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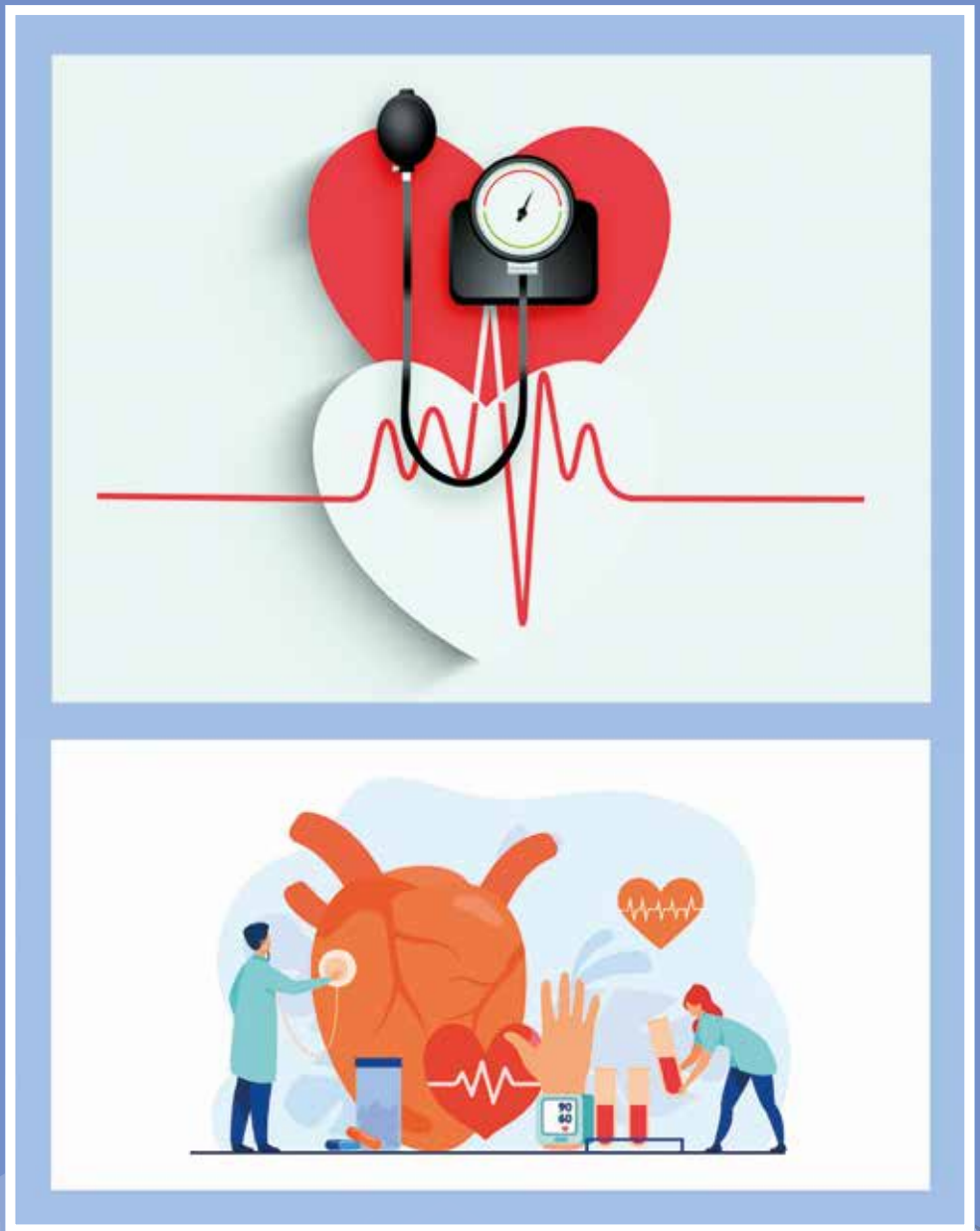



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## Cover Story : Manage your Hypertension Better

NINEWELLS
A LIFETIME OF CARE

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## CONTENTS



## SLMA President

**Dr Vinya Ariyaratne**
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Specialist in Community Medicine,
Past President of College of Community
Physicians of Sri Lanka,
President of Sarvodaya Movement

# President's Message

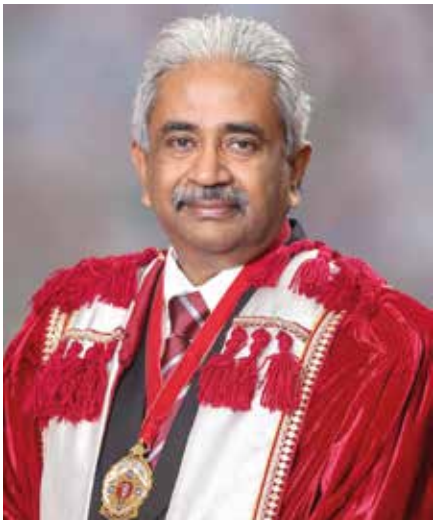
Dear SLMA Members,

The year is nearly coming to a close. However, the multiple challenges that the health sector faces do not seem to have waned; not as yet perhaps. Shortages of medicines, concerns on drug quality and safety, drain of human resources in the health sector with closure of some primary care medical care units and specialist care units for lack of medical personnel and specialists, continue to affect the health service delivery in our country. There have also been some significant changes in health care governance with some major changes in several key positions in the health sector.

According to the World Health Organization (WHO), Health System Governance refers to *"the rules and norms that shape roles and responsibilities, incentives, and interactions in the health sector." It further elaborates by stating that "Governments play a major role in setting the governance arrangements in the health sector. They act through a broad range of legal, policy, planning and monitoring instruments. Health service providers, both public and private, and citizens, further constitute the core actors in conventional health governance models. Linkages between these three groups are essential to health system performance and the achievement of universal health coverage (UHC)."*

International organizations, corporations and other networks also play a role in health system governance. Beyond the legal and other formal instruments available to government, a variety of conventions, norms, cultural traditions, forms of persuasion, force, economic pressures, and other mechanisms, are increasingly shaping governance arrangements and health system performance.

In this regard, professional medical associations play a vital role in health improvement and health governance on multiple levels. One of the key roles of professional associations is policy advocacy. Such organisations advocate for policies that enhance healthcare delivery, patient safety, and public health. They often collaborate with



governments and policymakers to shape healthcare legislation, regulations, and guidelines. Over many a year, the Sri Lanka Medical Association (SLMA) has engaged with the Government, key policy makers and other stakeholders in issues identified above. The most recent engagement was on a "Charter of Patients' Rights and Responsibilities". The Parliament Sectoral Oversight Committee on Health invited SLMA to give its expert advice on formulating a Charter of Patient's Rights and Responsibilities. Senior members of SLMA Ethics Committee participated in the deliberations and it is most encouraging to note that the current draft is based on the principles first postulated by SLMA in the mid-1990s. SLMA also contributed actively to the formulation of the "National Policy on Use of Human Genetic Material and Data in Sri Lanka". Parallel to engagement with key stakeholders on national policies related to health care, SLMA continues to perform its role in engaging with and educating the public on their role in promoting health. SLMA's presence in all media continues to be a prominent feature with its opinion being sought and treated as reliable and trustworthy by many institutions and the public alike.

However, engaging in policy matters has significant challenges. One of the main challenges is the complexity of the policy landscape. Navigating through the intricate web of policies, regulations, and legislative processes is a daunting phenomenon. Understanding the implications of proposed policies and their potential impact on healthcare delivery requires specialized knowledge and expertise. When we are under time pressures, it is often an unnerving task to get a convergence of diverse opinions to arrive at a consensus. SLMA continues to face this trial regularly. This is made more challenging by SLMA not having dedicated human, financial, or time resources to actively engage in policy matters. This limits its ability to conduct thorough research, participate in advocacy efforts, or employ dedicated staff for policy work. Another challenge is balancing the diverse interests of stakeholders within the healthcare paradigm. Professional organizations often need to advocate for policies that align with their goals while considering the broader needs of patients, providers, insurers, and other stakeholders. Healthcare policies are subject to frequent changes due to evolving societal needs, advancements in medical technology, budget constraints, and political dynamics. Keeping up with these changes and adapting strategies accordingly, can be demanding. Another aspect that needs to be considered in policymaking in healthcare is the political dimension, a facet which is often not openly discussed. Health sector policy making is often influenced by political ideologies and interests which can later turn out to be what is known as *political determinants of health*. Navigating through partisan divides and advocating for policies that benefit healthcare delivery while managing differing political agendas can be complex and require a nuanced approach.

