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SLMA NEWS+

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What can we offer during a person's last days of life?

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What lies beyond death?

Page 13

Sexual and gender diversity?

Page 15-19

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Cover Story : Life and Death

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"Wijerama House", No. 6, Wijerama Mawatha, Colombo 07, Telephone: +94 112 693 324, Email: office@slma.lk

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SLMA President

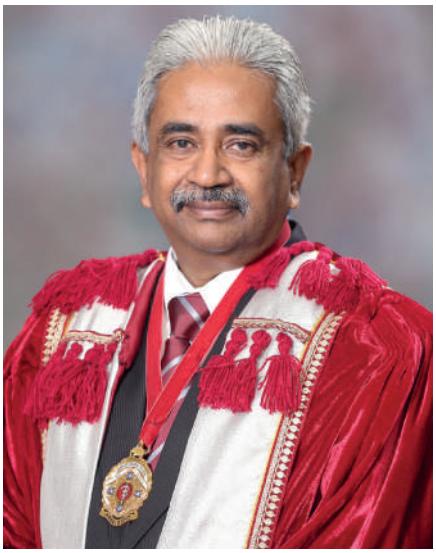
Dr Vinya Ariyaratne
MD, MPH, MSc Com. Med. MD Com, Med., FCCPSL
Specialist in Community Medicine,
Past President of College of Community
Physicians of Sri Lanka,
President of Sarvodaya Movement

President's Message

Dear SLMA Members,

Providing optimal care to a person who has to live with a debilitating illness for an extended period of time, or a chronic incurable illness, or someone who is diagnosed to be having a terminal illness, is a challenging task. Sri Lanka is a country with a rapidly ageing population and as a result, must face an increasing disease burden associated with longevity. Increasing life expectancy of the population and with the advancement of medical science, as well as the wider usage of modern technology in clinical care, there are also growing expectations among the public for prolongation of life that can even extend the suffering of the patient. Hence the field of Palliative Care is gaining increasing recognition as an important sub-speciality in medicine.

This month's issue of the SLMA Newsletter focuses on palliative care and end-of-life care. Recognizing the importance of disseminating current scientific knowledge related to palliative care, the SLMA as Sri Lanka's premier professional body in medicine, established the Palliative and End-of-life Care Task Force (PCTF) in 2016; one which is now functioning as an



Expert Committee. In 2017, the Task Force formulated a Manual for the Management of non-cancer patients as a guide to the health care professionals to control symptoms. In 2021, the Task Force published a revised and expanded edition *'Palliative Care Manual for Health Care Professionals in Sri Lanka'*, and *'Practice guidelines in the end-of-life care'*. These are excellent resources for doctors and other care providers in palliative care at an interdisciplinary field.

There are associated issues such as 'DNR: Do Not Resuscitate' order given by a patient. In this situation, even if the possibility of restarting the heart and breathing by Cardiopulmonary Resuscitation (CPR) exists for those who suffered cardiac arrest, the person does not want any life-saving measures to be administered. The Ethics Committee of SLMA has taken up this issue, one which also has serious legal implications as well.

Another issue connected to end-of-life care, one which has been of public interest, is organ transplantation. In recent months there has been much debate on organ transplantation in professional circles as well as in the media, and we have seen an increased willingness on the part of the citizens towards organ donations. Palliative care, end-of-life care, organ donation and organ transplantation are interconnected subjects and SLMA has tried in this Issue of the Newsletter to highlight the main considerations in the decision-making process.

Finally, on a different gear, we are looking forward to having your active participation at our forthcoming **136th SLMA International Medical Congress** scheduled to be held from the **25th to the 28th of July 2023** at the Bandaranaike Memorial International Conference Hall (BMICH). We have an interesting lineup of academic sessions under our theme for this year ***'Towards human healthcare; Excellence, Equity and Community'.***

Dr Vinya Ariyaratne
President SLMA.

Activities in Brief
(16th May 2023 - 15th June 2023)

SLMA Saturday Talks

20th May

'Human Ageing and Immunosenescence' by Dr Chamila Dalpatadu, Senior Lecturer in the Department of Physiology, University of Colombo.

27th May

'Septic Arthritis' by Dr K Kandeepan, Senior Lecturer in Surgery, University of Jaffna.

3rd June

'Approaches to Diarrhoea in Children' by Dr Wathsala Hathagoda, Lecturer in Paedeatrics, University of Colombo.

10th June

'An Approach to Insomnia and its Management' by Dr Suhashini Ratnatunga, Senior Lecturer in Psychiatry, University of Colombo.

Other Activities

16th May

A clinical meeting was held with the collaboration of the Sri Lanka College of Dermatology on the topic *'Cutaneous T Cell Lymphomas: Varying Presentations'*.

Dr Janaka Akarawita, Consultant Dermatologist, did a lecture on the topic, Drs Krishani Rajakaruna and Amanda Danthanarayana, Registrars in Dermatology, presented cases and Dr Bhagya Fernando, Senior Registrar in Dermatology, concluded the session with a picture quiz and MCQs in General Dermatology

All resource persons were from the NHSL, Colombo

17th May

SLMA organized a guest lecture on *'The New Zealand Public Health System and Lessons from Covid-19 Response'* by Dr Anura Jayasinghe, Specialist in Public Heath, TE WHATU ORA, New Zealand Health.

The occasion was graced by Mr Michael Appleton, the High Commissioner of New Zealand in Sri Lanka

18th May

SLMA held a joint Regional Meeting with the Sri Lanka College of Military Medicine on the theme *'An Overview of Environment Health, One Health & Planetary Health'*

The resource persons and their lectures were as follows; Dr Ananda Mallawatantri, Advisor to the President on Environment, Climate Change & Green Finance on *'Ecosystem Management in a Changing Climate in the Context of One Health'*, Admiral (Rtd) Piyal de Silva, Advisor, SL & IORA Countries for CRIMARIO, on *'Safe & Secure Global Society'*, Surgeon Captain Duminda Samarawickrama, A/ Commodore Superintendent of Health, Eastern Naval Command, on *'SL Navy's role in Environmental Health Security, steps to achieve goals of One Health, Eco Health & Planetary Health'*, Professor Indika Karunathilake, Professor in Medical Education, University of Colombo, on *'Role of Technology in Capacity Building on Planetary Health'* and Dr Sajith Edirisinghe, Honorary Secretary, SLMA on *'Microplastics & Human Health: The unseen aspects of a known disaster'*

23rd May

A clinical meeting was held with the collaboration of the Sri Lanka College of Internal Medicine, on *'Maternal Health'* Lectures delivered were as follows.

Dr Priyankara Jayawardhena, Consultant Physician in Internal Medicine on *'Liver Disease in Pregnancy'*, Dr Shamitha Dassanayake, Consultant Physician in Internal Medicine, CSTH, Colombo on *'Hypertension in Pregnancy'* and Dr Indika Boteju, Consultant Resident Physician, CSHW, Colombo on *'Hyperglycaemia in Pregnancy'*

23rd May

The SLMA Expert Committee on Communicable Diseases organized a symposium on 'Rise of *Leptospirosis* in the South: Trends, Challenges & Options' in collaboration with the Galle Medical Association.

