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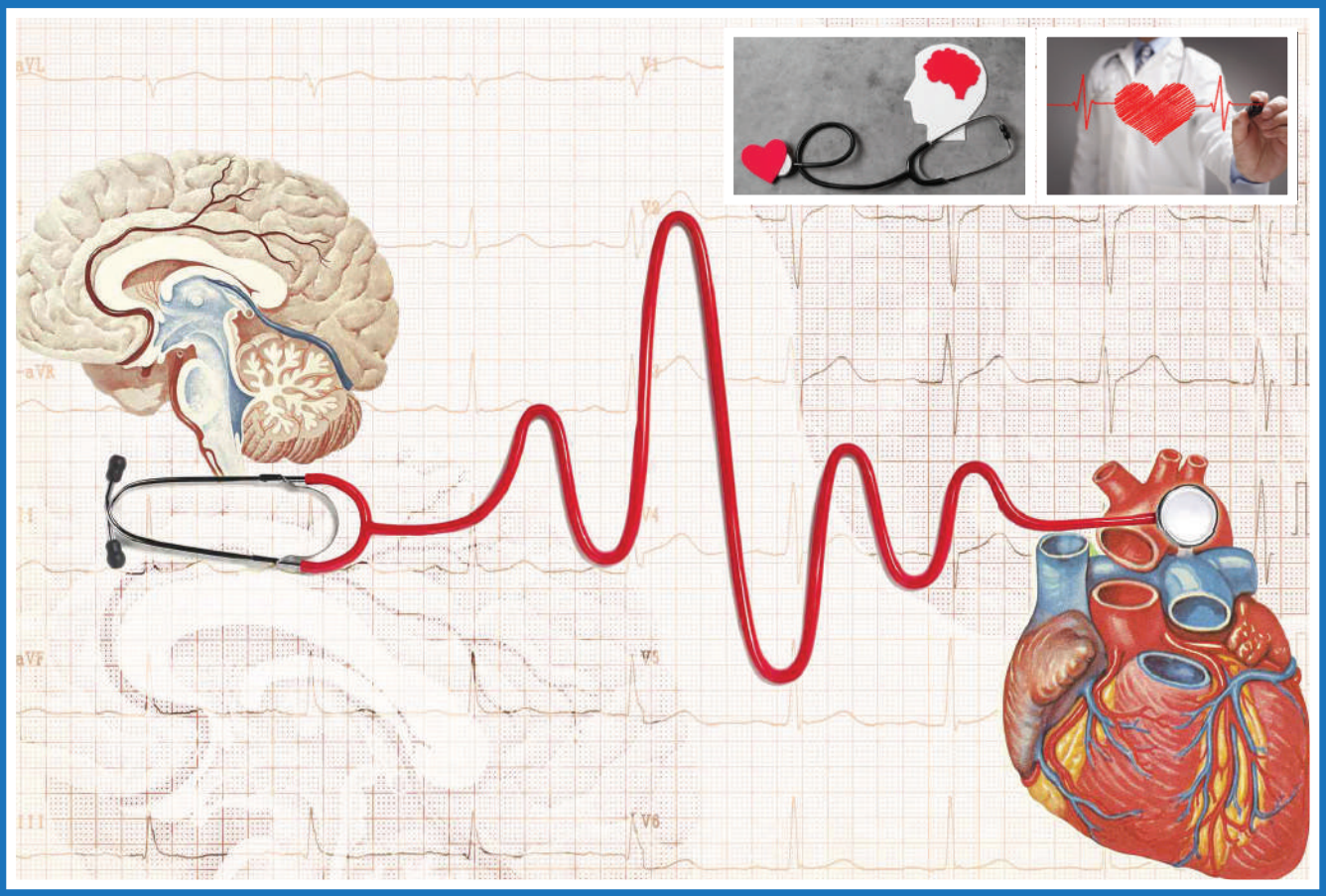

Preventing Strokes in Atrial Fibrillation

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CONTENT

SLMA President

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

President's Message

Dear SLMA Members,

It is with tremendous delight that I would like to inform you of a successful achievement of a great cause that was championed by the SLMA since 2003.

It was the then President Dr Sunil Seneviratne Epa who introduced the National Continuing Professional Development (CPD) programme for medical doctors in Sri Lanka through the SLMA. This was initiated at a time where there was much resistance and controversy on the topic of CPD, which even continued for quite a while.

After 20 years of sustained and determined advocacy efforts through the SLMA Expert Committee on CPD, together with the professional colleges and trade unions, the Ministry of Health was able to get the support of all for this timely initiative. The National CPD Programme was officially launched on 27th February 2024 at the National Blood Transfusion Service (NBTS) Auditorium, in the presence of the Minister of Health Dr Ramesh Pathirana, Ministry Officials and all relevant stakeholders.

It is also a great honour for the SLMA that the very first Chairperson of the National Committee on CPD, appointed by the Ministry of Health, is Professor Indika Karuantilaka, Past President of SLMA and the Professor of Medical Education, Faculty of Medicine, University of Colombo.

The latest achievement on this was endeavour is when Sri Lanka was included in the list of Accreditation Council for Counting Medical Education (ACCME), which like the World Federation of Medical Education (WFME) is the International body for regulating quality and standards in CPD/ CME.

Continuing Medical Education (CME) is defined as the discipline of educational activities which serve to maintain, develop, or increase the

knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, and the profession. The content of CME is that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public[1].

Activities can be derived from multiple instructional domains, are learner centred, and support the ability of those professionals to provide high-quality, comprehensive, and continuous patient care and services to the public and their profession. (COCPD) (1985) (June 2023 BC)[2].

There can be many advantages of CPD programmes;

As medicine is a field which evolves constantly and with systems, policies, and regulations changing regularly, CPD can equip the receiver with new research, technologies and treatment modalities, allowing them to provide the most effective and evidence-based care to their patients, and get involved in skills development programmes and simulations, to help enhance their clinical skills in performing procedures, diagnosing conditions, or communicating with patients, while encouraging doctors to adopt a mindset of continuous learning and improvement throughout their careers.

CPD is essential for doctors to stay current, competent, and effective in their practice, ultimately benefiting both healthcare providers and the patients they serve within evolving healthcare environments

Therefore, I would request all medical doctors to look at CPD as a positive and unequivocally beneficial initiative, take it up as an academic challenge and use all opportunities to improve their knowledge and skills.

SLMA provides CPD through many activities done throughout the year (Pre-congresses, 137th Medical Congress, Saturday Talk, Therapeutic Updates, Regional Meetings, Foundation Sessions, Clinical Meetings, etc) and through the SLMA CPD Portal (https://slma.lk/cpd/).

I am ever so pleased to invite and urge all to visit our FB page (https://www.facebook.com/SLMAonline), website (https://slma.lk/) and also becoming a SLMA member so that you could get new updates on our activities and by enthusiastically participating in them.

'Education is the passport to the future, for tomorrow belongs to those who prepare for it today'.

Malcolm X
African American Muslim minister and Human Rights Activist

Dr Ananda Wijewickrama
President, SLMA

1. Available from https://www.aafp.org/about/policies/all/continuing-medical-education-definition.html (Accessed on 5th March 2024)
2. Available from https://www.accme.org/accreditation-rules/policies/cme-content-definition-and-examples (Accessed on 5th March 2024)

Activities in Brief
(16th February 2024– 15th March 2024)

SLMA Saturday Talks

Dr Probodhana Ranaweera, Senior Lecturer, Department of Obstetrics & Gynaecology, Faculty of Medicine, Colombo delivered a lecture on **17th February** on *'Management of Labour'*.

Dr Udayangani Ramadasa, Head/ Senior Lecturer Department of Medicine, Faculty of Medicine, University of Sabaragamuwa delivered a lecture on **24th February** on *'Introduction to Palliative Care'*.

Dr Kapila Ranasinghe, Senior Consultant Psychiatrist, National Institute of Mental Health (NIMH) delivered a lecture on **9th March** on *'Healing Symphony: Overcoming Depression with medical co-morbidity'*

Monthly Clinical Meetings

The January clinical meeting was held in collaboration with the Sri Lanka College of Haematology on **27th February** on *'Navigating the spectrum of bleeding disorders'*.