I am pleased to note that, despite these constraints, SLMA has played an effective and constructive role on critical policy matters and issues affecting public health in Sri Lanka. I can humbly say that we tried our best to base our advocacy work strictly on hard evidence, objective outlooks, and non-partisan perspectives. SLMA will continue to be a strong advocate for the right policies that will promote health and wellbeing of our people in the whole of this resplendent isle.

**Dr Vinya Ariyaratne**
**President SLMA.**

# Activities in Brief
## (16th October 2023 - 15th November 2023)

## SLMA Saturday Talks

### 21st October

*'Inhalers in Paediatric Asthma'* by Dr Anuradha Kodippili, Lecturer in Paediatrics, Faculty of Medicine, Colombo.

### 28th October

*'Interventional Radiology: advancements, applications and future perspectives'* by Dr Chinthaka Appuhamy, Senior Lecturer, Faculty of Medicine, University of Kelaniya.

### 11th October

*'Handling a skin rash: Case based discussion'* by Dr Indira Kahawita, Consultant Dermatologist, NHSL, Colombo.

## Other Activities

### 17th October

A clinical meeting was held with the collaboration of the Sri Lanka College of Obstetricians & Gynaecologists (SLCOG) on the topic *'Lupus Nephritis in Pregnancy'*.

Dr Chandana Jayasundara, Head of Department, Obstetrics & Gynaecology, Faculty of Medicine, Colombo made a case presentation, Dr Shemoon Marleen, Hon Senior Lecturer, Faculty of Medical Sciences, University Sri Jayawardenapura discussed the presented case and Professor Hemantha Dodampahala, Professor in Obstetrics & Gynaecology, Faculty of Medicine, Colombo discussed a few MCQs on the same topic.

### 25th October

The Sir Nicholas Attyagalle Oration 2023 on *'Allergy - a Neglected Epidemic in Sri Lanka'* was delivered by Dr N Rajive de Silva, Consultant Immunologist, MRI, Colombo.

### 30th October

A webinar on *'The Drug registration process & Waiver of registration'* was organized jointly by the Expert Committee on Medicinal Drugs and the Sri Lanka Association of Clinical Pharmacology & Therapeutics (SLACPT).

The resource persons were Professor Rohini Fernandopulle, Senior Professor of Pharmacology, General Sir John Kothalawela Defence University and Vidyajothi Professor Asita de Silva, Senior Professor of Pharmacology, University of Kelaniya.

### 31st October

The SLMA Expert Committee on Communicable Diseases organized a symposium on *'Insights in to eye infections in children'*.

Dr Prasad Chathurangana, Senior Lecturer, Department of Paediatrics, University of Colombo spoke on *'Clinical presentations of eye infections in children'*, Dr Dhammika Vidanagamage, Consultant Microbiologist, LRH, Colombo on *'Pathogens responsible for eye infections in children'* and Dr Hiranya Abeysekara, Consultant Eye surgeon, LRH, Colombo on *'Management of eye infections in children'*.

### 1st November

The International Road Safety Conference 'Safe Roads – Safe Children' organized by the SLMA Expert Committee for Prevention of Road Accidents was held under the patronage of Transport Minister of State Lasantha Alagiyawana.

Reducing preventable deaths and lifelong disability in children from road accidents was the primary focus of this year's conference. There were several rounds of discussion on the role of education, health, transportation, law and order.

A report was handed over to the minister regarding the measures to prevent vehicle accidents.

For this occasion, Minister of Education Susil Premajayantha, Chief of Presidential Staff and Senior Adviser on National Security to the President Mr Sagala Rathnayake, Chairman of the National Medcines Regulatory Authority Specialist Dr Ananda Wijewickrama, President of Sri Lanka Medical Association Dr Vinya Ariyarathne, representives of various fields including health, information technology, engineering, transportation and representatives and other sectors, members of the armed forces and Sri Lankan police, representatives of international organizations including UNICEF, Red Cross and foreign ambassadors also participated in the event.




## 3rd November

The SLMA Expert Committee on Non Communicable Diseases organized a *'Breast Cancer Awareness Programme'*.

The resource person was Dr Nurad Joseph, Consultant Clinical Oncologist, DGH Hambanthota.

## 7th November

A clinical meeting was held with the collaboration of the Faculty of Dental Sciences, Sri Jayawaardenapura on 'Oral health for the General Practitioner'.

The resource persons and their topics of discussion were; Dr Rasika Ekanayake, Senior Lecturer in Oral Pathology on '*Introduction to oral health'*, Dr V Rajaganesh, Senior Lecturer in Orthodontics on *'Common dental diseases and their presentations'* and Dr Ananda Rathnayake, Senior Lecturer, Department of Oral Surgery on *'Oral & systemic link'*.

## 8th November

A joint regional meeting was held in collaboration with the Killinochchi clinical society at the Auditorium, DGH Killinochchi.

Dr M Jeyarasa, Senior Medical Officer, Palliative Care Services spoke on *'Palliative care services in Killinochchi District'*, Dr K Ranchan, Regional Epidemiologist on *'Notification of communicable diseases: what we should know'*, Dr Sardha Hemapriya, Senior Consultant Obstetrician & Gynaecologist on *'Care for the survivors of gender-based violence: The clinicians role'* and Dr Y Shivakaran, Consultant Obstetrician & Gynaecologist on *'Respectful maternity care'*.

## 9th November

A joint regional meeting was held in collaboration with the Vavuniya Medical Association at the Auditorium, DGH Vavuniya.

The resource persons and topics of discussion were as follows;

Dr S Sashikaran, Consultant Orthopaedic Surgeon on *'Ortho-geriatric co-management in elderly care'*, Dr Sivayogasundaram Premraj, Consultant Physician on *'Frailty & sacrcopaenia: An integrated approach to comprehensive geriatric care'*, Dr Sardha Hemapriya, Senior Consultant Obstetrician & Gynaecologist on *'Care for the survivors of gender-based Violence: The clinicians' role'* and Dr S Sasikanth, Consultant Nephrologist on *'Chronic Kidney Disease of unknown aetiology (CKDu) in Sri Lanka'*.


## 11th November

Dr Vinya Ariyaratne, President, SLMA attended a discussion on TV1 (MTV), The People's Platform on the topic *'Health Governance in crisis'*.

## 12th November

The Expert Committee on Health Management organized the annual *'Career guidance seminar for junior doctors'*.

Experts from the main specialties, sub specialties, Ministry of Health, Private sector, armed forces, medical faculty and PGIM delivered lectures.

## 14th November

A clinical meeting was held with the collaboration of the College of Chemical Pathologists of Sri Lanka on *'Unravelling the mysteries of hypercalcaemia: role of the Chemical Pathologist'*.

Dr BMCM Balasooriya, Dr Zeenath Thowfeek, Dr N Sujeewa, all Senior Registrars in Chemical Pathology at the NHSL, presented three cases and Dr Gaya Katulanda, Consultant Chemical Pathologist, NHSL discussed the cases.

## 15th November

The SLMA Expert Committee for Prevention of Road Accidents in collaboration with the Royal College Social Services League held a workshop for the Drivers of vehicles transporting children to schools at the Royal College Skills Centre.

# Out-of-Office Blood Pressure Monitoring: For a better hypertension management

**Dr. Niroshan C. Lokunarangoda**
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## Introduction

Systemic hypertension is sustained elevation of arterial blood pressure. The prevalence of systemic hypertension among Sri Lankans has significantly increased, with nearly one in three Sri Lankan adults being hypertensive and requiring antihypertensive treatment [1]. Since hypertension is a modifiable risk factor associated with strokes, kidney diseases, and cardiovascular diseases, early diagnosis and management of hypertension are vital in current clinical practice. Table 1 shows the different cut-off values to diagnose hypertension using different methods.

| | SBP | | DBP |
|---|---|---|---|
| Office BP | ≥140 | and/ or | ≥90 |
| Ambulatory BP (mean) | | | |
| • Daytime (or awake) | ≥135 | and/ or | ≥85 |
| • Nighttime (or sleep) | ≥120 | and/ or | ≥70 |
| • 24-h | ≥130 | and/ or | ≥80 |
| • Home | ≥135 | and/ or | ≥85 |

Table 1- Definitions of blood pressure according to office, ambulatory, and home blood pressure levels in mn4g : SBP- Systolic Blood Pressure: DBP- Diastolic Blood Pressure

The method of blood pressure (BP) measurement plays an essential role in the diagnosis of hypertension. Blood pressure can be measured in-office with Manual Office Blood Pressure (MOBP) and Automated Office Blood Pressure (AOBP) or out-of-office with Home Blood Pressure Monitoring (HBPM) and Ambulatory Blood Pressure Monitoring (ABPM) (Table 2). Even though office blood pressure measurements are commonly used to diagnose hypertension, their use can be limited due to the false negatives (masked hypertension) and false positives (white-coat) hypertension) [2]. Out-of-office blood pressure monitoring methods are good alternatives in such a context.

| In-office BP measuring methods |
|---|
| 1. Manual office blood pressure (MOBP)<br>2. Automated office blood pressure (AOBP) |
| **Out-of-office BP measuring methods** |
| 1. Home blood pressure monitoring (HBPM)<br>2. Ambulatory blood pressuremonitoring (ABPM) |

Table 2 – Methods of BP Measurements

### 1. Home Blood Pressure Monitoring (HBPM)

Home blood pressure monitoring is a commonly used out-of-office blood pressure measuring method. It is easily reproducible, well tolerated, relatively inexpensive, and superior to clinic BP for the prognosis of cardiovascular morbidity and mortality [3].

