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Confronting the wolf in sheep's clothing Unmasking the risks of vaping....

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8 PLENARIES

2 PANEL DISCUSSIONS

11 SYMPOSIA

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CONTENT

'Healthy lungs, happy life. Stay away from tobacco'

#No Tobacco

President's Message

Dear SLMA Members,

This year too, as in the previous years, we have undertaken many activities to enhance the knowledge and skills of medical professionals, as well as playing key roles in advocacy.

Tobacco and substance abuse is an area that SLMA will continue to play a key role in advocating among the policy makers and other key stake holders to act against promotion of smoking, especially amongst the adolescents.

'World no tobacco day' falls this month on 31st May and SLMA plans to hold a media seminar with the participation of all stake holders, at the SLMA Auditorium in early June in commemoration of this day. This will be a hybrid meeting and all of you are invited to join, either online or in-person.

World No Tobacco Day was created in 1987 by Member States of the World Health Organization (WHO) to raise awareness of the harm caused by tobacco products to people, public health, communities, and the environment. This year, WHO is focusing on preventing youth tobacco product use and the tobacco industry's attempts to attract youth. The SLMA will also hold its activities on the same lines.

As we are aware, the use of any narcotic substance, including tobacco, can have many negative effects on all, young people included, impacting both their immediate health and long-term well-being (both physical & psychological). Young adults are mostly drawn to smoking, alcohol and other substance abuse due to promotion by social media and peers. Peer pressure is one of the major drivers of attracting young persons to these harmful substances

– at parties/ big matches/ funerals/ weddings/ etc. Use of alcohol in a group especially, is unfortunately depicted as belonging to a specific group or social class.

According to the World Health Organization (WHO), the prevalence of smoking among boys and girls aged 15 year was 15% in 2021/22 and the prevalence of smoking e-cigarettes was 20%.

There are policies in place in Sri Lanka where smoking is banned in public places, as well as graphic warnings on tobacco packaging, bans on tobacco and alcohol advertising, promotion and sponsorship and taxation measures to increase the price of alcohol and tobacco.

National Authority on Tobacco and Alcohol (NATA) of Sri Lanka, established in 2006, is empowered to regulate the production, importation, sale and use of tobacco and alcohol products in the country. It plays a major role in enforcing tobacco control measures and monitoring compliance with regulations. However, it has to be strengthened with amendments to the law enabling them to handle the current challenges.

SLMA also has a separate Expert Committee on Tobacco, Alcohol & Illicit Drugs, which consists of health experts in this field who works tirelessly to advocate safeguarding the population, especially the children and adolescents regarding narcotics abuse and plays a part in advocacy and lobbying with the government for stringent laws on tobacco, alcohol, and other narcotics.

The latest menace, as you all must be aware that is being promoted as a substitute for cigarettes and being advertised as less harmful among the youth, is e-cigarettes or vapes.

Most e-cigarettes contain nicotine, which has known deleterious health effects like a normal cigarette and is a highly addictive substance. The e-cigarette aerosol also contains other chemical substances that harm the body. Convincing evidence is there about the serious lung injury and deaths caused by smoking e-cigarettes. Contrary to the popular belief e-cigarettes do not help quitting smoking.

I would like to invite all our members to support the SLMA in its advocacy efforts to ban the promotion and import of e cigarettes to the country and in its efforts to educate the public on the harmful effects of tobacco, alcohol, and all other narcotic substances.

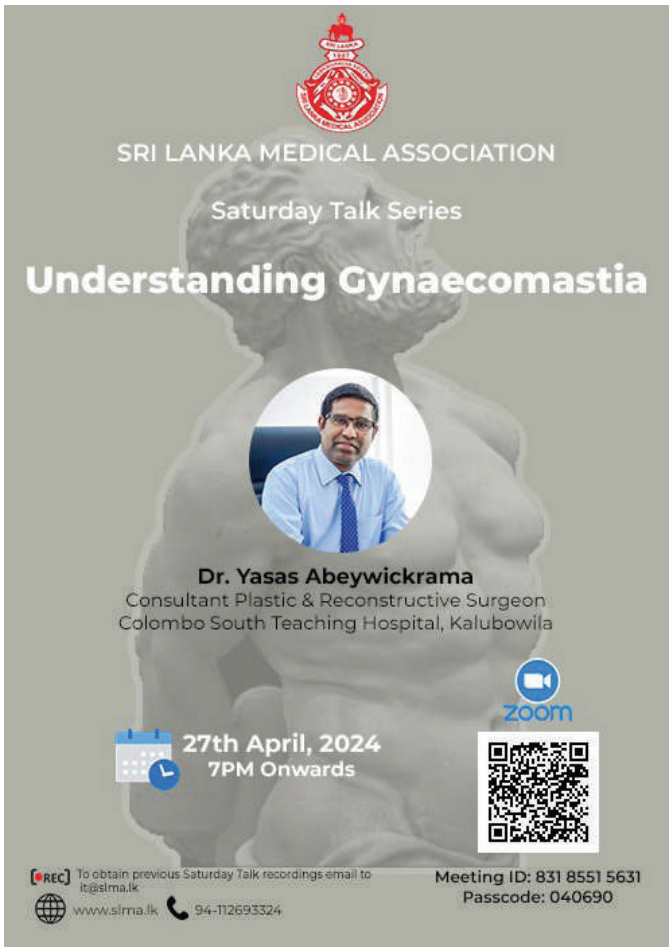
Dr Ananda Wijewickrama
President, SLMA
MBBS, MD, MRCP (UK), FCCP
Consultant Physician,
National Institute of Infectious Diseases

Activities in Brief
(16th April 2024 – 15th May 2024)

Saturday Talks

Following SLMA Saturday Talks were held.

27th April - *'Understanding Gynaecomastia'* by Dr Yasas Abeywickrama, Consultant Plastic & Reconstructive Surgeon, Colombo South Teaching Hospital, Kalubowila.



4th May - *'Back to the Future: Cannabis & Tobacco'* by Drs Mahesh Rajasuriya, Lead, Centre for Combating Tobacco, Faculty of Medicine, Uiversity of Colombo, Dr Manoj Fernando, Senior Lecturer in Health Promotion, Rajarata University & Dr Malsha de Silva, Consultant Psychiatrist, NIMH.

Monthly Clinical Meetings

The April clinical meeting was held in collaboration with the Sri Lanka College of Pulmonologists on **30th April** on *'Lung voyage with Bronchiectasis'*.

Case presentations on bronchiectasis were done by Drs Hiruni Nimesha & Kalana Jayaweera, Senior Registrars in Respiratory Medicine attached to NHRD, Welisara.

Dr Eshantha Perera, Consultant Respiratory Physician, NHRD, Welisara spoke on *'Navigating Bronchiectasis with Expert Guidance'*.