Dr Amila Chandrasiri spoke on *'Current rise of Leptospirosis in the South'*, Dr Lilani Karunanayake on *'Correct diagnosis for correct management'*, Dr Wimalasiri Uluwattage on *'Different presentations of Leptospirosis; not to get misled'* and Dr Chamin Weerasekara on *'Options for critically ill Leptospirosis patients in ICU: what is in store?'*

28th May

Sri Lanka Cricket in partnership with Sri Lanka Medical Association held the inaugural *'Doctors Cricket League'* from 20th May at Welagedara stadium Kurunagala & Asgiriya stadium Kandy.

Doctors teams from Jaffna, Galle, Dambulla, Kandy and Colombo competed in the Tournament. The Kandy Knights team won the trophy.

28th May

The SLMA Expert Committee on Medical Rehabilitation organized a lecture on *'Neonatal Feeding Management'* by Dr Isuru Dharmarathna (PhD), Post-Doctoral Research Fellow, Toronto Rehabilitation Research Institute, Canada

30th May

A clinical meeting was held with the collaboration of the Sri Lanka Association of Clinical Pharmacology & Therapeutics on *'Management of Hyperlipidaemia beyond statins'*

Dr Madushya Abeywickrama, Senior Registrar in Clinical Pharmacology & Therapeutics, NHSL did a case presentation, Professor Priyanga Ranasinghe, Professor in Pharmacology, University of Colombo did a lecture on *'siRNA Therapeutics, Other Agents & Health Technology* Assessments *(HTA)'* followed by a MCQ discussion and Professor Asitha de Silva, Professor in Pharmacology, University of Kelaniya on *'PCSK9 inhibitors: The trials'*

7th June

The first Pre-Congress workshop was held on *'All about Research: from Design to Presentation'*

Professor Carukshi Arambepola, Professor in Community Medicine, University of Colombo, spoke on *'Designing your research: from concept to proposal'*, Dr Pubudu Chulasiri, Consultant Community Physician on *'Applying the statistical methods'*, Professor Prasad Katulanda, Professor in Medicine on *'Collaborative Research'*, Porfessor Sharmini Prathapan, Professor in Community Medicine, University of Sri Jayawardenapura on *'Getting your research published: some helpful tips'*, Dr Chathurie Suraweera, Secretary, Ethics Review Committee, SLMA on *'Obtaining Ethical Clearance'* and Professor Kumara Mendis, Professor in Family Medicine, University of Kelaniya on *'Applying research findings: Evidence-based practice'*

8th June

The SLMA Expert Committee on Women's Health organized a lecture on *'Hypertension in women: Impact on Health'* by Professor Udaya Ralapanawa, Professor & Head of the Department of Medicine, University of Peradeniya

9th June

SLMA organized a guest lecture on *'Lifestyle Medicine: The Future of Chronic Disease Management'*, by Dr Samandika Saparamadu, Primary Care Physician.

9th June

Dr Vinya Ariyaratne, President SLMA and Professor R Surenthikumaran, Vice President SLMA met Ms Vijaya Rao, Director, International Collaboration Office (ICO), SingHealth and the Deputy Director of Clinical Health Systems Programme at SDGHI and Ms Irene Ang Yue Tein, Manager, Programme Development, ICO of the Singapore Health Services Pvt (Ltd) at SLMA.

Their visit was to explore the possibility of initiating a longstanding relationship with SLMA for providing quality healthcare to the Sri Lankan public

11th June

The SLMA Doc 247 organized a webinar on *'Identification of Common Flues'*

The resource persons were Dr Ananda Wijewickrama, Consultant Physician, IDH and Dr Viraj Jayasinghe, Consultant Paedeatrician, ETU, LRH.

11th June

SLMA Expert committee on Disaster Resilience and Management, in collaboration with Sri Lanka College of Military Medicine (SLCOMM), and the Sri Lanka Navy conducted a beach clean-up at Uswetakeiyawa. After the beach cleaning Dr Sajith Edirisinghe, Secretary-SLMA, conducted an educational session to the naval officers involved in the process on the importance of this microplastic disaster, how it affect the human health and risk in pregnancy

13th June

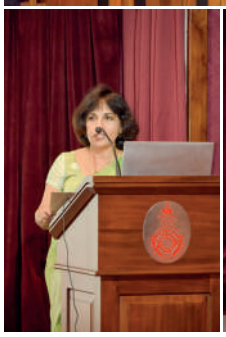
A clinical meeting was held with the collaboration of the College of General Practitioners of Sri Lanka on *'Explaining medically unexplained symptoms'*

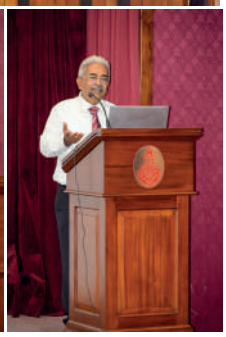
Drs Shane Malitha, Registrar in Family Medicine and Dr T Sayanthan, MCGP trainee, made case presentations and Drs Preethi Wijegunawardena, Senior Family Physician & Past President CGPSL, and Dr Sankha Randenikumara, Family Physician followed with the case discussion

14th June

The second Pre-Congress workshop was held on 'Postgraduate training in Sri Lanka'

Professor Senaka Rajapaksha, Director, PGIM, spoke on *'Introduction to postgraduate training and role of the PGIM'*, Dr Himani Molligoda, Senior Lecturer in Medical Education, PGIM on *'What is postgraduate training? Is it different?'*, Professor Chandanie Wanigatunge, Deputy Director PGIM on *'Overseas training & board certification'*, Professor Gominda Ponnapperuma, Professor in Medical Education, University of Colombo, on *'Examinations at postgraduate level'*





This was followed by a brief introduction/ panel discussion on major specialties and sub specialties offered at the PGIM.

15th June

A session of Expert Talks on *'Health sector sustainability through SCP based equipment maintenance'* was held with the collaboration of Sustainable Consumption and Production (SCP) Forum and the College of Medical Administrators, Sri Lanka

Eng. Nimal Perera, President, Sustainable Consumption and Production Forum, spoke on *'Health sector sustainability through sustainable consumption and production based equipment maintenance'*, Dr Sudath K Dharmaratne, DDG Laboratory Services, MoH on *'ABC of medical equipment management'* and Dr HM Arjuna Thilakarathne, Director, TH Peradeniya, on *'Medical equipment management in Hospitals'*.

15th May

Dr Vinya Ariyaratne, President, SLMA and Dr Nilanka Anjalee Wickramasinghe, Council Member attended a programme at the SLBC introducing the *136th Anniversary International Medical Congress 2023.*

LIFE

SMOOTH ROADS NEVER MAKE GOOD DRIVERS.
CALM SEAS NEVER MAKE GOOD SAILORS.
PROBLEM-FREE LIFE NEVER MAKES A STRONG AND GOOD PERSON.
BE STRONG ENOUGH TO ACCEPT THE CHALLENGES OF LIFE.
DO NOT ASK LIFE "WHY ME?". INSTEAD, SAY "TRY ME."

