presenting to sexually transmitted infection (STI) services. We report a recurrent parameatal cyst of the glans penis in an adult male, highlighting the importance of recognizing this condition and considering definitive treatment.
Case Report: A 24-year-old heterosexual man presented to the Central STD Clinic, Colombo, Sri Lanka, with a cystic nodular lesion on the glans penis that had been noticed for three days. He had no other STI-related symptoms but reported alteration of urinary flow. Eight months earlier, a similar lesion had developed at the same site and had been incised with a sterile needle and drained by a general practitioner, following which it resolved before recurring at the identical location. Examination showed a non-tender, cystic 2 × 1 cm lesion protruding into the external urethral meatus, without a punctum, discharge, erythema, oedema, or inguinal lymphadenopathy; STI screening was negative.
Discussion: Based on the clinical presentation, a recurrent parameatal urethral cyst was considered, with differential diagnoses including epidermoid cyst, pilosebaceous cyst, fibroepithelial polyp, and juvenile xanthogranuloma. The patient was referred to the genitourinary clinic, where the lesion was diagnosed as a urethral duplication cyst and treated by marsupialisation under subarachnoid anaesthesia. The reported case studies documents resolution after the initial needle drainage and subsequent surgical management, but does not provide a specific duration of postoperative follow-up or detailed long-term outcome. Recurrence following needle drainage is consistent with the

persistence of the cyst wall, supporting definitive surgical management for recurrent or symptomatic lesions.

Conclusion: Parameatal urethral cysts should be included in the differential diagnosis of recurrent glans lesions encountered in STI clinics, particularly when urinary-stream alteration is present. Accurate recognition can reduce anxiety and inappropriate STI-directed treatment, while recurrent or symptomatic lesions may require definitive surgical management. Careful examination and appropriate referral can facilitate timely diagnosis and treatment.

PPC-11

When Elimination Does Not Reach Everyone: Congenital Syphilis among Vulnerable Women in Sri Lanka; A Case Series

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Introduction: Sri Lanka has achieved elimination of mother-to-child transmission (EMTCT) of syphilis and continues to maintain validation. Nevertheless, congenital syphilis may still occur among women poorly reached by conventional services. We describe four mother–infant pairs presenting to the Central STD Clinic during June–August 2026.

Case Histories: All four mothers had positive urine toxicology for amphetamines or heroin; 3 of them sex workers. Engagement with antenatal care was not optimal.

Case 1: A 26-year-old primigravida, had two antenatal visits but not screened. At 37 weeks, maternal VDRL done was 1:128; She delivered a male infant with a VDRL of 1:512 and was treated for congenital syphilis.

Case 2: A 35-year-old multiparous sex worker who had no antenatal care, was escorted by a peer leader, with VDRL 1:16, and Syphilis of unknown duration, received only one treatment dose at 30 weeks of POA. Her female infant had a non-reactive VDRL on day 5, received presumptive therapy for congenital syphilis, indicated by incomplete maternal treatment and hepatitis C infection was subsequently detected in the baby.

Case 3: A 33-year-old primigravida attended one antenatal visit without syphilis screening. Syphilis was diagnosed at 31 weeks with a VDRL titre of 1:128 when she delivered preterm, but she absconded after delivery. Her female infant had a VDRL titre of 1:256 on day 8 and received presumptive treatment because the mother remained untreated.

Case 4: A 32-year-old primigravida with no antenatal visits was diagnosed with syphilis VDRL 1:128 and HIV infection at 30 weeks POA, received one dose of penicillin, and subsequently absconded. Her infant was delivered at 32 weeks and treated presumptively for congenital syphilis with VDRL 1:256 as baby was delivered within 28 days of treatment.

Discussion: These cases demonstrate a common intersection of drug use, sex-work, social instability and poor engagement with public health services, resulting in missed opportunities for screening, treatment and follow-up. They do not indicate failure of Sri Lanka's EMTCT achievement but highlight vulnerable populations at the margins of an otherwise successful elimination programme.

Conclusion: Sustaining validation requires continued surveillance and targeted strategies to identify, engage and retain women who remain outside conventional antenatal care.

PPC-12

Newly Diagnosed Hepatitis C Despite Previously Negative Serology: A Diagnostic Challenge in Distinguishing Acute Hepatitis C from Drug-Induced Liver Injury in a Patient with HIV/TB Coinfection

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Introduction: Hepatitis C is increasingly recognized as a significant cause of liver injury worldwide, particularly among individuals with high-risk sexual behaviors. In people living with HIV(PLHIV), hepatitis C infection may be asymptomatic and often presents only with elevated liver enzyme levels. Thus, reevaluation for viral hepatitis is warranted when suspicion arises, regardless of previous negative screening.
Case: We present a case of a 35-year-old MSM newly diagnosed with HIV and latent Tuberculosis. Initial CD4 count was 497 cells/microliter and HIV viral load was 347,000copies/ml. Hepatitis B s Antigen and Hepatitis C antibodies were negative. AST was 44 U/L and ALT Was 62 U/L. Mantoux showed 6mm induration with negative sputum AFB and TB GeneXpert. He was commenced on weekly Isoniazid 300mg and Rifapentine 300mg to treat latent TB. Two weeks later, TDF+3TC+DTG was initiated as antiretroviral therapy(ART).
Two months into treatment, liver enzymes rose sharply, with AST 188U/L and ALT 309 U/L, progressing to ALT 504 U/L, AST 343 U/L, and ALP 275 U/L over two weeks. TB treatment and ART were temporary discontinued due to persistent elevation in liver enzymes. However, liver enzymes showed persistent elevation despite cessation of ART and latent TB treatment. Patient was asymptomatic. Ultrasound scan abdomen was normal. Repeat testing showed negative Hepatitis B surface antigen but positive Hepatitis C antibodies, with HCV RNA of 281,000 IU/mL, suggesting hepatitis C infection.
Discussion: HIV and Hepatitis C co-infection is common among MSM. Evidence reveals hepatocellular injury caused by Hepatitis C can be accelerated in PLHIV due to compromised immune mechanisms, oxidative stress by both viruses and drug toxicities, leading to reduced spontaneous clearance and increased risk of chronic infection. Furthermore, many PLHIV may remain asymptomatic, with liver function abnormalities only detectable through serological testing. Hence, in individuals with high-risk behaviors, it is vital to perform regular screening for hepatitis C whenever there is an unexplained liver enzymes deterioration.
Conclusion: Repeated STI screening is essential for patients with high-risk sexual exposures, even when initial tests are negative, to ensure early detection and timely treatment of infections that are newly acquired while on ART.

PPC-13

Vulvar Syringoma: A rare cause of vulval papules

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Introduction: Vulvar syringoma is a rare benign adnexal neoplasm arising from intraepidermal eccrine sweat ducts. It predominantly affects young women, presenting as multiple, bilateral, skincoloured papules on the labia majora with chronic pruritus. These lesions may mimic infectious, inflammatory, and cystic vulvar disorders, causing diagnostic delay. Histopathology is the gold standard for diagnosis. We report a case presenting to an STD clinic, highlighting the importance of considering vulvar syringoma in the differential diagnosis of chronic vulvar papules.
Case Report: A 23-year-old unmarried woman presented to the STD clinic with multiple pruritic papules on both labia majora for two years, increasing in number. She also reported whitish vaginal discharge for three years. She denied sexual activity, genital ulceration, dysuria, menstrual related exacerbation, or systemic symptoms. Examination revealed symmetrical, smooth, skin-coloured papules measuring 2–5 mm over both labia majora, without tenderness or ulceration. There was no inguinal lymphadenopathy or STI evidence. Differential diagnoses included vulvar syringoma, epidermal cysts, and lymphangioma circumscriptum.
A 5-mm punch biopsy showed numerous small eccrine ducts lined by two layers of cuboidal cells, with characteristic comma- or tadpole-shaped structures in fibrous stroma, confirming vulvar syringoma.