Compared to in-office blood pressure measurement (OBPM), HBPM is more approximate to ABPM [2].

In HBPM, a representative day-to-day blood pressure profile for the patient is created by measuring their blood pressure over several days. Patients are given instructions on the correct method of blood pressure measurement to adhere to when measuring blood pressure at home.

Do not smoke, exercise, or drink caffeine for 30 minutes before checking your blood pressure.

Sit at rest for 5 minutes before taking the blood pressure reading.

Sit on a chair with your back straight.Keep your legs uncrossed and feet flat on the floor.

The cuff should be placed on your arm, 2-3 cm above the elbow, at the same level as your heart.

Do not talk during the 5-minute rest period or while taking your blood pressure.

Box 1 – Advice to patients on HBPM

Patients are advised to take two readings twice daily around the same time for seven days.The average of all the blood pressure measurements, excluding the first day, is taken as the home blood pressure and 135/85 mmHg is taken as the threshold for hypertension [3].

**2. Ambulatory Blood PressureMonitoring (ABPM)**

Ambulatory blood pressure monitoring is considered the gold standard for blood pressure measurement [2].

**Indications for ABPM**

For initial diagnosis and during the follow-up of hypertensive patients, ABPM is useful. (Table 3)

| In the initial diagnosis |
|---|
| • To diagnose hypertension<br>• To detect white-coat and masked hypertension<br>• To identify nocturnal hypertension and non-dippers<br>• To assess blood pressure changes due to autonomic failure |
| **In treated hypertension** |
| • To identify the white-coat effect and masked hypertension<br>• To ensure 24-h BP control<br>• To confirm the diagnosis of uncontrolled and resistant hypertension<br>• To assess nocturnal hypertension and non-dipping<br>• To confirm symptomatic hypotension due to excessivetreatment<br>• To evaluate disagreement in diagnosis between office BP measurements and home BPmeasurements |

Table 3 - Indications for ABPM

**Method of ABPM**

The inflatable cuff is placed on the non-dominant arm unless there are contraindications like the presence of an arteriovenous (AV) fistula for haemodialysis or axillary clearance following breast cancer surgery. Concurrent measurements with ABPM and a sphygmomanometer or validated monitor are taken during initiation to ensure adequate configuration. The device is programmed to measure and record blood pressure every 15-30 minutes. BP is recorded for 24 hours.

The following instructions are given to patients.

| |
|---|
| • Follow your usual daily activities.<br>• Remain still while keeping your arm relaxed during each measurement.<br>• Avoid driving. If driving is necessary, stop driving during measurement (if possible) or ignore measurement.<br>• Avoid taking a shower or bath.<br>• Place the monitor on the bed or under your pillow while sleeping.<br>• If the monitor is malfunctioning, switch it off |
| The patients are asked to report the following in the diary -<br>• Time of sleep<br>• Symptoms (if present)<br>• Disturbances to sleep (if any occurred) during ABPM. |

Table 4- Instructions to the patients before ABPM

For ABPM, validated devices with proper cuff size should be used, and the clinicians can refer to the lists available on different websites such as STRIDE BP, the British and Irish Hypertensive Society (BIHS) website, and the American VALIDATE BP [2].

**Interpretation of ABPM**

After processing the data from the recordings following the monitoring period of 24 hours, a report is given to the patient.

Firstly, a clinician must assess the adequate quality of the ABPM report. The study should include the patient's routine 24-hour period with no missing time interval and should have valid day (≥20) and night (≥7) BP readings. If this step is satisfactory, he can then proceed to the next step by analyzing the BP values to come to a diagnosis. (Table 5)

| **Step 1: To assess the quality of 24-h ABPM** |
|---|
| 1. Was it a routine 24-hour period?<br>2. Overview of the 24-hour curve (Plot) - Ensure no missing time intervals<br>3. Number of valid day (≥20) & night (≥7) BP readings |

| Step 2: To come to a diagnosis |
|---|
| 1. 24-h BP average (< 130/80 mmHg)<br>2. Day BP Averages (<135/85 mmHg)<br>3. Night BP Averages (<120/70 mmHg)<br>4. Nighttime Dip (10-20%) |
| **Step 3: Other indices (optional)** |
| 1. BP variability (usually defined by the standard deviation of SBP at day and night)<br>2. BP load (the proportion of BP measurements above the threshold)<br>3. Morning BP surge (the difference between morning BP and the nocturnal nadir) |

Table 5 – Steps to interpret ABPM

Figures 1,2 and 3 show the information from an ABPM report, which is utilized to assess a report's quality and to arrive at a diagnosis.

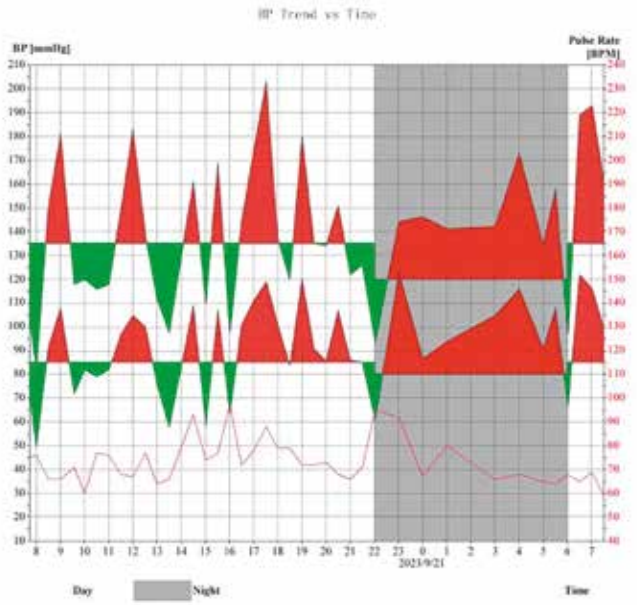


Figure 1 – 24-hour curve


Figure 2 – Identifying the number of valid readings

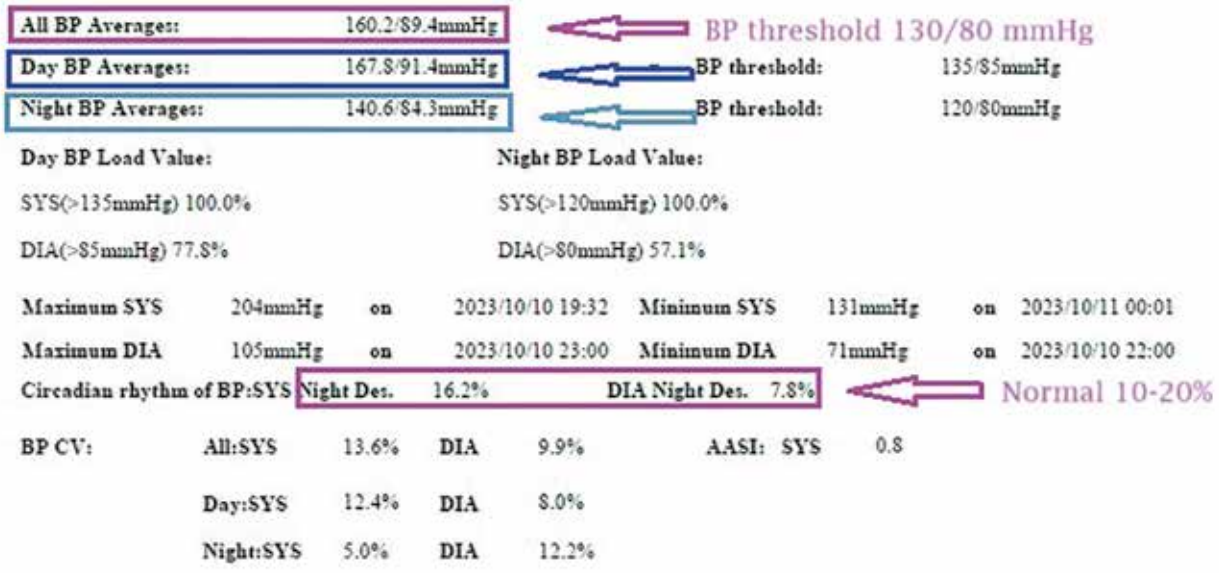


Figure 3 – Summary of ABPM report with valid day and nighttime readings

### Advantages of ABPM

ABPM assesses blood pressure during the patient's usual daily activities and gives objective results over 24 hours, including sleeping times. It gives a higher sensitivity and specificity in the diagnosis of hypertension [4]. It helps detect blood pressure phenotypes (Figure 4) and confirms uncontrolled and resistant hypertension.