Dr Vajira Gamage, Consultant Clinical Haematologist, TH Karapitiya and Dr Wasanthi Wickramasinghe, Consultant Clinical Haematologist, TH Mahamodara did case presentations and a discussion. Dr Uthpala Neththikumara, Lecturer, Department of Pathology & Forensic Medicine, Faculty of Medicine, University of Moratuwa conducted a haemotology quiz, *'A journey through blood cells'*.

Pre-congress Workshop

The second pre-congress workshop on *'Emergency Point of Care Ultrasound (Em PoCUS)'* was held at the Auditorium, Infectious Diseases Hospital on **23rd February** in collaboration with the Sri Lanka College of Emergency Physicians.

The resource persons were as follows;

Dr Nandana K Jayatillake, Consultant Emergency Physician/ President SLCEP, Dr Madurangi Ariyasinghe, Consultant Emergency Physician/ Chair Ultrasound Chapter/ Scientific Secretary SLCEP, Dr Thushinie Goonewardene, Acting Consultant Emergency Physician, Dr Thilina Ariyasinghe, Registrar in Emergency Medicine, Dr MDM Priyankara, Registrar in Emergency Medicine, Dr EU de Silva Jayawarna, Registrar in Emergency Medicine, Dr R Rajavarman, Honorary Emergency Physician, Accident & Emergency Unit, Teaching Hospital Batticaloa, Dr AG Thanuja Darshani, Consultant Emergency Physician/ General Secretary SLCEP & Dr GA Dinesh Weerasinghe, Consultant Emergency Physician.

Topics of Discussion;

Extended Focused Assessment with Sonography for Trauma (EFAST) *demonstration & KNOBOLOGY, Lung demonstration – Pneumothorax/ Pleural effusion, a demonstration in Volume resuscitation in shock, Ultrasound guided IV cannulation & Demonstration on Joint effusion.*

All demonstrations were followed by a practical hands-on session and a quiz at the end.

Orations

Deshabandu Dr CG Uragoda on History of Medicine 2024 was held on the **26th February** at the Dr NDW Lionel Memorial Auditorium.

The oration was delivered by Dr Indira Kahawita, Consultant Dermatologist, Anti-Leprosy Campaign, Colombo on the topic *'History of Leprosy in Sri Lanka: A saga of three millennia'.*

Other meetings

The Intercollegiate Committee of the Sri Lanka Medical Association hosted Dr Neelam Dhingra, Coordinator for the Patient Safety and Quality Improvement Unit, in the Service Delivery and Safety Department at the World Health Organization headquarters in Geneva, Switzerland **on 22nd February** at the SLMA to discuss the proposed Patient Safety Charter for Sri Lanka.

A rich discussion followed, with suggestions and recommendations to improve the content of the Patient Safety Charter and a firm commitment by all the college representatives to work towards strengthening this worthy cause.

The launching of National Continuous Professional Development (CPD) for health professionals took place on **27th February** at the NBTS Auditorium.

SLMA has been actively involved in advocating for the introduction of CPD through the Expert Committee for Medical Education.

Professor Indika Karunathilake, Professor in Medical Education & Past President SLMA is the current chair of the National CPD Committee.

Regional Meetings

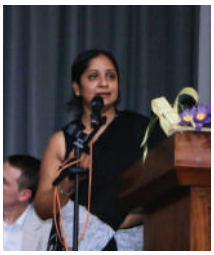
The first regional meeting for the year was held in collaboration with the Huddersfield University, UK and Kalutara Clinical Society at the Auditorium, Teaching Hospital, Kalutara on **15th March** on '*Disaster Preparedness in Hospitals: The Next Wave of Emergency Preparedness in Healthcare'*.

Dr Ananda Wijewickrama, President SLMA introduced the objectives of the regional meetings and Dr. S. M. P. Karunarathne, Director, Teaching Hospital, Kalutara welcomed the overseas faculty.

The resource persons and the topics of discussion are given below;

Prof. Richard Haigh, Professor of Disaster Resilience, University of Huddersfield, United Kingdom on *'Disaster Management Perspectives: the Current Context'*, Dr Lahiru Kodituwakku, Honorary Secretary, Sri Lanka Medical Association & Dr Chintha Rupasinghe, Registrar in Community Medicine, Department Of Public Health Training, National Institute of Health Sciences, Kalutara on *'ABCs of Hospital Disaster Preparedness'*, Prof. Dilanthi Amaratunga, Professor of Disaster Risk Reduction and Management, University of Huddersfield, United Kingdom on *'Framework and principles for effective Emergency Preparedness, Resilience and Response (EPRR): A Case study from the UK'*, Dr. Sajitha Gunasekara, Consultant Emergency Medicine Physician, Teaching Hospital Kalutara on *'Mass Casualty Plan at TH Kalutara; Are we ready'*, Dr Vidura Jayasinghe, Acting Consultant Community Physician, Department of Field Services, National Institute of Health Sciences, Kalutara & Dr Nelum Samarutilake, Deputy Director of Field Services/ Consultant Community Physician, National Institute of Health Sciences, Kalutara on '*Outbreak Response; How Clinicians Can Help'*.

The vote of thanks was given by Dr. Bhathiya Ranasinghe, Consultant Cardiologist, President - Kalutara Clinical Society.



"Whoever is happy will make others happy too."

Anne Frank

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Preventing Strokes in Atrial Fibrillation

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Consultant Cardiologist
Sri Jayewardenepura General Hospital

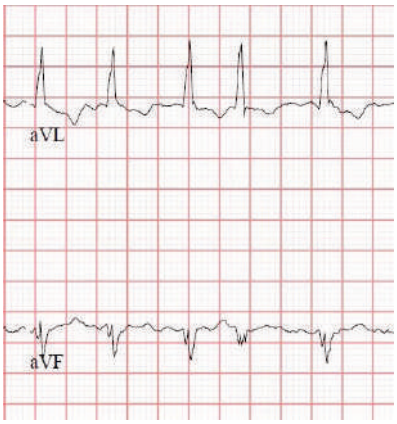
Introduction

Atrial fibrillation (AF, AFib or A-fib) is an abnormal heart rhythm (arrhythmia) characterized by rapid and irregular beating of the atrial chambers of the heart. It often begins as short periods of abnormal beating, which become longer or continuous over time. It may also start as other forms of arrhythmia such as atrial flutter, which then progresses into AF.

Symptomatic episodes may involve heart palpitations, fainting, light-headedness, shortness of breath, or chest pain. Episodes can be asymptomatic as well. Atrial fibrillation is associated with an increased risk of heart failure, dementia, and stroke. It is a type of supraventricular tachycardia.

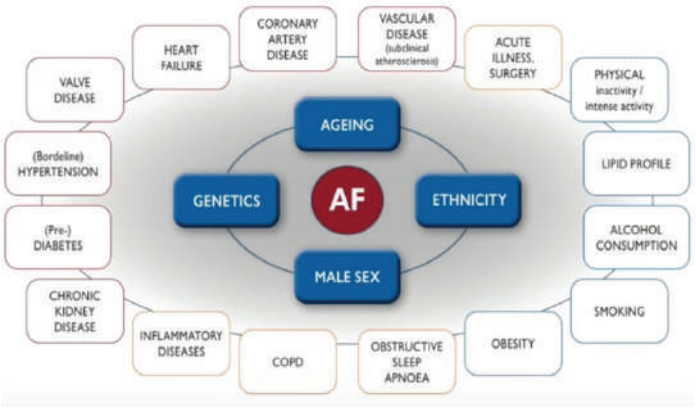
Atrial fibrillation is found in a third of all ischaemic strokes, even more following post-stroke atrial fibrillation monitoring. Data from stroke registries show that both unknown and untreated or under treated atrial fibrillation is responsible for most of these strokes, which are often fatal or debilitating. Most could be prevented if efforts were directed towards detection of atrial fibrillation before strokes occur, through screening or case finding, and treatment of all patients with atrial fibrillation at increased risk of stroke with well-controlled vitamin K antagonists(VKA) or non-vitamin K antagonist anticoagulants[1][2]

ECG in Atrial Fibrillation



Leads aVL and aVF of an ECG showing AF. There are irregularly irregular intervals between heart beats. No P waves are seen and there is an erratic baseline between QRS complexes.