Therapeutic Lectures

A therapeutic update on *'Rational Use of Antifungals in Superficial Fungal Infections'* was delivered by Dr Nayani Madarasinghe, Consultant Dermatologist, Base Hospital, Mulleriyawa, on **3rd May**.

Pre-congress Workshops

The fourth pre-congress workshop on *'Management of Common Paediatric Emergencies'* was held at the SLMA Auditorium on **10th May** in collaboration with the Paediatric Intensive Care Chapter of the Sri Lanka College of Paediatricians.

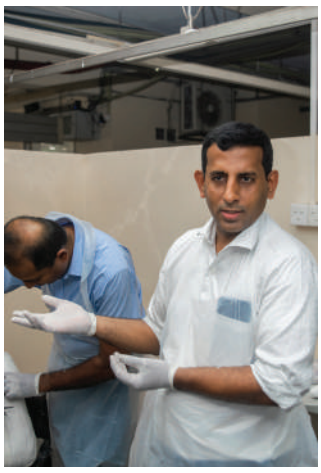
Topics of discussion were as follows;
Dr Udaya de Silva *'Snake Bite'*, Dr Deshan Adihetti *'Acute severe asthma'*, Dr Manjula Hewageegana *'Overview of sleep disorders, septic shock, meningococcal sepsis & hypertensive emergencies'*, Dr Deshan Adihetti *'Diarrhoea, dehydration & electrolyte imbalance'*, Dr Nalin Kitulwatte *'Shock, anaphylaxis, status epileptics & raised intra cranial pressure'*, Dr Nimesha Gamhewage *'Sick neonate'*, Dr Lakshitha Samaranayaka *'Acute kidney injury'* & Dr Duminda Samarasinghe *'Cardiac arrhythmias'*.

The fifth pre-congress workshop on *'Non-operative management of fractures & dislocations with hands-on training on casting techniques'* was held at the Epilepsy Building Auditorium, NHSL on **12th May** in collaboration with the Sri Lanka Orthopaedic Association & National Hospital of Sri Lanka, Colombo.

Topics of discussion were as follows;
Dr Upali Banagala *'Fracture healing & non-operative treatment'*, Dr Sundaralinga Sutharshan *'Clavicle fracture'*, Dr Kanapathipillai Umapathy *'Proximal humerus fractures,* Dr Shivantha Fernandopulle *'Humeral shaft fracture'*, Dr Kanagaratnam Kandeepan *'Supracondylar fracture'*, Dr Udai de Silva *'Colies fracture'*, Dr Nanda K Amarasinghe *'Extra-capsular neck of femur fracture'*, Dr Jeyakumar Janaarthanan *'Patellar fracture'*, Dr Eshan Jayaweera *'Tibia fibula fracture'*.

Dr Rajeswaran Vimalaranjan *'Hip dislocation'*, Dr Parakrama Dharmaratne *'Acromio Clavicular joint dislocation'*, Dr Dilshan Munidasa *'Shoulder joint dislocation'*, Dr Velayutham Swarnakumaar *'Elbow joint dislocation'*, Dr Pradeep Amarasinghe *'Ankle joint fracture'* & Dr Sunil Wijayasinghe *'Paediatric fractures'*.

Five practical sessions followed the lectures;
Application of plaster U slab, dorso radial slab, above knee POP back slab, below knee plaster full cast & joint reduction maneuvers: hip, knee, shoulder, elbow & application of useful splints



Regional Meetings

The second regional meeting for the year was held with the collaboration of the Office of the Regional Director of Health, Galle & the Clinical Society,Base Hospital, Udugama at the Hospital on **6th May** on *'Health & wellbeing in the elderly'*.

Dr Lasantha Ganewatta, Consultant Physician, District General Hospital Matara spoke on *'Prescribing in the elderly'*, Dr Amila Chandrasiri, Consultant Community Physician, RDHS Office, Galle on *'The concept of health ageing'* and Dr Lakmal Vithanage, Consultant Physician, Base Hospital, Udugama on *'Common medical conditions among the elderly'*.

Intercollegiate Committee Meetings

The Intercollegiate Committee of the Sri Lanka Medical Association held a meeting with the participation of the Honorable Minister of Health, Dr. Ramesh Pathirana **on 8th May** at the SLMA, recognizing the significant commitment/ contributions made by the health professionals for the upliftment of the health of the country & its people.

The meeting was attended by over 42 participants including Presidents of Professional Colleges/ Associations and their representatives.

Hon. Minister highlighted the importance of guiding national health policy matters by the professionals through their technical expertise and reiterated that the Ministry of Health always welcome their valued guidance.

Main points of discussion at the meeting were on the proposed patient safety charter, rational prescribing/ investigations, issues regarding mangement of adolescents in adult/ paediatric wards, establishment of the proposed NCD bureau, legislation on vaping/ e cigarettes, national digital health blue print, etc.

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Confronting the wolf in sheep's clothing Unmasking the risks of vaping....

Dr.Neranjan Dissanayake

MBBS (Peradeniya) MD (Medicine) MRCP(UK)
FRCP(Lon) FCCP(SL) FCCP(USA)
Consultant Pulmonologist

Vaping has become an epidemic, especially amongst the teens, women, and children.

It has been estimated that each day, more than 3000 of the younger generation, who were never smokers, commences vaping in the USA alone. Most unfortunately, majority of them do not understand the major health and psychological consequences that they are predisposed to due to vaping. In Sri Lanka, there is evidence to suggest an increasing trend in vaping and other recreational inhalation devices amongst young adults, women and teenagers.

It is intriguing to note that a significant number of Health care professionals are unaware of this trend and are uninformed of the potential harm that vaping and these devices. This article tries to bring ito light what vaping really is and attempts to highlight the harmful effects and hopefully to build a consensus amongst the medical fraternity and policy makers to build up measures to mitigate its effects in the Sri Lankan population.

What is Vaping…

Vapes, or e-cigarettes, function by heating a liquid (E liquid) by using an atomizer to produce an aerosol, often known as vapor, which the user inhales. (Fig 1. Structure of a Vaping device).

This inhalation process of the vape is called vaping. There are many devices that has the same mechanism and gradually they have developed form the first-generation disposable e cigarettes to the fourth generation Pod-Mods which allows refills and to modify according to the users' preferences. These fourth generation devices, comes in various colors and designs that are appealing to the younger generation. (Fig 2 Vaping Devices). Especially the current highly popular device called JUUL is designed in a way that it can be used in a very discreet way. It produces minimum visible vapor and comes in different shapes, and may even resemble a data pen or a similar device that is used commonly by children.