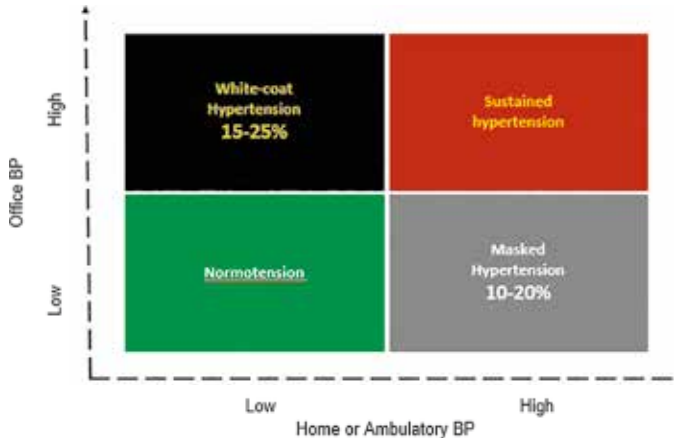


Figure 4 – Blood pressure phenotypes

Patients with white-coat hypertension account for 15-25%, and patients with masked hypertension account for 10-20% of the population.

*White-coat hypertension (WCH)*

In WCH, the patient meets hypertension criteria in-office blood pressure measurements, but out-of-office measurements show normotensive levels. The term WCH is used in untreated patients, whereas the term white coat effect (WCE) describes the difference between an elevated office BP and a lower out-of-office BP in both treated and untreated patients.

A systematic review and meta-analysis in 2019 showed that untreated WCH was associated with an increased risk for cardiovascular events, cardiovascular mortality and all-cause mortality [5]. Patients with WCH who received antihypertensive therapy did not show any of these adverse outcomes. Further, WCH increases the risk of developing sustained hypertension [2].

Therefore, ABPM is a valuable tool in improving patient outcomes. Patients with WCH are managed aggressively with lifestyle modifications such as smoking cessation, reduction in alcohol use, dietary modification, exercise, and weight loss. Even though antihypertensives are not routinely recommended, blood pressure monitoring at 6 to 12 month intervals with an out-of-office method is recommended, depending on the risk factors [2].

*Masked Hypertension (MH)*

When a patient's out-of-office blood pressure measurement is elevated, but the office blood pressure is within the normal range, it is termed masked hypertension. Masked Uncontrolled Hypertension (MUCH) is when this phenomenon occurs in individuals who are on antihypertensive treatment. MH is associated with an increased risk of cardiovascular events, nearly reaching the risk seen in sustained hypertension [2]. Therefore, treatment with lifestyle modifications and antihypertensive therapy is commenced in patients with MH. Hence, utilizing ABPM is useful in improving patient outcomes.

ABPM is superior to OBPM in providing prognostic information on the development of cardiovascular events, chronic kidney disease (CKD), ischaemic stroke, and mortality [2].

### Nocturnal Dipping

Normal individuals get a 10-20% drop in blood pressure while asleep, termed 'nocturnal dipping'. The dipping types are shown in table 6.

| | |
|---|---|
| Risers | Nocturnal BP is elevated compared to awake values. |
| Non-Dippers | Nocturnal dip in BP is <10% of their awake values |
| Dippers | Nocturnal BP is less than 10-20% of their awake values |
| Extreme dippers | Nocturnal dip in BP is >20% of their awake values |

Table - 6 –Types of nocturnal dipping

All these categories except "dippers" are associated with an increased cardiovascular risk [6].

A single 24-hour ABPM recording cannot determine the dipping status of an individual. To confirm the diagnosis, another ABPM is necessary. Furthermore, poor sleep quality and apnoea must be excluded when diagnosing a dipping state.

### ABPM in Special Populations

ABPM is also valuable for special populations; Office BP measurements are less reliable inpatients with CKD since they have a higher incidence of nocturnal hypertension, non-dipping and masked hypertension. Both type 1 and type 2 diabetes mellitus patients tend to have altered circadian BP patterns and are likely non-dippers [7]. Therefore, ABPM helps diagnose hypertension in these patient groups. ABPM has a vital role in diagnosing essential hypertension or white-coat hypertension in

pregnant women who have elevated office BP early in pregnancy [2].

**Practical Limitations of ABPM**

Lack of availability and cost have limited the access of ABPM to the patients. ABPM causes sleep disturbances and bruising in some patients [4]. Since the measurement is done in 24 hours, patients tend to dislike undergoing a repeat ABPM.

In summary, OBPM has many useful applications in optimizing hypertension management, which can be incorporated into the service of general practitioners and specialists.

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# ANNUAL GENERAL MEETING: 22ND DECEMBER 2023

The Annual General Meeting of the Sri Lanka Medical Association will be held at 7.00 p.m. on Friday, 22nd December 2023, at the NDW Memorial Auditorium, "Wijerama Mawatha, Colombo 7. All members are cordially invited to be present.

Any proposals/ resolutions to be taken up at the AGM should reach the Honorary Secretary, SLMA on or before 15th December 2023.

The agenda of the meeting is given below.

Dr. Sajith Edirisinghe
Honorary Secretary, SLMA

Agenda for the Annual General Meeting: 22 - 12 - 2023

1. National Anthem
2. Reading of the notice calling for the Annual General Meeting
3. Observation of one minute silence for departed members of SLMA
4. Adoption of the minutes of the last Annual General Meeting held on 23rd December 2022
5. Confirmation of new members of the SLMA who joined in 2023
6. Resolutions
7. President's address
8. Secretary's report for 2023
9. Treasurer's report for 2023
10. Election of office bearers and council members for the year 2024
11. Appointment of auditors
12. Address by the new President

# Stressed doctors, stressed patients:
## Learned helplessness in healthcare landscape.

**Dr. Vajira Dharmawardene**
*MD, FSLCPsy*
Consultant Psychiatrist
Department of Psychiatry
Sabaragamuwa University of Sri Lanka

I will start with a true story.

Simulated patients are a fashionable educational tool in medicine these days. There are several reasons for this including the convenience and ability to "manufacture" the patient according to the assessment needs. Such patients are especially suitable for assessment purposes in disciplines like psychiatry where rarely a physical sign exists.

Doctors and other healthcare workers are often selected to play the role of the patient as they know patient stories very well. A few weeks back I had a conversation with a group of doctors on the possibility of a few of them volunteering to simulate as patients for a psychiatry short case examination. A response from one doctor momentarily startled the group. He said, "there is no need to simulate," merely describing their current true self would be sufficient for them to be considered as a psychiatric short case! The noticeable reaction from the others was that nobody laughed and many nodded in agreement.

This illustrates a critical issue in Sri Lanka's health landscape that we need to take notice of immediately. It appears that at least some doctors currently practicing in Sri Lanka consider themselves as patients from the mental health standpoint and they as no different from patients. One may argue this could help in empathy, but certainly we do not want stressed doctors to see patients.

Doctors have always been an enviable social group in this country. They have always been successful in maintaining a social status above the ordinary folk, most if not all parents from the general population wanting their children to achieve the status. The situation appears to be strikingly different now. Though becoming a doctor is still something parents and students aspire to, many do not see their future as a doctor in this country.

The reasons for heightened stress among doctors are multiple. Economic factors have played a key role in the recent past in Sri Lanka, with many doctors now finding it difficult to sustain the social status and lifestyles they used to enjoy a few years ago. Practicing medicine in this country has become less attractive and the rush towards migration by doctors indicates the extent of the dissatisfaction. It is documented that medical students while still being in the medical school are considering overseas options. A cross sectional descriptive study done in 2013 among a sample of 375 undergraduates from Colombo Medical School, 24 % had already decided to migrate.[1] The most cited reasons for migration were a perceived better quality of life, better earnings, and more training opportunities in their destination country. Do not be surprised if that percentage has doubled or tripled now.