Risk Factors for Atrial Fibrillation



The individual patient risk of stroke depends on the presence of specific stroke risk factors. Not all stoke risk factors carry the same weight. [3]

A systematic review of stroke risk factors

Stroke risk factors	Relative Risk for stroke	Positive studies/ All studies
HF/LV dysfunction	1.85	7/18
Hypertension	2.27	11/20
Aged ≥75 years	1.46*	9/13
Diabetes mellitus	1.62	9/14
Stroke/TIA/TE	2.86	15/16
Vascular disease	2.61	6/17
Aged 65–74 years	1.46*	9/13
Sex category (female) **	1.67	8/22

*Per decade increase

**Vascular disease, prior myocardial infarction, peripheral artery disease or aortic plaque.

- Clinical AF vs subclinical AF
- First detected AF
- Paroxysmal AF
- Persistent AF (>7 days)
- Long standing persistent AF (>12 months)
- Permanent AF
- [Obsolete: Chronic AF, Valvular and Non valvular AF, Lone AF]

Stroke Risk Assessment Score

The most validated is the CHA_2DS-$VASc_2$ score. Stroke rates generally increase with increasing CHA_2DS_2-VASc score value

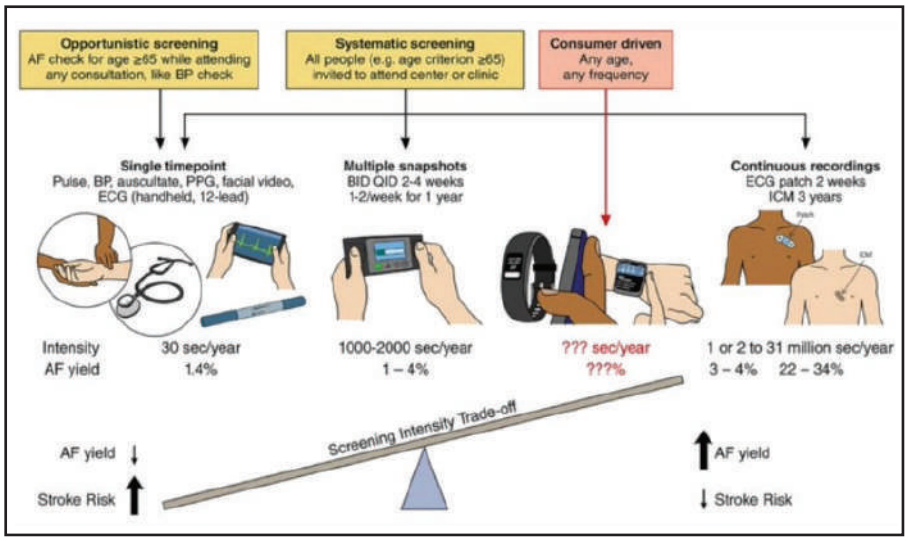
The CHA_2DS_2-VASc score

Condition	Point(s)
Congestive heart failure	1
Hypertension	1
Age ≥ 75	2
Diabetes Mellitus	1
Stroke / TIA / Systemic thromboembolism (prior)	2
Vascular disease (MI / PAD / Aortic plaque)	1
Age 65-74 (inclusive)	1
Sex category (Female)	1

Screening for Atrial Fibrillation

The More You Look, the More AF Will Be Found; However…

Trade-off between duration/intensity of screening for detection of AF and AF stroke risk



What Do the Guidelines Say?

ESC 2020

Class Ib recommendations:

- Opportunistic screening by pulse taking or ECG rhythm strip in patients 65 years and older
- Individuals undergoing screening to be informed about implications of detecting AF
- A structured referral platform to be organised for screen-positive cases

Class IIa recommendations:

- Systematic ECG screening should be considered in individuals 75 years or older or at high risk of stroke.

ACC/AHA/ACCP/HRS 2023

- Most screening RCTs have shown higher AF detection using intermittent or continuous ECG recordings and focusing on patients with higher predicted risk for AF
- An AI-guided selection of individuals for AF screening was recently associated with increased AF detection
- Conversely, mass population screening with a smartwatch app only rarely detected a new diagnosis of AF
- Ultimately, for risk stratification models and screening programs to be useful, they would need to improve outcomes and be cost-effective
- It is not yet established that patients at high risk of developing AF by a validated risk score benefit from screening and interventions to improve rates of ischemic stroke, systemic embolism, and survival

Risk factor-based approach to Stroke Risk Management in patients with AF

- First identify low risk patients – CHA_2DS_2-VASc sore of 0 (males) and 1 (females) who should not be offered stroke prevention therapy.
- Then offer stroke prevention if CHA_2DS_2-VASc 1 or greater (males) of 2 (females)
- Assess bleeding risk and address modifiable bleeding risk factors
- Choose OAC (Oral Anti-Coagulant) - DOAC (Direct Oral Anti-Coagulant) or VKA (Vitamin K Antagonist – warfarin).[4]

Anticoagulation and Atrial Fibrillation

Oral anticoagulation is the cornerstone in effective therapy in prevention of stroke in atrial fibrillation. However, there is a risk of major bleeding.

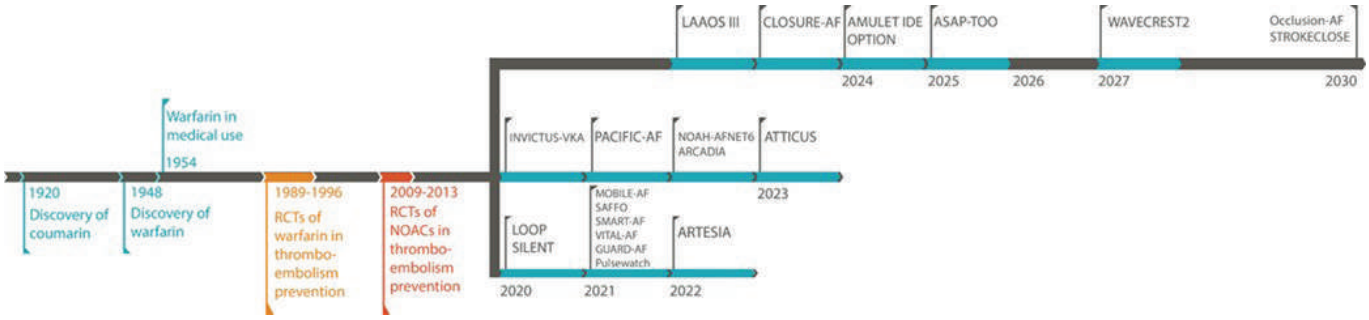
Stroke and bleeding risks are dynamic and risk reassessment at periodic intervals is recommended to inform treatment decisions (e.g. initiation of OAC in patients no longer at low risk of stroke) and address potentially modifiable bleeding risk factors.