AUTHOR UNKNOWN
SENT BY DR B. J. C. PERERA

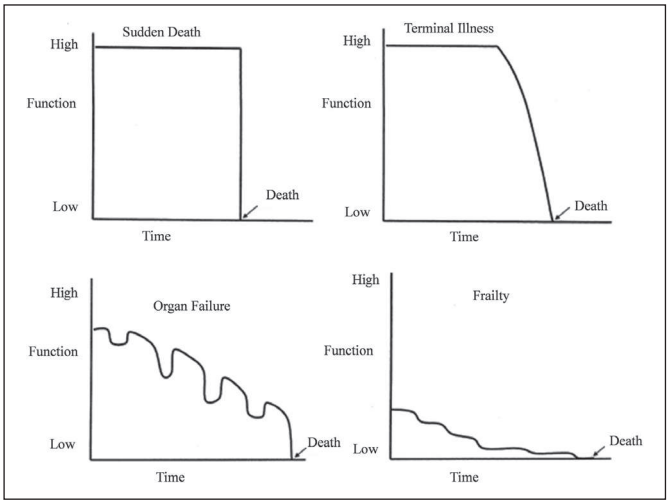
With best compliments from

What can we offer during a person's last days of life?

Dr. Udayangani Ramadasa
MBBS (Col), MD (Medicine) (Col), FRCP(Lon), FRCP (Edin), FCCP (SL), Dip Pall Med (Clinical) RACP
Specialist in General (Internal) Medicine
Head and Senior Lecturer,
Department of Medicine, Faculty of Medicine
Sabaragamuwa University of Sri Lanka

Caring for someone during the last days of his or her life is a challenge. Every individual has different values and preferences when talking about death and dying. People die at any age due to various causes. Understanding physical illness trajectories and trajectories of dying due to acute or chronic illnesses will help in the **diagnosis of dying** (1,2). (See figure 1).

Figure 1



Supportive and Palliative Care Indicators Tool (SPICT™) can be easily used to identify people who are reaching the end-of-life phase (see Figure 2).

Figure 2

Supportive and Palliative Care Indicators Tool (SPICT™)

- **General indicators of poor or deteriorating health.**
  1. Unplanned hospital admission(s).
  2. Poor or deteriorating performance, with limited reversibility.

     (eg. The person stays in bed or in a chair for more than half the day.) In old aged people the tolls such as Clinical Frailty Scale and Electronic Frailty Index can be used. Australia modified Karnofsky performance scale can be used in patients who have other comorbidities (3).
  3. Depends on others for care due to increasing physical and/or mental health problems. The person's carer needs more help and support.
  4. Progressive weight loss; remains underweight; low muscle mass.
  5. Persistent symptoms despite optimal treatment of underlying condition(s).
  6. The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.
- **Specific indicators depend on the underlying co-morbidities**

Diagnosis of dying and terminal phase

Terminal phase is the last days and hours of life when a person has entered irreversible decline.

In order to facilitate a good death, diagnosis of terminal phase is of vital importance to the patient and especially to the family. (See Figure 3)

Figure 3

Clinical features in recognising the terminal phase include;

- Rapid decline of performance status within days or hours
- Lying in bed for most of the day
- Feels extremely tired and weak
- Need assistance even for personal care
- Poor interest in food or drink
- Difficulty swallowing oral medications
- Socially withdrawn and less responsive and minimum communication
- Very sleepy and sometimes drowsy
- Reduced urine output
- Cessation of passing stools or fecal and urinary incontinence
- Delirium (restlessness, agitation and confusion)
- Changes in their normal breathing pattern
- Death rattles
- Poor circulation with mottled skin and cold extremities
- Person expresses that he/she feels like dying.

Components of good death

In studies searching for components of good death six major criteria are identified (4,5).

(See Figure 4)

Figure 4

The six major criteria identified in search of good death

1. Care related to physical symptom control and personal care.
    - Pain and other symptom management
    - Being clean
    - Having physical touch
2. Clear decision making
3. Preparation for death
    - Getting personal affairs to be in order
    - Making sure that the family is prepared
    - Preparation of the person
    - Exploring wishes of the person
    - Putting things in order according to the person's wishes
4. Sense of completion
    - Saying good bye to loved ones
    - Recognizing person's own accomplishment
    - Resolving unfinished business
5. Dealing with caregivers, family, society and transcendent (not sure what this is)
    - Trust and comfort with health care professionals and others
    - Being able to discuss personal fears including fears of death and dying
    - Not being a burden to the family and society
    - Contribution to others
    - Dealing with spirituality
6. Affirmation of the whole person.
    - Maintaining dignity and sense of humour
    - Not being alone when dying
    - Having someone to listen to

In 1960s the practice was "closed awareness" of death by the patient. However, early 2000 showed that patients need to be aware of the diagnosis, what happens in the course of the illness, prognosis, including uncertainties in their life course, which will help to put their personal things in order.

Home deaths are associated with a higher satisfactory outcome for the family members when they are around and promotes better patient outcomes.

Physical care

- Place of nutrition and hydration at the terminal phase

  Artificial nutrition or hydration has no effect on improving the quality of life or prolongation of life in the last days (6). Encourage family members to continue oral feeds if the patient could tolerate them.

  Mild dehydration helps to reduce swelling and oedema due to excess body fluids, respiratory congestion and cough. It further reduces fluids in the gastrointestinal tract, which will reduce nausea, regurgitation and bloating as well as reduction in the urine output. If the patient feels thirsty, keep the mouth moist by giving small sips of water, allowing to suck ice chips.

- Physical symptom control

  Stop all non-essential medications and keep or increase the dose of prescribed medications which provide comfort. Prescribe new medications as needed. If the patient is unable to swallow, change the route of administration of medications to subcutaneous, transdermal or rectal. Insert a smaller gauge IV cannula subcutaneously in the upper chest or abdomen and use it to administer medications which can be given subcutaneously, until proper subcutaneous canulae could be made available in Sri Lanka.

- Pain

  Some of the dying patients experience increased pain or new pain. e.g. urinary retention, immobility, pressure sores. As they are unable to express, observe carefully the signs of discomfort in their facial impressions when moving or turning around.

  For opioids naïve patients start with 2.5mg morphine sulfate (immediate release morphine) orally, sublingually, or rectally or morphine 2mg subcutaneously every 4 hours.

  Give supplimentary breakthrough doses which could be given every 1-2 hours as needed.

  For older people, start with a lower dose of 1mg subcutaneously and titrate up.

  For those who had been on chronic opioids, they will need 10-15% increase when reaching the terminal phase. If the patient is already on sustained-release morphine, convert it to immediate-release morphine and divide the total dose by 6 and calculate the 4-hourly dose. If the patient has renal or liver impairment, reduce the frequency to 6 to 8 hourly.

  If there is difficulty in swallowing, either you could crush the tablet and mix it with semisolid food, such as yoghurt. Currently oral liquid morphine of 2mg/1ml is available in hospitals.

- Breathlessness

  Breathlessness is seen in the last days of life, especially in patients with respiratory diseases. Give supplementary oxygen via nasal prongs to people who are breathless with hypoxia. It has a placebo effect on the patient, as well as the family members.

  Keep the patient in an upright position in a well-

ventilated place. Blowing air to the face with a fan would be helpful.

Give oral or subcutaneous morphine 2mg every 2 hours. For those who are already on opioids, increase the dose by 10-15% of the basal daily requirement.