Many doctors who were not keen on doing private practice had to start their own practice in the recent past to pay the bank loan installments that had gone up and supplement the increasing household expenditure. The free time they had for family engagement and leisure activities have significantly gone down with obvious mental health implications. These ventures have not been a success either for many as the public also struggles with the economic downturn and is increasingly less likely to seek private consultations.

Economics is, however, only part of the story. Workplace stressors have compounded the doctors' problems more. Many healthcare facilities are now experiencing staff shortages, and this has added to the workload of the staff who remain. More ordinary people are flocking to the hospitals as they cannot afford private sector services and in turn contributing to the increased workload of the doctors. Shortages of medications and other essential consumables are described daily in news coverages. These shortages when present are pressurizing doctors to provide care that is deviant from the ideal. A dutiful doctor who cares for the welfare of his or her patients finds this scenario unacceptable and extremely stressful. Many are angry, others feel helpless.

Poor patients coming to clinics to collect the regular supply of cheap generic lithium, the first line treatment for prophylaxis of bipolar disorder, feel helpless and seeing doctor's inability to do anything about it worsens the patient's emotional state. No wonder doctors feel like patients.

The conditions are very well set for raising the rates of burnout among Sri Lankan doctors and the day-to-day conversations reveal that the situation is serious.

Burnout is a situation considered in relation to a job and designated as an occupational syndrome. ICD 11 considers it under the category occupational phenomena, specifically under the category of problems associated with employment or unemployment.[2] Burnout has many similarities to the idea of learned helplessness first described by Martin Seligman decades ago when he studied dogs who were subjected to electric shocks

with no chance of escape.[3]After being conditioned to the helpless situation of no escape, the dogs were so resigned to fate so much that no attempt was made to escape even when the option is available. A person affected by burnout similarly has learned that nothing will work as a solution and gives up trying even when the opportunity occurs. The cynical feeling a proportion of doctors have towards the health system is that "nothing will work and there is no point trying to change it" has many similarities to a learned helpless situation. It is a response of resignation or giving up.

Burnout is typically considered to have three distinct features, Exhaustion or lack of energy, cynicism, and a reduced sense of professional efficacy. When individuals experience burnout, work that was once seen as challenging and meaningful becomes increasingly unfulfilling and unsustainable over time.

There is loss of interest and energy, impaired concentration and significant negative cognitions consistently associated with burnout that make one wonder whether it is a variant of depression. The medical officer who feels as a distressed psychiatric patient that they see in day-to-day practice could be experiencing the syndrome of burnout. Even if the syndrome of burnout does not amount to a psychiatric diagnosis, it is known to be a risk factor or development of depressive illness.

Increased workload has been noted to a significantly associated with the burnout and intention to leave the job across the health care workforce. Doctors, nurses, and non-clinical staff are all affected by the heavy workloads. Studies indicate burnout may be affecting nursing staff more than doctors.

Inquiry into burnout among Sri Lankan doctors has not been a subject of wide study. A few studies conducted prior to the current economic downturn had given prevalences ranging from 20% to 50%. A study done a decade ago using Oldenburg Burnout Inventory in Galle and Mahamodara among 155 medical officers, showed that 36.1% were exhausted and 34.2% were disengaged. Overall burnout rate was 20.6%.[4] Doing private practice was significantly correlated with the burnout and men were more affected than female. A more recent study has looked at the rate of burnout among the postgraduate trainees in Colombo and found work-related burnout to be 30.6%.[5] It is difficult to assess the extrapolation of latter study's results to current scenario as it has used a very wide definition of burnout. However, it is not invalid to suggest that these rates have significantly climbed up in the last 1-2 years.

Burnout has significant implications not only for the individual affected, but also for the healthcare system the medical officer works. It is consistently correlated with the intention to leave the job, hence the risk of further deterioration of the strength of the workforce.

Moreover, doctors inflicted with burnout poses a risk to the patients. Findings from a large comprehensive systematic review and meta-analysis assessing the association of burnout with the career engagement of physicians and the quality of patient care that was published in BMJ in 2022 are relevant to understanding the extent of the issue and the impact.[6]

Summarizing the results from 170 observational studies with 239,246 physicians, the paper found compelling evidence for the adverse impact of burnout on doctors, health care system and the patient outcomes. Doctors with burnout are up to four times more likely to be dissatisfied with their job and more than three times as likely to have thoughts or intentions to leave their jobs or to regret their selection of medicine as a career.

When analyzed for the impact on patient care it indicates that doctors experiencing burnout are twice as likely to be involved in patient safety incidents. They also show low professionalism and are over twice as likely to receive low satisfaction gradings from patients.

This is not to say there are no other factors that mediate the pathway to burnout including lifestyle, the area of practice, private versus hospital practice etc. But disregarding system factors for individual focus will not serve well for health care landscape.

Interventions to address burnout are known and recognition of the problem and a concerted effort to address the issue are needed. Doctors can fail. But sometimes it is the system that fails the doctor.

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# Evidence Based Medicine: An introduction for clinicians

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## Introduction

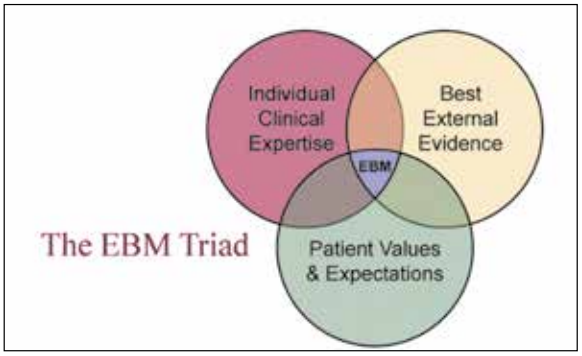
Evidence based medicine (EBM), a new paradigm for teaching and practice of clinical medicine introduced by a group led by Professor David Lawrence Sackett in 1992, has had a lasting impact on the practice of medicine(1). In 1996 Sackett & the group clarified what EBM is, and what it is not, in an editorial in the British Medical Journal (BMJ) (2). Celebrating two decades of EBM in 2014, the pioneers of EBM discussed the history, present issues, and the future, in a joint initiative sponsored by two general medical journals, BMJ and Journal of the American Medical Association (JAMA)[3].

This article presents the current perspective of what EBM is and focuses on one of the three components; identifying best evidence.

## What is EBM?

In 1990, Gordon Guyatt, the director of the Internal Medicine Programme at McMasters modified the traditional programme so that physicians managed patients considering what the research evidence showed which form of management worked. Later he named the new approach 'Evidence Based Medicine'.

Since its formal introduction in 1992, EBM has changed. The current definition of EBM is given in Box 1.




Box 1. 'Evidence-based medicine requires the integration of best research evidence with our clinical expertise and our patients' unique values and circumstances.'

- **best research evidence** means clinically relevant research, often from the basic sciences of medicine, but especially from patient centred clinical research into the accuracy and precision of diagnostic tests, the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive strategies.
- **clinical expertise** means the ability to use our clinical skills and past experience to rapidly identify each patient's unique health state and diagnosis, their individual risks and benefits of potential interventions, and their personal values and expectations.
- **patient values & expectations** mean the unique preferences, concerns, and expectations which each patient brings to a clinical encounter and which must be integrated into clinical decisions if doctors are to serve the patient.

'Good doctors use both individual clinical expertise and the best available external evidence, and neither alone is enough. Without clinical expertise, practice risks becoming dictated by evidence. Even excellent external evidence may be inapplicable to or inappropriate for an individual patient. External clinical evidence can inform, but can never replace, individual clinical expertise. It is this clinical expertise that decides whether the external evidence applies to the individual patient at all, and if so, how it should be integrated into a clinical decision. Without current best evidence, practice risks becoming rapidly out of date, to the detriment of patients.' (2)

Clinicians often think that one must be an expert at critical appraisal to practice EBM. That is not quite correct. EBM has its roots in clinical epidemiology and critical appraisal. Some clinicians identify EBM with the popular series of 17 articles on critical appraisal published by JAMA. PMID [8411578]. However, it is important to understand that though critical appraisal is an important aspect of EBM, it is not equivalent to EBM. In 2000, Guyatt explained the McMasters experience in physician training (4) . Most physician after seven years of training were not experts at critical appraisal. However, they understood the basics and used pre-appraised evidence in their clinical practice. Professor D. L. Sackett states that EBM goes beyond critical appraisal to combine the diagnostic skills of the doctor with the best evidence. In 2021, Guyatt again reiterates that understanding research results, evidence summaries and their applicability to patients are the core skills for clinicians that should be emphasized when promoting evidence based practice, much more than 'critical appraisal' (5).