Shisha; commonly known as hookah, is a device which burns flavored nicotine to produce a vapor and smoked through a water pipe which takes the vapor through water to cool it down before being smoked by the user. In either way the vapor which is produced through these devices travel all the way to the lungs through the airway.

E- Liquids…

Also known as vape juice or vape liquid, is the fluid used in electronic cigarettes & Vapes to create vapor. It typically contains:

- **Propylene Glycol (PG)** - A substance found in many food and pharmaceutical products, which carries the flavor and nicotine.
- **Vegetable Glycerin (VG)** - A thickening agent that produces the vapor.
- **Flavourings** - These give the e-liquid a specific taste.
- **Nicotine** - Available in various strengths, depending on user preference.

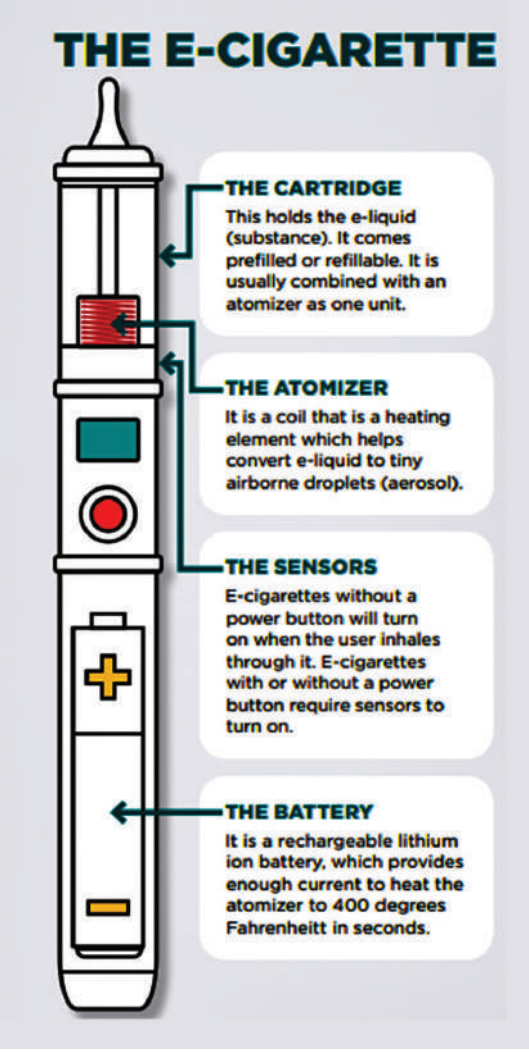


Figure 1: Structure of an E Cigarette

- **Cannabis Oil** – Some E liquids contains cannabis oil or other forms of Marijuana.

These e-liquids often come to the market with fruit and candy flavors and are designed using vibrant and eye catching colours which will grab the attention of young children and women.

Vapes and E-Cigarettes are growing in popularity among females and the younger generation, particularly in specific social groups in the country, due to their appealing design, high-tech operating system that is easy and user-friendly, and the fact that they do not leave bad breath or smoke. It has been an increasing problem in society because vape users are incredibly difficult to recognize due to the nature of its operation. The notion that these devices can be used as a support therapy for quitting smoking, perpetuated by vendors and influencers, plays a significant role in encouraging smokers to use them. However, existing smokers who start utilizing these gadgets to quit smoking often end up maintaining their smoking habits and become addicted to the use of vapes and e-cigarettes as well, in addition to traditional smoking.

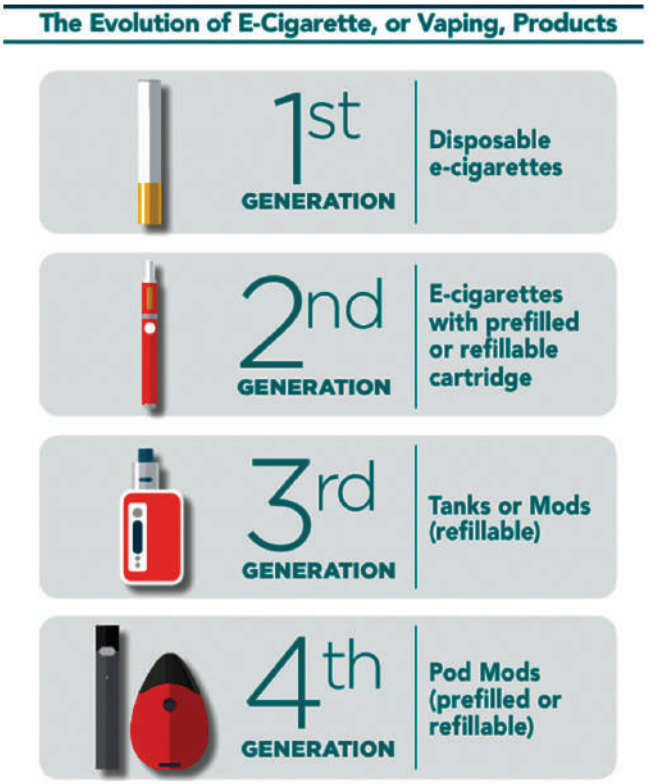


Fig 2 Evolution of Vaping Devices

Figure 3 - Fourth Generation Vape and E-Cigarette

It's a popular fallacy that vapes and e-cigarettes are perfectly safe, but the reality is far more complicated. While studies show that vaping is less dangerous than traditional smoking, it is not without risks. E-cigarettes and vapes do not contain tobacco and its combustible products, those being the principal cancer-causing ingredients in regular cigarettes. However, they still contain nicotine and other substances which are addictive and may expose users to other potentially dangerous drugs.

Most Asian countries, including Sri Lanka, do not have rigorous norms or regulations in place to monitor or manage these devices, which has created a significant regulatory gap that precludes adequate control of their rising use in the Sri Lankan market. These gadgets are frequently carried into the country by hand from other countries and are mostly promoted to young people and women via popular social media platforms such as Facebook, WhatsApp, Telegram, Viber, and SMS.

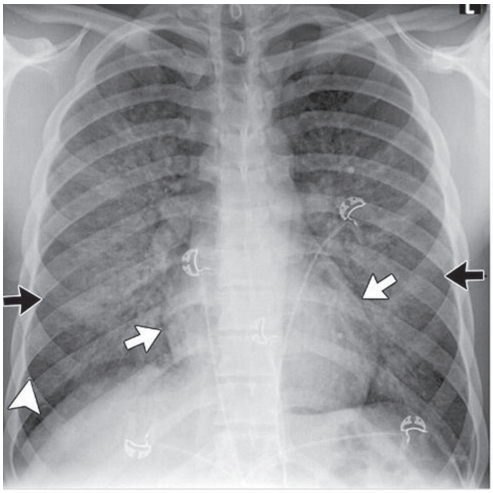
Lack of understanding and awareness among parents and influencers has resulted in young children as young as 12 years being addicted to these devices, and a few incidents have been documented of parents gifting these devices to their young children simply due to lack of knowledge and not knowing the severe harm these can cause to their child's life.