If the patient looks anxious give Midazolam 2.5-5mg every 2-4 hrs

- Nausea

Intractable nausea is not commonly seen in the dying phase. Select medications depending on the underlying cause.

For treatment of patients who have nausea, due to opioids, renal impairment or without an identifiable cause, give haloperidol 1 mg orally or 0.5 mg SC/IV every six to eight hours as needed (For patients over age 65, we use a lower dose (0.5 mg orally or 0.25 mg SC/IV every eight hours). The total dose in 24 hours (for any patient) should be limited to no more than 6 mg oral or 3 mg IV/SC.

Nausea due to constipation needs treatment for constipation. For those who have gastric stasis, prescribe metoclopramide, cisapride or mosapride.

- Delirium and agitation

Delirium can present as confusion, restlessness, agitation, and/or day-night reversal. It greatly disturbs the family members and challenges the nursing staff. Family members do not find the person with honoured personality who was with them anymore to communicate effectively during final days of their loved ones.

Delirium needs to be properly diagnosed and it is necessary to find any reversible cause/s even at the terminal phase. (see figure 6).

Figure 6

Possible reversible causes of terminal restlessness

- Urinary retention,
- Constipation,
- Inadequate pain control
- Medication withdrawal, such as opioids, benzodiazepine, alcohol, seizures,
- Metabolic factors such as hypercalcaemia, hypoglycaemia, hyponatraemia

Non-pharmacological measures need to be carried out such as increased daytime light and a calm peaceful environment with all the loved ones around. Those who respond poorly, prescribe antipsychotics and anxiolytics while maintaining lucidity as much as possible without restraining them from facilitating interactions with their family (See figure 7).

Figure 7

Medication in agitation at the terminal phase

- If the patient can swallow
  - Olanzapine 2.5 mg
  - Risperidone 0.25 mg
  - Lorazepam 1mg orally/ Sublingually
- Those who cannot swallow
  - **Haloperidol** 2.5 -5mg s/c every 8 hrly
  - **Midazolam** 2.5 mg-5mg S//c 2-4 hrly or or 0.5mg SC
  - You may need a continuous infusion of 20-30mg over 24 hrs in a syringe driver + midazolam SC 5mg hourly, as required or regular rectal diazepam 5-10mg 6-8 hourly
  - If not responded midazolam 40-80mg over 24hours in a syringe driver+ levomepromazine 12.5 mg- 25 mg, 6-12hourly, as required (stop any haloperidol)

    PS; Currently levomepromazine is not available in Sri Lanka

The decision of **Palliative sedation** with non-opioid drugs such as benzodiazepines, barbiturates, and propafol to control refractory symptoms (eg, pain, dyspnoea, agitated delirium) needs to be made by the specialist and the multidisciplinary team as last option.

Respiratory secretions

Noisy breathing at the terminal phase is due to secretions in the airway and it is identified as death rattles due to poor ciliary function of bronchioles and little amount of secretions moving with respiration causing a notice.

Although this condition does not cause distress to the patient, relatives feel it as if the person is choking. Reassurance of relatives is of the utmost importance. (See Figure 8).

Figure 8

- Reposition the person
- Avoid suction
- Stop IV or S/C fluids
- Medications (May not be effective)
  - Hyoscine hydrobromide 400mcg S/c 2 hrly as required
  - Glycopyrronium 200mcg s/c every 6-8hrs as required
  - Hyocine butrybromide 20mg S/c hrly as required maximum 120mg per 24hrs
  - S/C Atropine

Seizures

This is very occasionally happening in elderly dying without any comorbidities. It is suggested to give S/C clonazepam 0.5 to 1mg, S/C lorazepam 0.5-2 mg or rectal diazepam 10-30mg to control seizures and to prevent them over the next hours or days.

Management of incontinence

Urinary or faecal incontinence causes distress to the person and gives additional burden to caregivers. A urinary catheter (indwelling or condom catheter), absorbent pads, could keep the patient dry. Exclude urinary retention and overflow which causes severe pain.

Mouthcare

Following measures are suggested for mouth care.

- Remove dentures
- Thoroughly examine the mouth using a torch
- Check the lining of the mouth is clean.
- Give oral care every 4 hours or more frequently and apply water-based gel.
- Keep the mouth and lips clean, moist and intact by removal of plaque and debris.
- Keep it moist with oral sips of fluids or allowing to such ice cubes.
- If a patient has evidence of fungal infection apply oral miconazole gel, crushed nystatin lozenges or clotrimazole oral applications.

Providing emotional support

Explore whether the dying person is willing to talk to share his/her thoughts, and express his/her wishes before he or she passes away. Explain the family members to spend time with the person, encouraging to express what he/she wants without telling overly optimistic things. If the person has any religious interests, do the rituals together. (See Figure 9)

Figure 9

Providing emotional support

1. Allow the person to express their fear of death. Actively listen. Do not interrupt or try to give your opinion, and argue.
2. Allow the person to recall past memories of their life.
3. Do not withhold difficult information.
4. Honour the wishes of the person, even though you don't agree with them.
5. Preserve their dignity, and privacy.
6. Reassure and give permission to die.
7. Identify the things the person might be waiting to hear from you and others such as "**Please forgive me", "I forgive you", "Thank you", "I love you"**
8. Identify yourself and speak from the heart.
9. **You can say goodbye many different times and in many different ways**
10. **Talk to the person, touch the person, even at the unresponsive stage, because they may still hear.**

Dealing with spiritual issues

Spirituality is the way we seek and express meaning and purpose and, connection to the moment, self, others, our world and the significant or sacred. Be a sensitive listener by helping them by exploring their fears with empathy and responding rather than giving answers. Do not try to inflict your own religious beliefs or personal point of view on the person.

Dignity

Dignity conservation in a person is important to see them as a whole person worthy of honour by those who care. It will help the loved ones to prepare themselves during bereavement. (See Figure 10)

Figure 10

The key features attribute of dignity

- **Respect** - self-respect, respect for others, respect for people's privacy
- **Autonomy** - having choice, giving choice, making decisions, competence and independence
- **Empowerment** - self-esteem, self-worth, modesty and pride
- **Communication** - explaining and understanding information using verbal and non-verbal modalities.

Caregiver needs

The final stages of a terminal illness are challenging and it is a very emotional time. What they need is education and empowerment of practical care and assistance when looking after their loved one who is dying, the comfort of the person and maintenance of dignity.

Grief and bereavement

Anticipating a loved one's death can produce reactions from relief to sadness to feeling numb. It is important to prepare them before their loved one's death then they can prepare for the coming loss. Grieving after loss is normal. However, some grief reactions become complicated and may seriously compromise the health of an individual. There is no time frame for the grieving process. There are cultural differences in the way they express their grief.

Bereavement care needs to focus on integrating the grief and loss rather than trying to get over or move it on.

