RETINA
SRI LANKA
ASSOCIATION OF VITREO- RETINA SPECIALISTS OF SRI LANKA

15th COLOMBO RETINA MEETING

ASSOCIATION OF VITREO RETINA SPECIALISTS OF SRI LANKA

Innovate and Educate to Advance Sri Lankan Retina Care

PROGRAMME

4th - 6th June 2026
Hotel Cinnamon Grand, Colombo,
Sri Lanka.

www.retinasrilanka.org

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15TH COLOMBO RETINA MEETING 2026

"Innovate and Educate to Advance Sri Lankan Retina Care"

PROGRAMME BOOK

04TH – 06TH JUNE 2026

Hotel Cinnamon Grand, Colombo, Sri Lanka.

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MESSAGE FROM THE PRESIDENT

ASSOCIATION OF VITREO RETINA SPECIALISTS OF SRI LANKA

Dear Colleagues and Friends,

It is with great pleasure and privilege that I welcome you to the **15th Colombo Retina Meeting (CRM 2026)**, taking place from **4th–6th June 2026 in Colombo, Sri Lanka.**

Over the years, the Colombo Retina Meeting has evolved into an important academic platform that brings together retinal specialists, ophthalmologists, researchers, trainees, and industry partners committed to advancing vitreoretinal care. As we gather for this landmark 15th edition, we do so at a time when retinal disease patterns are rapidly changing and innovations in diagnostics, imaging, pharmacotherapy, and surgical management are transforming the landscape of retinal practice worldwide.

In this dynamic environment, our responsibility extends beyond simply adopting new technologies. We must ensure that innovation is meaningful, evidence-based, accessible, and adapted to the realities of healthcare delivery in Sri Lanka. Equally important is our obligation to educate, mentor, and inspire the next generation of retinal specialists who will continue to elevate standards of patient care across the country.

This year's theme, **"Innovate and Educate to Advance Sri Lankan Retina Care,"** reflects this shared vision and commitment. Through a carefully curated scientific programme, CRM 2026 will provide opportunities to explore contemporary advances in retinal imaging, medical retina, vitreoretinal surgery, uveitis and emerging therapeutic approaches. The meeting will feature lectures, panel discussions, case-based learning, video sessions, and interactive exchanges led by distinguished national and international faculty members.

Beyond academic enrichment, this meeting represents something even more valuable — collaboration and professional unity. Progress in retinal care can only be achieved through collective effort, multidisciplinary engagement, and the open exchange of knowledge and experience. I encourage all participants to actively engage in discussions, share their insights, build new professional relationships, and strengthen existing collaborations that will continue long after the meeting concludes.

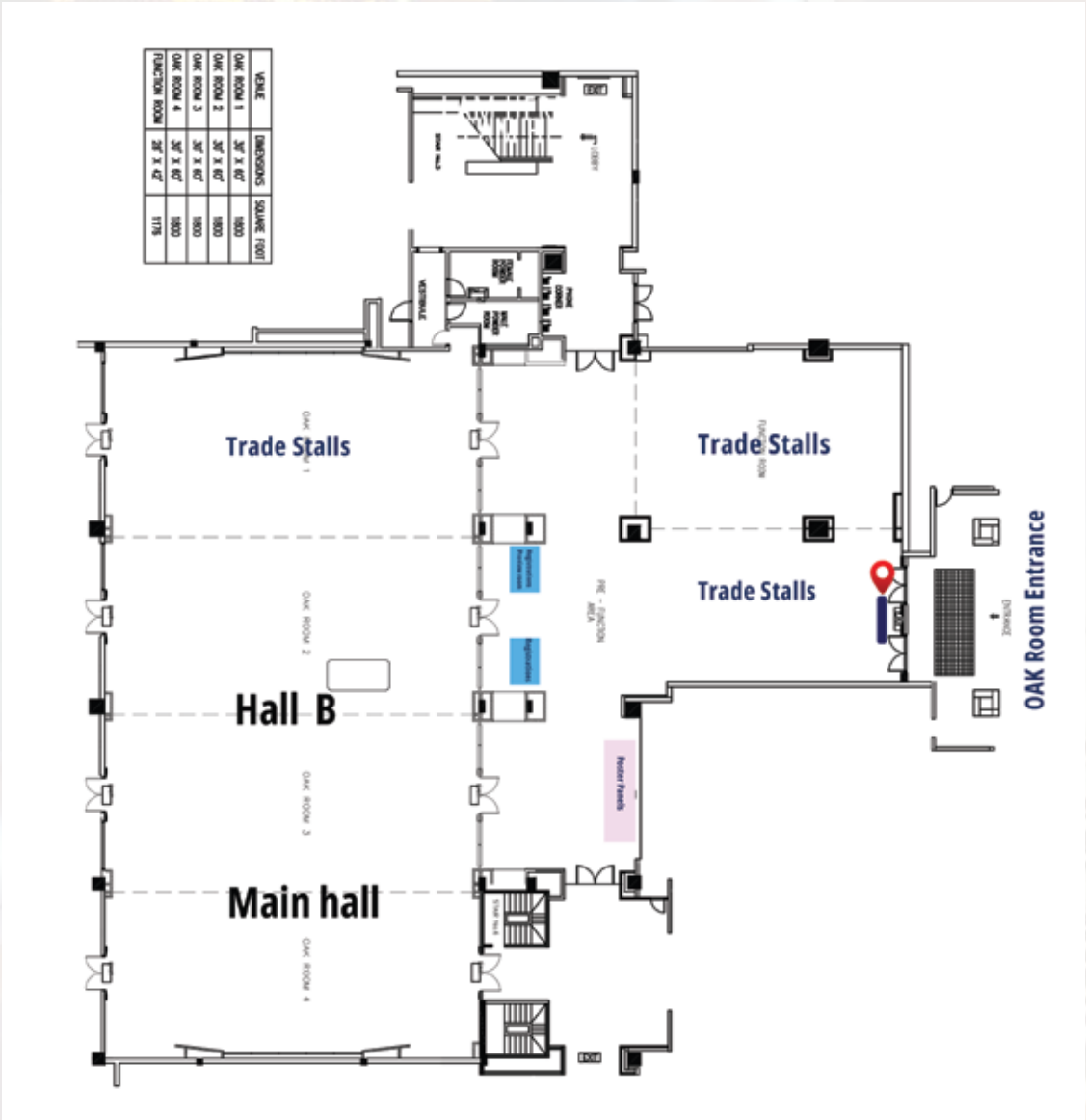
I extend my sincere gratitude to our invited faculty, organizing committee, sponsors, and all contributors whose dedication and hard work have made this event possible. Your continued support is instrumental in maintaining the high academic standards and growing international recognition of the Colombo Retina Meeting.

I look forward to welcoming you to Colombo for what promises to be an enriching and memorable scientific gathering.

With warm regards,

Dr. P. Sriharanathan
President, Association of Vitreo-Retina Specialists of Sri Lanka

CONGRESS FLOOR PLAN



COUNCIL OF THE ASSOCIATION OF VITREO RETINA SPECIALISTS OF SRI LANKA

2026 - 2027

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North Adelaide,
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Professor of Ocular Inflammation and
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Consultant Ophthalmic Surgeon
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Retinal Consultant & Chair of the
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Consultant, Vitreoretinal Surgeon
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Dr. Dilrukshi Tennekone
Consultant Rheumatologist
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Lecturer in Psychology
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Badulla

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Dr. M.I. Jayasundera
Consultant Ophthalmologist (Actg)
Teaching Hospital
Badulla

Pre-congress symposium

From Insight to Intervention: Precision Retinal Decision-Making

4th June 2026, Thursday, 8.30 a.m. – 1.00 p.m.

8.30 a.m.	**Registration**
8.50 a.m.	**National Anthem**
8.55 a.m.	**Welcome Speech** *Dr. P. Sriharanathan* *President, Association of Vitreo Retina Specialists of Sri Lanka*
9.00 a.m. – 9.15 a.m.	**Role of OCTA in retinal vascular diseases** *Dr Sumindu Edirisooriya*
9.15 a.m. – 9.30 a.m.	**Contrast-Enhanced Ultrasound in Vitreoretinal and Choroidal Disease: Seeing Beyond Media Opacity** *Prof Weng Onn Chan*
9.30 a.m. – 9.45 a.m.	**Diagnostic vitrectomy and retinal biopsy** *Dr Kapila Bandutilake*
9.45 a.m. – 10.00 a.m.	**Integrating Clinical cues and Investigations for diagnosing challenging retinal cases** *Dr. Dushyantha Wariyapola*
10.00 a.m. – 10.15 a.m.	**Cognitive bias, critical thinking, case-based analysis** *Dr. Dulmini Perera*
10.15 a.m. – 10.35 a.m.	**Panel Discussion**
10.35 A.M. – 10.55 A.M.	**TEA**
10.55 a.m. – 12.55 p.m.	**How I did it? Maximizing constellation vitrectomy machine -A video-based Panel discussion** **Moderator:** *Dr P. Sriharanathan,* **Panelists:** *Prof. Weng Onn Chan, Dr. Perfecto Cagampang III, Dr. Charith Fonseka, Dr. Mangala Dhanapala, Dr. Kapila Bandutilake*
12.55 p.m.	**Vote of Thanks** *Dr. K. Niruththan* *Secretary, Association of Vitreo Retina Specialists of Sri Lanka*
1.00 P.M.	**LUNCH**

15TH COLOMBO RETINA MEETING 2026

CEREMONIAL INAUGURATION

Thursday, 4th June 2026 at 7.00 p.m.
The Oak Room, Cinnamon Grand Hotel, Colombo

PROGRAMME

7.00 p.m. **Invitees take their seats**

7.05 p.m. **Arrival of the Chief Guest**

7.10 p.m. **Ceremonial Procession**

7.15 p.m. **National Anthem**

7.25 p.m. **Traditional Lighting of the Oil Lamp**

7.30 p.m. **Welcome Address**
Dr. P. Sriharanathan
President, Association of Vitreo Retina Specialists of Sri Lanka

7.35 p.m. **Address by the Guest of Honour**
Prof. Andrzej Grzybowski
Professor of Ophthalmology
University of Warmia and Mazury
Olsztyn, Poland

7.40 p.m. **Address by the Chief Guest**
Hon. Justice Dr. Sobhitha Rajakaruna
Justice of the Supreme Court of Sri Lanka

7.50 p.m. **Presidential Address**
Dr. P. Sriharanathan
President, Association of Vitreo Retina Specialists of Sri Lanka

8.20 p.m. **Vote of Thanks**
Dr. K. Niruththan
Secretary, Association of Vitreo Retina Specialists of Sri Lanka

8.30 p.m. **Fellowship**

15TH COLOMBO RETINA MEETING 2026

5TH JUNE 2026 / OAK ROOM, CINNAMON GRAND HOTEL, COLOMBO

07.55 a.m. **Welcome speech**
Dr. P. Sriharanathan,
President, Association of Vitreo Retina Specialists of Sri Lanka

08.00 A.M. – 10.00 A.M. MASTERING THE MACULAR EDEMA SPECTRUM SESSION 01

Chairpersons: *Dr. P. Sriharanathan, Dr. Prabha Samarakoon*

08.00 a.m. – 08.12 a.m. **Initiating Treatment in Treatment-Naïve DME:**
Dr. Lalantha Gurusinghe

08.12 a.m. – 08.24 a.m. **When the Second Generation Fails: Outcomes of Switching Between Faricimab and Aflibercept 8mg**
Prof. Weng Onn Chan

08.24 a.m. – 08.36 a.m. **Surgical options in DME**
Dr. Mangala Dhanapala

08.36 a.m. – 08.48 a.m. **Systemic Factors in DME: Practical FAQs**
Dr. Shani AD Mathara Diddhenipothage

08.48 a.m. – 09.00 a.m. **Same Edema, Different Disease: Diabetic vs RVO Macular Edema in Real-World Practice**
Dr. P. Sriharanathan

09.00 a.m. – 09.12 a.m. **Non-Vasogenic Cystoid Maculopathies: Beyond Leakage**
Dr. David Sarraf

09.12 a.m. – 09.24 a.m. **Postoperative Cystoid Macular Edema: Prevention and Management**
Dr. K.R. Dayawansa