**Best Evidence**

**'Point of Care Resources' (POCR)**

Web-based POCR provide predigested, rapidly accessible, comprehensive, periodically updated, evidence-based information intended for usage at the time of a doctor-patient consultation (6). The user-friendly interfaces improve the retrieval, synthesis and organization of evidence-based content and make POCR ideal for busy clinicians. The top POCRs are not free but come at a cost. However, some resources that may not fall within the exact definition of the POCR may provide valuable resources for evidence-based practice.

Reviews have compared POCR considering key features such as methodology, editorial quality, and speed of updating. The three resources that have come on top are DynaMed, Best Practice and UpToDate. These are subscription-based applications ranging from US$ 100 to US$300 annually. Some vendors provide institution subscriptions for a limited user-license and discounted rates for developing country physicians. The ideal tool for evidence-based practice will be one of these top ranking and paid POCRs depending on the level of care and your specialty.

**Point of Care Resources (POCR) with a subscription**

DynaMed - https://www.dynamed.com
UpToDate - http://www.uptodate.com/home
Best Practice - http://bestpractice.bmj.com/best-practice/welcome.html
Essential Evidence plus - http://www.essentialevidenceplus.com/

**Point of Care Resources (POCR) Resources without a subscription**

**Cochrane Library** - http://www.cochranelibrary.com/
Cochrane library has two POCRs.

* **Cochrane Database of Systematic Reviews (CDSR)** which is the leading source of high-quality systematic reviews in healthcare. About 8500 CDSRs are currently available.

* **Cochrane Clinical Answers (CCAs)** - Cochrane Clinical Answers (CCAs) provide a readable, clinically focused entry point to rigorous research from Cochrane Reviews which number about 3000. CDSR in its original format, is not very user friendly and readable as the paid resources mentioned in Box 2. CAAs is Cochrane's user-friendly version similar to the paid resources mentioned above.

**Choosing Wisely (CW)** - http://www.choosingwisely.org/

The American Board of Internal Medicine (ABIM) commenced this initiative to promote conversations between clinicians and patients. CW is mainly about investigations or procedures that is supported by evidence, free from harm, not duplicative of other tests and truly necessary. Following the initiative by the ABIM, CW has country specific sites in UK, Canada and Australia.

**HANDI** - http://www.racgp.org.au/your-practice/guidelines/handi/

The Handbook of Non-Drug Interventions is a new type of evidence-based website for interested clinicians in using effective non-drug treatments. The topics are arranged in alphabetical order e.g., Exercise for acute lower back pain, DASH diet to prevent and control hypertension.

**Clinical Practice Guidelines**

'Clinical Practice Guidelines (CPG) are statements that include recommendations intended to optimize patient care. They are assimilated by a systematic review of evidence, and an assessment of the benefits and harms of alternative care options' (7). Guidelines should follow a sound, transparent method to translate best evidence into clinical practice for improved patient outcomes. Ransoholf has summarized how to ascertain whether a guideline is trustworthy PMID [23299601]. (Ref 8)

In Sri Lanka there is no systematic process of having updated clinical practice guidelines in one central web-based portal that can be accessed by healthcare providers. The Ministry of Health provides CPGs for infectious diseases such as Dengue, Influenza, Leptospirosis, Rabies etc. Different Colleges and the Sri Lanka Medical Association provide guidelines for Non-Communicable Diseases, vaccination etc. in separate websites and print publications.

Examples of some of the leading international clinical practice guidelines are given below.

**National Institute for Health and Care Excellence (NICE)**

NICE produces evidence-based recommendations for healthcare in England developed by independent committees, including professionals and lay members, and consulted on by stakeholders.

https://www.nice.org.uk/guidance

**Agency for Healthcare Research and Quality (AHRQ) – Evidence-based Practice Centre**

AHRQ is the lead Federal agency charged with improving the safety and quality of America's health care system. AHRQ develops the knowledge, tools, and data needed to improve the health care system and help Americans, health care professionals, and policymakers make informed health decisions.

https://www.ahrq.gov/research/findings/evidence-based-reports/index.html

**Australian Clinical Practice Guidelines**

The Australian Government, National Health and Medical Research Council (NHMRC) produces the Clinical Practice Guidelines Portal.

https://www.clinicalguidelines.gov.au/

**Guideline Central**

Provides evidence-based clinical decision-support tools that are current, practical, and easily accessible. This site partners with over thirty-five medical societies and government agencies. This is maybe the largest guideline library in the world.

https://www.guidelinecentral.com/

The resources listed below can be used to find the best evidence, although it may not fall within the definition of POCRs or Guidelines.

**Google Scholar** - https://scholar.google.com/

Google Scholar provides an extremely fast and simple way to search for scholarly literature with a broad scope, but not limiting itself to healthcare or biomedicine.

The difference between Google Scholar and Google is that Google searches everything on the world wide web not limiting to scholarly articles or sites. Therefore, the results are enormous. For example, if you do the same search phrase 'acute uncomplicated appendicitis in children' in Google scholar you get about 14,800 and in Google the hits amount to 693,000.

Google Scholar search include journals that are not indexed in PubMed/Medline and from publishing companies such as Elservier and EBSCO etc. Some journals may let you access the full-text for free. When these citations are shown in Scholar, the PDF will be ready to download with your initial search link.

**MedlinePlus** – https://medlineplus.gov/

MedlinePlus is a service of the National Library of Medicine (NLM), the world's largest medical library. The access to MedlinePlus passed a billion hits few years ago.

MedlinePlus present high-quality, relevant health and wellness information that is trusted, easy to understand, and free of advertising.

Medline Plus includes presentations, videos, patient information sheets and health check tools that can be shared with patients written in simple language. This is an excellent source of teaching material if you are preparing lectures.

**TRIP database** – http://www.tripdatabase.com/

Turning Research Into Practice (TRIP) is a clinical search engine designed to allow users to quickly and easily find high-quality research evidence to support clinical care. TRIP searches systematics reviews, guidelines (from different countries), primary and secondary research, evidence-based synopses, controlled trials, blogs, medical images etc. There is a free version. The paid version gives access to a large number of full-text articles. Even if you are using the free-TRIP it will be an advantage if you use this search engine from within a medical library such as the PGIM, a Faculty or Ministry library. If the library has access to the resource list that TRIP searches the full-text article can be accessed even with the free version.

In conclusion,

Evidence-based medicine requires integrating best research evidence with clinicians' expertise and patients' unique values and circumstances.

Clinicians practicing evidence-based medicine have two main options when accessing the 'best evidence'. Subscribing to one of the top ranked POCRs is the best choice, that comes with a cost, for busy clinicians. The second option is to familiarise with the non-subscription resources listed above, with the time factor being the most significant disadvantage.

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# Where healing hands compete on the cricket field

Doctors Cricket League: Where Healing Hands Compete on the Cricket Field Cricket, a sport cherished by millions, possesses a unique ability to unite people from diverse walks of life. In Sri Lanka, a remarkable and inspirational cricket tournament known as the Doctors Cricket League (DCL) made its debut through a collaboration between the Sri Lanka Medical Association and Sri Lanka Cricket. This competition brings together medical professionals from various specialties and hospitals, affording them an opportunity to showcase their cricketing skills while simultaneously promoting camaraderie and the significance of a healthy lifestyle.

The DCL adopted a T20 format, ensuring that matches are thrilling and fast-paced, appealing to both players and spectators. The league featured five teams representing medical professionals from Colombo, Kandy, Galle, Jaffna, and Dambulla. Each team crafted creative names, often incorporating a medical twist, injecting an element of fun into the competition.

The DCL Championship spanned three weeks and took place at two venues, namely the Asgiriya International Stadium and Welagedara Stadium in Kurunegala. Following an intense group stage, the final match showcased Team Colombo and Team Kandy, competing for the inaugural DCL Sri Lanka champions title. In an exhilarating contest, Team Kandy emerged victorious, with Thilina Samarasinghe earning the Man of the Match title for his match-winning century, scoring 111 runs from 57 balls.

Notably, the tournament's top run-scorer was Dr. Rajiv Nirmalasingham from Team Jaffna, amassing an impressive 198 runs with a remarkable strike rate of 157.14 and an average of 44.75. His highest individual score was an outstanding 115, achieved in just 67 balls. Dilan Paranamana from the team Galle was named as the Player of the Tournament for his all-round performance with 194 runs with the bat and 05 wickets with the ball.