Due to the lack of information availability, it is being notified that even the medical professionals are not fully aware of the severity of damage these devices can cause.

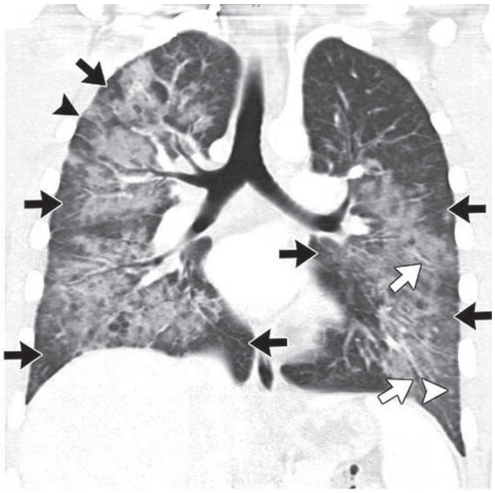
Vapes and e-cigarettes: the harm it causes…

Nicotine Addiction – Majority of E-cigarettes, vapes and Shisha contain extremely addictive nicotine, sometimes about 20 times more than a cigarette. Furthermore, it is manufactured in a way that it is easily absorbed with minimal side effects in high quantity. This addiction can lead to use of other tobacco products, mainly cigarette smoking, in later life, the very thing we plan to avoid.

Nicotine can negatively impact on brain development, especially in children and teenagers. Most e-cigarette & Vape aerosols include harmful compounds that has a high possibility of generating and developing cancer cells and a negative impact on fetal development during pregnancy.



a.



b.

E-cigarette or vaping product use–associated lung injury (EVALI) is a severe pulmonary illness associated with the use of e-cigarettes or vaping products that was officially identified and named in 2019. There were more than 2500 deaths directly attributed to EVALI in USA, and many had suffered permanent lung injuries.(figure 4 EVALI)

E-cigarette vapor contains dangerous chemicals including diacetyl, acrolein and formaldehyde which can cause significant lung damages and can lead to the development of COPD, Asthma and other lung disorders.

The World Health Organization (WHO) and other health institutions strongly advise against the use of e-cigarettes and vapes, especially by non-smokers, children, and adolescents, due to these health risks. The safest approach is not to consume either tobacco products or e-cigarettes (U S Department of health & Human services).

As Medical professionals we have a great responsibility and a crucial role to play in creating awareness about the potential harms of vape, E-Cigarettes, Shisha and any other devices in similar category. It has come to a point that we as medical professionals should include probing questions on usage of these devices from our patients who comes with potential signs and symptoms. It is time that we, as the medical fraternity in Sri Lanka, take the initiative to create awareness of the health risks and the effect these devices have on our children and the youth, amongst our colleagues. We can then develop a detailed strategy to educate the public as well as policy makers to mitigate its effects.

Some of the strategies that we can employ are,

- **Educational Campaigns -** Launching public health campaigns to inform the public about the risks associated with vaping, such as lung damage, addiction, and exposure to toxic chemicals.
- **Research and Publication -** Conducting and publishing research on long-term effects of vaping, which can provide evidence-based information to the public and policymakers.
- **Community Engagement -** Organizing community programmes and workshops, especially targeting youth & the female population, to educate them about the dangers of vaping and nicotine addiction.
- **Healthcare Settings -** Using the opportunity during patient visits to discuss the risks of vaping, use of E-Cigarettes & Shisha, especially with adolescents and parents.
- **Policy Advocacy -** Advocating for stricter regulations on vape products, including marketing restrictions and bans on flavours that appeal to children.
- **Social Media -** Utilizing social media platforms to reach a wider audience with educational content and measures to counteract the promotion of vaping products.
- **Collaboration -** Working with schools, parents, and other stakeholders to create a unified message about the dangers of vaping.
- **Support Services -** Providing resources and support for individuals who want to quit vaping, such as counselling services or nicotine replacement therapies.

Tackling the "Wolf" will need a broad alliance. The Sril Lanka Medical Association, the Sri Lanka College of Pulmonologists, and the Sri Lanka College of Paediatricians, together with likeminded professional organizations should take the lead in forming this alliance.

I hope that this will be the first step towards that journey

Acknowledgements:

Ms S A Thakshila Senani Ubeysena

MBA(UK), Dip. N

Psychoactive substance use management in Sri Lanka

Dr Amanda Kasturi Mudali
Senior Registrar in General Adult Psychiatry
University Psychiatry Unit, National Hospital of Sri Lanka

Dr Chathurie Suraweera
Consultant Psychiatrist
University Psychiatry Unit, National Hospital of Sri Lanka

Psychoactive Substances

The World Health Organization (WHO) defines psychoactive substances as compounds that, upon ingestion or administration into the body, impact mental functions such as perception, consciousness, cognition, and mood (1). These substances can be categorised based on their effects into opioids (heroin, methadone), stimulants (cocaine, ecstasy), cannabis, psychedelics, and other dissociative substances like Lysergic Acid Diethylamide (LSD), mescaline and psilocybin.

The number of psychoactive drug-related arrests in 2020 was 97,404. Compared with 2019, this is an increase of 9%. Out of the total drug-related arrests, 53% and 42.2% were for heroin and cannabis, respectively (2). Most of the drug-related arrests have been reported from the Western province (42%), followed by the North-Western province (12%) and the Southern province (10%) (2). Among the drug-related arrests, 23% were from Colombo District, 13.3% from Gampaha, and 7.5% from Kurunegala District. The prevalence of drug-related arrests was 478 per 100,000 population in the age category of 15-64 in 2020 (2).

Substance use presents a significant challenge, with 16% of Sri Lankan adolescents reporting the use of at least one illegal substance in their lifetime. In 2020, there were 97,416 arrests related to possessing, selling, or cultivating illicit substances, with 23.2% occurring in the Colombo district (3). A large percentage (75%) of individuals who completed existing rehabilitation programmes reported relapses of substance use disorder (3).

There are laws regulating the production and distribution of such substances worldwide. There may be variations in laws enforced to control these substances among countries and regions. Based on their health risks and therapeutic value, these substances are classified into different schedules at both national and international levels. Internationally, there are conventions focused on regulating the production and distribution of psychoactive drugs. This includes the 1961 Single Convention on Narcotic Drugs, as amended by a 1972 protocol; the 1971 Convention on Psychotropic Substances; and the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. Some of the acts relevant to Sri Lanka are summarised in Box 1(2).