09.24 a.m. – 10.00 a.m. **Panel discussion**

10.00 AM – 10.30 AM TEA / OPENING OF TRADE EXHIBITION / VIEWING POSTERS AND PHOTOGRAPHS

10.30 A.M. – 11.30 A.M. **COLLEGE KEYNOTE LECTURE**
Artificial Intelligence and the Retina: Update 2026
Prof. Andrzej Grzybowski
M.D., Ph.D., MBA
Professor of Ophthalmology and Chair of the Department of Ophthalmology,
University of Warmia and Mazury,
Olsztyn, Poland

11.30 A.M. – 12.30 P.M.	VRSI SYMPOSIUM – SURGICAL CHALLENGES IN VITREORETINAL SURGERIES	SESSION 02

Chairpersons: *Dr. Mahesh Gopalakrishnan, Dr. Naresh Babu, Dr. Simar Rajan Singh*

11.30 a.m. - 11.50 a.m. **Nuances in VR surgeries in Proliferative Diabetic Retinopathy**
Dr. Mahesh Gopalakrishnan

11.50 a.m. - 12.10 p.m. **Amniotic Membrane Grafts in Retinal surgeries**
Dr. Naresh Babu

12.10 p.m. - 12.30 p.m. **Lens sparing Vitrectomy in Stage 4 ROP**
Dr. Simar Rajan Singh

12.30 P.M. 01.15 P.M.	ALLERGAN SPONSORED LUNCH SYMPOSIUM INTRAVITREAL STEROIDS IN PRACTICE

Chairpersons: *Dr. Mangala Dhanapala, Dr. Chamara Kumarage*

12.30 p.m. - 12.50 p.m. **Intravitreal Dexamethasone implants in DME**
Dr. Aditya Sudhalkar

12.50 p.m. - 01.02 p.m. **Ozurdex in Practice – A Sri Lankan perspective**
Dr. Chamara Kumarage

01.02 p.m. – 01.15 p.m. **Panel discussion**

01.15 P.M.	LUNCH

02.00 P.M. – 03 .00 P.M.	FREE PAPERS	SESSION 03

Chairpersons: *Dr Nisala Attapattu, Dr Sumindu Edirisooriya*

02.00 p.m. – 02.07 p.m. **Artificial Intelligence (AI) Guided monitoring of Retinal Layers in Optical Coherence Tomography (OCT) in Clinical Practice.**
JM Owin Vindula, DMMDB Dhanapala, UHCA Madushanka, Manul Gunarathne, DSSP Yapa, Danilka Akarawita, Yehan Sajana

02.07 p.m. – 02.14 p.m. **Comprehensive Digital Transformation of an Ophthalmology Unit: Impact on Workflow, Efficiency, and Patient Care**
Shehani Bandara, Amali Samarathunga, Lasitha Athapaththu, Nethmi Nettikumara, Rasheeka Ranasinghe, Chamara Kumarage

02.14 p.m. – 02.21 p.m. **Intravitreal Dexamethasone in Macular Edema – An Observational Case Series**
K Niruththan

02.21 p.m. – 02.28 p.m.	**Fibrovascular stage predicts visual outcomes following vitrectomy for PDR: A prospective cohort study** *DMMDB Dhanapala, Robert Casson, MP Piyasena, PFSC Fonseka, G Gunawardena, UHCA Madushanka, KAMC Gunaratne, JMO Vindula, DSSP Yapa, Jagjit Gilhotra, U Senarath*
02.28 p.m. – 02.35 p.m.	**Rethinking Ocular Toxoplasmosis Treatment: Intravitreal Clindamycin in Sri Lankan Practice** *KC Batuwangala, P Sriharanathan*
02.35 p.m. – 02.42 p.m.	**Occupational exposure to Formalin and associated health effects among Operation theatre staff** *Nethmi Nettikumara, AP Samaratnga, ADLS Athapaththu , HMSD Bandara, RAR Ranasinghe, KLGD Senali, CJ Kumarage*
02.42 p.m. – 02.49 p.m.	**Retinal Red Herrings: Inflammation in Vascular Clothing** *K Niruththan , N Nanayakkara, MI Jayasundara, D Gunasekara*
03.00 P.M. – 03 .30 P.M.	**PLENARY LECTURE** **Intra ocular Lenses: dots and the Haze-what happens over time in IOL** *Dr. Perfecto Cagampang III*
03.30 p.m. – 04.15 p.m.	**RAPID FIRE – RETINA QUIZ** *Dr. K. Niruththan*
04.15 p.m. – 05.00 p.m.	**HOMEGROWN INNOVATIONS IN RETINA SURGERY** *Dr. P. Sriharanathan*

15TH COLOMBO RETINA MEETING 2026

6TH JUNE 2026 / OAK ROOM, CINNAMON GRAND HOTEL, COLOMBO

07.00 A.M. – 07. 40 A.M. BAYER SPONSORED BREAKFAST SYMPOSIUM – AMD : FOCUS ON EYLEA

Chairpersons: *Dr Ayasmantha Peiris, Dr Wathsala Gunasekara*

07.00 a.m. – 07.12 a.m. **OCT Biomarkers in AMD: From Diagnosis to Decision-Making**
Dr. Ayasmantha Peiris

07.12 a.m. – 07.24 a.m. **Polypoidal Choroidal Vasculopathy: Dye - Non-Dye based diagnosis**
Dr. Wathsala Gunasekera

07.24 a.m. – 07.36 a.m. **Neovascular AMD: Emerging Therapies and Evolving Strategies**
Dr. Kapila Bandutilake

07.36 a.m. – 07.50 a.m. **Q&A**

08.00 A.M. – 10.00 A.M. POSTERIOR UVEITIS – DIAGNOSIS TO THERAPY SESSION 04

Chairpersons: *Dr Mirna Kumaradas, Dr Kapila Bandutilake*

08.00 a.m. – 08.12 a.m. **Posterior Uveitis: A Structured Clinical Assessment**
Dr. P. Sahila

08.12 a.m. – 08.24 a.m. **MMI in Posterior Uveitis: Beyond the Basics**
Dr. Manishka Jayasundera

08.24 a.m. – 08.36 a.m. **Intermediate Uveitis: Practical Diagnosis and Management Strategies**
Dr. Lija Gajalaksan

08.36 a.m. – 08.48 a.m. **Spotlight on VKH**
Dr. Mirna Kumaradas

08.48 a.m. – 09.08 a.m. **Parasitic Uveitis**
Prof. Carlos Pavesio

09.08 a.m. – 09.20 a. m. **Intravitreal Steroids in Posterior Uveitis – Current practice**
Dr. Aditya Sudhalkar

09.20a.m. – 09.32 a.m. **Targeted Non-Steroidal Therapies for Posterior Uveitis – a rheumatologist's perspective**
Dr. Dilrukshi Tennekone

09.32 a.m. – 10.00 a.m. **Q & A**

10.00 AM – 10.30 AM	**TEA**	
10.30 A.M. – 12.30 P.M.	**RETINAL DETACHMENT**	**SESSION 05**

Chairpersons: *Dr. Saliya Pathirana, Dr. K.A. Salvin*

10.30 a.m. – 10.42 a.m.	**Macular Subretinal Fluid: A Practical Diagnostic Algorithm** *Dr. Duleepa Baranage*
10.42 a.m. – 10.54 a.m.	**Preoperative imaging biomarkers in RRD** *Dr. K. Niruththan*
10.54 a.m. – 11.06 a.m.	**Inferior Retinal Detachment: Challenges and Surgical Solutions** *Dr. Mahesh Gopalakrishnan*
11.06 a.m. – 11.18 a.m.	**Giant Retinal Tear: Current Management Strategies** *Dr. K.A. Salvin*
11.18 a.m. – 11.30 a.m.	**Encircling Bands in RD Repair: Principles and Practice** *Dr. Charith Fonseka*
11.30 a.m. – 11.42 a.m.	**PVR and MTX in management of RRD** *Dr. Naresh Babu*
11.42 a.m. – 11.54 a.m.	**Retinal Detachment in Pathological Myopia: Evolving Approaches** *Dr. Mangala Dhanapala*
11.54 a.m. – 12.30 p.m.	**Panel discussion**
12.30 P.M. – 1.15 P.M.	**ELSHADDI SPONSORED LUNCH SYMPOSIUM – INDIRECT LASER**

Chairperson: *Dr. P. Sriharanathan, Dr. K.R. Dayawansa*

12.30 p.m. – 12.50 p.m.	**PATTERN LIO HAS ARRIVED** *Dr. Paul Runge*
12.50 p.m. – 1.15 p.m.	**Panel discussion**
01.15 P.M. – 02.00 P.M.	**LUNCH**

02.00 P.M. – 03.00 P.M.	POSTER PRESENTATION	SESSION 06

Chairpersons: *Dr. Lalantha Gurusinghe, Dr. Lija Gajalaksan*

03.00 p.m. – 04.00 p.m.	PEDIATRIC RETINA	SESSION 07

Chairpersons: *Dr. Hemamali Senevirathne, Dr. Aruna Fernando*

03.00 p.m. – 03.12 p.m. **Pediatric Retinal Detachment: Unique Challenges and Management**
Dr. Paul Runge

03.12 p.m. – 03.24 p.m. **Retinopathy of Prematurity: Updated Classification and Clinical Relevance**
Dr. Tavisha Udupihille

03.24 p.m. – 03.36 p.m. **Paediatric Coats Disease: Diagnosis and Evolving Management**
Dr. Simar Rajan Singh

03.36 p.m. – 03.48 p.m. **Visual Rehabilitation in the Blind Child: Restoring Function Beyond Vision**
Dr. Mangala Dissanayake

03.48 p.m. – 04.00 p.m. **Q & A**

04.00 P.M. – 05.00 P.M.	VIDEO SYMPOSIUM	SESSION 08

Moderators: *Dr. K.A. Salvin, Dr. Duleepa Baranage*

5.00 P.M. **AWARDING CEREMONY, CLOSING REMARKS**

SUMMARIES OF THE PRESENTATIONS

Contrast-Enhanced Ultrasound in Vitreoretinal and Choroidal Disease: Seeing Beyond Media Opacity

Prof Weng Onn Chan

Contrast-enhanced ultrasound (CEUS) uses lipid-coated microbubbles to visualize the retinal and choroidal microcirculation in real time. This talk reviews its growing role across posterior segment disease — differentiating choroidal melanoma, hemangioma and metastasis by characteristic enhancement patterns; identifying retinal and choroidal detachments and their associated haemorrhage; and distinguishing detachment from benign mimics such as degenerative retinoschisis and posterior vitreous detachment. We will present illustrative cases, a practical scanning protocol, and the current limitations of ocular CEUS.

Cognitive bias, critical thinking, case-based analysis

Dr. Dulmini Perera

In today's fast-paced clinical environment, our internal responses significantly affect our work. For specialists, ongoing stress, time constraints, and the pressure to be accurate influence how we interpret situations. When fatigued or under pressure, we may make quick judgments or revert to familiar patterns without realizing it.

These internal processes are ongoing and interconnected. Our thoughts, reactions, and interpretations work together to guide our attention and decisions. Under pressure, our focus narrows, first impressions become stronger, and it becomes more difficult to examine alternative perspectives.

Awareness of these patterns can bring a meaningful difference. Taking a brief time to pause and reflect brings clarity, decreases errors, and supports better decisions. In a demanding healthcare environment, this awareness is necessary for maintaining professional effectiveness and personal mental health.

Initiating Treatment in Treatment-Naïve DME:

Dr. Lalantha Gurusinghe

Diabetic macular edema (DME) is a major cause of vision loss in diabetic retinopathy. In treatment-naïve, center-involving DME, anti-VEGF therapy remains first-line, particularly when BCVA is ≤20/30 or OCT central retinal thickness is ≥300 µm, and treatment should not be delayed for systemic optimization.

Key trials established aflibercept, ranibizumab, bevacizumab, and faricimab as effective options, with aflibercept offering greater benefit in poorer baseline vision and faricimab or high-dose aflibercept enabling longer treatment intervals with comparable efficacy.

Steroid implants are useful early alternatives in selected patients, especially those who are pseudophakic, vitrectomized, or unsuitable for anti-VEGF therapy. Focal laser remains appropriate for focal-leakage DME, while rescue laser may support mixed-pattern disease.

Management should begin with OCT-based confirmation and classification of the edema pattern. Diffuse or mixed DME is typically treated with loading anti-VEGF injections followed by treat-and-extend, whereas focal DME may be managed with focal laser with or without anti-VEGF. Non-responders may require switching agents or steroid implantation.