Starting Anticoagulation Treatment

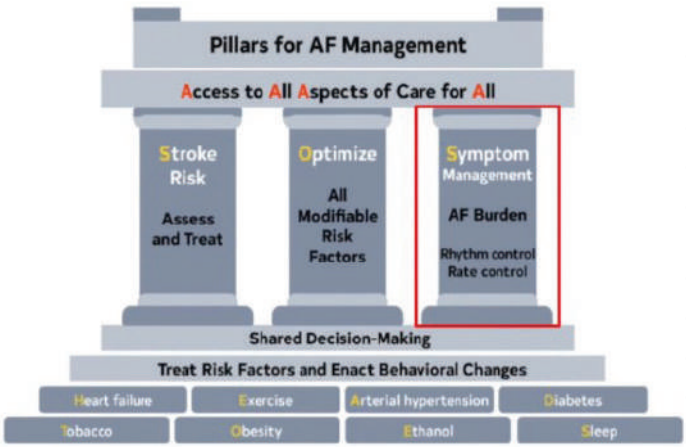
ESC 2020	ACC/AHA/HRS 2023
• For stroke risk assessment, **a risk-factor–based approach is recommended**, using the CHA_2DS_2-VASc clinical stroke risk score to initially identify patients at 'low stroke risk' (CHA_2DS_2-VASc= 0 in men, or 1 in women) who should not be offered antithrombotic therapy (Class I, A)	• Patients with AF should be evaluated for their annual risk of thromboembolic events using a validated clinical risk score, such as CHA_2DS_2-VASc (Class I, B-NR)
	• Patients with AF at intermediate annual risk of thromboembolic events by risk scores (e.g. equivalent to CHA_2DS_2-VASc score of 1 in men or 2 in women), who remain uncertain about the benefit of anticoagulation, can benefit from consideration of factors that might modify their risk of stroke to help inform the decision (Class IIa, C-LD)
• OAC is recommended for stroke prevention in AF patients with CHA_2DS_2-VASc score 2 or higher in men 3 or higher in women Class I, A	• For patients with AF and an estimated annual thromboembolic risk of 2% or greater per year (e.g. CHA_2DS_2-VASc score of ≥2 in men and ≥3 in women), anticoagulation is recommended to prevent stroke and systemic thromboembolism (Class I, A)
• OAC should be considered for stroke prevention in AF patients with a CHA_2DS_2-VASc score of 1 in men or 2 in women. Treatment should be individualized based on net clinical benefit and consideration of patient values and preferences (Class IIa, B)	• For patients with AF and an estimated annual thromboembolic risk of 1% or greater but less than 2% per year (equivalent to CHA_2DS_2-VASc score of 1 in men and 2 in women), anticoagulation is reasonable to prevent stroke and systemic thromboembolism (Class IIa, A)
• **Stroke and bleeding risk reassessment at periodic intervals** is recommended to inform treatment decisions (e.g. initiation of OAC in patients no longer at low risk of stroke) and address potentially modifiable bleeding risk factors (Class I, B)	• In patients with AF at risk for stroke, re-evaluation of the need for and choice of stroke risk reduction therapy at periodic intervals is recommended to reassess stroke and bleeding risk, net clinical benefit, and proper dosing(Class I, B-NR)

Warfarin Use for Cardioembolic Stroke Prevention

The discovery of warfarin in the 1920s on the prairies of North America, where healthy cattle were reported to die from internal bleeding after having grazed on spoiled sweet clover hay. Biochemist Karl Link was the first to identify the natural substance, later called coumarin, oxidized in mouldy hay. After extensive work with different variations of coumarin, Dr Link isolated the compound warfarin, which was successfully marketed in 1948 as a rodenticide and ultimately approved for medical use in 1954.



Past, present and future in cardioembolic stroke prevention and summary of RCT (Randomized controlled clinical trials evaluating stroke prevention strategies



Thromboembolism Prophylaxis [5]

- Aspirin – been around for a long time, but is not very effective and has a substantial bleeding risk
- Warfarin – targeting an INR between 2-3
- DOACS – Direct Oral Anti Coagulants
- 3 - Factor Xa inhibitors, Dabigatran – thrombin inhibitor
- ½ life 6-17 hours
- Significant advantages over warfarin
- Less intracranial haemorrhage
- All should be prescribed the higher stroke reduction dose unless contraindicated

DOACs	$T_{1/2}$	Renal	Dosing
Apixaban	10-12 hrs	25%	5 BID, 2.5 BID*
Dabigatran	12-17 hrs	80%	150 BID, 110 BID, 75 BID*
Edoxaban	9-11 hrs	35%	60 QD, 30 QD*, 15 QD
Rivaroxaban	6-9 hrs	35%	20 QD, 15 QD*, 10 QD

*Dose reduction for select population

DOACs	Stroke	Bleeding	ICH
Apixaban	Less	Less	Less
Dabigatran	Less	Same	Less
Edoxaban	Same	Less	Less
Rivaroxaban	Same	Same	Less

DOAC dose reduction

DOACs	Criteria	Dose Change
Apixaban	2/3 older than 80 yr, Wt. less than 60 kg, Cr greater than 1.5 mg/dl	5.0 → 2.5 mg BID
Dabigatran	ESRD	150 → 75 BID
Edoxaban	CrCl 30 to 50 ml/min Strong PGP inhibitor Wt. less than 60 kg	60 → 30 mg QD
Rivaroxaban	CrCl 30 to 50 ml/min	20 → 15 mg QD

DOAC under-dosing is common. Low dose DOACs are less effective at preventing strokes. 41% increased risk of ischemic stroke with low dose Edoxaban vs warfarin was demonstrated in the ENGAGE clinical trial.

Global impact

- At least 10 million people wih AF
- More than half not treated
- >200,000 preventable strokes per year

Conclusion

In patients with atrial fibrillation, the real necessity is to assess for the stroke risk and treat those with an increased risk of stroke with appropriate oral anticoagulants at the appropriate dose.

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Persistent Physical Symptoms

Professor Athula Sumathipala
Emeritus Professor of Psychiatry
School of Medicine
Faculty of Medicine & Health Sciences
Keele University
United Kingdom.

Despite the extraordinary progress of modern medicine in the 21st century, patients with persistent physical symptoms unexplained by physical causes, also known as medically unexplained symptoms' (MUS), remain a challenging problem worldwide in terms of terminology, classification, understanding and management (1, 2). The terms persistent physical symptoms, medically unexplained symptoms and somatoform disorders interchangeably to denote the same phenomenon; continued physical symptoms for which the doctors cannot find a cause in-spite of a comprehensive clinical examination and investigations.

Studies carried out throughout the world show that one third of primary care patients have MUS (3). The WHO study (4), carried out in 14 different countries (Ankara in Turkey, Athens in Greece, Berlin and Mainz in Germany, Bangalore in India, Ibadan in Nigeria, Groningen in the Netherlands, Manchester in the United Kingdom, Nagasaki in Japan, Paris in France, Rio de Janeiro in Brazil, Santiago in Chile, Seattle in United States, Shanghai in China, and Verona in Italy, has shown that patients with MUS are common across cultures and do not vary according to geography or level of economic development (4).

However, this problem is not confined to primary care. According to the Joint Working Party of the Royal College of Physicians, Psychiatrists and General Practitioners (1996), patients with medically unexplained symptoms account for ¼ of general practice consultations, ½ of the general out patients' consultations and a substantial number of hospital admissions (5).

It is a crucial public health problem as patients with MUS place a heavy burden on the health system with disproportionate consumption of resources, through repeated consultations with multiple providers (6), involving unnecessary investigations and symptomatic treatments, which maintain rather than resolve symptoms (7). Medically unexplained symptoms are associated with significant clinician frustration (8), negative illness perceptions, co-morbidity and disability. However, research on the management and outcome of MUS in primary care is limited throughout the world.

Natural History of Patients with Persistent Physical symptoms

In a 5 year follow-up of 500 patients with physical symptoms to primary care, one third remained medically unexplained but most of them had no mental disorder (10). The main predictors of symptom persistence were poor baseline functioning, longer symptom duration (six months or longer) and illness worries (10).

In a ten year follow-up of patients with chest pain who had negative coronary angiography, 75% remained symptomatic and disabled**.** In a comprehensive study at the Queen Square Neurology Hospital in London with a 6 year follow up study of patients with medically unexplained motor symptoms, patients were thoroughly investigated with modern diagnostic techniques and technology. This study revealed that motor symptoms remain unexplained medically, despite thorough investigation, but the emergence of subsequent organic explanations for these symptoms were rare (11) .

Heterogeneity of Persistent Physical Symptoms/ MUS and the Diagnostic Dilemma

Patients with medically unexplained symptoms are a heterogeneous group, and they can occur with depression, anxiety, and somatoform disorders. Some patients have neither a clear-cut physical illness nor a clear-cut psychiatric disorder (10), although psychological factors such as erroneous beliefs and worries significantly affect their interpretation of minor physiological sensations. Some doctors prefer to use clustering of symptoms which are referred to as 'functional somatic syndromes' such as fibromyalgia, irritable bowel syndrome, and chronic fatigue syndrome, but there is a considerable overlap between these symptom syndromes (10).

In the past many terms with pejorative connotations such as "thick folder patients", "crooks", "hysterics", "the terror of the doctor", "problem patients", "painful woman", "hypochondriac", "amplifiers" have been used. Those who believe that the underlying cause is psychological have produced terms such as "functional somatic symptoms" and "functional overlay" have been coined to introduce these patients.