Available preparations in the country

It is the most used illegal drug among young people in Sri Lanka, with a prevalence of 1.9% of the total population above 14 years (4). It is usually rolled into a joint and smoked like a cigarette or through a special pipe. It can make users feel relaxed, talkative, and giggly, but it can also cause panic, confusion, tiredness, and increased appetite. Heroin is a brownish-white powder that can be smoked, sniffed, or injected. It makes users feel very relaxed and disconnected from the world. Methamphetamine is usually inhaled. It is commonly used by polydrug users. As it is a stimulant, it can lead to an increase in physical activity and aggression in users. Other drugs used, though not commonly, include MDMA and cocaine, both of which are stimulants.

Box 1: Acts relevant to drugs in Sri Lanka

1. National Dangerous Drugs Control Board Act no. 11 of 1984
2. Drug Dependant Persons (treatment and rehabilitation) Act, no.54 of 2007
3. National Authority on Tobacco and Alcohol Act, no 27 of 2006

Conventions against illicit traffic in Narcotic Drugs and Psychotropic Substances Act, no.01 of 2008

Prescription medication misuse is also recognised by clinicians as a developing problem in their everyday practice, even though there is a lack of published data in this regard. These drugs commonly include pethidine, tramadol, different benzodiazepines (such as diazepam, clonazepam, lorazepam, alprazolam, and oxazepam), cough syrups containing dextromethorphan, the antipsychotic quetiapine, and anticonvulsants like pregabalin and gabapentin. Tramadol is also commonly abused in the country. It is an opiate and has effects like heroin but is far less potent. There is an emerging trend in the country where people have started abusing pregabalin and gabapentin, which are prescription drugs commonly prescribed to

relieve neuropathic pain. Pregabalin can be abused through various routes, including oral ingestion, intravenous injection, nasal insufflation, rectal administration (known as "plugging"), smoking, and "parachuting" (emptying the contents of the capsule into a pouch). The compounds are often called by their street names, some of which are given in Table 2.

Box 2: Street names of commonly used psychoactive substances

Cannabis – Ganja, madanamodaka, abin, mal, marijuana, dope, pot, grass, weed, head, Mary Jane, doobie, bud, hashish, hash, bhang

Heroin – Kudu, brown, H, hero, dope, Black Pearl, Black Stuff, Brown Crystal, Brown Rhine, Brown Sugar

MDMA – Ecstasy, Adam, Beans, Candy, Clarity, Dancing Shoes, Disco Biscuits, E, E-Bom

Tramadol - Apple

Methamphetamines - Speed, Crank, Ice, Crank, Cream, Crystal, Crystal Meth

Tramadol - Apple

Cocaine - C, Big C, Coke, Crack, Dust, Flake Line.

Dependence, harmful use, intoxication, withdrawal

Patients misusing psychoactive substances may present to healthcare services at various stages and with a multitude of complaints. They may present themselves, be brought by family and friends, or be referred through courts and the police.

Intoxication, as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), the International Classification of Diseases (ICD) tenth revision (ICD-10) and eleventh revision (ICD-11), is a transient syndrome resulting from recent ingestion of a substance that causes significant psychological and physical impairment. These impairments resolve once the substance is eliminated from the body. The specific psychological changes experienced during intoxication vary among individuals and substances. The 'withdrawal' state describes symptoms and signs that arise when a drug is decreased or discontinued. The characteristics of which depend on the type of substance used. According to ICD 10, 'Harmful use' refers to patterns of substance use that cause harm to physical and mental health without meeting the criteria for dependence. The criteria to diagnose 'dependence' include a heightened priority for using a substance over other behaviours that were once more important to the individual. A key characteristic is a strong, sometimes overpowering desire to consume psychoactive drugs, otherwise known as craving. An interesting phenomenon related to substance use is 'reinstatement', where substance use after a period of abstinence may lead to a faster recurrence of other features of the dependence syndrome compared to non-dependent individuals. The various categories of disorders that may arise with psychoactive substance use are given in Box 1 (5)(6)(7)(8).

Table 1: The substance-related conditions according to classification systems

DSM-5	ICD-10	ICD-11
Intoxication	Intoxication	Intoxication
Use disorder	Dependence	Substance dependence
	Harmful use	Episode of harmful psychoactive substance use Harmful pattern of psychoactive substance use
Withdrawal	Withdrawal state	withdrawal
Delirium	Withdrawal state with delirium	Substance induced delirium
Psychotic disorder	Psychotic disorder	Substance induced psychotic disorder
Neurocognitive disorder		
Amnestic disorder	Amnestic syndrome	
Mood disorder	Residual and late-onset psychotic disorder	Substance induced psychotic disorder
Anxiety disorders	Other mental and behavioural disorders	Substance induced anxiety disorder
		Substance-induced obsessive-compulsive or related disorder
		Substance-induced impulse control disorder

Abstinence and harm reduction

Abstinence involves complete cessation of substance use. This is usually the recommended approach for individuals with dependence syndrome and those who have experienced significant negative consequences from their substance use. Harm reduction strategies include needle exchange programs for intravenous drug users and supplying condoms and wound care supplies (9).

The cut-down approach involves reducing the quantity or frequency of substance use without complete cessation. This approach may be suitable for individuals with less severe substance use problems or those who are not ready or able to commit to total abstinence. While cutting down may be a more achievable goal for some individuals, it can be challenging to maintain, as it requires ongoing self-control and may not address the underlying issues driving substance use.

Detection of psychoactive substances

Out of the available methods, an immunoassay (IA) test is most used because it is the quickest and most cost-effective. However, IA tests can give false-positive results. False-negative results can also occur. The gas chromatography-mass spectrometry (GC-MS) test is more reliable than an IA test, and it can detect more substances (10). This is available at the National Dangerous Drugs Control Board (NDDCB), some government hospitals depending on the availability of the test kits and in the private sector (2). Consuming certain legal substances can lead to false-positive IA test results. For example, consuming high quantities of dextromethorphan, a common ingredient in cough syrups, can yield a positive result for phencyclidine (PCP).

In the hospital setting, the use of morphine and benzodiazepines will affect the interpretation of the test. Cut-off levels have been introduced to minimise the risk of false positives. This means that a result is only positive when the test detects an amount of a drug above a certain level. Cut-offs also reduce the likelihood of testing positive due to passive exposure to a drug, for example, second-hand smoke. Many factors can affect when a test can detect a particular drug. The person's body mass, hydration levels, the acidity of their urine, and last drug use affect the detection of the psychoactive drug in the urine. Overall, the more frequently and heavily drug use occurs, the longer the drug will be detectable. The detection time of some psychoactive substances in urine is given in Table 2.