In conclusion, treatment-naïve DME is best managed with a phenotype-guided, evidence-based strategy centered on anti-VEGF therapy, with longer-acting agents and steroid implants helping reduce burden in selected patients while preserving visual outcomes.

When the Second Generation Fails: Outcomes of Switching Between Faricimab and Aflibercept 8mg

Prof. Weng Onn Chan

Faricimab and aflibercept 8mg have raised expectations for durable disease control in neovascular AMD and DMO; but a subset of eyes still fail to extend on either agent. What happens when these eyes are switched to the other second-generation drug? This clinical audit reports outcomes in a cohort of 49 patients who failed one second-generation anti-VEGF, defined by repeatedly failed extensions, and were subsequently switched between faricimab and aflibercept 8mg in either direction. Treatment interval, anatomical response and visual outcomes are presented, with attention to which eyes appear to benefit from a further second-generation switch versus those in whom alternative strategies should be considered.

Systemic Factors in DME: Practical FAQs

Dr. Shani AD Mathara Diddhenipothage

Diabetic macular oedema (DME) is not purely a retinal condition, however, an end-organ consequence of systemic metabolic dysregulation. Despite advances in intravitreal therapy, treatment outcomes remain suboptimal when underlying systemic drivers are left unaddressed. This section explores frequent clinical questions at the crossroads of endocrinology and ophthalmology, utilizing contemporary evidence to inform collaborative management of DME in clinical settings.

We explore the impact of glycaemic control on DME incidence, including the important phenomenon of early worsening of diabetic retinopathy (EWDR) following rapid HbA1c optimization, affecting 10–20% of patients within three to six months of intensification and up to 40% in those with advanced retinopathy at baseline. A practical three-tier risk stratification framework for EWDR is discussed. The roles of hypertension, dyslipidaemia (with particular focus on fenofibrate and the ACCORD-Eye and FIELD trial data), diabetic nephropathy, and obstructive sleep apnoea as independent modifiable risk factors of DME are discussed, alongside evidence-based targets and co-management pathways.

Finally, the national diabetes prevalence is recorded at 10.2% (IDF 2024), yet this statistic probably underrepresents the true impact, since the SLHAS indicates a crude diabetes prevalence of 23% among adults, emphasizing the overlooked burden due to the absence of a comprehensive national screening Program.

Same Edema, Different Disease: Diabetic vs RVO Macular Edema in Real-World Practice

Dr. P. Sriharanathan

Macular edema secondary to retinal vein occlusion (RVO-ME) and diabetic macular edema (DME) may share overlapping OCT appearances, yet their biological behavior, diagnostic complexity, and functional outcomes differ substantially. This presentation explores the contrasting clinical behavior of these two common retinal vascular entities. RVO-ME typically behaves as an acute vascular event with sudden onset, territory-based edema, and a predominantly VEGF-driven response, often demonstrating rapid anatomical and visual improvement following anti-VEGF therapy. In contrast, DME represents a chronic metabolic microangiopathy characterized by persistent blood-retinal barrier dysfunction, inflammation, neurodegeneration, and variable treatment responsiveness.

Special emphasis is placed on the differing correlation between central retinal thickness (CST) and visual acuity (VA). While CST reduction in RVO-ME frequently parallels visual recovery, DME often demonstrates structure–function dissociation due to chronic retinal damage. The presentation also highlights important diagnostic distinctions, including the broader differential diagnosis of RVO such as retinal vasculitis, retinal arterial macroaneurysm, ocular ischemic syndrome, and hyperviscosity states. Practical OCT biomarkers, ischemic considerations, bilaterality patterns, and treatment implications are discussed to provide a clinically oriented framework for differentiating and managing these two major causes of macular edema.

Postoperative Cystoid Macular Edema: Prevention and Management

Dr. K.R. Dayawansa

Pseudophakic cystoid macular edema (PCME) remains one of the commonest causes of suboptimal visual recovery following cataract surgery. Although the incidence of angiographic or OCT-detected macular edema may be relatively high, clinically significant visual impairment is uncommon, leading to underdiagnosis in routine practice. Nevertheless, when visually significant PCME occurs, it becomes a distressing complication for both the surgeon and the patient following an otherwise successful cataract procedure.

PCME typically presents between four to six weeks after surgery, with the peak incidence occurring around the sixth post-operative week. Patients usually complain of reduced or distorted central vision despite an apparently quiet anterior segment and a well-positioned intraocular lens. Optical coherence tomography (OCT) of the macula plays a pivotal role in confirming the diagnosis and should be considered in patients presenting with unexplained poor visual recovery between four and eight weeks after cataract surgery.

The routine use of prophylactic topical non-steroidal anti-inflammatory drugs (NSAIDs) for all cataract patients remains controversial. Current evidence suggests that prophylactic therapy may be more beneficial in high-risk groups rather than universally administered. Patients with diabetes mellitus, uveitis, retinal vascular disease, epiretinal membrane, or complicated cataract surgery are at increased risk of developing PCME and may benefit from preventive treatment strategies.

Importantly, the majority of PCME cases resolve spontaneously with good visual outcomes. Only persistent or resistant cases require intensive medical or interventional treatment. Awareness of the condition, identification of high-risk patients, and timely OCT evaluation are essential to optimize post-operative visual outcomes while avoiding unnecessary prophylactic treatment in low-risk individuals.

Artificial Intelligence and the Retina: Update 2026

Prof. Andrzej Grzybowski

Artificial intelligence (AI) is rapidly transforming the diagnosis and management of retinal disorders. Using advanced machine learning and deep learning algorithms, AI systems can analyze retinal images—such as fundus photographs and optical coherence tomography (OCT) scans—with high accuracy and speed. These tools are particularly valuable in detecting common conditions like diabetic retinopathy, age-related macular degeneration, and retinal vein occlusion at early stages, often before symptoms become clinically apparent. AI-based screening programs have demonstrated performance comparable to, and sometimes exceeding, that of human specialists, making them especially useful in large-scale population screening and in regions with limited access to ophthalmologists. Automated systems can triage patients, prioritize urgent cases, and reduce the burden on healthcare systems.

Beyond diagnosis, AI is increasingly used for disease monitoring and prognosis. Predictive models can estimate disease progression and treatment response, supporting personalized medicine approaches. AI also aids in clinical decision-making by integrating multimodal data, including imaging, genetics, and clinical records.

Despite its promise, challenges remain, including data quality, algorithm transparency, regulatory approval, and ethical concerns. Overall, AI represents a powerful tool that is reshaping retinal care by improving efficiency, accessibility, and clinical outcomes.

Nuances in VR surgeries in Proliferative Diabetic Retinopathy

Dr. Mahesh Gopalakrishnan

This presentation will elaborate on case selection, pre-operative anti VEGF use, crunch phenomenon, bad outcome indicators and characteristics of young PDR. It will also discuss scenarios when not to operate. Case examples with learning points will be the main content.

Amniotic Membrane Grafts in Retinal surgeries

Dr. Naresh Babu

Human amniotic membrane graft (hAMG) has emerged as a promising adjunct in vitreoretinal surgery due to its anti-inflammatory, anti-fibrotic, anti-angiogenic, and nonimmunogenic properties. Recent advances have expanded its applications from refractory macular holes to complex retinal detachments (RD), optic disc pit maculopathy, and proliferative vitreoretinopathy (PVR). hAMG acts as a biological scaffold that facilitates closure of retinal defects, and may reduce the retinal pigment epithelium migration and epithelial–mesenchymal transition involved in PVR pathogenesis. Multiple surgical approaches have been described, including subretinal, epiretinal, fibrin glue-assisted, and sandwich techniques using fresh, cryopreserved, or lyophilized grafts. Clinical studies demonstrate high anatomical reattachment rates with acceptable safety profiles, though functional recovery remains variable. Technical considerations such as graft orientation, sizing, stabilization, and prevention of graft displacement are critical for surgical success. Methods including staining, diagonal corner cuts, and graft rolling facilitate identification of amnion and chorion surfaces intraoperatively. Surgical challenges due to graft folding and displacement may be overcome using PFCL, direct PFCL–silicone oil exchange, and modified implantation techniques. Emerging evidence suggests that hAMG may serve as a cost-effective biological barrier in managing complex retinal pathology, particularly in eyes with large retinal breaks, recurrent detachments, or high myopia.

Lens sparing Vitrectomy in Stage 4 ROP

Dr. Simar Rajan Singh

Lens sparing vitrectomy (LSV) has emerged as a critical intervention in the management of Stage 4 retinopathy of prematurity (ROP), offering the potential for retinal reattachment while preserving the crystalline lens and future visual rehabilitation. This presentation provides a comprehensive overview of the surgical nuances involved in managing Stage 4 ROP, emphasizing practical pearls and decision-making strategies for vitreoretinal surgeons. Key aspects discussed include preoperative preparation, the role of preoperative laser photocoagulation, and the evolving utility of preoperative and intraoperative anti-VEGF therapy in optimizing surgical outcomes. The session will highlight the importance of appropriate timing of surgery and understanding the unique anatomy of the premature infant eye, particularly its differences from the adult eye that directly influence surgical planning and instrumentation. Critical technical considerations such as trocar entry site selection, distance from the limbus, and the advantages of an all-nasal approach to vitrectomy will be demonstrated. Intraoperative objectives, surgical endpoint assessment, wound closure techniques, and strategies for long-term postoperative follow-up will also be discussed. Through surgical videos and expert insights, this presentation aims to provide a practical roadmap for achieving optimal anatomical and functional outcomes in Stage 4 ROP.

Intravitreal Dexamethasone implants in DME

Dr. Aditya Sudhalkar

Diabetic retinopathy (DR) is one of the leading causes of blindness worldwide. Multiple treatment options have been used over time to attempt to modify the natural progression of the disease in both proliferative diabetic retinopathy (PDR) and diabetic macular edema (DME). These two retinal complications are the result of microvascular occlusions and vascular hyperpermeability and are considered one of the leading causes of irreversible blindness in patients of working age. It is now well demonstrated that PDR and DME are associated with increased levels of inflammatory and pro-angiogenic factors in the ocular compartment. To date, laser photocoagulation, vascular endothelial growth factor (VEGF) inhibitors, and corticosteroids have demonstrated efficacy in their treatment in large randomized controlled trials and in real-life observational studies. This manuscript aims to provide a comprehensive review of current treatments, including the main drugs used in diabetic pathologic manifestations, as well as new therapeutic alternatives, such as extended-release intraocular devices.

Intra ocular Lenses: dots and the Haze-what happens over time in IOL

Dr. Perfecto Cagampang III

The increased number of cataract extractions has provided millions of second sight for patients. The intraocular lenses implanted in the eye, sometimes come with changes in the optic material overtime. These changes show as a whitish haze on the surface or in the intraocular lens itself. Identified are the following: glistenings which are water-filled vacuoles, from mild to severe; calcifications studied in the surface and inside the lenses; and sometimes nicks and scratches in the optic surface. The effect on vision can vary from negligible visual changes, most of the time; to a blurry haze, in severe cases. The studies composed of explanted lenses which were studied in the David J. Apple Laboratory, Heidelberg University. The ability to learn and distinguish these changes can help the examine ophthalmologist the best-informed decision whether to observe or explant the lenses.

OCT Biomarkers in AMD: From Diagnosis to Decision-Making

Dr. Ayasmantha Peiris

Age related macular degeneration- AMD- is a leading cause of debilitating visual impairment of older population worldwide. Its treatment can be quite complex as management depends on existing vision level, findings in fundus photographs, images in red free and auto fluorescence modes and FA, ICG, OCT and OCTA findings. The treatment protocols may be quite complex involving anti VEGFs of increasing specificity, at specific intervals to keep the disease at bay. OCT has identified several key biomarkers in early/ advanced stages of non neovascular and neovascular arms of the disease that help to prognosticate, predict future behaviour of the disease and probable response to treatment modalities. This overview maps the biomarkers with AMD stage and severity. Also, this demonstrates how AI is already playing a lead role in the diagnosis with the help of these biomarkers and other similar tools.

Posterior Uveitis: A Structured Clinical Assessment

Dr. P. Sahila

Posterior uveitis is a sight-threatening inflammation involving the retina, choroid, vitreous, or retinal vessels. A structured clinical assessment is essential for accurate diagnosis and management. History should include onset, laterality, visual symptoms, systemic complaints, travel, infections, immunosuppression, and exposure history. Ocular examination assesses visual acuity, vitritis, retinitis, choroiditis, vasculitis, hemorrhages, and optic nerve involvement. Imaging such as OCT and fluorescein angiography supports diagnosis.