Psychiatric classifications for MUS remained unsatisfactory and hinder the understanding and its management (1.2). The conceptual borders between somatic presentations and other psychiatric disorders were ill defined and inconsistent (1). Based on these conceptual issues and problems, the classification of unexplained symptoms has rested entirely within the psychiatric classificatory system.

The somatoform disorder category was introduced into DSM-III to draw together a disparate array of psychiatric disorders with a prominently somatic component. In the DSM-V revisions (to which the author also contributed to) this has been organized under the diagnosis of Somatic Symptom Disorder to address some of the issues, without any pejorative connotations implying 'it is all in mind'. The DSM-V has also moved away from the need to have no medical explanation in order to make the diagnosis of 'medically unexplained symptoms' and gain access to appropriate treatment. The emphasis now is on symptoms that are substantially more severe than expected in association with distress and impairment. The diagnosis includes conditions with no medical explanation and conditions where there is some underlying pathology but an exaggerated response.

'The major diagnosis in this diagnostic class, Somatic Symptom Disorder, emphasises a diagnosis made on the basis of positive symptoms and signs (distressing somatic symptoms plus abnormal thoughts, feelings, and behaviour in response to these symptoms) rather than the absence of a medical explanation for somatic symptoms. A distinctive characteristic of many individuals with somatic symptom disorders is not the somatic symptoms per se, but instead the way they present and interpret them.

There tends to be a high level of comorbidity between the experience of multiple medical unexplained symptoms and other common mental disorders such as anxiety and depression.

However, WHO Working Group on Somatic Distress and Dissociative Disorders to make recommendations regarding necessary revisions to the ICD-10 classification (2011- 2015) in which the author was also a member, recommended the definition; Bodily distress disorder in ICD-11. Even though not exactly identical, these classifications were

broadly similar. "The bodily symptoms and related distress and preoccupation result in severe impairment in personal, family, social, educational, occupational, or other important areas of functioning (e.g., unable to work, alienation of friends and family, abandonment of nearly all social and leisure activities)".

Management of these people are not that complex. There are certain do's and don'ts.

A through physical examination, along with review of all previous negative investigations are crucial. Should not perform unnecessary investigation or give placebo medication.

Her/his complaints and concerns should be understood as genuine and it is not taken as malingering. Explain that any symptom irrespective of its cause can make people distressed.

Never say there is nothing wrong, because there is something wrong in their interpretation of bodily perceptions. That should be explained not using biomedical model but patient's explanatory model; eliciting what the patient think is wrong with them and their attribution of perceived symptoms.

Structured & coordinated regular visits to one professional career ideally a well-informed primary care physician or even by the doctor who detect the nature of their symptoms, is important, because that can prevent iatrogenic harm caused by unnecessary repeated investigations.

The treatment of these people will be benefitted by a psychological approach, using cognitive behavioral therapy (CBT) principles. (https://www.ird.lk/?s=cognitive)

Only chronic patients will need a referral to a specialist who has expertise in CBT and preferably who is familiar with patients having multiple complaints for which a known organic cause can be detected.

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History of Leprosy in Sri Lanka: A Saga of Three Millennia

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The history of leprosy in Sri Lanka dates back to the history of the country itself. The words "leper" and "asylum," which are considered discriminatory and marginalising terms in today's context, are used here in the historical context and to depict the fate of those affected in the past. An understanding of the nomenclature is necessary in the quest for evidence of leprosy in the ancient Lanka. Even though leprosy in called "laaduru" in contemporary Sinhala the word used in the ancient literature is "kushta roga". This has been the practice in Indian literature too. The words "laasuru" and "laaduru" have been used in Sinhala writings in the 19th century.

The ancient era

Evidence for leprosy can be found in the ancient medical books written in the Anuradhapura era.

"Sarartha Sangrahaya" by the Surgeon King Buddhadasa in the 5th century, describes 7 types of maha kushta and 11 chula kushta. Pundarika kushta and sidhma kushta belonging to maha kushta and eka kushta (absence of sweating and skin like that of a fish) of the chula kushta group resemble different presentations of leprosy.

"Yogarnavaya", written by Bhikku Buddhaputhra in the 12th century, describes 18 varieties of kushta with 10 severe types and 8 types amenable to treatment. Sushrutha sanhitha, the ancient Ayurvedic text, describes 18 varieties with a slightly different classification. Even though individual types may be considered nonspecific, some of the types taken together describes the spectrum of leprosy accurately.

Bhesajja manjusawa mentions neuropathic lesions leading to ulceration and disability and features of lepromatous leprosy. Both the Sushrutha and charaka sanhitha give almost identical descriptions of "kushta poorwa roopa". The absence of sensation, absence of sweating, paraesthesia, goose bumps, unusual pain in the wound (neuropathic pain), ulcers that occur easily and last longer, as well as numbness of organs, have been described as symptoms of "kushta"

Based on the above one can deduct that the word "kushta" was an all-encompassing term with leprosy being one of them.

The "Mahawansa" narrates how King Buddhadasa cured a leper of his deranged mental condition when he used abusive language at the king in the marketplace. The statue "Kushtaraja Gala" in Weligama, is now established as an Avalokitheswara bodhisattva. Bodhisatava worship was used for relief from illness and it is believed that lepers of the South worshipped this statue seeking relief.

Stigma and discrimination in the ancient past

Going back to the folklore of the union of the "lion" and Suppa Devi" the presumed ancestors of the Sinhala race, the most plausible medical explanation for the "lion" would be a well-built young man with lepromatous leprosy, who had fled to the jungles due to his disease. The fact that the offspring of a person with leprosy were accepted at the Royal court is evidence that "othering/ discriminating" of leprosy was not practiced at that time.

The thripitaka contains the "suppabuddha kutti sutta" describing the story of "Suppabuddha" the leper, who gains enlightenment as the Buddha preached specifically for him despite his disease. The fact that he had access to the lord Buddha without restriction is evidence that persons affected were not discriminated against at that time.

Bioarcheological work from the Indus valley has also shown that persons affected by leprosy were not treated differently in the earliest periods. Later burial practices of removing the affected feet and burying the bodies with ash are indicative of a compassionate attitude towards those affected. Evidence for discrimination appears later with the vedas considering leprosy as a condition to be avoided in arranging a marriage.

The Portuguese era

No written records are available on leprosy during this period. It is postulated that the Portuguese destroyed the documents before the Dutch took over the rule of the coastal areas in 1658

The Dutch era

Extensive documentation from this era is available at the national Archives. The sources are the records of the Dutch political council, memoirs of the governors and other officials and placcaarts or directives.

Early in the rule the Dutch realized that leprosy, among the locals and Europeans both, was becoming a serious health risk.

In 1693 a panel of experts was appointed and entrusted with the task of conducting a comprehensive census in preparation to establish a hospital. According to the placcaart, all persons irrespective of race or status were to be screened for the disease and be banished to India if found to have symptoms.

In 1703, authority was given to build a leprosy asylum and a panel of officials were appointed to make the initial plans. After much deliberations the work at the present location in Hendala began during the rule of Governor Cornelius Joan Simons. The asylum was opened in 1708 by Governor Hendrik Becker.

Leper Asylum / Leprosy Hospital Hendala

The medical officers assigned to the care of leprosy received special training and carried out the treatments in vogue at that time. Dr. Don Sam De Simon, Medical Superintendent of Hendala, was honoured with an OBE in 1951 for his services to leprosy

Publications on the clinical features and treatment of patients at the leprosy hospital by these eminent doctors serve as rich sources of information. The nursing care was initially in the hands of religious sisters until 1964 when the government nurses took over.

The hospital houses some invaluable artifacts. Among them are the first electric washing machine, the funeral carts that carried the dead to their final place of rest, and the old notice board carrying the daily statistics.

In 2008 celebrations were held to commemorate the 300th Anniversary of the leprosy hospital with a stamp being released.

The British era

The highlights of the British era with regards to leprosy are the Lepers Ordinance and the establishment of the second leprosy asylum at Manthivu island off Batticaloa. Unlike the Dutch era very few administrative documents are available from the early British era.