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UNDEFEATED

(Dedicated to those who rise, every time; like the proverbial phoenix)

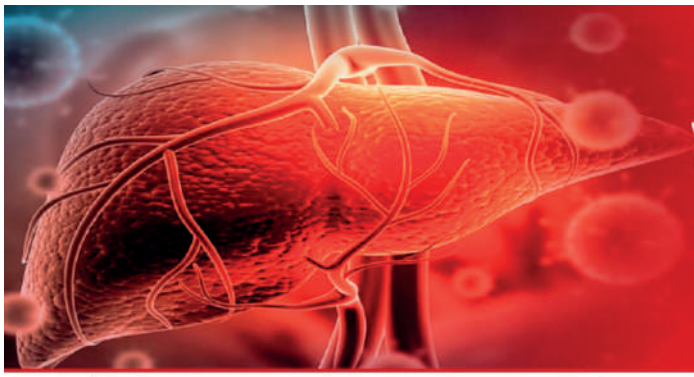
You have been abandoned and back-handed. Molested, rejected, infested,
and still left with a heart of gold that gets stronger when tested.

A thousand betrayals could not make you want to do the same,
you have tried and you have failed, well acquainted with shame.
You refuse to be changed and welcome the inevitable pain,
you have tasted what you thought was love, and learned it was only a game

You have cried in the rain until tears turned to laughter,
then walked away after, like none of it mattered.
You are so used to the cold that your teeth never chatter,
and you relish the challenge when your whole world is shattered.

You are undefeated, not because you never lose,
but because every time you do, you choose to become a better version of you.

J. Warren Welch
Famous writer of prose and poetry.
Extracted from a Facebook posting by Professor Piyanjali De Zoysa



Achieve Weight Management Goals to Improve Liver Health*

% Weight loss (WL)	5%		7%		10%	
NASH-resolution	10%	26%		64%		90%
FIBROSIS-regression	45%	38%		50%		81%
STEATOSIS improvement	35%	65%		76%		100%
% Patients achieving WL	70%	12%		9%		10%

- Decrease in body weight by ≥5% has been shown to reduce liver fat.
- Decrease in body weight by ≥ 10% has been shown to improve liver inflammation and reduce fibrosis by at least one stage.

* J Hepatol. 2017 May 23. pii: S0168-8278(17)32052-4

VLCD Intervention 1 – 8 Week
3 OPTIFAST MEALS

Food Reintroduction 9 – 12 Week
2 weeks – 2 OPTIFAST MEALS
2 weeks – 1 OPTIFAST MEAL

Weight Maintenance 13 – 32 Week
Food Based Diet

- Mean Weight Loss – 10.3kg

Week 1 (Visit 2)
Week 3 (Visit 3)
Week 5 (Visit 4)
Week 7 (Visit 5)
Week 10 (Visit 7)
Week 12 (Visit 8)
Week 16 (Visit 9)
Week 20 (Visit 10)
Week 24 (Visit 11)
Week 28 (Visit 12)

Very Low Calorie Diet (OPTIFAST) to Achieve a Sustainable 10% Weight Loss in Patients With NAFLD#

- ≥ 10 % WL – 34 %
- ≥ 7 % WL – 51 %
- ≥ 5 % WL – 68 %

OTHER BENEFITS

LIVER HEALTH

Overall, liver enzymes significantly improved from baseline to post-VLCD, and these improvements were maintained at 9 months.

METABOLIC CONTROL

Glucose, HbA1c, and insulin improved from baseline to post-VLCD, and these improvements were maintained at 9 months.

CARDIOVASCULAR HEALTH

Overall, there was a significant reduction in blood pressure from 144/86 to 133/81 mm Hg post-VLCD.

QUALITY OF LIFE

Patients reported a significantly increased QoL at 9-month follow-up with a decrease in weight-related symptoms.

Scragg J et al. Feasibility of a VLCD to Achieve a 10% wt loss in patients with NAFLD. Clin Trans Gastro. 2020

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0114 619399 | 0772 992131

What lies beyond death?; medico-legal perspectives

Dr A Dayapala
MBBS(Col.) DLM, MD (Forensic Medicine)
Additional Consultant JMO
Teaching Hospital
Colombo South
Kalubowila

What lies beyond death has been baffling man for eons. This fundamental question has given birth to various religions and philosophical speculation. But for the medico- legal community this question has a different meaning. The knowledge about medico-legal perspective of death seems useful and relevant to all medical personnel irrespective of their specialties.

Death can simply be defined as the irreversible cessation of cardio-respiratory functions (heart beat & respiration). If the heart beat and respiration are maintained by artificial means (by drugs and machines) death is diagnosed by the irreversible absence of brain stem functions (pupillary response to light, ocular movements with caloric test, corneal reflex, gag reflex , Doll's eye movement and motor functions in cranial nerve distribution.) in the absence of certain conditions such as hypothermia, poisoning, depressant drugs, metabolic or endocrine causes etc. which can give rise to reversible coma status including suspended animation. **(1)(2)(3)(4)**

A Declaration of Death document containing the cause of death issued by an attending medical practitioner or a permit issued by an Inquirer into the Sudden Death (ISD of Coroner) is necessary for disposal of the body and the registration of the death. **(5)**

Confirmation of death on neurological criteria is essential before discontinuation of life support and harvesting organs for transplantation. As most of such deaths are post traumatic cases, an inquest is also mandatory. In such instances special prior permission has to be obtained from the Inquirer into Sudden Death through the Police. Once the permission is obtained, informing the Judicial Medical Officer and clearly recording all surgical procedures and nature and condition of the organs harvested in the Bed Head Ticket is mandatory. **(3)** After harvesting the organs, an inquest will be conducted by the inquirer and if he thinks it is necessary, an order for the postmortem examination (autopsy) will be given.

Legally and scientifically the Cause of Death means the Underlying Cause of Death, and it must be a specific disease or an injury or circumstances which starts the chain of physiological changes leading to death. **(1), (6)** The common practice of giving the cause of death as "Cardio-respiratory failure " or nonspecific conditions such as" Shock"' "Sepsis" etc. without mentioning the underlying cause is meaningless and has to be avoided. **(7)**

Correct determination of causes of death is also important for the accuracy of mortality and morbidity statistics which is in turn used for health policy decisions of the country.

It should be born in mind that even though the immediate cause may seem natural, if there is an underlying unnatural cause for that, it must be considered as an unnatural death. (e.g. sepsis following urinary tract infection in a bed ridden patient on indwelling catheter following spinal trauma due to a fall)

It is legally required to refer the death for an inquest under the provisions of the Criminal Procedure Act of Sri Lanka if the cause of death is unknown or even if known, if the underlying cause seems unnatural. **(8).** But there is no legal requirement to ask for an inquest merely because the patient has died within 24 hours of admission unless charges of medical negligence is a possibility.

If the cause of death is unknown or unnatural, the Police must be informed in writing in the Bed Head Ticket to arrange an inquest which is conducted by the Inquirer into Sudden. At the same time the head of the hospital is also informed in hospital deaths. For this purpose, consent from the next of kin is not necessary. In cases of suspicious or criminal deaths including deaths occurring in prisons, mental or leprosy hospitals, the police will arrange an inquest by a magistrate. **(8)**

Though not a legal requirement, according to a special Ministry of Health circular, all deaths in pregnant women irrespective of the period of gestation during pregnancy and up to one year after delivery or abortion have to be subjected to inquests and judicial postmortems **(9)**

When there is a possibility of medical negligence allegations by next of kin of the deceased, it is prudent to refer the death for an inquest even if the cause of

death is known and natural so that concerns of the next of kin can be addressed at the inquest by an impartial inquirer.