Systemic assessment is vital, as posterior uveitis may be associated with tuberculosis, syphilis, toxoplasmosis, sarcoidosis, Behçet disease, and autoimmune vasculitis. Important systemic signs include oral or genital ulcers, skin lesions, arthritis, lymphadenopathy, respiratory symptoms, neurological signs, fever, and weight loss.

Pitfalls include starting corticosteroids before excluding infection, relying on nonspecific investigations, missing masquerade syndromes, and inadequate systemic evaluation. A systematic multidisciplinary approach improves diagnostic accuracy and visual outcomes.

MMI in Posterior Uveitis: Beyond the Basics

Dr. Manishka Jayasundara

Posterior uveitis encompasses a diverse group of inflammatory disorders in which multimodal imaging plays a critical role in diagnosis, assessment of disease activity, monitoring progression, and guiding treatment decisions. This case-based presentation will explore the practical application of multimodal imaging in common posterior uveitic entities.

Through selected clinical cases, the talk will demonstrate how different imaging modalities including fundus autofluorescence (FAF), fluorescein angiography (FFA), indocyanine green angiography (ICGA), optical coherence tomography (OCT), and OCT angiography (OCTA) provide complementary information regarding retinal, retinal pigment epithelial, and choroidal involvement.

Particular emphasis will be placed on identifying imaging biomarkers suggestive of active versus inactive disease, recognizing patterns specific to different uveitic conditions, and understanding the strengths and limitations of each modality. The discussion will also highlight situations where multimodal correlation is essential to avoid misinterpretation. By integrating recent consensus recommendations from the Multimodal Imaging in Uveitis (MUV) Taskforce with real-world clinical examples, this presentation aims to provide a practical framework for the interpretation of multimodal imaging in posterior uveitis.

Intermediate Uveitis: Practical Diagnosis and Management Strategies

Dr. Lija Gajalaksan

Intermediate uveitis (IU) is a chronic inflammatory eye disease involving the vitreous and pars plana. It commonly affects young adults and is often idiopathic, although important associations include multiple sclerosis (MS), tuberculosis, and sarcoidosis. Patients usually present with floaters and blurred vision with minimal pain or redness, making the condition easy to miss.

Typical findings include vitritis, vitreous haze, snowballs, and snowbanking. Despite its subtle presentation, IU can lead to significant visual complications. Cystoid macular edema is the main cause of vision loss, while cataract, epiretinal membrane, retinal neovascularization, glaucoma, and retinal detachment may also occur.

Diagnosis requires careful ocular examination, multimodal imaging such as OCT and fluorescein angiography, and targeted systemic investigations to identify underlying causes. MS-associated IU is especially important because eye inflammation may precede neurological symptoms.

Management is stepwise. Corticosteroids are the first-line treatment, followed by immunomodulatory therapy in resistant or bilateral disease. Surgical options such as laser, cryotherapy, or vitrectomy are reserved for refractory cases and complications. Early diagnosis and adequate control of inflammation are essential to preserve long-term vision.

Spotlight on VKH

Dr. Mirna Kumaradas

Vogt-Koyanagi-Harada disease is a multisystem, chronic autoimmune disease of unknown etiology. Untreated or inadequately treated VKH disease can progress to sunset glow fundus and vision loss.

The revised diagnostic criteria proposed by the First International Workshop on VKH disease help us to differentiate VKH from other exudative serous chorioretinopathies. Imaging plays a major role in the diagnosis of VKH, monitoring of ocular inflammation and response to treatment. The principle of treatment in acute VKH is to suppress the inflammation aggressively with corticosteroids and to start immunosuppression whilst the steroids are being tapered.

This early treatment has been shown to shorten the duration of the acute phase, prevent the progression to the chronic phase, and reduce the incidence of systemic manifestations.

Parasitic Uveitis

Prof. Carlos Pavesio

This presentation provides a review of the most common parasitic infections affecting the eye and their importance in modern ophthalmic and uveitis practice. It focuses on the clinical manifestations, diagnosis, and management of the major parasitic causes of ocular inflammation, highlighting the challenges these conditions continue to pose.

The presentation begins with ocular toxoplasmosis, discussing transmission, tissue cyst formation, clinical manifestations, vascular and optic nerve involvement, and current therapeutic strategies including systemic antibiotics and intravitreal clindamycin. It then reviews toxocariasis and diffuse unilateral subacute neuroretinitis (DUSN), emphasising the role of nematode infection in retinal inflammation and progressive retinal degeneration.

Further sections address onchocerciasis, ocular cysticercosis and ophthalmomyiasis.
Throughout the presentation, particular emphasis is placed on careful clinical examination, and the importance of recognising travel history and exposure risk factors when evaluating patients with atypical uveitis or retinal inflammation.

Intravitreal Steroids in Posterior Uveitis – Current practice

Dr. Aditya Sudhalkar

Purpose: To evaluate the real-life efficacy and safety of the intravitreal dexamethasone implant in uveitis. Methods: This retrospective observational multicentric study included 152 eyes treated exclusively by 358 dexamethasone implant injections. The main outcome measures included change in the best-corrected visual acuity, central macular thickness, and vitreous haze score.

Results: Patients were treated with dexamethasone implant for macular edema (51.3%), vitritis with macular edema (40.1%), vitritis (5.3%), and other causes (3.3%). The mean duration of follow-up was 19.0 months. The mean gain in best-corrected visual acuity during follow-up was +12.1 letters. An improvement in best-corrected visual acuity ≥5, 10, and 15 letters was found in 64.5, 50.7, and 35.5% of cases, respectively. 59.7% of eyes with macular edema at baseline were found to be anatomical responders. Vitritis resolution (vitreous haze = 0+) was obtained in 81.4% of cases. Ocular hypertension (intraocular pressure ≥25 mmHg and/or gain ≥10 mmHg from baseline) occurred in 28.3% of patients. No filtering surgery/laser therapy was required. A total of 40.2% of phakic subjects underwent cataract surgery on average 11.2 months after the first injection.

Conclusion: This study confirms the efficacy and safety of the dexamethasone implant in noninfectious uveitis. Cataract and ocular hypertension were not uncommon but easily manageable.

Targeted Non-Steroidal Therapies for Posterior Uveitis – a rheumatologist's perspective

Dr. Dilrukshi Tennekone

Majority of patients with uveitis have an immune-mediated process despite the heterogeneity of its etiology and the preferred choice of therapy will differ depending on the underlying condition. Early and aggressive treatment of non-infectious uveitis is recommended to prevent complications and loss of sight.

While corticosteroids are the mainstay of treatment in acute stage, corticosteroid sparing systemic immunosuppressive agents should be considered for long term suppression of inflammation.

Conventional synthetic immune-suppressors like Methotrexate, mycophenolate Mofetil, Azathioprine (antimetabolites), Cyclosporin (calcineurin antagonists) and cyclophosphamide (alkylating agents) are some of the first line agents used in uveitis. Biological agents (TNF inhibitors etc.) are increasingly used in the control of chronic uveitis and there is growing interest in using these as first line agents. If an agent in maximum doses for a significant duration of time has failed then switching to another, preferably from a different group is recommended. Combination therapy with different agents is recommended where only partial/suboptimal disease control is achieved with a single agent. It is essential that toxicity for these therapeutic agents is monitored with blood tests on a regular basis for the duration of therapy. Stopping of therapy has to be approached carefully and slow tapering is recommended to reduce risk of relapse.

Macular Subretinal Fluid: A Practical Diagnostic Algorithm

Dr. Duleepa Baranage

Macular subretinal fluid (SRF) is a common yet diagnostically challenging clinical finding encountered in retinal practice. While central serous chorioretinopathy remains a major cause, a wide spectrum of neovascular, inflammatory, vascular, degenerative, developmental, neoplastic, genetic, and drug-related disorders may present with similar OCT appearances. This presentation provides a practical multimodal imaging-based diagnostic approach to macular SRF, emphasizing key differentiating features on OCT, OCT-angiography, fundus autofluorescence, fluorescein angiography, and indocyanine green angiography. The talk will discuss important masquerade syndromes, pachychoroid spectrum disorders, inflammatory entities, optic disc pit maculopathy, retinal vascular diseases, and choroidal tumours, highlighting clinical pearls relevant to retinal specialists. A structured algorithm integrating imaging biomarkers, clinical examination, and systemic associations will be proposed to improve diagnostic accuracy, avoid misdiagnosis, and guide appropriate management. The role of OCT-A in differentiating chronic CSCR from occult choroidal neovascularization will also be highlighted.

Preoperative imaging biomarkers in RRD

Dr. K. Niruththan

Historically, optical coherence tomography (OCT) in rhegmatogenous retinal detachment (RRD) was primarily utilized postoperatively to identify outer retinal discontinuities and explain persistent vision loss despite successful anatomical reattachment. Recent advancements in widefield OCT, however, have significantly expanded its utility, offering deeper insights into the pathophysiology and mechanical evolution of retinal detachments.

This presentation highlights the expanding role of preoperative widefield OCT in mapping critical pathoanatomical changes within the outer retina. Key clinical applications will be discussed, including the detailed classification and delineation of detachment types including the regulated and dysregulated types, the identification of proliferative vitreoretinopathy (PVR) subtypes, and the mechanistic development of secondary macular holes. Furthermore, this session will demonstrate how these advanced preoperative imaging biomarkers directly influence surgical decision-making, optimize procedural timing, and facilitate personalized patient management to improve functional outcomes.

Inferior Retinal Detachment: Challenges and Surgical Solutions

Dr. Mahesh Gopalakrishnan

Presentation will highlight the specific problems of inferior retinal detachments including traumatic RD and RD in young patients. Use of buckle or encircling band, choice of tamponade, short or long tamponade and management of recurrences will be discussed

PVR and MTX in management of RRD

Dr. Naresh Babu

Proliferative vitreoretinopathy remains the leading cause of failure following retinal detachment surgery in approximately 5–10% of cases. It is characterized by a complex wound-healing response involving inflammation, cellular proliferation, and membrane contraction. Breakdown of the blood–retinal barrier permits migration of retinal pigment epithelial cells, inflammatory cells, and glial elements into the vitreous cavity leading to cytokine-mediated fibrocellular membrane formation and recurrent retinal detachment. Intravitreal methotrexate is an anti-inflammatory and anti-proliferative agent with a well-established intraocular safety profile and has emerged as a promising adjunctive therapy for PVR prevention and management. Its mechanism mainly targets the inflammatory and fibrotic pathways thereby reducing postoperative proliferative activity and risk of recurrent retinal detachment. Recent clinical evidence supports the role of serial intravitreal methotrexate administration as an effective strategy in improving anatomical outcomes in eyes with PVR particularly when used during immediate postoperative period where proliferative activity is highest. Compared with single dose regimen repeated dosing may provide sustained therapeutic benefit while maintaining a favourable safety profile with minimal reported ocular toxicity. Intravitreal methotrexate therefore represents a promising therapeutic strategy aimed at reducing surgical failure and improving outcomes in retinal detachment surgery

Retinopathy of prematurity: Updated classification and clinical relevance

Dr. Tavisha Udupihille

Retinopathy of prematurity (ROP) has a system of classification which ideally needs to be uniform throughout academia. This presentation aims to describe the standard nomenclature including the updated International Classification of Retinopathy of Prematurity, 3rd edition (ICROP 3) classification. The presentation also explores the different treatment modalities with the appropriateness of each modality in the Sri Lankan context and finally explores emerging therapies for ROP.

Paediatric Coats Disease: Diagnosis and Evolving Management

Dr. Simar Rajan Singh

Coats disease remains a challenging pediatric retinal disorder with highly variable clinical presentation and visual prognosis. This presentation will provide a comprehensive overview of the current concepts in the diagnosis and evolving management of pediatric Coats disease. The session will focus on the characteristic presenting features, including leukocoria, strabismus, decreased vision, and exudative retinal detachment, while emphasizing the importance of early recognition and timely referral. Particular attention will be given to differentiating Coats disease from Retinoblastoma, highlighting the clinical and imaging clues that aid accurate diagnosis and prevent unnecessary interventions.