Medical publications

There were several publications on clinical presentations of leprosy from the early British period. Among them a detailed description of leprosy of the joints by Dr. J. Kinnis and a series of 1700 patients treated at the leprosy hospital from 1863 by Dr. Heynsburg take pride of place. In addition to describing the clinico-epidemiological features, Heynsburg looks at the presence of a family history of leprosy in a fair percentage and raises the possibility of heredity in the causation. The discovery of the bacillus in 1873, and the infective theory does not seem to have been convincing enough.

In 1862 the Royal College of Physicians (RCP), on the invitation of the Colonial Secretary, formulated a five-member expert committee to study leprosy in detail with regards to its mode of spread, clinical features and the treatment options. Ceylon was one of the respondents, with Dr John Davy, Inspector general of Army Hospitals giving details of patients he had seen in 1816. The 1864 report of the RCP was influential in shaping the rules and regulation on leper colonies and to guide treatment according to then available evidence.

Administration and legislation

The Ceylon Administration Report served as an important source of information about leprosy. The report in 1895 mentions that segregation was voluntary. In 1899 concerns are raised about voluntary segregation as there were patients who had been in and out of the hospital at their discretion with the possibility of spreading the disease in the community.

In 1897 the first international leprosy conference was held in Berlin. Recommendations were made to bring legislation for segregation, mostly based in experience of Norway. The Lepers Ordinance No 4 of 1901 resulted from these recommendations.

The ordinance contains 37 sections covering all aspects with provisions to ensure prompt and accurate diagnosis and compulsory institutionalization and to facilitate home quarantine.

Several legislations including the establishment code and Muslim marriage law, deal with leprosy. Initial steps have now been taken to change some of these like the Lepers Ordinanace and the E code.

The logistic nightmare of transporting leprosy patients from the East, where there were a considerable number of patients, paved the way for a second leprosy hospital in the East. The proclamation by the governor, William Henry Manning, commissioning the hospital in Manthivu, was made on the 29th November 1921. In 1996 it was decided to close down the Manthivu hospital due to security reasons. Even though 38 patients were transferred to Hendala, 2 patients who refused to leave are still residing in Manthivu.

Surveys and recommendations

In 1932 and 1936 Dr. Robert Cochrane, renowned leprologist, visited the island to conduct a survey in the Western and Eastern Provinces. He had paid special attention to the presence of leprosy in children and concluded that the disease is mild in children and emphasized the importance of continuing their education. He has laid down recommendations on disease control activities as well as cases that need treatment.

In 1959 an island-wide survey was carried out by the Anti-Leprosy Campaign. There were almost 3500 registered cases in total, while 881 were within the institutions. 330 plus new cases were detected and put on dapsone therapy.

Evolution of treatment in leprosy

In the late 19th century 2 oils, gurjun oil and chaulmoogra oil, were used as external applications.

Chaulmoogra oil, extracted from the fruits of the Hydnocarpus plant, was used as an external application, oral suspension and later as an injection. In the 1920's addition of camphor and esterification were used to improve absorption of chaulmoogra oil. E.C.C.O. (combination of esterified chaulmoogra oil, creosote and camphor) was the mainstay of therapy. Poor response

(approximately 50% did not show improvement) and the adverse effects like pain were the drawbacks of this therapy.

In the 1930's sulphones were introduced. Sulphetrone (oral and injection) and Thiosemicarbazone were used to treat leprosy from the 1940's onwards. Dapsone was introduced in the 1950's and was used as monotherapy for long periods.

With the discovery of rifampicin and clofazimine and confirmation of their efficacy against *M. leprae*, the WHO formed a working group to formulate a treatment regimen. The aim was to find a regimen that could be feasible to use under field conditions and economical enough to treat the estimated population of 16 million people living with leprosy world-wide. Therefore, the present treatment, multi drug therapy (MDT) does not have an "evidence base" but has stood the test of time by bringing relief to millions of patients for over 40 years.

Anti-Leprosy Campaign

The Anti-Leprosy Campaign (ALC) was established in 1954. The administration of the 4 main centres (two leprosy hospitals, Central Leprosy Clinic and the colony in Uragasmanhandiya) and carrying out numerous disease control activities fell under the purview of the campaign.

The central leprosy clinic initially functioned as the coordinating centre for the peripheral clinics but was modified as a specialised treatment centre in 1957. The location has changed several times and the clinic now functions from Room 12, NHSL.

The leprosy colony in Uragasmanhandiya was designed for able bodied patients to receive treatment while being economically productive. It had a short lifespan from 1952 to 1963.

Statistics

Approximately 300 – 400 new patients were detected in the pre-MDT era. Since all diagnosed patients were in the registers (without an effective cure) the total numbers were in the thousands. A comparison of statistics from 1960 to 2021 show that the new case detection rate (NCDR) per 100 000 population fluctuated around 3 in the pre-MDT era. There was a gradual rise in the NCDR following the introduction of MDT. With the success of a social marketing campaign in the late 1980's the case detection improved markedly and has remained stable around 10 per 100,000 population since 2000. Following the COVID 19 pandemic there was a drop in case detection which is improving following improved public awareness.

In 1995 Sri Lanka was declared a country achieving the WHO target of elimination of leprosy as a public health problem. The highly technical point of "elimination as a public health problem" was understood widely as "no leprosy" or total elimination, whereas Sri Lanka had been within the WHO's elimination parameters throughout history. This misconception of elimination has been a major obstacle for leprosy awareness and control in Sri Lanka.

A high rate of children among diagnosed patients (10%) is a matter for concern and even alarm as the presence of leprosy in children is a proxy indicator for ongoing transmission in the community. But the majority of children have the non-infectious variety and have minimal disability denoting early detection of the disease in children.

The way forward

The current strategy of the ALC includes improving awareness leading to case detection and targeted interventions in high priority areas.

Sri Lanka is the first country to use the leprosy elimination monitoring tool proposed by the WHO and develop maps of the entire country under programmatic conditions. These maps and spot maps using GIS technology are used to identify areas of high priority and employ targeted interventions.

Dr S. D. Atukorala: A pillar of Sri Lanka's microbiology landscape is no more

Dr B. J. C. Perera
Specialist Consultant Paediatrician

Our very dear friend and professional associate, Dr S. D. Atukorala MBBS, MD (Microbiology), Diploma in Bacteriology, FACP, FRCPath, FSLCM, bid *adieu* to this mortal world on the 02nd of March 2024, following a sojourn in it for a most fruitful and exemplary 79 years. I write this eulogy as a person who has known him initially as a fellow medical student just one year junior to me, then as a junior doctor, and later as a much-admired consultant colleague, and above all, as a very close and cherished friend.

"Athu", as he was ever so affectionately known to all of us, was a man of singular eminence whose contributions to the healthcare of our nation, and most specifically to microbiology, would need reams of writing to even begin to do justice to them. Yet for all that, the main reason why he may not have been all that well-known outside the medical circles is the fact that he did what had to be done, without any fanfare and flourish. One never found him pontificating loudly on any initiative that he was involved in.

Dr Atukorala's real journey in microbiology began in 1981 when he was appointed as the first permanent Consultant Clinical Bacteriologist of the Department of Microbiology in the Colombo General Hospital which has now become The National Hospital of Sri Lanka in Colombo. This department always played a crucial role in diagnosing and managing infectious diseases even in the whole of Sri Lanka as specimens were sent to it from far and wide. Dr Atukorala's arrival there marked a pivotal moment, as he brought a most welcome touch of accomplished expertise in a field still evolving within the country. One of the most remarkable aspects of Dr. Atukorala's career was his ability to single-handedly run the microbiological services at the Colombo National Hospital of Sri Lanka, at the very helm of that department, during the early 1980s. That was a time of great upheaval and uncertainty. Yet for all that, the man rose to the occasion with grace, fortitude, and determination. His tireless efforts ensured that patients received the care and treatment they so desperately needed, even in the face of overwhelming challenges and adversity. He was also a great teacher and a renowned lecturer. He had the inherent capacity to make his teaching duties ever so exciting and productive with the added flair of bringing in some humour as well.