The diagnosis was explained, reassurance given, and cryotherapy administered, resulting in symptomatic improvement.
Discussion: Vulvar syringoma is an uncommon and often under-recognised variant of syringoma due to its rarity and nonspecific appearance. Lesions are usually multiple, symmetrical, skincoloured papules affecting the labia majora, with pruritus as the most common symptom. Hormonal influences have been suggested, as symptoms may worsen during menstruation or pregnancy, although this was not observed in our patient. Differential diagnoses include epidermal cysts, lymphangioma circumscriptum, Fox–Fordyce disease, steatocystoma multiplex, condyloma acuminata, vestibular papillomatosis, and lichen simplex chronicus. Clinical differentiation is difficult; therefore, biopsy is essential. Histology typically shows numerous eccrine ducts with comma- or tadpole-shaped extensions in fibrotic dermis. This case highlights the importance of recognising non-STI causes of vulvar papules, preventing unnecessary investigations, inappropriate treatment, and patient anxiety.
Conclusion: Vulvar syringoma should be considered in young women with persistent, symmetrical, pruritic labial papules, regardless of sexual activity. Histopathology confirms diagnosis, enabling appropriate counselling, avoiding STI misdiagnosis, and preventing unnecessary interventions.

PPC-14

Genital Herpes Presenting with Labial Adhesions in an Adult Woman with Poorly Controlled Diabetes Mellitus

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Background: Genital herpes simplex virus (HSV) infection typically presents with vesicular lesions progressing to painful ulcers. Labial adhesions are an under-recognized complication. They may also result from chronic inflammation, trauma, lichen sclerosus, or hypoestrogenism. Delayed recognition permits persistent inflammation and epithelial breakdown of opposing labial surfaces, resulting in fusion. Poorly controlled diabetes mellitus may further impair healing and increase the risk of secondary infection.
Case Presentation: A 34-year-old woman with type 2 diabetes mellitus (T2DM) presented with a two-week history of vulval pruritus and vesicular lesions followed by worsening painful genital ulcers. She had initially received treatment from a general practitioner, with no documented advice regarding appropriate genital hygiene or sitz baths. Due to worsening symptoms, she was admitted to a Gynaecology ward and subsequently referred to NSACP where first episode of genital herpes was diagnosed clinically.
She was diagnosed with T2DM during her last pregnancy. A fasting blood sugar done one week prior to presentation was 328 mg/dL. At presentation, she had difficulty separating the labia, associated with an altered urinary stream. Examination revealed painful genital ulcers with significant labial adhesions causing partial obstruction of the urethral and vaginal orifices, and suspected secondary bacterial and fungal infection. Other STI screening was unremarkable. She was treated with oral acyclovir 400 mg three times a day for 7 days, antibacterials, antifungals, adequate analgesia, sitz baths, and glycaemic optimization. Blunt adhesiolysis and punch biopsy were performed under subarachnoid block to release multiple dense adhesions. Histopathology excluded lichen sclerosus. Following medical and surgical treatment, the ulcers healed completely and the adhesions were successfully released.
Discussion: This case highlights delayed or inadequate management of genital herpes at the primary care level can result in preventable complications, particularly in patients with poor glycaemic control and impaired mucosal healing. Early recognition, appropriate antiviral and supportive treatment, management of secondary infection, and timely surgical intervention resulted in favourable resolution. This underscores the importance of recognizing genital herpes and its complications.
Conclusion: Labial adhesions are rare but preventable complications of genital herpes. Early recognition, treatment, and timely referral can prevent complications and improve outcomes.

PPC-15

When the biopsy says wart, but the clinical picture makes you pause- "A Diagnostic Dilemma: Carcinoma, Giant condyloma or Buschke–Löwenstein Tumour? A Case Report

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Introduction: Genital condylomata accuminata caused by human papillomavirus (HPV) are usually diagnosed clinically. During pregnancy, hormonal and immunological changes may result in rapid enlargement of condylomata. However, rapid growth and bleeding may also raise concern for an underlying malignancy or a Buschke–Löwenstein tumour (BLT), creating a diagnostic challenge.
Case Report: A 30-year-old pregnant woman was referred by her obstetrician for assessment of a recently noticed vaginal growth. She had first noticed a small lump a few weeks earlier, which had subsequently increased rapidly in size with no previous history of genital lumps. Both her and her husband's STD screening was negative. Examination revealed a 4 × 5 cm, cauliflower-like, non-tender growth arising from the lower vagina. No other genital lumps/growths were seen on speculum examination. Significant contact bleeding was noted. Considering the rapid growth and bleeding, a biopsy was performed. Histopathology showed hyperplastic papillary exophytic squamous epithelium with marked acanthosis and hyperkeratosis, without dysplasia or malignancy, consistent with a Condylomata accuminata. Therefore, cryotherapy was started with decision to follow up and monitor.
Discussion: Rapid enlargement of genital warts during pregnancy is well recognised. However, the recent onset, being a single lump, rapid growth, large size and contact bleeding in this patient were concerning features that warranted further evaluation. Although the biopsy was reported as a Condylomata accuminata, a superficial biopsy may not adequately assess the deeper component of a large exophytic lesion. BLT is a rare, locally aggressive variant of giant condyloma that may clinically resemble an ordinary wart, while deeper tissue may demonstrate characteristic local invasion. Therefore, a benign superficial biopsy does not always completely resolve the diagnostic dilemma when the clinical behaviour remains atypical.
Conclusion: This case highlights the importance of correlating clinical behaviour with histopathological findings, particularly during pregnancy. Rapidly growing or bleeding genital lesions should prompt a low threshold for biopsy and continued clinical vigilance. When BLT or malignancy remains a concern despite a benign superficial biopsy, an adequately deep biopsy or appropriate excision may be required to exclude deeper invasion.
Key words: Buschke–Löwenstein tumour, condylomata accuminata, Vulval lesion, Pregnancy, Human papillomavirus

PPC-16

Beyond Pemphigus: Concurrent HSV-1 Infection in a Patient with Newly Diagnosed Pemphigus Vulgaris

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Introduction: Herpes simplex virus (HSV) infection can complicate pemphigus vulgaris (PV), particularly during immunosuppressive therapy, and may clinically mimic refractory or exacerbated disease. We report a case of genital HSV-1 infection in a patient with newly diagnosed PV, highlighting the importance of investigating lesions that behave differently from the underlying disease.
Case report: A 29-year-old man referred from the dermatology clinic with a six-week history of flaccid vesicles rupturing to form painful shallow ulcers involving the scalp, axillae, oral cavity and glans

penis. Pemphigus vulgaris was diagnosed clinically and supported by histopathological examination of an axillary lesion.However, direct immunofluorescence was negative for IgG, IgA and C3. He was commenced on intravenous Dexamethasone pulse therapy, followed by Mycophenolate Mofetil and Prednisolone. Scalp and axillary lesions showed significant improvement to immunosuppressants. Few oral and most penile ulcers persisted, prompting referral to the sexual health clinic. A Tzanck smear from the genital ulcer demonstrated multinucleated giant cells, and HSV-1 was detected in PCR. Screening for other sexually transmitted infections was negative. In view of the ongoing immunosuppression and persistent ulceration, treatment was challenging. A prolonged 20-day course of oral acyclovir was administered, following which the oral and penile ulcers completely healed.