The talk will discuss a practical step-wise treatment approach tailored to disease stage and severity, including the role of retinal laser photocoagulation, cryotherapy, intravitreal anti-VEGF therapy, and vitreoretinal surgical interventions. Surgical pearls, indications for intervention, and realistic anatomical and functional goals of surgery in advanced disease will be reviewed through illustrative cases. The presentation will also underscore the critical role of detailed pre-operative counselling, helping parents understand the prognosis, treatment expectations, need for multiple procedures, and long-term follow-up essential for optimal patient care.

Visual Rehabilitation in the Blind Child: Restoring Function Beyond Vision

Dr. Mangala Dissanayake

Visual rehabilitation, consisting of visual stimulation and visual training, which is a common practice in multiple scenarios including the education of children with visual impairments, developing social skills, facing new challenges etc. However, when it comes to blind child, "visual rehabilitation" means not only about restoring sight itself in most cases, but also about maximizing function and development by training the brain and body to use other senses, motor skills, and cognitive strategies to compensate for no or low vision. The goal is to develop independence, mobility, learning, and social participation — not just "seeing". The concept of "beyond vision" matters as the brain is plastic, especially in kids. When vision is absent or limited, other systems take on more participation and load of work. - Auditory: sound localization, echolocation, auditory discrimination for learning - Tactile/haptic: Braille, object recognition by touch, spatial mapping - Proprioceptive/vestibular: balance, body awareness, navigation - Olfactory: sensing smell as a cue for place and safety This is why rehabilitation focuses on multi-sensory integration. Key factors that make it work- Neuroplasticity, Family involvement, Task-specific training, Tech as a tool.

LIST OF FREE PAPERS

CRM FP01 **Artificial Intelligence (AI) Guided monitoring of Retinal Layers in Optical Coherence Tomography (OCT) in Clinical Practice.**
JM Owin Vindula, DMMDB Dhanapala, UHCA Madushanka, Manul Gunarathne, DSSP Yapa, Danilka Akarawita, Yehan Sajana

CRM FP02 **Comprehensive Digital Transformation of an Ophthalmology Unit: I mpact on Workflow, Efficiency, and Patient Care**
Shehani Bandara, Amali Samarathunga, Lasitha Athapaththu, Nethmi Nettikumara, Rasheeka Ranasinghe, Dr. Chamara Kumarage

CRM FP03 **Intravitreal Dexamethasone in Macular Edema – An Observational Case Series**
K Niruththan

CRM FP04 **Fibrovascular stage predicts visual outcomes following vitrectomy for PDR: A prospective cohort study**
DMMDB Dhanapala, Robert Casson, MP Piyasena, PFSC Fonseka, G Gunawardena, UHCA Madushanka, KAMC Gunaratne, JMO Vindula, DSSP Yapa, Jagjit Gilhotra, U Senarath

CRM FP05 **Rethinking Ocular Toxoplasmosis Treatment: Intravitreal Clindamycin in Sri Lankan Practice**
KC Batuwangala, P Sriharanathan

CRM FP06 **Occupational exposure to Formalin and associated health effects among Operation theatre staff**
Nethmi Nettikumara, AP Samaratnga, ADLS Athapaththu , HMSD Bandara, RAR Ranasinghe, KLGD Senali, CJ Kumarage

CRM FP07 **Retinal Red Herrings: Inflammation in Vascular Clothing**
K Niruththan , N Nanayakkara, MI Jayasundara, D Gunasekara

ABSTRACTS OF FREE PAPERS

CRM FP01

Artificial Intelligence (AI) Guided monitoring of Retinal Layers in Optical Coherence Tomography (OCT) in Clinical Practice

JM Owin Vindula, DMMDB Dhanapala, UHCA Madushanka, Manul Gunarathne, DSSP Yapa, Danilka Akarawita, Yehan Sajana

Introduction / Purpose: OCT produces high-resolution, cross-sectional images of the retina. Basic Pathologies we see in retinal diseases are alteration of perfusion, leakage from blood vessels and neurodegeneration. AI algorithms, particularly address these challenges by: Automated Segmentation, Fluid Detection and Disease Progression Tracking.

Methods: OCT images captured using the CIRRUS 6000 OCT System were used to analyze six important retinal layers (NFL, INL, ONL, ELM, IS/OS, and RPE). A hybrid CNN-BiLSTM model was proposed, combining CNN-based feature extraction with BiLSTM-based sequential learning to predict retinal layer boundaries accurately. The model was trained using Huber loss, Gaussian cross-entropy, and monotonicity constraints, and evaluated using MAE and pixel-level accuracy.

Results: Experimental results showed that the CNN+BiLSTM (64×2) configuration achieved the best performance with an MAE of 0.9878 and approximately 95% accuracy, while maintaining low computational complexity with fewer than 1 million parameters.

Conclusion: The integration of AI into clinical practice has revolutionized the monitoring of retinal layers via OCT. By automating the segmentation and analysis of complex ocular structures, AI systems provide clinicians with high-precision tools for managing degenerative diseases.

CRM FP02

Comprehensive Digital Transformation of an Ophthalmology Unit: Impact on Workflow, Efficiency, and Patient Care

Shehani Bandara, Amali samarathunga, Lasitha Athapaththu, Nethmi Nettikumara, Rasheeka Ranasinghe, Chamara Kumarage

Background: The loss of patient records following the Dittwa floods in Sri Lanka highlighted the vulnerability of paper-based systems in ophthalmic care. This disruption prompted the development and implementation of our own comprehensive digital solution within the ophthalmology unit at WKMH. The system was designed by us to integrate patient demographics, clinical history, diagnostic investigations (including OCT and biometry), and electronic diagnosis cards into a unified, secure platform, ensuring continuity of care and data protection.

Methods: A pre–post interventional study design was employed to evaluate the impact of digital transformation on workflow efficiency and patient care. Baseline data were collected prior to implementation, followed by post-intervention assessment after full system integration. Key outcome measures included patient throughput, documentation accuracy, retrieval time of clinical records. Data security and patient confidentiality measures were incorporated in accordance with institutional standards.

Results: Implementation of the digital system resulted in a significant improvement in clinical workflow efficiency, with reduced patient waiting times and faster access to medical records. Documentation completeness and accuracy improved substantially, while retrieval of historical patient data became instantaneous. Integration of diagnostic imaging and investigation reports enhanced clinical decision-making. Staff reported increased satisfaction due to streamlined processes, and patient care continuity was notably improved, particularly for follow-up and surgical planning.

Conclusion: The comprehensive digital transformation of the ophthalmology unit demonstrated substantial benefits in workflow optimization, operational efficiency, and quality of patient care. This model highlights the importance of resilient, integrated digital health systems in resource-limited settings, particularly in the face of natural disasters. Wider adoption of similar systems could significantly strengthen healthcare delivery and data security in comparable environments.

CRM FP03

Intravitreal Dexamethasone in Macular Edema – An Observational Case Series

Niruththan K

Introduction: Intravitreal dexamethasone injections have been used in various etiologies of macular edema (ME), though they are not routinely preferred due to their short intravitreal half-life. Instead, dexamethasone intravitreal implants are more commonly utilized. However, there is limited published evidence evaluating the efficacy of repeated intravitreal dexamethasone injections in this context.

Objective: To evaluate the anatomical and functional outcomes of intravitreal dexamethasone injections in diabetic macular edema (DME) and macular edema secondary to retinal vein occlusions (RVO).

Methods: This is an observational case series conducted at the Ophthalmology Unit, Teaching Hospital Badulla, over a 6-month period. Patients with macular edema who showed poor response after at least three doses of intravitreal anti-VEGF therapy (Bevacizumab) for ME due to Diabetes or vein occlusions and demonstrated biomarkers with poor prognosis to anti-VEGF were included. All patients received monthly intravitreal dexamethasone injections. Pre- and post-treatment assessments included optical coherence tomography (OCT) for anatomical outcomes and best corrected visual acuity (BCVA) for functional outcomes.

Results: A total of 22 eyes from 22 patients were included in the study. Outcome analysis is ongoing and will be presented.

Conclusion: To be determined upon completion of data analysis. The study aims to clarify the role of intravitreal dexamethasone injections as a potential alternative or adjunct in refractory macular edema.

CRM FP04

Fibrovascular stage predicts visual outcomes following vitrectomy for PDR: A prospective cohort study

DMMDB Dhanapala, Robert Casson, MP Piyasena, PFSC Fonseka, G Gunawardena, UHCA Madushanka, KAMC Gunaratne, JMO Vindula, DSSP Yapa, Jagjit Gilhotra, U Senarath

Purpose: To evaluate the association between fibrovascular stage and visual outcomes following vitrectomy for proliferative diabetic retinopathy (PDR).

Methods: Prospective observational cohort study of consecutive patients undergoing pars plana vitrectomy for vision-threatening diabetic retinopathy at a tertiary referral centre in Sri Lanka. Eyes were categorised into four ordered fibrovascular stages (vascular, fibrovascular thin, fibrovascular thick, fibrous) based on clinical, imaging, and intraoperative findings. The primary outcome was best-corrected visual acuity (BCVA) at 12 months. Non-parametric tests and trend analyses were used to assess associations between stage and outcomes.

Results: A total of 72 eyes were included. Visual acuity improved substantially following surgery, with the proportion of eyes achieving BCVA ≥ 6/12 increasing from 2.8% at baseline to 15.5% at 12 months, and legal blindness decreasing from 54.9% to 28.2%. Postoperative visual acuity differed significantly across fibrovascular stages (Kruskal–Wallis $p = 0.0078$), with a strong ordered trend toward worse outcomes in more advanced disease (Jonckheere–Terpstra $p = 0.00058$). In regression analysis, increasing stage was associated with worse final visual acuity ($\beta = 0.438$, $p < 0.001$). When grouped clinically, later-stage disease was associated with approximately 0.6 logMAR worse visual acuity compared with earlier-stage disease, independent of baseline vision ($p = 0.0015$). Surgical indication was not significantly associated with visual outcome.

Conclusions: Fibrovascular stage is a strong predictor of visual outcome following vitrectomy for PDR and appears to outperform conventional surgical indications. These findings support a biologically informed approach to surgical decision-making and suggest that earlier intervention may improve visual outcomes.

CRM FP05

Rethinking Ocular Toxoplasmosis Treatment: Intravitreal Clindamycin in Sri Lankan Practice

Batuwangala KC Sriharanathan P

Purpose: To evaluate intravitreal clindamycin as a pragmatic first-line strategy for active ocular toxoplasmosis in a setting where systemic therapy is often limited.

Methods: Two patients presented with acute unilateral visual loss and clinical features of active toxoplasma retinochoroiditis, supported by IgG-positive/IgM-negative serology. Systemic therapy was not feasible due to drug intolerance (Case 2) and renal comorbidity (Case 1). Both received two intravitreal clindamycin injections (1 mg/0.1 ml) at two-week intervals; Case 2 additionally received a posterior sub-Tenon triamcinolone acetonide injection with the first dose. Outcomes were assessed using serial fundus photography BCVA and OCT.

Results: Both cases showed rapid regression of active lesions, reduced intraocular inflammation, and restoration of macular architecture on OCT, without injection-related complications. In Case 1, BCVA improved from 1.1 to 0.9 logMAR within 2 weeks and was sustained. In Case 2, BCVA improved from 0.8 to 0.4 logMAR at 2 weeks, further improving to 0.2 logMAR after the second dose.

Conclusion: Intravitreal clindamycin provided effective, well-tolerated control of active toxoplasma retinochoroiditis while circumventing systemic limitations. To our knowledge, this represents the first report of its use in Sri Lanka.

CRM FP06

Occupational exposure to Formalin and associated health effects among Operation theatre staff

Nethmi Nettikumara, Samaratnga AP, Athapaththu ADLS, Bandara HMSD, Ranasinghe RAR, Senali KLGD (NO), Kumarage CJ

Background: Formalin (aqueous formaldehyde) is widely used in operating theatres for sterilization and specimen preservation. Despite its effectiveness, formalin exposure poses potential health risks to healthcare workers, particularly operating theatre nurses who are frequently exposed to its vapors. These risks include respiratory, ocular, dermatological, and neurological symptoms.

Objective: To assess the level of occupational exposure to formalin and evaluate the associated acute and chronic health effects among operating theatre nurses.