On the bowling front, the highest wicket-taker was Dr. Nishantha Karunarathne from Team Colombo, securing a total of 10 wickets, with one of his standout performances occurring against Team Kandy, where he claimed 4 wickets while conceding only 8 runs in his four overs.

The Doctors Cricket League in Sri Lanka stands as a testament to the fact that medical professionals can excel not only in their respective fields but also on the cricket field. This unique initiative promotes unity, sportsmanship, and a healthy lifestyle while contributing to charitable causes. It serves as a source of inspiration for the medical community, underscoring that doctors are not just healers but also individuals deeply committed to the well-being of society.

Lastly, but certainly not least, we express our gratitude to everyone who contributed to making this tournament a resounding success, particularly extending our thanks to Prof. Vinya Ariyaratne, President of the Sri Lanka Medical Association, Dr. Sajith Edirisinghe, Secretary of Sri Lanka Medical Association, Mr. Sujeewa Godaliyadda, Treasurer, Sri Lanka Cricket, and Mr. M.K.C. Nalaka, Secretary, Sri Lanka Health Sports Club.

As the Doctors Cricket League continues to evolve, it will undoubtedly leave a lasting legacy in the hearts and minds of both participants and spectators, demonstrating that cricket and compassion can indeed go hand in hand. We look forward to returning with an enhanced version of the Doctors Cricket League in 2024.

# Inaugural Meeting of the SLMA Forum on Sports and Exercise

The Inaugural meeting of the SLMA Forum on Sports and Exercise, was successfully held on 15th of September 2023 in the presence of esteemed members including Dr. Vinya Ariyaratne, President of SLMA. Office bearers were elected with Prof Chathuranga Ranasinghe as the Chairperson and Dr. Rajiv Nirmalasingham as the Convener. In adherence to SLMA traditions, a symbolic cake-cutting ceremony marked the establishment of this vibrant forum. Dr. Nirmalasingham's presentation on the current state of sports in the medical community and the forum's potential impact was followed by an open discussion of innovative ideas to be explored in future meetings.

# The legacy of a lady like no other

**Dr B. J. C. Perera**

Preprint of extracts from the tribute to be published in the December 2023 issue of The Sri Lanka Journal of Child Health

It is with unbearable grief and a profound sense of despair that we noted the demise of Professor Chandra Kumari Abeysekera on 26th October 2023. She succumbed to a short illness which she bore with tremendous equanimity, aplomb, and courage.

She was the Emeritus Professor of Paediatrics in the Faculty of Medicine, University of Peradeniya and an exceptional figure in the field of medicine, and more specifically, in the realm of Paediatric Nephrology. Throughout her illustrious career, she demonstrated a unique blend of academic brilliance, genuine warmth, and a deep commitment to her students and her field of expertise. An alluring light of dazzling brilliance has finally been extinguished. The legacy she left behind is one of unwavering dedication and a lasting impact that would continue to shape the world of paediatrics of Sri Lanka.

She began her journey in medicine at the University of Peradeniya and went on to earn many postgraduate degrees such as DCH, MD, MRCP, FRCP and FSLCPaed. One of her most significant achievements was her pioneering work in the field of Paediatric Nephrology. She dedicated her career to understanding and treating kidney diseases in children; a niche area that had been relatively underexplored. One of her most notable accomplishments was the establishment of the first dedicated Pediatric Nephrology unit in Sri Lanka. This unit became a glittering hub for research, education, and treatment, leaving an enduring mark of excellence on the field. She took up Paediatric Nephrology as a special interest when that speciality was virtually *in utero*. She cradled that baby and saw it through its infancy and childhood. Today it is a full-blown speciality that has reached adulthood in its own right.

While Professor Abeysekera's academic contributions were undoubtedly most impressive, what truly set her apart was her remarkable personality. She was loved by all who had the privilege of knowing her, both personally and professionally. Her warmth, compassion, and humility endeared her to students, colleagues, and patients alike. It has been said that there are hundreds of languages in the world but a smile speaks them all. Professor Abeysekera firmly believed that the best smile is the one that shines through good times as well as troubled ones. Her genuine smile could light up even a darkened room and very often, it was the silver lining even in a cloud of desolation. She will always be remembered as a beloved figure, a brilliant academic, and a compassionate healer. As we mourn her passing, we also celebrate the incredible life she lived and the profound contributions she made to pediatric nephrology, forever bringing this vital field into the limelight.

Dear Chandra, having known you for over four decades, I am convinced that we will be faced with a totally different world without you. We would dearly miss you, as much as your husband Tilak and your immediate family would do. Their loss is our loss too.

Our most fervent wish is for you to ever so rapidly attain the supreme bliss of Nibbana, following the shortest possible sojourn in samsara.

# AWARDS FOR PAPERS AT THE 136TH ANNIVERSARY INTERNATIONAL MEDICAL CONGRESS 2023

*The following Awards are made for papers (Oral and poster) presented at the congress*

**E M Wijerama Award - for the best paper**
**OP015**
**Assessing reversibility of liver fibrosis in patients with transfusion-dependent beta thalassaemia following intensive chelation**

Padeniya AGPM, Ediriweera D, Niriella MA, De Silva A, Premawardhena AP

**S E Seneviratna Award - for the best paper**
**OP 017:**
**Impact of the present economic crisis on health-seeking behaviour in the general public of Sri Lanka: A comparative study between Western Province and Uva Province**

Nilaweera AI, Fernando DR, Adikaranayake AMPR, Perera AN, Daksina TDT, Wijayatilaka NT, Nethmini ULT, Hettiarachchi EDH, Weerakoon KGSH, Jayalath WKDN, Wijayaratne D, Katulanda P

**H K T Fernando Award - for the best paper**
**OP 019:**
**Genetic hybridization proved between cutaneous and visceral strains of Leishmania donovani within its natural vector Phlebotomus argentipes**

Riyal FH, Paun A, Ferreira TR, Samaranayake TN, Sacks D, Karunaweera ND

**Sir Nicholas Attygalle Award - for the best paper**
**OP 010:**
**Caregiver burden and quality of life among family caregivers of advanced cancer patients attending palliative care clinic at National Cancer Institute (NCI), Maharagama – Sri Lanka**

Dharmakan MD, Senaratne L, Vidanapathirana J

**Wilson Peiris Award - for the best paper**
**OP024**
**Socio-demographic, anthropometric and biochemical determinants of dialysis adequacy among patients undergoing haemodialysis in selected government hospitals in Sri Lanka**

Lasanthika TLC, Wanigasuriya JKP, Hettiaratchi UPK, Amarasekara AATD, Goonewardena CSE

**Daphne Attygalle Award – for the best paper in Cancer**
**OP 010:**
**Caregiver burden and quality of life among family caregivers of advanced cancer patients attending palliative care clinic at National Cancer Institute (NCI), Maharagama - Sri Lanka**

Dharmakan MD, Senaratne L, Vidanapathirana J

**Sir Frank Gunasekera Award – for the best paper in Community Medicine / Tuberculosis**
**PP011**
**The knowledge and practices of GCE Advanced Level students in Kandy city regarding antibiotics and antibiotic resistance**

Abeysinghe AABC, Abeywardena MU, Abeysinghe AAGH, Agalawatte AVDP, Abeygunawardena SDV, Amarakoon AMTND, Abeywardhana AMDT, Afkar AKM, Adikari AMID, Alwis PKDPS, Akeshwari GHGA, Liyanapathirana V

**Kumaradasa Rajasuriya Award – for the best paper in Tropical Medicine**
**OP 019:**
**Genetic hybridization proved between cutaneous and visceral strains of Leishmania donovani within its natural vector Phlebotomus argentipes**

Riyal FH, Paun A, Ferreira TR, Samaranayake TN, Sacks D, Karunaweera ND

**SPECIAL Prize in Cardiology – for the best paper in Cardiology**
**PP170**
**Anthropometric parameters of newly diagnosed patients with myocardial infarction admitted to tertiary care hospitals of Western Province of Sri Lanka – a case-control study**

Perera DAPS, Samaranayaka TPS, Chulasiri PU

**S Ramachandran Award - for the best Scientific Communication in Nephrology**
**OP024**
**Socio-demographic, anthropometric and biochemical determinants of dialysis adequacy among patients undergoing haemodialysis in selected government hospitals in Sri Lanka**

Lasanthika TLC, Wanigasuriya JKP, Hettiaratchi UPK, Amarasekara AATD, Goonewardena CSE

**Award for the best presentation in Pharmacology**
**PP140**
**Efficacy and safety of Ivermectin in the treatment of COVID-19 patients in Sri Lanka: IVERCOV, a multi-centre double-blind randomised controlled clinical trial**