His career in medicine was characterized by his tireless dedication to his patients and his unwavering commitment to excellence. As a consultant microbiologist at the National Hospital of Sri Lanka, he played a pivotal role in providing care to those in need, particularly during the darkest days of the Sri Lankan Civil War. During that tumultuous period, Dr Atukorala worked tirelessly to provide medical assistance to soldiers who had been injured in battle. Despite the chaos and uncertainty that surrounded the entire country, he remained steadfast in his determination to save lives and alleviate suffering. His selflessness and courage served as a beacon of hope for those who were in desperate need of medical attention.

Athu's dedication to humanity extended beyond clinical practice. He recognized the importance of fostering a competent workforce and actively participated in training medical professionals. The NHSL Department of Microbiology, under his guidance, became an approved training centre for medical officers and laboratory technologists. He nurtured countless students, instilling in them the essential knowledge and skills required to combat infectious diseases effectively. Furthermore, Dr Atukorala actively engaged in research, both independently and in collaboration with other institutions. His research interests encompassed various aspects of medical microbiology and infection control, contributing valuable insights into the local disease burden and the development of effective diagnostic and treatment strategies. His research, presented and published on both local and international platforms, garnered recognition for Sri Lanka's contributions to the field of microbiology.

Beyond his professional accomplishments, Athu was known for his warmth, humour, and his infectious smile. He had a knack for bringing joy and laughter to those around him, even in the most trying of times.

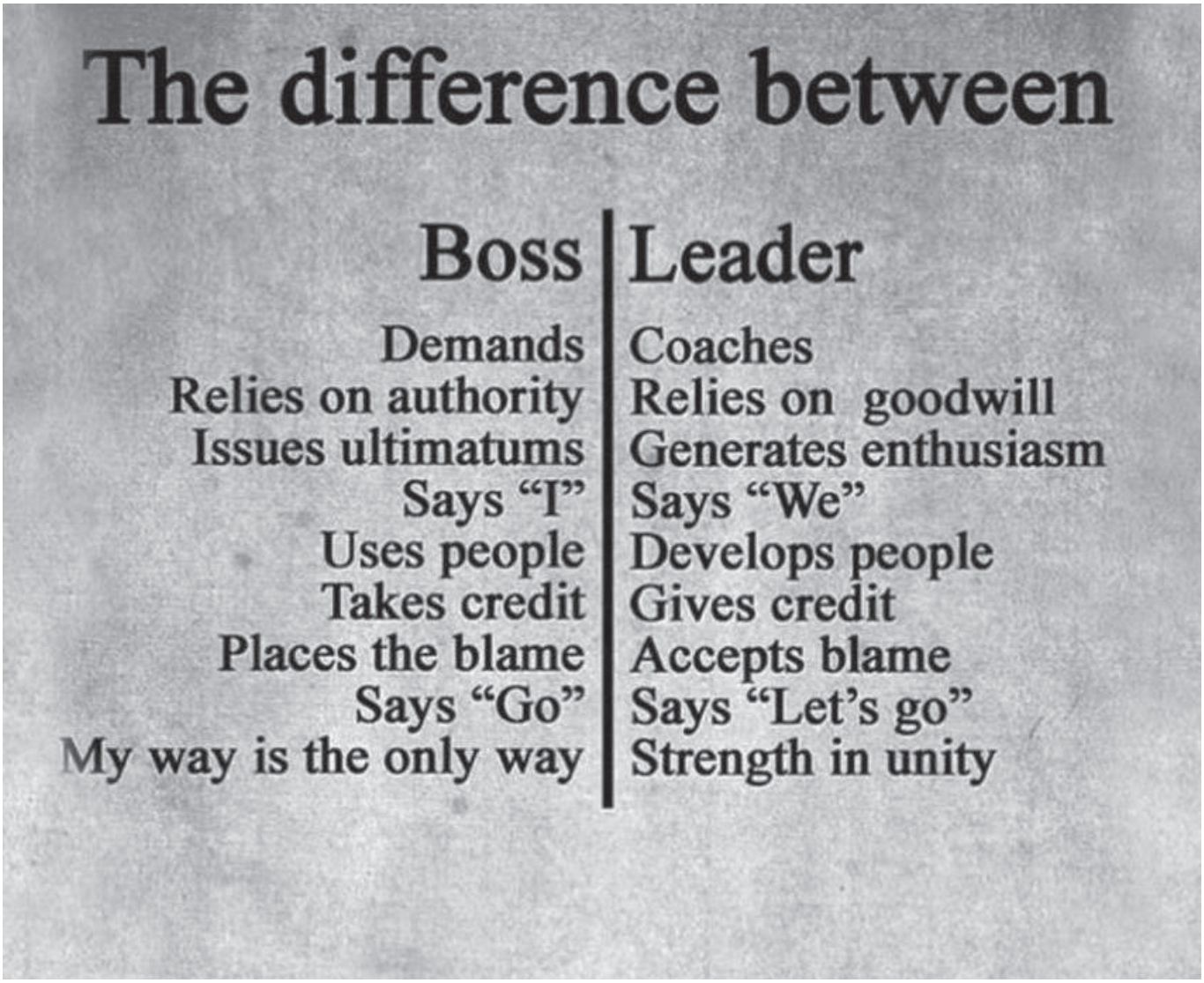
He also had the knack of bestowing specially selected nicknames to people around him. Those were designed most humorously and he made it a point to see that they would not hurt anyone. There was never a dull moment with him around us. His presence lit up the room, and his kind-hearted nature endeared him to all who had the privilege of knowing him. More than anything, most of us will miss that sense of closeness and camaraderie when he was around.

We have in this world, people who have rendered yeoman service to a nation as a whole, and performed so very well to give of their best while staying virtually backstage. They are the unheralded and unsung heroes of this land. Dr S. D. Atukorala was one such person. His contributions to medicine are well known to the medical fraternity. Yet for all that, he is not all that well known outside of it. This author found it impossible even to get a photographic image of him on the internet and had to go over to the family for the photograph that was inserted into this article. In a way, that is the real beauty of all that has been so gallantly and quietly provided by him in a lifetime that was dedicated to the welfare of humanity sans any major salutations.

We offer our heartfelt condolences to his wife Emeritus Professor Sunethra and their children and grandchildren. As we mourn our loss, we need to acknowledge the legacy that Dr S. D. Atukorala left behind. His dedication to his work, the seminal care he provided for the patients, his commitment to excellence, and his unwavering compassion, should serve as an inspiration to many a generation to come. Though he may no longer be with us physically, his spirit would live on in the lives of all of us whose hearts he touched with sheer compassion, warmth, and unbridled friendship. We need to reminisce with gratitude the time we shared with such a unique personality and the memories we hold so dear.

May the heritage left by this supreme human being; a man indeed for all seasons, continue to inspire us to strive wholeheartedly for greater responsibility towards serving others with compassion, and to live our lives with purpose and meaning. The man will be deeply missed, but the impact of his wonderful life will never be forgotten.

We do wish him eternal bliss in his next life.
Excerpted from The Island Newspaper of 06-03-2024



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Reminiscences of a Superlative Lady: A Beacon of Service and Ethics in Healthcare

Dr B. J. C. Perera
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One of the most respected teachers in healthcare, and a fabulous doctor *par excellence*, Dr Mrs Nandrani Swarnamitta De Zoysa left this worldly life on the 24th of February 2024, following an 89-year-long fruitful sojourn on Mother Earth. That fateful and critical incident induced her close family, her loved ones, and all of us in the medical fraternity, to be submerged in a sea of intense sadness and despair. However, in the aftermath of that event, the annals of the healthcare history in Sri Lanka are likely to be made ever so resplendent and complete, with a substantial chapter dedicated to the illustrious life of Dr De Zoysa, as well as the tremendous and impactful contributions made by her. As the former Director of the Sri Lankan National Blood Transfusion Service (NBTS), her name has been etched on a canvas of splendour with the artistic tools of dedication, innovation, and unwavering ethical principles. With heavy hearts, we bid farewell to an amazing human being, whose legacy would continue to inspire many a generation to come.

Dr Nandrani De Zoysa's journey on planet Earth was marked by a relentless pursuit of excellence in serving humanity. Her tenure at the helm of the National Blood Transfusion Service of Sri Lanka was characterized by transformative initiatives that reshaped the landscape of blood donation and transfusion practices in Sri Lanka. The pioneering changes and streamlining of the functioning of the services of the NBTS initiated and propagated by her, are far too numerous to be chronicled in a short eulogy such as this. Suffice it to say that under her visionary leadership, the service evolved into a model of efficiency, safety, and compassion. What we see today in that institution are the rewards of the mission undertaken by a lady like no other.