It must be clearly understood that clinicians cannot order a postmortem examination, but can only request an inquest into the death. Even when a death is referred for an inquest, the clinicians can document the probable medical cause of death in the bed head ticket. This may help the inquirer to come to a decision in non-criminal circumstances without going for an unnecessary postmortem examination. The clinicians must not be fearful whether the cause of death detected at the postmortem be different from the probable cause given by them in the bed head ticket because such discrepancies occur worldwide, even in developed health care systems. (**10**) **(11) (12)**

The Declaration of Death Form must not be issued by the clinicians if the cause of death is unknown or even if known, it is unnatural or if the death has occurred in prisons, mental or leprosy hospitals. At the same time, such deaths must not be subjected to "Non-Judicial Postmortems" or so called "Pathological Postmortems" which requires the knowledge of, at least, the probable cause of death which invariably must be a natural one. In addition, written consent of the next of kin of the deceased is a must for Non-Judicial postmortems. If the body is subjected to a non-judicial or pathological postmortem, the clinicians have to issue the declaration of death form. (**7**)

The term "Non-Judicial Postmortem" seems much more appropriate than the term "Pathological postmortem" because even in judicial postmortems, the dissection of the body and all organs and ancillary medical investigations such as histology and microbiology are done with the aim of establishing the cause and mechanism of death, in addition to an array of specific medico-legal investigations to answer the potential medico-legal issues as tabulated below.

At the inquest, the Inquirer into Sudden Death is legally empowered to call evidence from any person including the next of kin of the deceased, the police and the clinicians, and asked for any document including the Bed Head Ticket or clinical notes. If there is no criminality or negligence detected at the inquest and if he can find the cause of death, manner and circumstances of the death, the Inquirer into Sudden Death is empowered to release the body without a postmortem examination.

But if he suspects criminality or negligence or if he cannot formulate a cause of death or determine the manner or circumstances of the death, the Inquirer into Sudden Death will order a government medical practitioner (a doctor) to perform a postmortem examination and report to him**. (8)**

Unlike in non-judicial postmortems, the consent of the next of kin is not required here.

Contrary to the popular belief that the postmortem examination is "just cutting the body" to find the cause of death and it can be finished in no time, the postmortem examination is a much more complex task and can take a lot of time and effort. In a judicial postmortem, the doctor has to think of possible future legal repercussions and try to address relevant medico-legal issues as far as practically possible. At the end of the postmortem examination the doctor has to submit a postmortem report to the inquirer or the magistrate. In criminal cases he may be required to appear in person in a high court and face cross examination by the defense as an expert witness. (**13**)

The relevance of these medico-legal issues varies from case to case and tabulated below for easy reference. **(14)(15)**

Medico-legal issue	Case Example	Techniques	Remarks
Identification of the Deceased	Unidentified bodies, Decomposed, Fragmented or Mutilated bodies	Documentation of clothing, personal effects, bodily features, deformities, dental features. tattoos, scars, surgical implements etc.	Photography of specific features and preservation of nails, hair, teeth, blood for DNA profiling done.
Collection of trace materials on the clothing and body	Sexual assaults, Hit and run traffic accidents, Homicides.	Collecting into clean containers and labeling and sealing	When handing over to the police for Forensic analysis at the Dept. of Government analyst proper Chain of Custody has to be maintained

Determination of time since death	When found dead without eyewitness or a crime is suspected	Measuring core temperature, Assessing the distribution and extent of rigor mortis and hypostasis, Other postmortem changes such as changes in eyes, Assessing the degree of decomposition and collecting entomological data	The progress of postmortem changes is affected by environmental factors, physical activities before death, diseases and physical features of the body. Therefore, exact time of death cannot be established with mathematical accuracy. Only a range can be given. **(15)**
Establishing the nature of the weapon used in assault or the features of the vehicle involved	Cases with injuries such as assaults, RTAs	Accurate description of the injuries with their type, measurements, location, disposition and stage of healing and complications	Photography with a scale and drawing on body diagrams. Stage of healing or infection also gives an idea about the survival time since injuries
Establishing the Cause and Mechanism of death	**In all postmortems this is the main object**	History of the incident and the deceased, perusal of available documents, external examination including the examination of the clothing, careful description and analysis of injuries, examination of all body cavities and dissection of all the organs are done routinely in most of autopsies. Sometimes the examination of the death scene is also required. Relevant samples have to be collected and subjected to investigations in some cases when macroscopic cause of death cannot be found at the autopsy or a greater degree of certainty is required	In some cases, histological, toxicological, bacteriological and virological studies are necessary before establishing the cause and mechanism of death.
Establishing the Manner and Circumstances of Death	Natural, Accidental, Suicidal, Homicidal or Undetermined Fall, assault, accident, Possible position of the deceased and the assailant	The postmortem report must be compiled by the doctor giving all facts which can be used to form an opinion about the manner of death by the inquirer	The cause and mechanism of death, nature and distribution of injuries are used to determine the manner and circumstances of death. The ultimate responsibility lies with the inquirer

So, though death seems an end, it can be the beginning of the medico-legal investigations. Clear understanding of this fact by the clinicians will help the next of kin, the police, the judiciary and the forensic practitioners. It can save much trouble for the clinicians too.

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TEN WORDS TO REMEMBER

- The most selfish one-letter word is 'I' – Avoid it
- The most satisfying two-letter word is 'WE' – Use it
- The most poisonous three-letter word is 'EGO' – Overcome it
- The most used four-letter word is 'LOVE' – Value it
- The most pleasing five-letter word is 'SMILE' – Show it
- The fast-spreading six-letter word is 'RUMOUR' – Ignore it
- The hardest working seven-letter word is SUCCESS – Achieve it
- The most enviable eight-letter word is JEALOUSY – Distance it
- The most powerful nine-letter word is KNOWLEDGE – Acquire it
- The most valued ten-letter word is FRIENDSHIP – Maintain and cherish it

From an e-mail video sent by Professor Sanath P. Lamabadusuriya
Extracted and presented by Dr B. J. C. Perera

Is there a limit to sexual and gender diversity?