Table 2: Detection time of some psychoactive substances in urine

Drug	Detection times after use
Alcohol	7–12 hours
Amphetamines	2–3 days
Short-acting benzodiazepines	3–5 days
Long-acting benzodiazepines	up to 30 days
Buprenorphine	up to 11 days
Cannabis - Single use	2 days
Cannabis - Three times a week	2 weeks
Cannabis - Daily use	2-4 weeks
Cannabis - Heavy daily use	Up to 12 weeks
Cocaine metabolites	2–4 days
Codeine	1–2 days
Fentanyl	2–3 days
Heroin or morphine	1–3 days
Methadone	3–4 days
Oxycodone	1–3 days

Rating scales have been designed to help detect substance use disorders and associated conditions like harmful use and withdrawal. They help in planning further management for people using psychoactive substances.

The Alcohol Use Disorders Identification Test (AUDIT) developed by the WHO is designed to assess a spectrum of risk levels, ranging from low-risk drinking to hazardous drinking and alcohol use disorders. Both clinician-administered and self-report versions are available (11). It has ten items, each scored out of four and is validated for Sri Lanka. A score of eight or more suggests hazardous use, while a score of more than 20 indicates the need for pharmacologically assisted withdrawal. The Clinical Institute Withdrawal Assessment for Alcohol–Revised (CIWA-Ar) is a standard objective method of assessing and planning management to treat alcohol withdrawal. It has ten items assessed by observation or by eliciting information from the patient. This includes components such as agitation, anxiety, auditory disturbances, clouding of sensorium, headache, nausea/vomiting, paroxysmal sweats, tactile disturbances, tremors, and visual disturbances, each of which is given a score of 0 – 7. A score of more than ten should prompt

assisted withdrawal with benzodiazepines (12). The Clinical Opiate Withdrawal Scale COWS) is an 11-item clinician-administered scale used to assess the severity of opiate withdrawal objectively. This includes resting pulse rate, pupil size, sweating, restlessness, runny nose, bone aches, gooseflesh, anxiety, yawning, tremors, and gastrointestinal upset. A score of 5 to 12 indicates mild withdrawal, while 13 to 24 indicates moderate withdrawal. A score of 25 to 35 indicates moderately severe withdrawal and a score of 36 or higher indicates severe withdrawal (12).

Acute management

The acute management of patients consuming psychoactive substances depends on the stage of presentation. If patients present with withdrawal symptoms and signs, they can be offered treatment to alleviate these symptoms and ensure the safety of both patients and others. Care must be taken to assess for psychotic and affective symptoms when patients present with withdrawal symptoms. These patients should be referred to the local psychiatric clinic or dedicated substance abuse clinics to instigate psychological therapies and medication to maintain abstinence and treat comorbid psychiatric illnesses.

Alcohol

Patients with alcohol dependence will usually require pharmacologically assisted withdrawal with benzodiazepines if they consume more than 15 units of alcohol per day or have significant withdrawal symptoms (13). It is important to decide on the setting of managing alcohol withdrawal as it may be associated with serious complications such as delirium tremens and withdrawal seizures. Inpatient detoxification is usually warranted if the patient consumes more than 30 units of alcohol per day, has a comorbid mental or physical illness, has a history of delirium tremens or seizures, has concurrent use of benzodiazepines or other substances, and is pregnant, or has poor social support or has a history of failed community detoxification (12). Community detoxification is possible, given the patient does not have any of the conditions mentioned above and has good social support.

These patients will require treatment with benzodiazepines, usually chlordiazepoxide or diazepam, due to their long half-life or lorazepam in the presence of liver disease and thiamine. Benzodiazepines are administered according to a fixed dose regimen based on number of alcohol units consumed daily. A common outpatient treatment regimen for alcohol withdrawal typically begins with a dose of 20–30 mg of medication four times daily, with the dose gradually reduced and then stopped over 5–7 days. Those without neuropsychiatric complications should ideally be provided with a minimum of 300mg daily oral thiamine during assisted alcohol withdrawal and periods of ongoing alcohol consumption. All patients undergoing inpatient detoxification should receive intramuscular thiamine 250 mg daily for five days as prophylaxis (12).

Methamphetamine

The management of withdrawal of patients using methamphetamine is mainly supportive and rarely requires inpatient treatment unless there are effects of psychosis or overdose. They should be allowed to rest in quiet surroundings for a few days, sleep, and eat as needed. Stimulant-induced psychosis is a phenomenon associated with 10 – 15% of methamphetamine use and can be seen among methamphetamine users in Sri Lanka (14). These patients will experience psychotic symptoms such as persecutory delusions and tactile hallucinations. This will require admission to a psychiatric unit. The psychotic symptoms will usually resolve with abstinence. Still, they may need a short course of benzodiazepines and antipsychotics if the patient is disturbed and poses a threat to themselves or others. However, it has been found that patients who use methamphetamine have a fourfold increased odds of developing extrapyramidal side effects after being treated with antipsychotics. Therefore, agents such as olanzapine are preferred for such patients (12). Depressive symptoms may commonly appear during withdrawal as well. However, as it may be a part of the withdrawal phenomenon, the patient should be reassessed around two to four weeks after the last use to determine whether there had been an underlying depressive episode which warrants treatment with antidepressants.

Opioids

Patients dependent on opioids such as heroin will experience severe withdrawal symptoms commonly called 'the sick' in lay terms. These symptoms usually start six hours after the last use, reach a peak in 48 hours and resolve within a few days. They will require symptomatic management during detoxification with analgesics, antihistamines, sedatives, and proton pump inhibitors, depending on the distressing withdrawal symptoms they experience (12). Opioid substitution treatment using methadone or buprenorphine is another option to manage withdrawal symptoms and reduce drug use (12).

Cannabis

The management of cannabis withdrawal is by supportive care and reassurance. Patients may experience insomnia,

anxiety, decreased appetite and mood swings. The use of cannabis has been associated with effects on anxiety, mood, cognition, and psychotic illness. Research shows that cannabis can increase the risk of developing bipolar affective disorder by five times in vulnerable individuals and bring forward the age of onset. It has similar effects on the development of schizophrenia in users, with a 2.5 times increase in mild users and a six times increase in heavy users. Chronic use of cannabis can also lead to 'amotivational syndrome' with impairments in memory, executive functioning, attention, and inhibitory processes (15). Therefore, these patients should be started on psychological therapies to help maintain abstinence from cannabis and other psychoactive substances.

Pregabalin

The management of pregabalin withdrawal involves a gradual tapering of the medication under supervision to minimise withdrawal symptoms. Abrupt discontinuation of pregabalin can lead to withdrawal symptoms such as anxiety, insomnia, nausea, sweating, and muscle spasms. Prescribe Supportive medications such as benzodiazepines may be prescribed to manage specific withdrawal symptoms (14)(13).