One of Dr De Zoysa's most significant contributions was her ground-breaking efforts in securing blood safety. Recognizing the urgent need to mitigate the potential risks of infections that were known to be susceptible to transmission through blood and blood product transfusions, she took bold steps to introduce rigorous testing protocols, including screening donated blood for Human Immunodeficiency Virus (HIV) and Hepatitis B. Despite facing scepticism and opposition from some quarters, even from outside our shores, Dr De Zoysa remained steadfast in her commitment to prioritizing the safety of patients above all else. Her foresight and determination undoubtedly saved countless lives and set a precedent for ethical leadership in the provision of safe healthcare.

Beyond her professional achievements, Dr De Zoysa's impact was deeply felt in the lives of the countless numbers of students she mentored and inspired. As a teacher, she possessed a rare combination of sublime intellect, empathy, and humility, instilling in her students not only the requisite knowledge but also the values of integrity and compassion. Many of the medical profession who had the privilege of being her students would unhesitatingly attest to the profound influence she had on their personal and professional development. I am only too well aware of her influence on some members of the medical fraternity as my late wife came under her tutelage when she was the Medical Officer of the Blood Bank in the Badulla General Hospital from 1979 to 1985. Madam De Zoysa treated her just as if she was her daughter. Even years later, when we met socially, her delight at seeing and interacting with both of us was very definitely nothing short of a splendid occasion of seminal camaraderie.

Dr De Zoysa's contributions to healthcare were not confined to the borders of Sri Lanka. She was a respected figure in the international medical community, known for her expertise in blood transfusion practices and her unwavering advocacy for global health equity. Through her participation in conferences, collaborations with international organizations, and dissemination of research findings, she played a pivotal role in advancing the field of transfusion medicine on a global scale. What truly set Dr De Zoysa apart was her unwavering commitment to her principles and ethics, even in the face of adversity. She was a gentle yet resolute leader who stood firm and exhibited her courage in her convictions, never

compromising on matters of integrity or patient safety. Her fantastic moral compass guided her every decision, earning her the admiration and respect of colleagues and peers alike.

In recognition of her outstanding contributions to the field of healthcare, Dr Nandrani De Zoysa was honoured with the prestigious National Titular Honour of Vidya Jyothi by the Executive President of Sri Lanka in 1988. This accolade, conferred just two years after the commencement of the award, underscored the magnitude of her achievements and the profound impact she had made in her field as the Director of the National Blood Transfusion Service. It was a fitting tribute to a visionary leader whose dedication and service had left an indelible mark on the healthcare landscape of Sri Lanka. Yet for all that, it was so humbling for all of us to see how lightly these accolades sat on her unassuming shoulders.

In Sinhala, her second name "Swarnamitta" means "Golden Friend"; "Swarna" translates to "golden," and "mitta" means "friend." In effect, when combined, "Swarnamitta" conveys the gorgeous notion of a cherished and much-valued friend, symbolizing qualities of warmth, sincerity, loyalty, and trustworthiness. That just about describes what she really was, and what she will always be, in the hearts of a whole lot of us.

As we look back and reflect on Dr Nandrani Swarnamitta De Zoysa's remarkable life and legacy, let us not mourn her passing but celebrate the enduring impact and influence of her contributions. She may have departed from this world, but her spirit lives on in the countless lives she touched and the principles she embodied. We are duty-bound to honour her memory by continuing to uphold her precious values of excellence, integrity, and compassion in all our endeavours, thereby keeping alive the flame of her wonderful heirlooms that she left behind for many a generation to come. That is the least we could do to present a supreme tribute to the memory of an individual who was ever so special and a beacon of hope. Madam De Zoysa may have left this mortal world forever, but her bequest of service and ethics will continue to reverberate, inspire, and guide us, and even those of many a future cohort to come, in the pursuit of a healthier, more equitable world, where our fellow human beings come first and foremost.

Dear Madam De Zoysa, the entire medical community would join me in expressing our fervent wish for you to attain the supreme bliss of nirvana through the shortest possible voyage in samsara, as outlined in the philosophy of the religion of Buddihism that you believed in.

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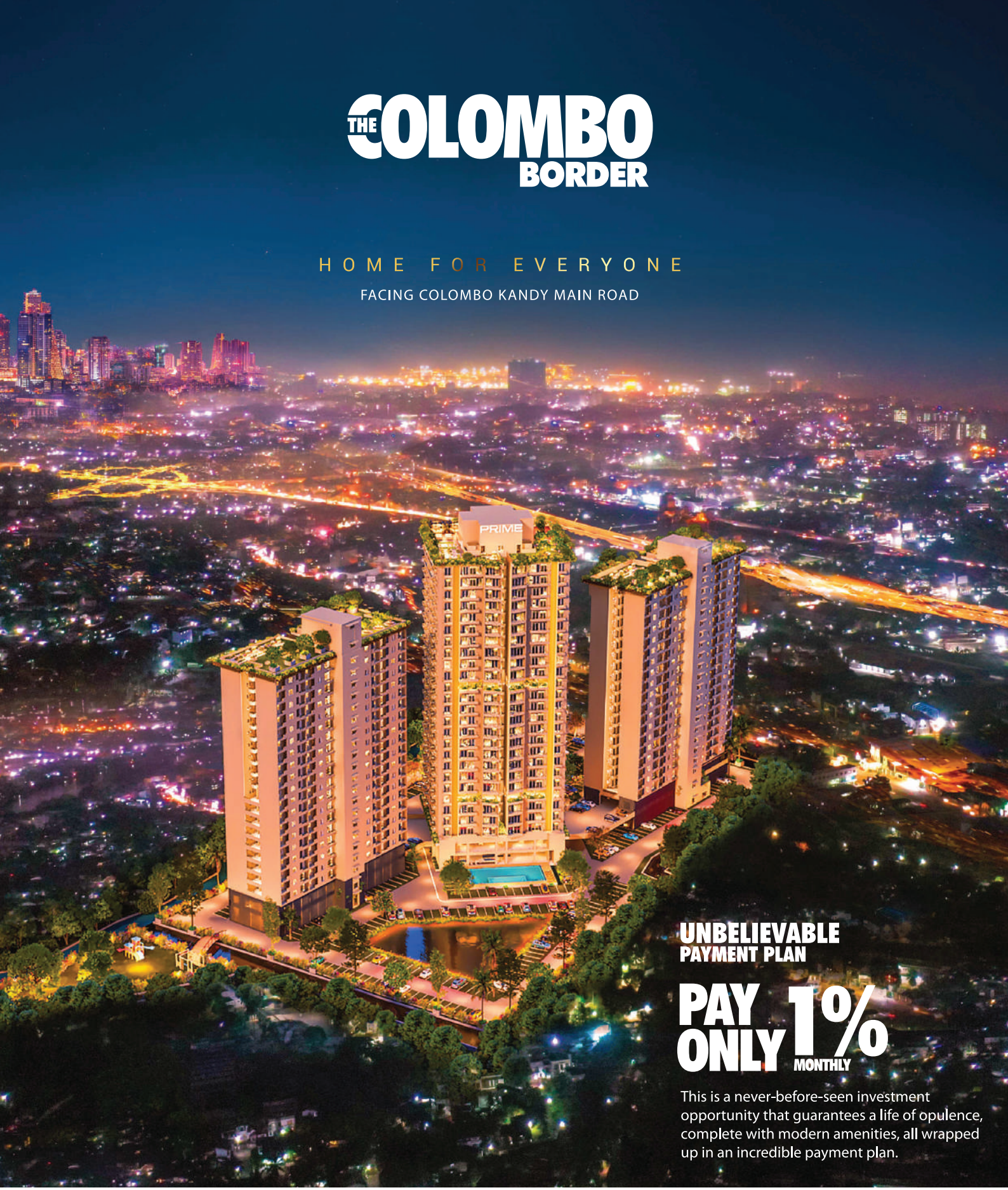

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