Dr Ajith Karawita
MBBS, PGDVEN, MD, FSLCoSHH
Consultant Venereologist,
Teaching Hospital,
Anuradhapura

Sexual and gender diversity can easily be explained by considering three main domains as given below:-

1. BIOLOGICAL SEX

2. GENDER IDENTITY and

3. SEXUAL ORIENTATION

(Figure 1)

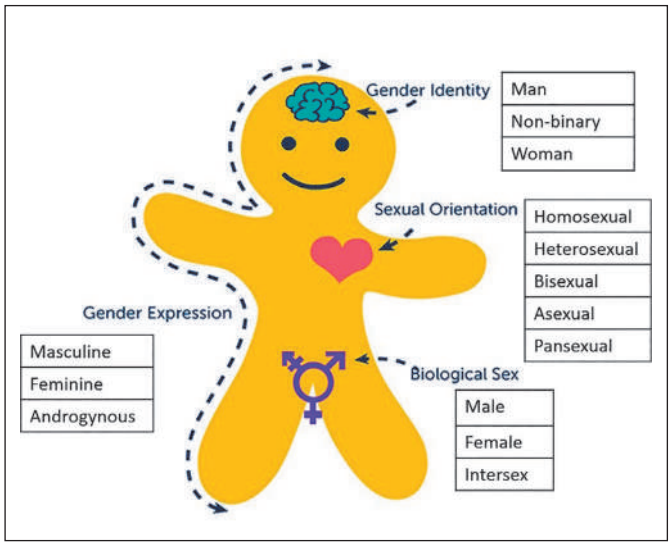


Figure 1 Sexual and gender diversity

BIOLOGICAL SEX or the anatomical sex with its physiological characteristics describes the assigned sex at birth (ASAB) as male, female or intersex. Determinants of biological sex start from chromosomal sex (XX, XY, XXY, XO etc.) which is followed by many steps of embryological development to make one's internal genital sex organs and the external genital structures (external genital sex). If the external genital sex organs are very clear and normal at birth as a penis and scrotum, the neonate's assigned sex at birth is male or assigned male at birth (AMAB). If the external genitalia are similar to the normal labia majora, minora, vagina and clitoris, the neonate's sex at birth is female or assigned female sex at birth (AFAB). If the external genitalia are not very clear as male or female or in an in-between situation (ambiguous) the neonate's sex at birth is considered to be intersex. The name of intersex has been around since the 1700 years AD. New terminology came in 2005 as DSD meaning Disorders of Sex Development in medical settings, considering the disorders of the whole spectrum of chromosomal sex, internal genital sex and external genital sex. The DSD term was controversial and It means that the condition is a medical problem that needs treatment rather than a natural variation and parents of intersex children treated with corrective surgery and hormonal treatments. In 2018, California passed legislation protecting intersex infants from non-consensual surgical or medical treatment and also considered it as a piece of human rights violation. Therefore, arguments are going on to respect the intersex states as another category or whether to go for a correction. However, currently, the acronym DSD is used to describe the Differences of Sex Development, removing the word 'disorder'.

GENDER - The World Health Organization (WHO) defines gender as "Characteristics of women and men, girls and boys that are socially constructed (as nurtured, but not as nature). This includes norms, behaviours, and roles associated with being a woman, man, girl, or boy as well as relationships with each other. As a social construct, gender varies from society to society and can change over time.

In simple words, gender describes how socially constructed masculinities and femininities are mixed in a person or in other words, how maleness and femaleness are mixed in a given person. There are masculinity-femininity scales (MF scales) to measure these senses among different persons.

GENDER IDENTITY is the inner psychological sense of self as a man or a woman or non-binary identity (those are termed as categories of gender identity). Usually, people get into one of the main two gender identities and say I am a man or a woman. However, there are people who say that they are neither man nor woman and say that they are different. Therefore, they are identified under the umbrella term of non-binary gender identity. (Note that, man and woman are categories of gender identity while male, female, and intersex are categories of biological sex).

When the biological sex is aligned with the gender identity (sense of self as man, woman) called cis-men or cis-women but when a biological male or a female having the psychological feeling of self as both men and women together, it is called androgynous (two-spirited).

If the biological sex is not aligned with the gender identity, for example, biological male is feeling self as a woman or non-binary gender identity, that person is called a transgender person. Transgender persons are someone whose gender identity does not correspond with the biological sex or the assigned sex at birth (ASAB). Some transgender people desire to transition permanently to the desired gender identity and seek gender-conforming hormonal treatment and surgery and those who are taking gender-confirming treatments are called transsexuals. The medical needs of transgender people need to be considered including the reproductive tract health of transmen.

The variations of gender identities are many and the binary concept of man and woman is no longer valid. Terms of non-binary gender identities are considered to be getting complicated. Some argue that these hundreds of gender identity terms are introduced in their writings as a completion point of view, examples of terms include:-

1. Agender, also called **genderless, gender-free, non-gendered** or **ungendered** men are those who identify as having no gender identity even as they say not to use pronouns such as He or She for them.

2. Bigender (also **bi-gender or dual gender**) meaning people who have two gender identities and behaviours having two distinct gender identities simultaneously or fluctuating between them.

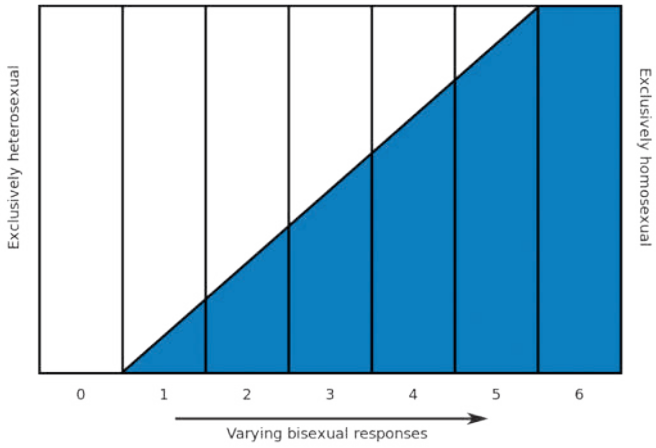
3. Trigender means people shifting among man, woman and third gender.

4. Demi gender, people identify partially or mostly with one gender and at the same time with another gender.

5. Pangender (also **polygender** or **omnigender**) people have multiple gender identities and some may identify as all genders simultaneously.

Having different gender identities within the broader spectrum makes gender identities a complicated subject. Some schools of thought do not want to have hundreds of gender identities while others are arguing to respect their identity in society. In some societies it is courteous to ask which pronoun to be used when I am referring to you, whether she or he. So then would there be a limit to gender identities is a popular question. Some argue that ignorance about gender diversity is not a defense to consider and respect their identity and some argue that it is a difference of personality.

SEXUAL ORIENTATION (SEXUAL ATTRACTION) is another domain in sexual and gender diversity. The brain regions of the temporal lobe, the Amygdala is responsible for sexual orientation. The major areas of diversity in sexual orientation would be heterosexuality, homosexuality, bisexuality and asexuality. Then who are the pansexuals? Pansexual is the term used to describe "someone who is attracted to anyone regardless of their sex gender identity. The scale put forward by Alfred Kynsey in 1948, describes many more diverse expressions of the sexual orientations.



Kynsey scale also called the heterosexual-homosexual rating scale which is used in research to describe a person's sexual orientation based on one's experience or response at a given time. The scale typically ranges from 0 meaning exclusively heterosexual to 6 meaning exclusively homosexual, an additional grade X in the Kynsey scale indicate asexuality (no socio-sexual attraction or reactions). Addressing the prevention of sexually transmitted infections and other health issues in relation to variation of sexual attraction and sexual behaviours cannot be sidestepped by healthcare professionals and need to have an all-inclusive approach.

All the international development agendas highlight gender equality and equity which means not only the equity of men and women. It is the equity of all the different gendered persons. Therefore, it is of utmost importance for medical professionals to identify the human sexual and gender diversity and non-discriminatory and all-inclusive approach to healthcare.