Long-term pharmacological management

Naltrexone, disulfiram and acamprosate are the medications used to maintain abstinence in patients with alcohol dependence syndrome (12). Patients who have been dependent on opioids such as heroin can be offered naltrexone to assist in maintaining abstinence. Another two medications used in other countries are methadone and buprenorphine (12).

Psychological Therapies

Psychosocial approaches for substance misuse treatment typically involve a crucial worker who implements strategies like counselling, education, and motivational interviewing. Practical assistance with benefits and information about services is also provided.

Brief interventions

Brief interventions for substance misuse aim to enhance an individual's motivation to address their misuse problem, thereby promoting changes in their behaviour. There is evidence that Brief intervention can be helpful for both hazardous drinkers and those with alcohol use disorders and can be effective in reducing alcohol consumption and related problems, primarily when delivered by trained professionals in a supportive and empathetic manner. Effective brief interventions often follow the FRAMES format, emphasising feedback, responsibility, advice, a menu of options, empathy, and self-efficacy (16). These concepts do not require extensive training and can be implemented in various settings, including primary health care. During a brief intervention session that may last only a few minutes, the practitioner may provide simple advice to the patient and follow up on this during subsequent clinic visits (15).

Motivational Interviewing (MI) aims to enhance personal motivation and commitment to change by eliciting and exploring the individual's reasons for change in an atmosphere of acceptance and compassion (17). Four fundamental processes guide the flow of conversation. The first process is engaging, which focuses on actively listening to and reflecting on the person's experiences and perspectives and supporting their autonomy. Focusing involves negotiating an agenda that draws on the client's and practitioner's expertise to agree on a shared purpose, enabling the clinician to initiate a directional conversation about change. In the evoking process, the clinician gently explores and helps the person build their motivation for change by eliciting their ideas and motivations, normalising ambivalence. Finally, planning explores the "how" of change, with the MI practitioner supporting the person to consolidate their commitment to change and develop a plan based on their insights and expertise.

These treatments aim to enhance recreational and personal skills, reducing reliance on drugs and the drug culture for satisfaction. Involving the patient's partner and family in structured couple and family therapy can also be helpful (15). Cognitive behavioural techniques are used to identify triggers for drug use in advance and develop coping strategies, which are essential in relapse prevention. Cue exposure therapy desensitises individuals to cues for drug use through repeated exposure, improving their ability to remain abstinent (18).

Rehabilitation

Many drug users struggle to integrate into mainstream society. The goal of rehabilitation is to help individuals dependent on drugs leave the drug subculture and establish new social connections (19). Social support is typically needed as individuals transition to everyday work and living. The government and private institutions conduct rehabilitations. They offer counselling and motivational interviewing to help patients stay abstinent.

Social and forensic issues

Patients with psychoactive substance dependence face a range of social and forensic issues. They face

discrimination and stigma, which hinder help-seeking in these individuals. Substance dependence can also lead to financial problems, unemployment, homelessness, and strained family dynamics. Forensically, individuals with substance dependence may encounter legal issues related to drug possession or trafficking (13). These legal challenges can result in arrests, fines, and incarceration, leading to social stigmatisation. A multidisciplinary team approach to managing these individuals would be beneficial. This team, headed by a consultant psychiatrist and consisting of psychiatric doctors, social workers, psychologists, and community psychiatric nurses, can provide long-term support, especially considering the various social and forensic challenges that may impact the substance users' motivation to stay abstinent (19).

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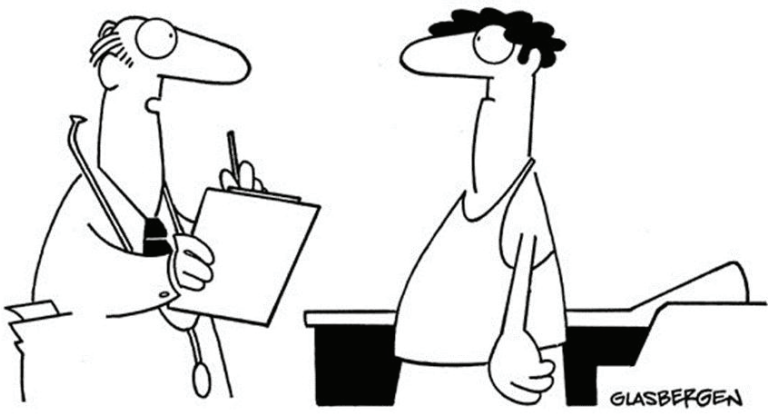
"Excellent health statistics - smokers are less likely to die of age related illness"



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Empowering a tobacco-free future: A comprehensive insight

Dr Alan Ludowyke

Chairman, National Authority on Tobacco and Alcohol (NATA)

In the realm of public health, few challenges loom as large as the pervasive use of tobacco and alcohol. These substances, with their insidious grip on individuals and communities, exact a toll not only on physical health, but also on social and economic well-being. In this discourse, we delve into the multifaceted efforts of the National Authority on Tobacco and Alcohol (NATA) in Sri Lanka to combat these scourges and pave the way for a healthier, tobacco-free future.

Foundations of Commitment: NATA's Mandate and Framework

Established under the National Authority on Tobacco and Alcohol Act, No. 27 of 2006, NATA stands as a bastion of hope in the fight against tobacco and alcohol abuse. Our mandate, rooted in legal frameworks, underscores our unwavering dedication to enacting and enforcing measures aimed at mitigating the harmful effects of these substances on society. Central to our mission is the Framework Convention on Tobacco Control (WHO-FCTC), a seminal Global Health Treaty developed by the World Health Organization in 2003. Sri Lanka's early ratification of this treaty underscores our commitment to implementing evidence-based tobacco control measures, thereby positioning us as a leader in the global fight against tobacco consumption.

Unveiling Tobacco Consumption Patterns in Sri Lanka

Despite concerted efforts, tobacco use remains a significant public health challenge in Sri Lanka. The findings from the Global Adult Tobacco Survey (GATS) conducted in 2020 offer critical insights into the prevalence and patterns of tobacco consumption across the nation. Approximately 3.2 million adults, constituting 19.4% of the population aged 15 years and older, currently use tobacco in some form. This includes smoked tobacco products such as cigarettes and beedees, as well as smokeless forms like betel quid with tobacco. Of particular concern is the disproportionately high prevalence of tobacco use among men, with 19.7% reporting current smoking compared to less than 0.1% of women. Moreover, smokeless tobacco use is more prevalent among men, with 23.4% of male adults using such products compared to 4.9% of female adults.