Wijewickrema A, Banneheke H, Pathmeswaran A, Refai FW, Karunaratne M, Malawige N, Jeewandara C, Ekanayake M, Samaraweera D, Thambawita D, Galappatthy P

**SLMA Prize for the best Poster**
**PP170**
**Anthropometric parameters of newly diagnosed patients with myocardial infarction admitted to tertiary care hospitals of Western Province of Sri Lanka – a case-control study**

Perera DAPS, Samaranayaka TPS, Chulasiri PU

## LIST OF RESEARCH AWARDS

- **CNAPT award**

"Knowledge on prevention of occupational health hazards and utilization of safety measures among construction trade workers in Colombo District"

Dr Kasunee Chamila Kalubowila

- **SLMA Research Grant**

"Perceptions, prevalence and associated factors of cancer cachexia among patients with advanced stage cancers attending the Oncology unit, Teaching Hospital, Karapitiya, Galle and the effectiveness of an intervention targeting its prevention"

Dr I L A N Darshana

"Impact of Mindfulness-Based Rehabilitation on Psychological Outcomes of Patients with Breast Cance Undergoing Surgery: Randomized Control Trial"

Dr Umesh Jayarajah

- **Dr. Thistle Jayawardena Grant for Intensive and Critical Care**

"Platelet recovery in sepsis: An early marker of recovery"

Dr I. A. Abeyagunawardena

- **Professor Wilfred SE Perera Travel Grant**

"Knowledge and attitudes towards LGBT people and their healthcare needs among doctors in two selected hospitals in Sri Lanka"

Dr Nadeeka Kumudini Chandraratne

- **Glaxo Welcome Research Award**

"Russell's viper (Daboia russelii) envenomation: Epidemiology, clinical profile, morphological and molecular study"

## SLMA AWARDS FOR EXCELLENCE IN HEALTH JOURNALISM 2023

**1. Sinhala Medium**

Ms. Harindi Liyanage of the "Navaliya" newspaper for her article "ප්‍රතිජීවක ඖෂධ හිතුමතේට බොන්න එපා"

**2. Tamil Medium**

Ms. M H F Husna of the "Thinakkural" newspaper for her article "**இலங்றக டபண் கறை மிரெ்டும் மார்பக புறுலநாய்**"

**3. English Medium**

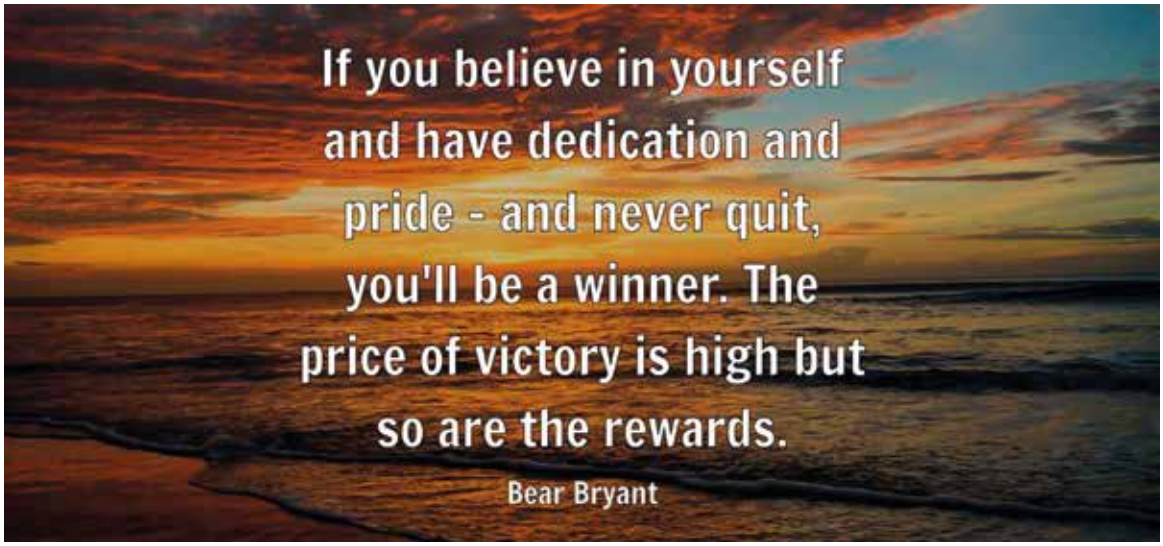
Ms. Nadira Gunatilleke of the "Daily News" for her article "Defeating Deadly Dengue"

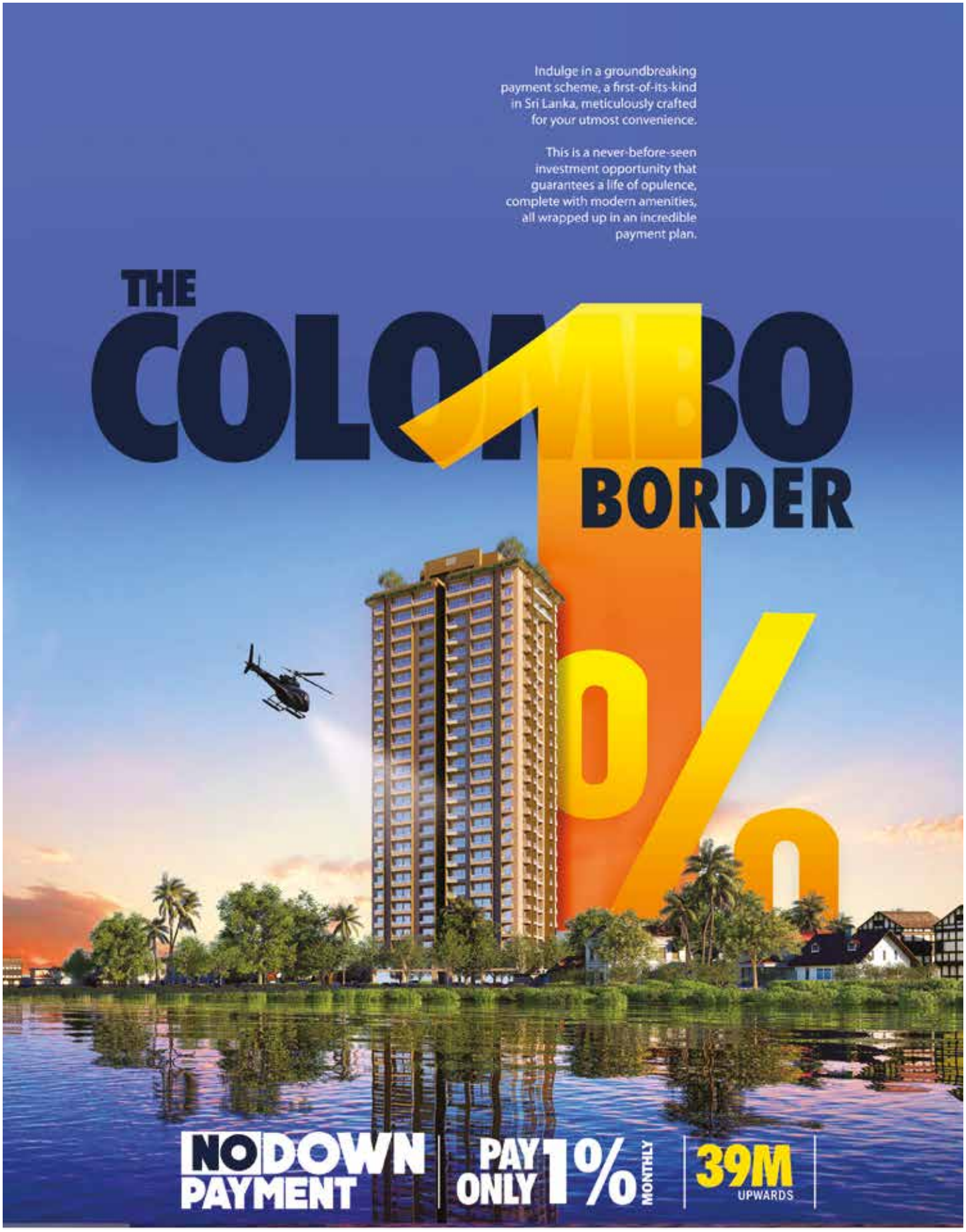
**4. Sinhala Medium – Merit Award**

Ms. Nadeeshani Pathirana of the "Ada" newspaper for her article "මනස ලෙඩ කරන ප්‍රචණ්ඩත්වය වැඩි වෙලා"

**5. English Medium – Merit Award**

Ms. Fathima Razik Carder of the "Sri Lanka Broadcasting Corporation" for the interview extract on "Good Health"



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