Discussion: HSV infection has been reported as a poor prognostic factor in PV. Persistent lesions in PV may represent refractory disease or superimposed HSV infection. Persistent or atypical genital ulceration in patients with PV should be investigated for HSV. If HSV lesions fail to improve after 7–10 days of adequate antiviral therapy, or clinically resistant infection is seen, higher doses and repeat testing from new lesions are recommended. IVIG is an immunomodulatory option for refractory PV without further conventional immunosuppression. Suppressive antiviral therapy for recurrent disease should be considered in patients on immunosuppressants.

Conclusion: Persistent genital lesions in PV warrants evaluation for HSV, particularly when cutanious manifestations of PV are responding to immunosuppression. Virological confirmation can prevent escalation of immunosuppressive therapy and facilitate appropriate antiviral treatment. This case highlights the value of close collaboration between dermatology and sexual health services when managing persistent mucocutaneous lesions in immunosuppressed patients.

PPC-17

A Complex Presentation of Advanced HIV with Tuberculosis and Gastrointestinal Involvement

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Introduction: Tuberculosis (TB) is a common opportunistic infection in advanced HIV and may present with atypical pulmonary and extrapulmonary manifestations. Gastrointestinal TB can mimic malignancy, inflammatory bowel disease, or opportunistic infections. Worsening symptoms after initiation of antituberculosis therapy (ATT) and antiretroviral therapy (ART) should raise suspicion of immune reconstitution inflammatory syndrome (IRIS).

Case Report: A 47-year-old man from Kelaniya, Sri Lanka, with a history of intravenous drug use and sexual exposures, presented with one month of fever, weight loss, anorexia, abdominal pain, increased bowel frequency with mucoid stools, cough, haemoptysis, and headache. Examination revealed pallor, oral candidiasis, and lower abdominal tenderness. Sputum GeneXpert detected *Mycobacterium tuberculosis* with negative smear microscopy. Chest radiography was unremarkable. Four-drug ATT was commenced. Abdominal ultrasonography revealed enlarged para-aortic lymph nodes and mild ascites, suggestive of abdominal TB and raising suspicion of TB ileitis; however, no biopsy was performed for histological confirmation. No biopsy was performed at the sites. HIV was confirmed, with a viral load of one million copies/mL; baseline CD4 count was not available. Tenofovir DF, Emtricitabine, and Dolutegravir-based ART was initiated two weeks after ATT. With normal baseline liver enzymes and alkaline phosphatase, oroesophageal candidiasis was treated with fluconazole.

Two weeks after ATT, he developed severe anaemia, worsening abdominal pain, and paraaortic lymphadenopathy, with elevated ALP and LDH. MAC-IRIS was suspected. Azithromycin was added with continuation of dose-adjusted ethambutol, resulting in marked clinical improvement and resolution of fever.

Discussion: Despite ATT for confirmed pulmonary TB, post-ART deterioration was considered possibly due to paradoxical TB-IRIS or unmasking MAC-IRIS. The abdominal mass was presumed TB related; however,

worsening abdominal symptoms after ART and response to MAC therapy raised the possibility of unmasking MAC-IRIS, which cannot be excluded. Limited diagnostic facilities precluded definitive etiological diagnosis, highlighting the need for high clinical suspicion and consideration of multiple opportunistic infections.

PPC-18

Progressive Neurological Manifestations due to New CNS Lesions in Patient with HIV and Tuberculosis: A Diagnostic Dilemma

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Introduction: Neurological complications in advanced HIV infection result in diagnostic challenges due to overlapping manifestations of opportunistic infections. Cerebral toxoplasmosis and CNS tuberculosis cause seizures and ring-enhancing lesions, while TB-IRIS following ART can cause radiological worsening despite clinical improvement.
Case Presentation: A 42-year-old man presented with bilateral cervical lymphadenopathy, anorexia and significant weight loss. Fine-needle aspiration cytology confirmed tuberculous lymphadenitis, and ATT with HRZE was commenced. HIV infection was diagnosed subsequently, with a CD4 count of 12 cells/µL and viral load of 307,200 copies/mL. ART was initiated eight weeks after ATT. A few weeks later, he developed focal seizures and bilateral lower-limb weakness. CSF showed lymphocytic pleocytosis, elevated protein and low glucose, with negative GeneXpert MTB/RIF. MRI demonstrated multiple ring-enhancing lesions in both cerebral hemispheres, some with eccentric enhancing nodules. Cerebral toxoplasmosis and CNS tuberculosis were considered, and high dose cotrimoxazole was commenced. He improved clinically and repeat MRI after three weeks showed reduction in lesion size and surrounding oedema. He stopped cotrimoxazole. Eight weeks later, he presented with generalized seizures progressing to status epilepticus. MRI showed increased ring-enhancing lesions with surrounding oedema. Cotrimoxazole was restarted for presumed worsening cerebral toxoplasmosis. He subsequently developed progressive bilateral lower-limb weakness, followed by neurological improvement and recovery of power. However, follow-up imaging showed enlargement of a frontal lesion. In view of immune recovery with ART, underlying tuberculosis and clinical-radiological dissociation, paradoxical TB-IRIS with tuberculoma was considered. High-dose corticosteroids were commenced while ATT and anti-toxoplasma therapy were continued. His clinical course was also complicated by drug-induced hepatotoxicity, pancytopenia, oral candidiasis, Candida septicaemia and high CMV viraemia without retinitis, which were successfully managed.
Discussion: Initial clinical and radiological improvement supported presumptive cerebral toxoplasmosis with possible tuberculoma. Subsequent radiological progression despite neurological improvement raised the possibility of paradoxical TB-IRIS with tuberculoma rather than treatment failure.
Conclusion: Advanced HIV infection may present with concurrent opportunistic infections and complex neurological manifestations, creating diagnostic challenges. Clinical-radiological correlation, particularly when radiological progression occurs despite clinical improvement, is essential. Recognition of paradoxical TB-IRIS, treatment adherence, serial neuroimaging and multidisciplinary management are crucial for navigating such diagnostic dilemmas and successful outcomes.

PPC-19

Extensive Mucocutaneous Herpes Simplex Virus Type 2 Infection in a Renal Transplant Recipient

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Introduction: Herpes simplex virus (HSV) infection may follow a more severe and prolonged course in solid-organ transplant recipients than in immunocompetent individuals. Severe disease may require prolonged antiviral therapy.

Case report: A 45-year-old man, eight years following kidney transplantation, presented with gradually worsening multiple skin and genital ulcers of three weeks' duration. He had a one-day history of fever, five days before presentation. His medical history included type 2 diabetes mellitus, hypertension, dyslipidaemia and previous cytomegalovirus nephritis. He had been maintained on immunosuppression since transplantation and was receiving prednisolone 5 mg once daily, mycophenolate mofetil 500 mg once daily and tacrolimus 2 mg twice daily at presentation. Examination revealed multiple deep ulcers with necrotic centres involving the penile shaft, prepuce and pubic region, together with superficial ulcers over the face, chest and both shins. There was no evidence of central nervous system involvement. He was initially commenced on oral Acyclovir 400 mg three times daily and subsequently converted to intravenous Acyclovir 5 mg/kg three times daily following a positive HSV-2 PCR. HIV serology was negative. A biopsy from a shin lesion revealed mixed dermal inflammation. He required multimodal analgesia. Liver and renal functions were monitored closely. Despite a transient rise in AST to 78 U/L, serum creatinine remained stable at approximately 1.4 mg/dL. Following 14 days of intravenous Acyclovir, there was marked clinical improvement with healing of the cutaneous and genital ulcers. He was discharged on oral Acyclovir for a further week. Long-term suppressive antiviral therapy was deferred following multidisciplinary assessment, with a plan to reconsider it if recurrence occurred.