Tobacco Cessation Efforts: A Multifaceted Approach

In our relentless pursuit of a tobacco-free future, NATA adopts a multifaceted approach to combat tobacco consumption. Central to this strategy is the promotion of tobacco cessation efforts, aimed at supporting individuals in their journey towards quitting tobacco use. The data from GATS reveals that 34.6% of adults who smoked tobacco made quit attempts in the past year, reflecting varying levels of success. While a significant proportion attempted to quit without assistance, there remains a notable cohort who sought support from family, friends, or healthcare providers. However, challenges persist, particularly in addressing the high prevalence of smokeless tobacco use and the associated health risks. Only a small percentage of smokeless tobacco users attempted to quit in the past year, highlighting the need for targeted interventions to support cessation in this population.

Mitigating Second-hand Smoke Exposure: A Call to Action

In addition to supporting cessation efforts, NATA recognizes the imperative of mitigating second-hand smoke (SHS) exposure, which poses risks to non-smokers in workplaces, homes, and public spaces. The data from GATS paints a concerning picture, with 16.7% of adults working indoors reporting exposure to tobacco smoke in their workplace within the past 30 days. This underscores the urgency of implementing comprehensive smoke-free policies to safeguard the health and well-being of all individuals. Furthermore, SHS exposure in public settings such as cafes, restaurants, and transportation facilities remain a pressing concern, necessitating concerted efforts to address this persistent issue.

Understanding the Economic Impact of Tobacco Use

Beyond its toll on individual health outcomes, tobacco consumption exerts a significant economic burden on households and national economies. The data from GATS sheds light on the substantial expenditures incurred on tobacco products, with the average monthly spending on manufactured cigarettes and beedees being noteworthy. In this context, increasing the price of tobacco products through taxation emerges as an effective strategy to reduce affordability and discourage consumption, thereby alleviating the economic burden associated with tobacco use. Yet for all that, although taxation might have some effect, the total impact of it in

a situation where the subjects are markedly addicted to smoking is rather unpredictable.

Harnessing Media and Awareness: Amplifying the Message

Media plays a pivotal role in shaping public perception and behaviour towards tobacco use. While there is widespread awareness of the health risks associated with smoking and smokeless tobacco use, targeted anti-tobacco campaigns can further amplify these messages and encourage cessation efforts. Additionally, stringent enforcement of regulations on tobacco advertising, promotion, and sponsorship across various media platforms is essential to counteract industry marketing tactics and protect public health.

1948 Telephone Counselling Service: A Lifeline for Recovery

At the heart of our mission lies the 1948 Telephone Counselling Service—a lifeline for individuals seeking to break free from the grip of tobacco and alcohol addiction. Since its inception in 2016, our dedicated team of counsellors has been providing round-the-clock support to Sri Lankan citizens, offering personalized guidance to empower individuals on their path to wellness. Through this service, individuals struggling with addiction to tobacco products such as cigarettes, beedees, and cigars, as well as smokeless tobacco products like "Bulevita", can access confidential counselling from the comfort of their homes. Our counsellors are trained to provide personalized support tailored to each individual's unique needs, empowering them to overcome the challenges they face on their path to recovery. Moreover, our commitment to supporting individuals on their recovery journey extends beyond mere counselling. Through Act 1948, employees grappling with tobacco or alcohol addiction can avail themselves of psychological counselling services provided by our dedicated officers, ensuring that no one is left behind in their quest for a healthier, tobacco-free life.

A Beacon of Hope: Navigating the Path Forward

As we navigate the complex landscape of addiction, NATA remains steadfast in its mission to empower individuals, families, and communities to lead healthier, more fulfilling lives. Together, we can break the chains of addiction and pave the way for a brighter, tobacco-free future for all Sri Lankans. Through sustained efforts, evidence-based interventions, and multisectoral collaboration, we remain committed to realizing our vision of a tobacco-free society, a vision that promises improved health outcomes, enhanced well-being, and a brighter future for generations to come.

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The Forgotten President

Dr Malik Fernando
Past President, SLMA (1992)

It has been the practice for the Sri Lanka Medical Association (SLMA) to list the names of its Past Presidents in publications such as the Annual Reports, the Anniversary Scientific Sessions booklets, and in its website. The name of the President for the period 1918/19 has been 'Dr R. L. Brohier' for many years.

In truth, the correct title for a President during this period of the association's existence would have been 'President of the Ceylon Branch of the British Medical Association'. Yet for all that, I was often puzzled by the name which was listed as 'R. L. Brohier' as it was familiar to many as the geologist Richard Leslie Brohier, the Superintendent of Surveys at the time, who authored the well-known book *Ancient Irrigation Works in Ceylon*, under the direction of the then Minister of Agriculture the Honourable D. S. Senanayake. It was published in three parts in the nineteen-thirties. To add to the confusion, there was no photograph of 'Dr R. L. Brohier' in the SLMA Council Room amongst the others, in the collection of Past President images; photographs of a number of other Past Presidents too were also missing.

Some years ago, I started searching for photographs that were missing. During this search I approached Deloraine Brohier, RL's daughter. She was quite insistent that her father had never been president of a medical association and suggested that perhaps it was R. H. L. Brohier who had been the President, a cousin. But I could not find any references of a Dr R. H. L. Brohier.

In 2023 I started collecting biographical information about our pioneering Past Presidents of the SLMA and started looking through the Brohier ancestry in the pages of the Dutch Burgher Union publications. R. H. L. Brohier turned out to be a planter, born in 1906. I dropped the Brohier conundrum and turned to other Presidents, only to come back to the Brohier ancestry in 2024.

Searching for medically qualified Brohiers led me to the entry for Eric Stanley Brohier, born 1894, RL's younger brother. He was qualified L.M.S. (Ceylon), L.R.C.P. and S. (Edin.), L.R.C. P. and S. (Glas.) and was attached to the Civil Medical Department. But was never President of the medical association. He was an Appointed Member of the Parliament of Ceylon on two occasions and was decorated with the Coronation Medal on the occasion of the Coronation of Queen Elizabeth II, so he might have been a military officer too.

Much searching led me to Louis Cyrus Brohier, born 1866, who turned out to be an uncle of the brothers Richard Louis and Eric Stanley. Louis Cyrus was a Provincial Surgeon, qualified M.R.C.S., L.S.A*. who seemed to have been completely overshadowed by his two nephews. Not only was his name not recorded correctly in the list of the Association's Presidents, but even in the pages of the Journal of the Ceylon Branch of the British Medical Journal of 1918 the name 'Dr. R. L. Brohier' appears in the records of those present at meetings!!!!

The Forgotten President of SLMA was found again and re-instated this year and now the name 'Dr L. C. Brohier' appears in the list carried on the SLMA website.

That strategic adjustment of a course correction is better late than never !!!

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*L.S.A. = Licenced Surgical Assistant

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