Methods: A descriptive cross-sectional study will be conducted using a structured, self-administered questionnaire among operating theatre nurses. Data collected will include duration of work experience, frequency and level of exposure to formalin vapors, and use of personal protective equipment (PPE). It also evaluates the prevalence of symptoms related to respiratory, ocular, neurological, and dermatological systems, as well as chronic medical conditions and their potential aggravation with exposure

CRM FP07

Retinal Red Herrings: Inflammation in Vascular Clothing

Niruththan K, Nanayakkara N, Jayasundara MI, Gunasekara D

Introduction and objective: Retinal hemorrhages often prompt an initial diagnosis of vascular occlusion, driven by anchoring bias, while inflammatory clues may be overlooked (confirmation bias), leading to premature diagnostic closure. This case series highlights such pitfalls and their clinical consequences.

Methods & Setting: Three cases from the Ophthalmology Unit, Teaching Hospital Badulla, over 3 months.

Case 1: A 65-year-old man treated as branch retinal vein occlusion (BRVO) with anti-VEGF developed vitritis and was referred as possible endophthalmitis. OCT revealed a choroidal granuloma; diagnosis: tuberculous choroidal granuloma with vasculitis. He improved with anti-tuberculous therapy and steroids.

Case 2: A 32-year-old man with acute vision loss (VA 6/60) and CRVO-like features was planned for anti-VEGF elsewhere. Peripheral vascular sheathing suggested vasculitis. History of recurrent oral ulcers led to a diagnosis of Behçet disease. Vision improved to 6/9 with steroids and intravitreal bevacizumab.

Case 3: A 29-year-old man presented with altitudinal field loss, disc edema, and normal blood pressure, initially suspected as NAION. History of oral ulcers and thrombophlebitis led to a diagnosis of Behçet disease which is an uncommon presentation. Vision improved to 6/9 with steroids.

Conclusion: Inflammatory retinal disease can closely mimic vascular occlusions, leading to misdiagnosis through cognitive biases such as anchoring and premature closure. Careful history, peripheral retinal examination, and multimodal imaging are critical to identifying inflammatory etiologies. Recognizing these "red herrings" can significantly alter management and improve visual outcomes.

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CRM EP01

Beyond CHRPE: Bilateral Giant Retinal Tears in a Teenager with Familial Adenomatous Polyposis Phenotype: Coincidence or Connection?

Mendis BMIU, Dayawansa KR, Upendran N, Munasinghe TD, Guruge KGAU, Aravindika GAD

Background: Familial adenomatous polyposis (FAP) is an autosomal dominant disorder associated with colorectal polyposis and characteristic extracolonic manifestations, including congenital hypertrophy of the retinal pigment epithelium (CHRPE). These ocular lesions are typically benign and confined to the retinal pigment epithelium, with no known association with vitreoretinal interface pathology.

Case Presentation: We report a 14-year-old girl with a strong family history of FAP, whose father and paternal sibling died of colorectal carcinoma. She had previously been noted to have very few bilateral fundus lesions consistent with early CHRPE. She presented with intermittent photopsia in both eyes and was found on examination to have bilateral giant retinal tears with associated localized retinal detachment. There was no history of trauma, high myopia, or other predisposing factors. The patient underwent successful bilateral vitreoretinal surgical repair with satisfactory anatomical outcomes.

Conclusion: The occurrence of bilateral giant retinal tears in a young patient with phenotypic features of FAP is highly unusual and, to our knowledge, has not been previously reported. While this may represent a coincidental finding, a potential association cannot be excluded. This case raises the possibility of an expanded ocular phenotype in FAP and highlights the importance of careful peripheral retinal evaluation in such patients.

CRM EP02

Cytomegalovirus Retinitis as Unmasking IRIS Following ART Initiation in an HIV-Positive Patient

Nilanka KAS, Gurusinghe L, Warnakula PMT, Seneviratne MD, Jithmini KA

Introduction: Cytomegalovirus (CMV) retinitis is a sight-threatening opportunistic infection seen in advanced HIV infection. Following initiation of antiretroviral therapy (ART), immune recovery may trigger immune reconstitution inflammatory syndrome (IRIS), leading to unmasking of previously subclinical infections.

Case Presentation: A 29-year-old retroviral-positive male presented with a 2-day history of progressive, painless blurring of vision in the left eye, occurring two weeks after initiation of ART. There were no associated systemic or neurological symptoms.

Visual acuity was 6/6 in the right eye and 6/12 in the left eye. Anterior segment examination was normal. Fundoscopy of the left eye revealed retinal whitening with yellow-white granular lesions, flame-shaped haemorrhages with retinal vasculitis, and mild vitritis, producing a characteristic "cheese and ketchup" appearance. The right eye was initially normal but later developed similar changes. The patient had been recently diagnosed with retroviral positive and commenced on first-line ART with cotrimoxazole prophylaxis. Baseline investigations excluded tuberculosis and other infections.

Management: The patient was started on intravenous ganciclovir (5 mg/kg twice daily) with intravitreal ganciclovir to the affected eye. When the right eye became involved, intravitreal injections were given to both eyes. Serial fundoscopic examinations showed improvement, and step-down to oral valganciclovir was planned. ART was continued.

Discussion and Conclusion: This case highlights CMV retinitis as an unmasking IRIS shortly after ART initiation. The temporal association, clinical features, and progression support this diagnosis. Early recognition and prompt antiviral therapy are essential to prevent irreversible visual loss and bilateral disease. Routine ophthalmic screening in patients initiating ART is crucial for early detection and improved outcomes.

CRM EP03

Rewiring the Visual Brain Outcomes of Vision Therapy in Post-Traumatic Visual Dysfunction

Roshayni Ashka Jayasinghe, Kumarage CJ

Purpose: To evaluate the effectiveness of structured vision therapy in improving functional visual outcomes in pediatric patients with persistent visual deficits following ocular trauma and surgical intervention, where residual deficits are identified as functional rather than structural in origin.

Methods: A prospective pre–post case series was conducted involving two pediatric patients with visual deficits following ocular trauma.

- **Patient 1 (Age 11):** Left eye pseudophakia with reduced visual acuity despite optimal correction. Underwent phacoemulsification with intraocular lens implantation.
- **Patient 2 (Age 12):** Right eye hypotropia and absent stereoacuity, underwent cryo-buckle surgery for retinal detachment, with a baseline visual acuity of 6/60. Optical Coherence Tomography (OCT) confirmed no structural abnormalities, indicating a functional deficit.

Standardized orthoptic assessments were performed. Patient 2 underwent 25 sessions of office-based vision therapy over 3 months, including VIVID software training, fixation exercises, and vergence rehabilitation.

Results: Both patients demonstrated significant clinical improvements in visual acuity and stereopsis.

- **Patient 1:** Left eye visual acuity improved from 6/18 to 6/12, with stereoacuity improving from 110 to 55 seconds of arc.
- **Patient 2:** Right eye visual acuity improved from 6/60 to 6/18. Stereoacuity improved from absent to 340 seconds of arc.

Conclusions: Structured vision therapy resulted in significant functional visual improvements—including gains in visual acuity, recovery of stereoacuity, and restoration of binocular function—outcomes not achieved by surgical intervention alone. These findings suggest that persistent post-surgical visual deficits may have a functional component requiring targeted rehabilitation. Vision therapy should be considered a routine adjunct in the post-surgical management of pediatric ocular trauma patients.

CRM EP04

Where is the lesion? A rare case of ICA aneurysm originating from clinoid segment

Wathsala Gunasekera, Waruna Wijayasiriwardena

Introduction: It is widely known that oculomotor palsy can be caused by compression of an aneurysm at the junction of the internal carotid artery (ICA) and the posterior communicating artery, the junction of the basilar and superior cerebellar artery, or the cavernous segment of the ICA. We experienced a rare case of an anterolaterally projecting aneurysm at the clinoid segment of the ICA causing oculomotor palsy.

Internal carotid artery aneurysms that arising from the clinoid part may produce a mass effect and consequently a set of neurological deficits, including diplopia from oculomotor nerve involvement, decreased visual acuity from optic neuropathy, facial hypoesthesia from involvement of the trigeminal nerve, and less frequently facial pain.

Methodology: A 52-yr old female presented with sudden onset binocular diplopia and drooping of the left upper eye lid for 1 week duration. On examination VA is 6/9. Left side partial ptosis and pupil affected 3rd cranial nerve palsy. Left abducens nerve impaired. 1st, 2nd and 3rd branches of trigeminal nerve was intact. Fundus examination revealed normal optic nerve. Patient underwent urgent contrast CT which revealed a large mass involving left cavernous sinus which could be meningioma or ICA aneurysm. Patient underwent CT angiogram which revealed large ICA aneurysm at clinoid part. Patient was immediately referred for neurosurgical intervention.

Conclusion: Unruptured intracranial aneurysms account for up to 3% of the general population and are commonly seen at the bifurcation of arteries of circle of Willis. They are generally asymptomatic unless they rupture resulting in subarachnoid hemorrhage which is the most dreaded complication. Aneurysms of the carotid artery that arise from the internal carotid artery particularly supraclinoid Internal carotid artery (ICA) can remain asymptomatic if small (<10 mm in diameter) or may progress and enlarge causing headache and cranial nerve palsies particularly visual deficits caused by the local mass effect of the aneurysm on the anterior optic pathway. Unruptured supra-clinoid carotid aneurysms are more frequently diagnosed with MRI particularly those presenting with compressive symptoms on the visual pathway. MRI is also useful in ruling out other differential diagnoses and follow up. Digital subtraction angiography remains the gold standard for confirmation of diagnosis and assessment for potential surgical or endovascular planning. However, their management is still controversial due to the natural history of these vascular lesionsand associated risks of their repair. There are two types of treatment: surgical clipping and endovascular coiling. Both treatment methods effectively prevent rupture. Otherwise, conservative management is reserved for asymptomatic aneurysms measuring less than 10 mm as they are less likely to rupture.

CRM EP05

Superotemporal Branch Retinal Vein Occlusion Following Electrocution in a Young Healthy Adult Without Vascular Risk Factors: A Rare Case to Report

Banu AMS, Dias JD

Purpose: To report a rare case of superotemporal branch retinal vein occlusion (ST BRVO) following accidental electrocution in a young patient without identifiable systemic or ocular vascular risk factors, and to explore possible underlying mechanisms.

Methods: A single case report of a 32-year-old previously healthy male who presented with sudden painless blurring of vision in the right eye two days following low-voltage electrical injury. Comprehensive ophthalmic evaluation, including fundus examination, optical coherence tomography (OCT), and fundus fluorescein angiography (FFA), was performed. Systemic evaluation excluded hypertension, diabetes mellitus, hyperlipidemia, and thrombophilia.

Results: Best-corrected visual acuity was 6/18 in the affected eye. Fundus examination revealed sectoral intraretinal hemorrhages, dilated tortuous veins, and cotton wool spots localized to the superotemporal quadrant, consistent with ST BRVO. OCT demonstrated macular edema with cystoid changes. FFA confirmed delayed venous filling and capillary non-perfusion in the corresponding area. No embolic source or systemic abnormality was identified. The temporal association with electrocution suggested a causative link. The patient was managed with intravitreal anti-VEGF therapy, showing anatomical improvement and partial visual recovery over follow-up.

Conclusions: Electrical injury, even at low voltage, may precipitate retinal vascular occlusions through mechanisms such as endothelial damage, vasospasm, or thrombotic events. This case underscores the importance of considering retinal vascular complications in patients presenting with visual symptoms after electrocution, even in the absence of traditional risk factors. Early recognition and prompt management are crucial for visual prognosis.

CRM EP06

Bilateral Panuveitis – Ocular manifestation associated with chikungunya

Sahila P, Malaravan M

Purpose: To describe a case of bilateral panuveitis, developed three months after Chikungunya viral infection

Method: A middle-aged female patient with DM presented with reduced vision in her right eye over the last four days. Best corrected visual acuity was 6/18 in her right eye and 6/6 in her left eye. Previous examination by another Ophthalmologist was only a disc edema in the right eye. As she was doing OCT macula the next day, the technician noticed subretinal fluid at macula and suspected a retinal detachment and referred the patient to VR clinic.

On examination she had AC cells 2+ in both eyes. Occasional cells in vitreous with multiple serous retinal detachment with disc edema in the right eye with choroidal detachment. There was minimal subretinal fluid in the left eye with very peripheral choroidal folds were also identified. Patient denied any ocular trauma or surgery. There was an associated right sided headache. No hearing impairment. Patient also mentioned she had suffered from Chikungunya three months earlier.

Results: Basic blood investigations were normal other than thrombocytosis. Blood picture concluded that it was due to reactivity. Other investigations such as CXR, ESR, CRP, HIV, VDRL were all negative. IgG for Chikungunya was weakly positive and IgM was negative. High dose of systemic steroid (oral prednisolone 1mg/kg) was started. And the ocular signs started to improve from 3rd day.

