

investigation revealed mild neutrophil leukocytosis with elevated C-reactive protein; serum amylase, renal function test, and liver function test were unremarkable. X-ray showed no gas under diaphragm; USS showed a Trace amount of free fluid with possible bowel perforation. Urgent CECT abdomen was taken, which showed suspicion for concealed perforation of the D2-D3 part of the duodenum with air-fluid collection.

Results: The patient was managed in the intensive care unit with close monitoring, intravenous antibiotics, a proton pump inhibitor infusion, and analgesics. The interventional radiology team noted that the retroperitoneal fluid collection observed on CECT was not amenable to image-guided biopsy. The patient was successfully managed conservatively.

Discussion and Conclusions: Acute small bowel diverticulitis is a rare presentation compared to large bowel diverticulitis. It often presents with complications such as abscess, perforation, or fistula formation. Patients with diverticular perforation typically present with an acute abdomen. Surgical management is usually reserved for cases complicated by bowel perforation and may involve open or laparoscopic-assisted resection of the affected segment, although endoscopic resection has also shown success. Interestingly, despite presenting with an acute abdomen due to diverticular perforation, the patient was successfully managed non-operatively, demonstrating that conservative treatment can be a viable option in selected cases.

PP 32

Early Experience in Developing a Vascular Surgery Database in a Low- and Middle- Income Country

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Introduction: Vascular diseases are a growing concern in low- and middle-income countries. To address this, a structured vascular surgery database was developed to capture clinical profiles, interventions, and outcomes.

Objectives: To establish a vascular database, evaluate its implementation, and identify trends in patient demographics, disease burden, and care delivery.

Design: Implemented at Wards 29 and 23A, Teaching Hospital Jaffna, the cloud-based database used a unique ID system to avoid duplication. Over six months, prospective data entry was performed by consultants, junior doctors, and pre-interns, including inpatient and outpatient details.

Results: A total of 172 inpatients (mean age-58.7) were recorded, predominantly male (n=121, 70.9%). Common comorbidities included diabetes (n=68, 39.5%), hypertension (n=48, 27.9%), end-stage renal failure (n=41, 23.8%), ischaemic heart disease (n=29, 16.8%), and dyslipidaemia (n=24, 14%). Leading presentations were Chronic limb threatening ischaemia (n=54, 31.4%), dialysis access issues (n=36, 20.9%), and varicose veins (n=34, 19.8%). Key interventions included AVF creation (n=31, 18%), angioplasty (n=24, 14%), endovenous laser ablation (n=24, 14%), and lower limb bypass (n=18, 10.5%). Additional procedures included amputations, wound debridement, arterial explorations, foam sclerotherapy, and aortic aneurysm repairs. Outpatient data included 261 clinic follow-up patients.

Conclusion: The clinical trends from our database highlight a clear male predominance in vascular and renal diseases. CLTI emerged as the most common presentation, reflecting a high burden of peripheral arterial disease. Mean age of 58.7 years indicates age-related vulnerability. Diabetes and hypertension were prevalent, reinforcing their role as key risk factors. Integrated follow-up tracking and discharge summaries enhanced care continuity. The system fostered team collaboration, enabled audits, and proved that structured clinical databases are feasible and impactful even in low-resource settings. Limitations include incomplete records, limited data, entry support, missed data in day admissions and lack of hospital-wide digital integration.