Discussion: This case highlights the potential for HSV-2 to cause extensive mucocutaneous and genital disease in a renal transplant recipient. Management required balancing effective antiviral therapy against potential Acyclovir nephrotoxicity while maintaining adequate immunosuppression to minimise graftrelated complications. Close collaboration between venereology, dermatology, nephrology and microbiology facilitated decisions regarding antiviral dosing, treatment duration and immunosuppression.

Conclusion: Disseminated HSV-2 infection should be considered in immunocompromised patients presenting with atypical genital and mucocutaneous lesions. Careful antiviral dosing and monitoring of renal and hepatic function are important, particularly in renal transplant recipients.

PPC-20

An Unusual Presentation of Erythroplasia of Queyrat in a 69-Year-Old Man: A Case Report

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Introduction: Erythroplasia of Queyrat (EQ) is a rare form of squamous cell carcinoma *in situ* affecting the glans penis and prepuce, predominantly in older men. It is considered within the spectrum of penile intraepithelial neoplasia (PeIN). The typical presentation is a well-demarcated erythematous plaque. It may also mimic other dermatological conditions. Early diagnosis and treatment are important because of its potential to progress to invasive squamous cell carcinoma. We report an atypical presentation with whitish plaques, superficial erosion, ulceration, and erythema.

Case Presentation: A 69-year-old man presented to the Dermatology Clinic of the National Hospital with a painless penile lesion of three months' duration. He had initially received topical antifungal treatment from a general practitioner (GP), but the lesion failed to resolve. Subsequently, he developed itching and excoriation. There was no bleeding or lower urinary tract symptoms. He denied genital warts or high-risk sexual behaviour. Examination revealed whitish plaques involving the glans penis, with superficial erosion, ulceration, and erythema. There was no clinical evidence of infection. The urethral meatus and scrotum

were normal, with no inguinal or generalised lymphadenopathy. A punch biopsy was performed on clinical suspicion. Differential diagnoses included EQ, squamous cell carcinoma. Histopathology demonstrated hyperkeratosis, parakeratosis, and focal full-thickness epidermal dysplasia without dermal invasion, consistent with PeIN (EQ).
The patient was referred to the Urology Clinic for further management.
Discussion: Persistent penile lesions in older men require careful assessment. EQ commonly affects the glans, prepuce, or urethral meatus. EQ may be asymptomatic or penile mimic inflammatory or infective conditions. Histopathological examination is essential to confirm the diagnosis and exclude invasive carcinoma. The atypical whitish plaque with erosion and ulceration in this patient may initially lead to antifungal treatment. Management depends on histological appearance and lesion extent. Treatment options include surgical excision, laser ablation, or topical therapies such as 5-fluorouracil or imiquimod. Close follow-up is important as recurrence may occur.
Conclusion: EQ should be considered in persistent penile lesions, particularly in older men. Early biopsy and appropriate management are essential to prevent progression to invasive penile squamous cell carcinoma.
Keywords: Erythroplasia of Queyrat; penile intraepithelial neoplasia; squamous cell carcinoma.

PPC-21

A case of non-Hodgkin B cell lymphoma presented as obstructive jaundice in a patient living with HIV

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Introduction: Lymphoproliferative disorders are important manifestations of HIV, though presenting as a retroperitoneal collection and mass causing biliary obstruction is rare.
Case Report: A 37-year-old heterosexual man was diagnosed with HIV in March 2026. One month after starting antiretroviral therapy (ART), he presented with obstructive jaundice. On admission, his CD4 count was 610 cells/µL, and his HIV viral load was undetectable.
Contrast-enhanced computed tomography (CECT) of the abdomen revealed extrahepatic biliary duct dilatation secondary to external compression by a right-side perinephric fluid collection. He was transferred to CNTH, Ragama, for the management of a suspected perinephric abscess. ART was temporarily withheld to exclude Immune Reconstitution Inflammatory Syndrome (IRIS) & due to elevated liver function tests. Tuberculosis screening was negative.
The perinephric collection was drained, and a biopsy specimen was obtained. Initial liver function tests (LFTs) were significantly deranged including high ALP & bilirubin level, whereas C-reactive protein was only marginally elevated. An external biliary drainage catheter was placed to relieve the obstruction, resulting in marked LFT improvement, after which ART was restarted.
Histopathology report revealed non-Hodgkin B-cell lymphoma with necrotic foci. Chemotherapy was initiated, and the external biliary drainage was converted to internal drainage. The patient demonstrated a favorable response to chemotherapy, with resolution of jaundice and clinical improvement.
Discussion: In this patient with HIV, antiretroviral therapy (ART) was briefly paused due to suspicion of IRIS and rapidly elevated LFTs. Diagnostic management included biliary decompression, drainage, and tissue biopsy. However, CECT of the abdomen lacked features suggestive of IRIS, such as intra-abdominal lymphadenopathy, hepatosplenomegaly, or ascites—and screening for tuberculosis was negative. Biopsy findings subsequently demonstrated a lymphoproliferative disorder, prompting the resumption of ART. Systemic chemotherapy was initiated following definitive immunohistochemical confirmation.
Conclusion: Lymphoproliferative disorders can present as obstructive jaundice in individuals living with HIV. Early biliary decompression, prompt tissue diagnosis, ART optimization, and timely chemotherapy initiation within a multidisciplinary team framework are critical to effective management.

Poster Presentations- Clinical Audits

PPA-01

Assessment of Quality of Life Among People Living with HIV at the Badulla STD Clinic: A Comparative Clinical Audit of 2025 and 2026

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Background: This clinical audit evaluated whether patient-centred improvements in HIV care at the Badulla STD Clinic were associated with measurable changes in the quality of life of PLHIV.
Objective: To compare the quality of life of PLHIV attending the Badulla HIV Clinic in 2025 and 2026, identify domains requiring further improvement, and assess the impact of service-level interventions implemented following the initial audit cycle.
Methods: 2 cycle clinical audit was conducted among 50 adult patients attending the Badulla HIV Clinic. Quality of life was assessed using validated WHOQOL-HIV questionnaire across physical, psychological, level of independence, social relationships, environmental and spiritual domains. Following the first audit cycle, a series of patient-centered interventions were implemented, including staff training, updating clinical management in accordance with current guidelines, strengthening counselling and empathetic communication, improving patient awareness, assessment of potential drug interactions, strengthening nursing care, and active follow-up of patients who had been lost to follow-up. A repeat audit was subsequently conducted to assess changes in QoL among same patients.
Results: A significant improvement in overall QoL was observed between the two audit cycles, with the mean score increasing from 7.58 in 2025 to 8.78 in 2026 ($p<0.000001$). Significant improvements were observed in physical health (14.34 to 15.60; $p=0.00035$), psychological health (14.68 to 16.10; $p<0.0001$), level of independence (13.42 to 14.46; $p=0.00014$), social relationships (13.56 to 14.00; $p=0.0148$) and environment (16.34 to 17.40; $p=0.00020$). The spirituality domain did not demonstrate a statistically significant change (6.74 to 6.60; $p=0.412$). Improvement in overall QoL was observed across both genders and all assessed age groups.
Conclusion: This comparative clinical audit demonstrated a substantial improvement in the quality of life of PLHIV attending the Badulla STD Clinic following the implementation of patient-centred service interventions. Improvements were observed in five of the six assessed WHOQOL-HIV domains, suggesting that comprehensive HIV care extending beyond ART provision may contribute to improved patient wellbeing. Strengthening empathetic communication, counselling, staff capacity, nursing care, attention to social needs and continuity of care may be important components of holistic HIV services.