Conclusion: Ocular examination following Chikungunya like viral illness should be carefully done for the features of panuveitis which responds well with timely systemic steroid treatment.

CRM EP07

Likely Lupus Retinopathy

Mathugamage D, Gamage N, de Silva J. de Soyza A, Wewalwala D

Purpose: Systemic lupus erythematosus (SLE) is a complex autoimmune inflammatory disease of unknown etiology. It is characterized by involving multiple organ systems, often with a relapsing and remitting clinical course. Almost one third of SLE patients demonstrate an array of ocular manifestations. The most common manifestation is SLE retinopathy.

Methods: Single case presentation.

Results: 19 yrs old girl treated for suspected Tb lymphadenitis with ATT developed SJS to rifampicin. While managed at ICU she experienced Sub acute vision loss bilaterally. Fundus findings showed pale discs. attenuated vasculature and features of CRAO, vasculitis and macula edema. Currently treated with systemic and periocular steroid and Anti VEGF.

Conclusion: Retinopathy is an important manifestation of SLE, which develops with an incidence of 3-29%. SLE retinopathy points to active lupus, anti-phospholipid antibody syndrome (APS), central nervous system lupus or drug-induced. Fundus examination is important because ocular fundus is the only part of the human body where small vessels can be directly visualized in a noninvasive manner. A characteristic finding of lupus retinopathy is vasculitis of retinal capillaries associated with local microinfarction. Large retinal vessel occlusions (central or branch; vein or arteriole) are more common with APS associated with SLE. The mainstay of treatment is systemic immune-suppression.

CRM EP08

Nutritional Retinopathy in Practice: Electrophysiology-Guided Diagnosis and Recovery

Warnakula PMT, Ragunathan R, Munasinghe TD, Wariyapola D

Nutritional deficiencies are important, potentially reversible causes of retinal dysfunction that are often under-recognized in clinical practice. We present two cases demonstrating electrophysiological and functional retinal changes associated with Vitamin A and Vitamin B12 deficiencies.

Case 1

A 41-year-old male presented with progressive nyctalopia over eight months, with no history of diabetes or systemic illness. Fundus examination revealed peripheral retinal atrophic changes. Humphrey Visual Field (30-2) testing showed peripheral field involvement. Full-field electroretinography demonstrated extinguished b-waves, reduced a-wave amplitudes, and delayed flicker responses, consistent with severe rod-cone dysfunction. Serum analysis confirmed Vitamin A deficiency. Following supplementation, the patient showed marked symptomatic improvement.

Case 2

The second case involved a 33-year-old male, a strict vegetarian, presenting with gradually worsening vision over one year. Electrophysiological evaluation revealed a reduced P50 response, suggestive of macular dysfunction. Laboratory investigations confirmed Vitamin B12 deficiency. Following parenteral Vitamin B12 supplementation, there was improvement in the P50 amplitude along with stabilization of visual symptoms.

Early recognition through careful clinical history and targeted investigations is essential, as timely supplementation can lead to significant functional recovery and prevent irreversible visual loss.

CRM EP09

Searching vision after chasing elephants - A case report of LASER Retinopathy

Wathsala Gunasekera

Objective: LASER retinopathy is increasingly prevalent among general population at present due to free availability of commercial LASER incorporated devices such as pointers, toys, lights, and torches. Even though it is freely available to use there is lack of awareness about how to protect the eyes and the potential damage it can cause among the public. This has led to increased incidence of LASER eye injuries. In our case we studied an accidental LASER injury due to torch usually used to chase wild animals in order to protect crops from them by the farmers.

Methodology: A 25-yr old female presented to eye clinic with sudden loss of left eye vision after accidental exposure to torch containing LASER. Her VA 6/60 left eye. Fundus showed RPE changes. OCT showed disruption of the ellipsoid zone and RPE under the fovea.

Results: Patient was treated with NSAID eye drops and followed up with serial VA and OCT testing. Her VA gradually increased upto 6/18. Patient and family education was done.

Conclusion: LASER retinopathy can happen due to accidental or intentional exposure to LASER light. It can cause mild to severe reduction of vision. Key OCT features are disruption of ellipsoid zones and RPE. No proven treatments available. With time vision can be improved to a varying degree. Public awareness is utmost important in order to prevent LASER injuries.

CRM EP10

Delayed Auto-Closure of a Macular Hole Under Long-Term Silicone Oil Tamponade After Repair of Macular Hole Retinal Detachment

Batuwangala KC, Sriharanathan P

Objectives: To report delayed anatomical closure of a persistent macular hole under long-term silicone oil tamponade following macular hole retinal detachment repair.

Methods: Observational case report of a 62-year-old male with a pseudophakic macular hole retinal detachment associated with proliferative vitreoretinopathy grade A, managed with pars plana vitrectomy, internal limiting membrane peeling, and silicone oil tamponade, followed with serial optical coherence tomography examinations.

Results: The macular hole remained open for at least 6–7 months postoperatively despite complete retinal reattachment. Subsequent OCT demonstrated complete macular hole closure under silicone oil. After silicone oil removal, anatomical closure remained stable with improved visual acuity, with final best-corrected visual acuity of 20/50 (0.4 logMAR) recorded in January 2026.
Conclusion: Macular hole closure may occur after prolonged persistence under silicone oil tamponade. Extended observation with serial OCT may be justified in selected, anatomically stable eyes following macular hole retinal detachment repair.

CRM EP11

Spontaneous peeling of epiretinal membrane (ERM)

Sahila P

Purpose: To describe a case of spontaneous peeling of ERM while awaiting for the surgery for four months with improved vision.

Method: A 50 year old male patient had undergone vitrectomy for rhegmatogenous retinal detachment in the right eye couple of years ago. He also had 360 degree prophylactic barrier laser for his left eye at the same time. He presented with significant visual loss in the left eye from 6/9 to 5/60 over 2-3 weeks. On examination he had an ERM with macula puckering. OCT showed ERM extending over the macula with diffuse macular oedema. He was registered for a routine surgery of Left vitrectomy with membrane peel.
Results: The patient presented 4 months after with the complain of flashes in the left eye. However, the uncorrected visual acuity had improved to 6/9 with the fundus examination showed rolled out ERM towards the temporal aspect and opened up superior break that was anterior to the barrier laser. OCT was done to confirm the rolled out ERM with the macula thickness became normal. The patient was explained the spontaneous peeling of ERM.

Conclusion: Spontaneous peeling or separation of ERM is a rare (1-3%) but well documented phenomenon. The probable mechanism would be completion of PVD which simultaneously pulled the ERM or the contractual forces of the membrane itself. Therefore, it might be worth to follow-up or observe the patients with relatively recent onset of ERM to assess the progression before deciding on surgical intervention.

CRM EP12

Idiopathic Intracranial Hypertension in a Non-Obese Adolescent Male: A Diagnostic Challenge

Jithmini KA, Warnakula PMT, Nilanka KAS, Gurusinghe L, Goonesekara DT

Purpose: To report an atypical presentation of Idiopathic Intracranial Hypertension (IIH) in a non-obese adolescent male, emphasizing the importance of neuro-ophthalmic evaluation and appropriate neuroimaging in atypical demographics.

Methods: A 15-year-old non-obese male with high astigmatism and spectacle use since age six presented with a three-week history of headache, tinnitus, and binocular diplopia. Comprehensive ophthalmic examination, contrast-enhanced CT, MRI brain and orbits, MR Venography, and lumbar puncture were performed. Diagnosis was established using modified Dandy criteria.

Results: Examination revealed bilateral papilledema and left lateral rectus palsy with preserved visual acuity and colour vision. Intraocular pressure was normal bilaterally. Contrast-enhanced CT was unremarkable. MRI demonstrated prominent CSF sheaths surrounding bilateral optic nerves. MR Venography excluded cerebral venous thrombosis. CSF opening pressure was elevated at 26.6 cmH_2O with normal biochemical and cytological composition. BMI was 21.6 kg/m^2, confirming non-obese status. No secondary cause was identified. Diagnosis of IIH was confirmed. Oral acetazolamide 125mg twice daily was initiated with gradual resolution of symptoms.

Conclusions: IIH should not be dismissed in non-obese adolescent males, as this case demonstrates that the condition can occur outside its classic demographic profile. Lateral rectus palsy as a false localizing sign and optic nerve sheath distension on MRI are important diagnostic clues. A high index of clinical suspicion, prompt neuroimaging, and lumbar puncture are essential in atypical presentations. Early diagnosis and timely initiation of acetazolamide can achieve favorable outcomes and prevent irreversible visual morbidity.

CRM EP13

Ocular Syphilis in the OCT Era: A Retinal Window into a Re-emerging Syphilis

Sathiyaraj B, Sriharanathan P, Kanchana Wijesinghe

Purpose: To report a case of ocular syphilis presenting as unilateral intermediate uveitis in a patient and to highlight its relevance in the context of the rising syphilis incidence in Sri Lanka.

Methods: A 54-year-old man presented with two weeks of painless unilateral visual blurring. Clinical examination showed left intermediate uveitis with a quiet anterior segment, no snowbanking, no disc oedema, and no retinal vasculitis. The fellow eye was normal. Because the phenotype was not typical of pars planitis, targeted systemic screening was performed for infectious and inflammatory causes. OCT was used as the primary imaging tool, as fluorescein angiography was declined.

Results: OCT revealed outer retinal changes suggestive of syphilitic outer retinitis (SOR). Serology confirmed active syphilitic infection with a serum VDRL titre of 1:256 and positive confirmatory testing. Although CSF analysis was negative, the ocular phenotype was managed as ocular syphilis/neurosyphilis. The patient received intravenous aqueous crystalline penicillin with corticosteroid cover. Following treatment, ocular inflammation resolved, OCT showed structural recovery of the outer retina, and VA improved from 0.8 logMAR to 0.2 logMAR.

Discussion: A primary diagnostic challenge in SOR is the deceptively normal funduscopic appearance. Our patient presented without systemic symptoms, and no disclosed sexual risk history. Ocular syphilis may present as vitritis, intermediate uveitis, posterior uveitis, outer retinal disruption, subretinal deposits, or subtle OCT changes. National data show an upward trend in syphilis, with 637 early syphilis cases and 832 late syphilis cases reported in 2024, predominantly among males.

Conclusion: The eye is a window—not just to the body, but to the diagnosis. OCT helps us discern. Ocular syphilis should be considered as form of neurosyphilis, and treatment should not be delayed because of negative CSF findings.

CRM EP14

Laser Pointer Maculopathy: A Preventable Threat from Excessive Power in Commercial Laser Pointers

Ranasinghe RMSDK, Sathiyaraj B, Karunarathna KPRP, Bandaranayaka YMTGRS, Kuruppu I

Purpose: To raise awareness of laser pointer maculopathy, its risks and clinical impact, while emphasizing the importance of education, regulation, and prevention to reduce avoidable vision loss.

Introduction: There is a growing trend of laser-related ocular injuries associated with high-powered handheld laser devices. The lack of awareness about their sight-threatening potential increases the risk of both inadvertent and intentional misuse. Strengthening public awareness regarding the hazardous effects of lasers is essential to prevent permanent vision loss as treatment options are currently limited

Case study: A previously well 14-year-old boy presented with a central scotoma in his right eye. The symptoms noticed two days after a direct exposure to a laser pointer through cornea. he experienced no discomfort during or immediately after the incident. The laser, which he had used at school laboratory as pointer, was labelled as class 3B with a wavelength of 650nm. At presentation, visual acuity of the right eye and left eye was 6/18 and 6/6, respectively. Funduscopic examination revealed pale spots in the left maculae involving fovea. Right side oct shows Loss of the normal smooth foveal depression with localized disruption at the fovea, focal hyperreflectivity and disruption of the ellipsoid zone at the foveal center and subtle irregularity of RPE. Fundal autofloroscene showed high uptake.

Discussion: Permanent tissue damage occurs through three mechanisms; ionization, thermal and photochemical. The type of laser used, wavelength, exposure time and spot size are major determinants of the extent of tissue injury. Thermal injury occurs with exposures ranging from microseconds to up to 10 seconds. If exposure exceeds 10 seconds, tissue destruction is due to photochemical, with phototoxic chemical reactions resulting in cell death and permanent vision loss. this patient exposed laser more than 30 seconds Prognosis: At sixth week oct showed thinning and loss of photoreceptor integrity at fovea and visual regain and follow up arranged for monitor the choroidal neovascularization.