PPA-02

Audit of cervical cancer screening and follow-up among women living with HIV (WLHIV) attending the STD Clinic, Ragama from 1 July 2021 to 30 June 2026

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Introduction: Women living with HIV(WLHIV) are at increased risk of cervical intraepithelial neoplasia and invasive cervical cancer. Regular cervical cytology screening facilitates early detection and treatment of premalignant lesions. This audit assessed adherence to recommended cervical cancer screening and follow-up among WLHIV attending the STD Clinic, Ragama.
Objective: To assess adherence to the recommended cervical cancer screening and follow-up guidelines at the STD Clinic, Ragama, among WLHIV from 1 July 2021 to 30 June 2026.

Methodology: The audit was conducted among WLHIV diagnosed by 31 December 2025 who were attending follow-up (n=60) at the STD Clinic, Ragama. An audit questionnaire was developed based on WHO and SLCOG guidelines. Anonymous data were collected from patients' notes and EIMS. Adherence to cervical cancer screening and follow-up was assessed according to recommended intervals, with annual screening for women with normal cytology and guideline-based follow-up for those with abnormal cytology. Women not due for screening in 2026 were excluded. Data were analyzed using descriptive statistics.
Results: The mean age was 48 years (SD,12.2). Overall, 52(86.7%) women had undergone at least one Pap smear, and 39(75.0%) had their most recent screening during 2023–2026. Of 83 Pap smears documented, 55(66.3%) reports were available with an average turnaround time of 3 months. Based on eligible screening opportunities, only 20(38.5%) women achieved 100% adherence, 14(26.9%) achieved 50–74% adherence, and 18(34.6%) achieved less than 50% adherence. Four(7.3%) available Pap smear reports showed abnormal cytology, and all women requiring further evaluation were appropriately referred. Reasons for missed annual screening were not documented in most cases(70%). Among documented reasons, patientrelated factors(10%) and temporary unavailability of Pap smear services(20%) were identified.
Conclusion: Adherence to cervical cancer screening and follow-up for WLHIV was suboptimal, with only 38.5% achieving complete adherence to recommended screening intervals. Although abnormal cytology cases were appropriately referred, gaps were identified in screening coverage, documentation, service availability, and timely reporting. Strengthening patient reminders, ensuring uninterrupted screening services, improving turnaround time for cytology reports, and documenting barriers to screening are essential to improve cervical cancer prevention among WLHIV attending the STD Clinic, Ragama.

PPA-03

Audit of Family Planning Service Provision and Contraceptive Utilization in the Nugegoda MOH Area

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Introduction: Family planning is an essential component of sexual and reproductive health, contributing to the prevention of unintended pregnancies and, through condom use, reduction of sexually transmitted infections and HIV. Ensuring the availability of contraceptive methods, appropriate service provision and follow-up is important for quality family planning services. Auditing service delivery against national standards can identify gaps and guide quality improvement.
Objective: To assess the availability, provision and utilisation of family planning services in the Nugegoda Medical Officer of Health (MOH) area against relevant national standards, assess key family planning indicators against national targets, and identify areas requiring improvement.
Methodology: A clinical audit was conducted using family planning records, service registers, stock records and electronic Reproductive Health Management Information System (eRHMIS) data from January 2025 to June 2026. Service delivery was assessed against predefined audit criteria derived from national family planning standards, such as family planning counselling, correct documentation and record keeping based on a sample of 100 records selected by simple random sampling. Availability of contraceptive methods was assessed using stock and service records. Key family planning indicators, including contraceptive prevalence rate (CPR) and prevalence of modern contraceptive method-use, were compared with national targets. Findings were used to identify areas for service improvement, and a re-audit was recommended.
Results: The audit included 17,079 eligible couples and 16,617 women of reproductive age. All assessed contraceptive methods were available throughout the audit period. Overall, 55.0% of eligible couples were reported as using a family planning method. CPR was 64.3%, compared with the national target of 66.4%, while prevalence of the use of modern contraceptive methods was 41.7%, compared with the national target of 57.2%. The family planning gap in the second quarter was 7.21% in 2025 and 7.49% in 2026. Counselling was documented in 41% of reviewed records, while follow-up documentation was present in 81%.

Conclusion: While all contraceptive methods were available, the CPR and modern contraceptive use were low compared with national targets. The audit identified gaps in record keeping and deficiencies in providing counselling services.

PPA-04

Clinical Audit of Drug–Drug Interaction Documentation and the Impact of Pharmacist Intervention among Patients Receiving Antiretroviral Therapy at the STD Clinic, Badulla

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Background: Patients living with HIV frequently receive antiretroviral therapy (ART) together with concomitant medications, increasing the risk of clinically significant drug–drug interactions (DDIs). Accurate assessment and documentation of DDIs are essential to support safe prescribing, appropriate clinical decision-making, and continuity of patient care. A clinical audit was undertaken at the STD Clinic, Badulla, to assess the quality of DDI documentation and determine the impact of pharmacist-led intervention.
Objective: To evaluate documentation of DDI assessment, identified interactions, and corresponding clinical actions among patients receiving ART, and to assess improvement following pharmacist intervention.
Methods: A two-cycle retrospective clinical audit was conducted among HIV-positive patients receiving ART who attended the STD Clinic, Badulla, from 1 January to 30 June 2026. Fifty patient records were reviewed in each audit cycle using a structured clinical audit checklist. The audit assessed documentation of DDI assessment, identified interactions, severity, clinical actions, healthcare-provider documentation, and documentation dates. Following the baseline audit, a dedicated pharmacist was requested for HIV prescription review and DDI documentation. Pharmacists were trained to use the Liverpool HIV Drug Interaction Checker, and DDI documentation was implemented in EIMS.
Results: At baseline, none of the 50 patient records had documented DDI assessment (0%). Following pharmacist-led intervention, 17 of the 50 records were classified as not applicable because DDI assessment was not required; among the 33 patients requiring assessment, documentation compliance increased to 100% (33/33). Documentation of clinically significant DDIs increased from 0% at baseline to 100% (19/19) after intervention. Appropriate clinical action for identified DDIs also increased from 0% to 100% (19/19). All three audit standards therefore achieved the predefined target of 100%. Polypharmacy was common, with 73.5% of patients receiving five or more medications. Further, highlights the importance of systematic DDI assessment and documentation.
Conclusions: Pharmacist involvement was associated with achievement of all predefined audit standards, with DDI assessment, documentation of clinically significant interactions, and appropriate clinical actions reaching 100% compliance. Pharmacists or dispensers should be trained to identify and document DDIs, with continued collaboration with other specialties. The standards achieved should be maintained through ongoing monitoring and periodic review under consultant supervision.

PPA-05

Audit of HIV Pre-Exposure Prophylaxis (PrEP) Service Delivery at the STD Clinic, Ragama

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Introduction: Pre-exposure prophylaxis (PrEP) is a highly effective biomedical intervention for preventing HIV acquisition among individuals at substantial risk of HIV infection. The National STD/AIDS Control Programme (NSACP), Sri Lanka, has expanded PrEP services as part of the national strategy to reduce new HIV infections.
Objectives: To determine compliance with PrEP service delivery standards according to the 2023 national PrEP guideline, from 1st of January to 31st of December 2025 at STD clinic Ragama.
Method: A retrospective clinical audit was conducted using paper based and EIMS records. The audit assessed adherence to recommendations given by the national PrEP guideline 2023, including Eligibility assessment, baseline HIV and STI screening, PrEP regime selection, counselling and follow-up. Data was collected from the PrEP clients attending the STD Clinic, Ragama during the period of 1st of January 2025 to 31st of December 2025. Fifty-five records were reviewed. The results were expressed as percentages.
Results: All clients (100%, n=55) met the recommended eligible criteria for PrEP. At baseline assessment HIV testing has been done for all clients (100%, n=55), while presence or absence of HIV seroconversion symptom was documented only in 63.6% (n=35). All clients have undergone Syphilis screening while hepatitis B, C, and gonorrhoea screening were performed in 70.9% (n=39), 58.2% (n=32), and 18.2% (n=10), respectively. All clients received guideline-recommended PrEP regiments. Event-driven PrEP was provided to 80.0% (n=44) and daily PrEP to 20.0% (n=11). Follow-up was documented in 67.3% (n=37). Baseline and follow-up creatinine testing were documented in 56.4% (n=31) and 32.7% (n=18), respectively. Follow up -PrEP 18.1% (n=10), Repeat HIV testing, STI screening, and counselling/condom promotion were documented in 50.9% (n=28), 32.4%, and 54.5% (n=30).
Conclusion: The audit demonstrated good compliance with PrEP eligibility assessment, baseline HIV and syphilis screening, and appropriate PrEP prescription. However, documentation of HIV seroconversion, hep B, C and gonorrhoea testing at baseline was not up to the standard. Gaps were identified in baseline and follow-up investigations, repeat HIV and STI screening, counselling. Strengthening documentation, follow-up, and adherence to recommended monitoring standards is needed to improve PrEP service delivery.

PPA-06

Audit: Evaluation of Management of Genital Herpes at STD Clinic, Ragama in 2025

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Introduction: Genital Herpes is one of commonest STI among STD clinic attendees in Sri Lanka. In 2024, Total of 2891 cases reported which is nearly one quarter of total STIs reported. Inappropriate management can lead to complications resulting in transmission and poor quality of life.
Objectives: To evaluate management of genital herpes among clinic attendees of STD clinic, Ragama in relation to National STI management guideline.
Method: This retrospective audit included all STD clinic attendees diagnosed with genital herpes in 2025 at STD clinic, Ragama. Diagnosed cases were identified from patient's health records and clinic registers. Adherence to national STI management guideline was assessed.
Results: A total of 53 patients were diagnosed to have genital herpes in 2025.
Symptom assessment and documentation was satisfactory in 98.1%(52). Documentation of complications in history was present only in 53%(28). Genital examination was performed in all

patients. However, presence or absence of complications such as secondary bacterial infections and adhesions were documented only in 52.8%(28). Tzanck smear was performed in 69.8%(37). Out of 16 patients in whom Tzanck smear was not performed, 81%(13) wasn't performed due to unavailability of laboratory staff and 3 patients refused. HSV PCR wasn't performed in any of the cases due to non-availability of the test.
Acyclovir was prescribed in all indicated patients and the dose was accurate in 100%(50). First episodes in 87%(46). Correct duration was prescribed in 98%(49). However, pain relief was documented only in 60%(33). Saline washes were documented in 90%(47). Complications were documented in 11. However, appropriate management was documented in only 9. All 5 pregnant patients (100%) were managed and documented as per national guideline. Condom promotion and abstinence during symptomatic episodes were discussed only in 36(19) %.
Conclusion: Although symptom assessment, examination, prescription of antiviral treatment and pregnancy management were satisfactory as per guideline, documentation and management of HSV related complications were found to be suboptimal. HSV diagnosis was mostly clinical due to nonavailability of laboratory staff and HSV PCR testing. Documentation of appropriate counselling was significantly lacking. We recommend regular in-service training and improve access to the laboratory diagnostic services to ensure guideline-based care.

PPA-07

HIV Care Provision at the STD Clinic, Base Hospital Panadura: A Clinical Audit

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Introduction: Comprehensive HIV care requires sustained viral suppression, monitoring of treatment, and comorbidities. Also managing opportunistic infections, sexual and reproductive health, and psychosocial wellbeing. This clinical audit assessed the completeness of HIV care documentation and identified gaps requiring quality improvement at the STD Clinic, Base Hospital Panadura.
Methodology: A retrospective clinical audit was conducted among 44 people living with HIV receiving care at Panadura STD clinic. Data were extracted using a structured audit tool covering ART initiation and adherence, virological and immunological monitoring, renal and liver function, cardiovascular and metabolic risk assessment, tuberculosis and STI screening, mental health, reproductive health, and contact tracing. Data were analysed descriptively using frequencies and percentages. Findings were compared with the National ART guideline recommendations.
Results: Among 44 patients, the mean age was 38.5 years (range 23–68 years), and 38 (86.4%) were male. Forty-two (95.5%) were diagnosed at WHO stage-1. ART initiation within four weeks was documented in 35(79.5%). Baseline viral load was documented as performed in 20(44.4%), a further 10(22.2%) had a test performed but the result was unavailable, while 14(31.1%) had no documented baseline viral load. Six-month and one-year monitoring were documented in 12(27.3%) and 34(77.3%), respectively. Renal and liver function monitoring were documented in 42(95.5%) and 41(93.2%), while diabetes and lipid screening were each documented in 40 (90.9%). No cardiovascular risk assessment was documented among patients aged over 40 years. Blood pressure and BMI were recorded in only 2(4.5%) and 1(2.3%), respectively. TB, hepatitis B, hepatitis C and syphilis screening were documented in 40(90.9%), 41(93.2%), 39 (88.6%) and 44(100%) patients, respectively. PHQ-9 assessment was documented in 9(20.5%). Among six women, cervical cancer screening was documented in three (50.0%), with annual screening in one (16.7%). Partner screening/contact tracing was documented in 32(72.7%).
Conclusion: The audit demonstrated good documentation of ART-related care, renal and liver monitoring, metabolic screening, and screening for TB, viral hepatitis and syphilis. However, significant gaps were identified in viral-load monitoring, cardiovascular risk assessment, BP/BMI documentation, mental health screening and cervical cancer screening. Standardized documentation, monitoring checklists, and regular audit-feedback cycles are recommended to improve the quality and continuity of HIV care.

PPA-08

Tuberculosis-Human Immunodeficiency Virus Bidirectional Screening Outcomes: A Clinical Audit on Collaborative Services at the Kalutara District Chest Clinic (2024–2025)

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Introduction: Tuberculosis (TB) and Human immunodeficiency virus (HIV) are well known disease entities which lead to immunosuppression in individuals and often may co-exist. Bidirectional screening for these infections is essential to reduce morbidity, mortality and to prevent spread of infection in the community.
Objectives: To evaluate compliance with national bidirectional screening guidelines for Tuberculosis and human immunodeficiency virus.
Methods: A retrospective clinical audit conducted at the Kalutara District Chest Clinic (2024–2025) of registered TB patients and PLHIV referred for TB screening registered separately. Bidirectional screening results of HIV and TB patients for TB and HIV, TB screening results for PLHIV (sputum and Mantoux tests), diagnostic outcomes (Active vs. Latent TB infectionLTBI), and clinical outcomes (cure rate, treatment completion, loss to follow-up) were analysed with SPSS version 27. The study included all TB patients registered at the clinic and PLHIV who completed TB screening.
Results: Of 1249 registered TB patients (663 in 2024; 586 in 2025), 99.2% (n=1240) completed HIV screening, and 0.4% (n=5) were HIV-positive. All HIV-positive TB patients were male; 80% (n=4) were aged 31-40. Of 26 PLHIV screened for TB (12 in 2024; 14 in 2025), 26.9% (n=7) were diagnosed with LTBI; no active TB cases were found. Among LTBI patients, 57.1% (4/7) were male and 42.8% (3/7) were aged 31-40. Regarding outcomes, 3 out of 5 HIV positive TB patients were cured and 2 out of 5 completed treatment, 6 out of 7 HIV-LTBI patients completed preventive treatment, while 1 out of 7 was lost to follow-up.
Conclusion: Patients living with HIV and latent TB infection in Kalutara district is estimated to be 55 to 135, therefore the relatively low volume of PLHIV presenting to TB screening, and loss to follow up indicates, in-clinic screening assessment such as Mantoux and sputum samples collected at HIV clinic, could possibly be effective in minimizing dropout rates. Furthermore, active screening strategies for latent TB in HIV patients are essential to promote prevention of disease transmission in the community.