Conclusion: Inappropriately used class 3 or 4 lasers should be considered weapons that can cause permanent blindness, even with brief exposures. We advised the school staff and students regarding the laser injuries and letter written to health ministry and government to limit the commercial availabilities of high-power hand-held laser devices.

CRM EP15

Hidden No More: Capturing the Evolution of Pigmented Paravenous Retinochoroidal Atrophy

Vitharana BHNR, Wariyapola DHH, Pavithran S, Iqbal FA, Dias S

Purpose: Pigmented Paravenous Retinochoroidal Atrophy (PPRCA) is a rare retinal disorder of unknown etiology, with diagnosis primarily based on characteristic fundus changes. Serial documentation of fundus evolution in PPRCA is seldom reported. We present an 8-year series of fundus images illustrating gradual pigmentary progression, supported by multimodal retinal investigations.

Methods: A 26-year-old female patient was referred for repeat electroretinography (ERG). Fundus examination and color fundus photography were performed, and previous clinical records were reviewed. Additional investigations included refraction, visual field assessment, optical coherence tomography (OCT), fundus autofluorescence (FAF), and ERG.

Results: Initial fundus photographs demonstrated subtle, non-specific retinal pigment epithelial (RPE) alterations without classical pigment clumping. Sequential imaging revealed gradual development of paravenous pigment clumping with progressive retinochoroidal atrophic changes, eventually evolving into a characteristic PPRCA phenotype. FAF demonstrated increasing hypoautofluorescent paravenous areas corresponding to RPE atrophy. OCT showed peripapillary and temporal peripheral outer retinal layer discontinuity. Visual field testing revealed peripheral defects with preserved central vision. ERG indicated rod–cone dysfunction with possible borderline macular involvement.

Conclusions: This case illustrates the sequential evolution of PPRCA in a symptomatic patient prior to the appearance of classical fundus findings. Serial imaging suggests a progressive pattern of pigmentary change, with abnormalities initially arising in the peripheral retina before extending along retinal veins to produce the characteristic paravenous phenotype.

CRM EP16

Seeing Beyond Redness: A Case of Indirect Carotid-Cavernous Fistula

Aberathna BMTP, Waruna Wijayasiriwardana, Kumudu Anthony

Purpose: To emphasize the importance of early recognition of indirect carotid-cavernous fistula (CCF) in patients presenting with persistent red eye and subtle ocular signs, as delayed diagnosis may lead to progressive ocular and neurological complications.

Methods: A 45-year-old female presented with progressive redness of the right eye, ocular pain, and gradual reduction of vision over five months. Clinical examination revealed a red eye with mild proptosis. Slit-lamp examination showed dilated, tortuous episcleral vessels in the right eye, suggestive of elevated episcleral venous pressure and an underlying vascular cause. Further investigations were performed to evaluate vascular causes, including cerebral angiography and digital subtraction angiography for confirmation of the diagnosis.

Results: Cerebral angiography confirmed a right-sided carotid-cavernous fistula. Digital subtraction angiography demonstrated arterial supply from branches of the bilateral external carotid arteries. The clinical and radiological findings were consistent with a low-flow dural CCF. Following diagnosis, the patient was referred for definitive neuro-interventional management, including embolization.

Conclusions: Indirect CCF should be considered in patients with persistent unilateral red eye, particularly when associated with pain and visual impairment. Anterior segment examination to identify dilated episcleral vessels, along with imaging, is essential for early diagnosis and appropriate management. Delayed recognition may result in persistent venous hypertension, leading to secondary glaucoma, diplopia, and permanent visual deterioration. Early recognition is important to prevent these complications.

CRM EP17

Evolving Diagnosis in a Patient with Optic Disc Edema and Vitritis: From Presumed Tuberculosis to Neurosyphilis

Munasinghe TD, Dayawansa KR, Upendran N, Aravindika D, Guruge A, Fonseka S

Purpose: To describe a case of ocular inflammation with evolving clinical diagnosis, highlighting the challenges in differentiating infectious uveitic etiologies in a tuberculosis-endemic setting.

Methods: A single case report of a patient presenting with progressive visual loss in the left eye associated with optic disc edema. Initial evaluation suggested optic neuritis. Subsequent development of vitritis with vitreous haze and cells, along with elevated inflammatory markers (ESR 60 mm/hr) and a positive Mantoux test (14 mm), raised suspicion of ocular tuberculosis, and anti-tubercular therapy (ATT) was initiated. MRI brain with contrast showed no significant abnormalities involving the optic nerves.

Results: Despite ongoing ATT, further evaluation was undertaken due to diagnostic uncertainty. Serological testing revealed positive treponemal and non-treponemal markers, including syphilis serology with TPPA and VDRL, leading to a diagnosis of neurosyphilis. The patient was commenced on intravenous Penicillin G for 14 days, followed by intramuscular Benzathine Penicillin. Lumbar puncture and further systemic evaluation are ongoing.

Conclusions: This case demonstrates the evolving nature of diagnosis in ocular inflammatory disease and highlights the importance of maintaining a broad differential in patients with disc edema and vitritis. Neurosyphilis should be considered even in the presence of supportive findings for tuberculosis, particularly in regions with overlapping infectious disease burdens.

CRM EP18

When VKH deviates; Blinding atypical VKH requiring early immunosuppressants

Karunarathne M, Niroshan N, Navarathna N, Vaikunthan N, Sidath S

Purpose: To describe the diagnostic challenges and successful therapeutic interventions in a teenage male with blinding bilateral acute VKH features. By detailing a case that was refractory to steroids but responsive to immunosuppressants, this report seeks to provide evidence for escalating treatment protocol when standard of care 'steroids' fail to arrest progressive intraocular inflammation.

Method: A case report is presented. A 23-year-old previously healthy male presented with bilateral granulomatous pan uveitis with exudative retinal detachments. With presenting visual acuity of bilateral HM, clinical data, multimodal imaging (OCT, FFA, MRI, ERG) and therapeutic interventions were analyzed. Patient's clinical course was tracked from initial presentation through corticosteroids failure to successful induction of remission using IV Infliximab. Visual acuity and anatomical resolution were primary outcomes.

Results: Patient was extensively investigated for possible differentials yet all being negative. Left eye TPPV+ SIO done. Initial trial of corticosteroids failed to achieve remission substituted with IV Infliximab monthly 3 doses resulted in BCVA recovery from HM to 6/12 and marked reduction in SRF with complete resolution of exudative RD. Patient was successfully tapered off systemic steroids while maintaining clinical stability on immunosuppressants.

Conclusion: This case demonstrates that steroid refractory VKH in a teenage male can be successfully managed with targeted immunosuppressants. Clinicians must be ready for quick transition to 2nd line agents if SRF persists despite high dose of steroids. Early aggressive management is the key to prevent progression to chronic sunset glow stage and serve favorable visual prognosis.

TRADE EXHIBITORS PROFILE

15th Colombo Retina Meeting 2026

STALL NO	NAME OF THE COMPANY
I.	Allergan (An Abbvie Company)
2.	Allergan (An Abbvie Company)
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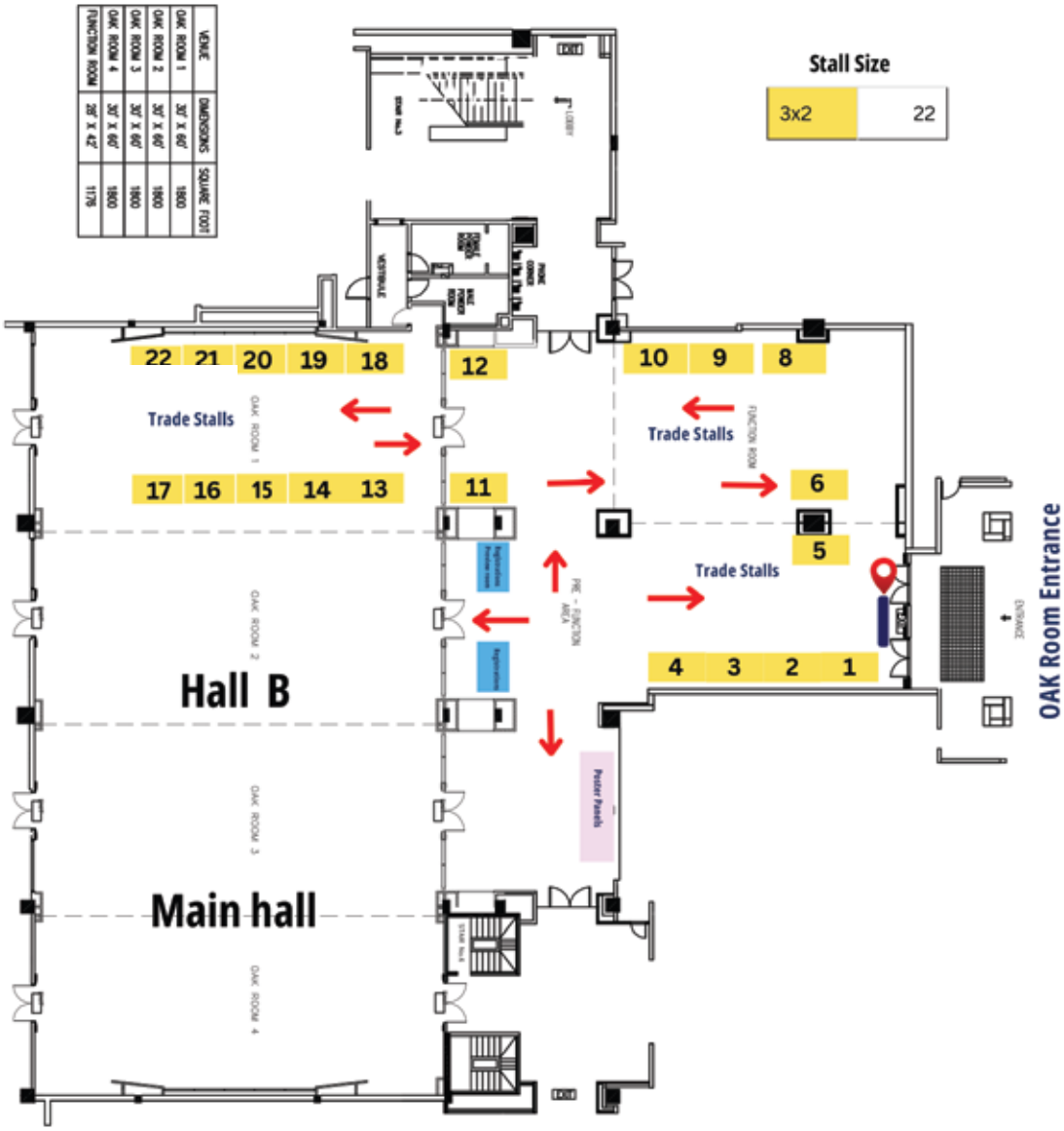
21.	A Baur & Co. (Pvt) Ltd -Distributor for Novartis Products
22.	Jayasuriya Associates

TRADE EXHIBITORS PROFILE

15th Colombo Retina Meeting 2026



15th Colombo Retina Meeting 2026

SPONSORSHIP ACKNOWLEDGEMENT

On behalf of the President and the Council of the Association of Vitreo Retina Specialists of Sri Lanka, we wish to express our deepest gratitude and sincere appreciation to all our supporting organizations. Your continuous support has been instrumental in making the 15th Colombo Retina Meeting 2026 a great success.

Thank you for your invaluable contribution to this important event.

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ACKNOWLEDGEMENT

The President & the Council Members of the Association of Vitreo-Retina Specialists of Sri Lanka extend their sincere gratitude and heartfelt appreciation to the following individuals and organizations for their generous support, dedication, and invaluable contributions towards the successful organization of the **15th Colombo Retina Meeting 2026.** Their commitment, collaboration, and unwavering assistance played a pivotal role in making this prestigious academic event a remarkable success. We deeply value their partnership and contribution to advancing retinal education and patient care in Sri Lanka.

- Guest Speakers
- Chairpersons
- Judges of the Free Paper, Poster, Surgical Video, and Photography Competitions
- Vitreo Retina Society of India
- Delegates Presenting Papers
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16TH COLOMBO RETINA MEETING 2027

ASSOCIATION OF VITREO RETINA SPECIALISTS OF SRI LANKA

1st to 3rd July 2027

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