PPA-09

Continuity and Quality of HIV Care at a Peripheral HIV Clinic in Eastern province, (Trincomalee), Sri Lanka: A Retrospective Quality Improvement Audit

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Background: Trincomalee District, with an estimated population of 442,745, has a cumulative reported HIV case rate of 12.2 per 100,000 population. The STD Clinic functioned without a Consultant Venereologist for approximately four years. Continuity and quality require regular clinical review, timely ART,viral load monitoring and retention in care services. This audit assessed patient characteristics, outcomes, retention and service gaps.
Methods: A retrospective cross-sectional quality improvement audit was conducted among all 54 people living with HIV(PLHIV) registered at the Trincomalee STD Clinic from 2019 to July 2026. Demographic characteristics, ART status, CD4 count, viral load monitoring, clinical outcomes, preventive care, retention and transfer status were extracted from clinic records and registers. Frequencies and percentages were calculated.

Results: Of 54 registered PLHIV, Forty-two (77.8%) were male and 12(22.2%) female, age range was 24–66 years. 16(29.6%) were registered as transferred in patients. Key population category was undocumented for 16 and unknown for 15, there were nine (16.6%) MSM, two (3.7%) commercial sex workers and one injectable drug user.

According to the entry point in ART register, 12(22.3%) patients tested following ward referrals, followed by visa screening (10,18.5%), OPD screening (7,13%), blood donor screening (3,5.5%) and ANC screening (2,3.7%). At the end of the second quarter of 2026, 47 were alive and retained in care, including 36 followed at the same clinic and 11 transferred out; five (9.3%) had died and two (3.7%) defaulted. Of 33 patients with recent viral load results, 30(83.3%) had undetectable viral loads, three (8.3%) low-level viraemia and three awaited results. Gaps were identified in baseline CD4 monitoring, hepatitis B/C screening and vaccination, cervical cancer screening, partner screening, and cardiovascular and fracture risk assessment. One patient had HIV–TB co-infection with a CD4 count of 365cells/mm^3 but was not receiving cotrimoxazole prophylaxis. Only 17(47.2%) had received one hepatitis B vaccine, and one of 12 women (8.3%) had undergone a Pap smear. Liver, renal and metabolic monitoring was consistent. Most patients were on TDF+3TC+DTG (33/36). Only three patients had regular EIMS updates over the preceding three years.

Conclusion: Important gaps remained in preventive care, laboratory monitoring, documentation and EIMS updating. Strengthening specialist oversight, standardized checklists, viral load/CD4 monitoring, preventive screening, partner services and EIMS documentation is recommended.

PPA-10

Closing the Gaps in Genital Wart Care: A Clinical Audit of Management Practices at the STD Clinic

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Introduction: Genital warts (GW) are a common sexually transmitted infection caused by human papillomavirus (HPV), requiring accurate documentation, appropriate treatment, screening for other sexually transmitted infections (STIs), counselling, and follow-up. This clinical audit assessed the quality of management and documentation of patients with GW attending the STD Clinic, Kalubowila, and identified areas for service improvement.

Objectives: To assess the quality of clinical management and documentation of patients with GW and identify gaps requiring service improvement.

Methodology: A clinical audit was conducted using records of newly diagnosed GW cases registered from 1 January to 31 December 2025. Data were extracted using a structured audit tool covering demographic characteristics, lesion documentation, STI screening, cervical cytology, treatment, treatment response, counselling, and follow-up. Findings were compared with recommendations of the National STD Management Guidelines.

Results: Among 186 patients, 126 (67.7%) were male and 60 (32.3%) females. Wart site was documented in 182 (97.8%) records, distribution in 148 (79.6%), and morphology in 42 (22.6%). Follow-up diagrams were documented in 169 (90.9%) records. HIV and syphilis screening were documented in 181 (97.3%) and 182 (97.8%) patients, respectively, while gonorrhoea screening was documented in 161 (86.6%). Cervical cytology was offered to 48/60 (80.0%) females. Provider-applied treatment was documented in 181 (97.3%), with guideline-recommended treatment options prescribed for all patients. TCA was the most frequently used treatment (115, 61.8%), followed by combined cryotherapy and TCA (55, 29.6%). Follow-up was offered at the initial and subsequent visits. Overall, 34 (18.3%) patients defaulted during the year, 15 (8.1%) changed treatment modality, and 2 (1.1%) showed no response. At three months, 53 (28.5%) achieved complete clearance and 82 (44.1%) showed reduction. Health education on the natural history of GW was documented in 171 (91.9%), while condom promotion was documented in 108 (58.1%). Partner screening was documented in 34 (18.0%) patients.

Conclusion: Management of GW was generally satisfactory regarding lesion-site documentation, STI screening, treatment, and follow-up. Gaps were identified in documentation of lesion morphology, follow-up diagrams, condom promotion, and partner screening. Standardized documentation, strengthened counselling, and regular monitoring may improve the quality and continuity of GW care.

PPA-11

Goonorrhoea Management at Anuradhapura Sexual Health Clinic (SHC): A Retrospective Clinical Audit, 2023–2026

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Introduction: Effective gonorrhoea management requires prompt antimicrobial treatment, screening for coexisting STIs, clinical examination, counselling, partner management, and follow-up, including test of cure (TOC) where indicated.
Objective: To assess the quality of gonorrhoea management at the Anuradhapura SHC against the current National STD Treatment Guidelines (2019), BASHH and WHO recommendations.
Methods: A retrospective clinical audit was conducted from 01/01/2023 to 01/06/2026 at Anuradhapura SHC. Fifty-five patients diagnosed with gonorrhoea based on smear positivity. Data were collected using a data extraction sheet and analyzed using SPSS. Descriptive statistics assessed patient characteristics, management, partner management, follow-up, and TOC.
Results: Mean age was 30.1 years (median 27; range 18–55), and 47 (85.5%) were male. Eleven (11/55; 20.0%) were MSM. Urethral discharge was the commonest presentation in males (43/55, 78.2%) and among females, only 2 had vaginal discharge. Same-day treatment was documented for all patients. Cefixime 400 mg was prescribed to 30 (54.5%) and ceftriaxone 1 g IM to 20 (36.4%); four received ceftriaxone 500 mg IM and one cefixime 800 mg. Overall, 51/55 (92.7%) regimens were compatible with national (2019) and BASHH recommendations, including the 2026 update. Chlamydia treatment was provided to 54 (98.2%), while HIV and syphilis testing were completed in 52 (94.5%) each.
Genital examination was documented in 33/54 (61.1%) evaluable records, with no extragenital examinations documented. Gonococcal culture was performed in two patients (3.6%), reflecting limited-service availability. Counselling and partner notification were documented in 23 (41.8%) and 30 (54.5%), respectively. Sexual contacts were elicited in 39 (70.9%), but treatment of at least one contact was documented in only 15 (38.5%). According to WHO 2024 guideline treatment failure patients, pharyngeal infection who were treated with Cefixime need to be offered TOC. However, TOC was not performed except for one patient.
Conclusion: The audit demonstrated high adherence to prompt treatment, chlamydia cover, and HIV/syphilis testing. However, gaps were identified in examination documentation, counselling, partner management, follow-up, and TOC. Limited culture availability was a constraint. A standardized management checklist strengthened partner and follow-up systems, improved access to culture and TOC, and regular staff training are recommended, followed by a repeat audit.

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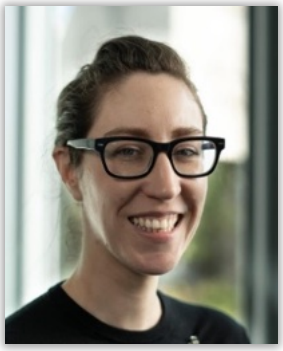
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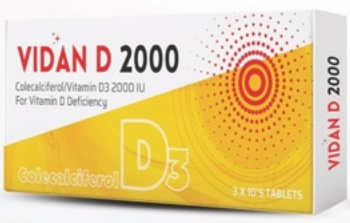


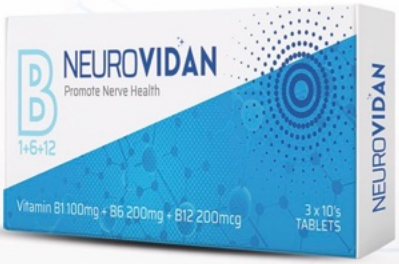




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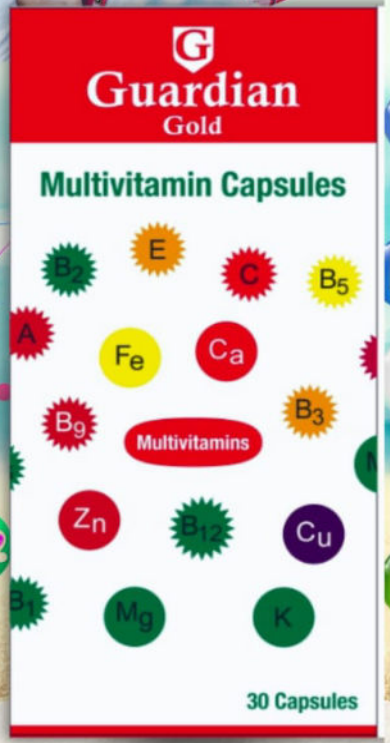
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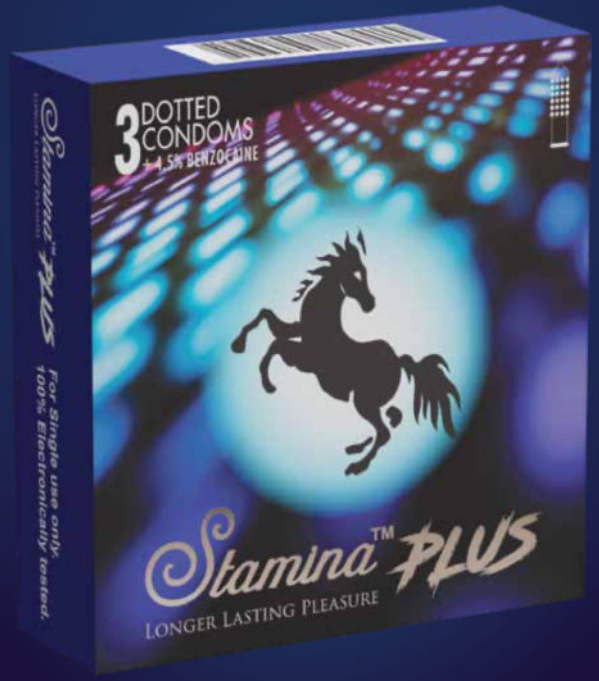
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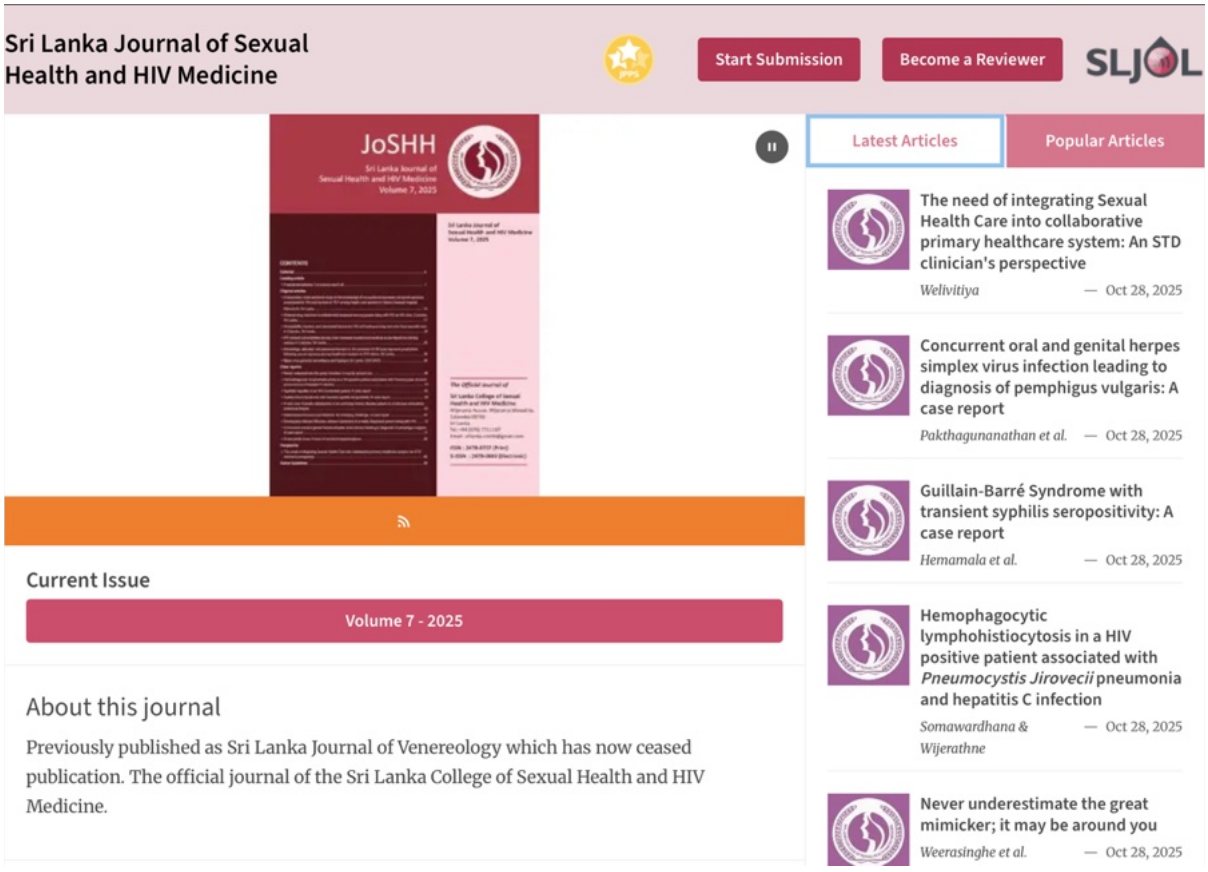
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