'ABG run - making it safe' - Introducing the innovative Arterial Blood Gas (ABG) sample carrier

Kanchana Wijesinghe[1] WAM Nilanthi[1]
Lasantha Kodituwakku[1] KA Yohan Chamara[1]
University surgical unit,
Colombo South Teaching Hospital

Introduction

An arterial blood gas (ABG) analysis is one of the most frequently used tests to measure oxygenation and acid base balance. These are two very important measures that would give a direct idea of the clinical status of the patient. Accurate interpretation of an ABG report can lead to quicker and better changes in the plan of care. This is a commonly performed test in the intensive care unit (ICU) setting; however, ABGs can also be drawn on any patient on any ward depending on their diagnosis [1].

Unlike a usual blood investigation, the ABG procedure has some unique requirements and steps to adhere to. A whole blood sample of 1ml in a heparinized syringe is required which is rolled between the hand to gently mix it. Once the blood sample is drawn, there should be no air bubbles within the syringe. The syringe should be capped to prevent contact between the sample and the air, this will also prevent any leaking during transport to the laboratory. The specimen should be transported immediately in an ice slurry and it is recommended that the sample should be analyzed within 30 minutes. The main reason to store the blood sample in an ice slurry is to reduce the metabolic rate and reduce errors in the report [2].

Some of the key steps in the ABG procedure are,

1. Obtaining a correct sample adhering to universal precautions
2. Accurate transportation of the sample
3. Correct analysis of the sample by the ABG analyzer and
4. Accurate interpretation of the report

The practice in our setting

In our surgical unit, we carry out around 50-75 ABG analyses per month; 24 hours around the clock. ABG samples are usually drawn by the intern house officer or a medical student on clinical rotation. The sample is analyzed in a blood gas analyzer which is available only in the ICU. The sample once drawn is swiftly taken by the medical student or a health care staff member to the ICU, which goes along a pathway crowded with patients, visitors and hospital staff.

Transportation hazards

It is well known that clinical specimens of all types pose a health hazard to workers involved in the process of handling and therefore utmost care should be exercised. Guidelines strongly recommend clinical specimens to be properly packaged to avoid any leakage and for shock absorption during transport.

The current method used to transport an ABG sample in our setting is a kidney tray with the syringe immersed in ice cubes. The kidney tray is usually loosely covered by another kidney tray. This creates a bulky and loose fitting transportation technique which is quite unstable. This significantly exposes the health care workers transporting a sample at risk of a bio hazard.

Along with this, a number of other problems have been observed in the current transportation technique of the ABG sample.

It was reported several times that the kidneys trays which are an inventory item of the ward being accidentally misplaced during this procedure. The ward staff has to go into great lengths to search for the missing trays.

Also, each time the ABG procedure was performed a tray of ice cubes had to be readily available for transportation. And on busy casualty days, with several ABG requests the ward would quickly run out of ice cubes.

Triggering event for a change

A few months ago, one of the health care workers of our unit was on the run with an ABG sample when she had accidentally collided with another worker. The kidney tray had fallen on the ground with ice splattering on the floor and the syringe being thrown out as well. The health care worker had quickly collected a few ice cubes and the syringe and had run in haste to the ICU as she was worried about the delay.

This particular hazardous incident triggered the need for a change and the ward 24 staff headed by Nursing Sister Lasantha Kodituwakku and Senior Nursing Officer WAM Nilanthi brain stormed for a remedy for this tribulation.

Unveiling the novel ABG carrier

The result of this event was the invention of a very user friendly, simple and cost effective ABG carrier which

addressed the limitations of the current technique (Figure 1).

Figure 1: Comparison of the old and new ABG sample carrier

This concept and creation is the brain child of Ms M G Dilhari an enthusiastic team member of ward 24, Colombo South Teaching Hospital.

This new ABG carrier requires only one used face shield to construct one item.

The transparent screen or the visor is cut appropriately to create a box and a covering lid. (Figure 2) The left over padding on the head strap is then cut appropriately to snugly fit inside the box. This creates a channel or gully to safely keep the syringe.

Figure 2: Equipment needed to create the New ABG carrier

Once constructed an adequate amount of water is poured in to the box to completely soak and cover the padding. Next, it is placed in the deep freezer compartment of the fridge to form ice.

Once water is frozen, this is ready for use.

When an ABG blood sample is drawn, the syringe will be placed in the iced channel in the box on top of a gauze strip. The box can be closed securely and is ready for transport.

The strip of gauze can be discarded and the ABG carrier can be replaced back in the freezer for re-use.

Our experience

Our health care staff have found this new carrier to be very safe, user friendly and sturdy to be used. The health care workers also felt more comfortable in transportation of the ABG sample with the new carrier compared to the previous technique.

This is also an environmental friendly innovation that re-uses discarded face shields promoting recycling of non-biodegradable products.

This also requires no new equipment to create the carrier thus, adding no financial burden to the already strained health care system.

This also occupies only a small area in the freezer compartment, is readily available, re-usable and is not part of the permanent ward inventory!

Recommendation

At a time when the country is facing a financial crisis, innovations and solutions to problems have to be cost effective, practical and sustainable.

We would like to appreciate Ms M G Dilhari for creating this innovative ABG carrier which was done with a compassionate intention to ensure the safety of her colleagues. (Figure 3)

Figure 3: New ABG carrier presented to Ward 24 Nursing Sister Ms Lasantha Kodituwakku (L) and Senior nursing officer WAM Nilanthi (R) by Ms M G Dilhari (Middle)

This was presented at the director led work improvement team meeting at the Colombo South Teaching Hospital to share this new concept with the other wards as well.

It is our responsibility to ensure that all potential hazards are minimized to the health care workers who are obtaining and transporting specimens whilst maintaining the integrity of the specimen. Thus we would like to share this novel intervention with all our Sri Lankan medical colleagues and hope to improve the safety of our health care workers.

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2. WHO Guidelines on Drawing Blood: Best Practices in Phlebotomy. Geneva: World Health Organization; 2010. 5, Arterial blood sampling. Available from: https://www.ncbi.nlm.nih.gov/books/NBK138661/

AWARDS AND RESEARCH GRANTS SLMA 2023

It is hereby called for applications for the following Awards and Grants for the year 2023

CNAPT Award: Applications are invited from doctors *(who are SLMA Members)* for the best research publication (article, book chapter or book) in medicine or in an allied field, published in the year 2022, for the Richard and Sheila Peiris Memorial Award (CNAPT).

Closing date: 31st July 2023

GR Handy Award: Applications are invited from SLMA Members, for the best publications in ***cardiovascular diseases*** published in the year 2022 for the G R Handy Memorial award.

Closing date: 31st July 2023

Glaxo Welcome Research Award: Applications are invited from SLMA Members for research proposals on topics related to medicine.

Closing date: 31st July 2023

Professor Wilfred SE Perera Fund: Applications are called from Life Members of the SLMA, requiring financial support to attend an Academic Conference, provided an Abstract has been selected for presentation at the event.

Closing date: 31st July 2023

SLMA Research Grant: This grant is offered for research proposals on topics related to any branch of medicine. The maximum financial value of the grant is LKR 100,000.00. The grant is targeted at young researchers (*should be SLMA members*) in their early career, for proposals on applied research that could be initiated (e.g. pilot study) or completed (e.g. audit) with the grant. The project should have a supervisor.

Closing date: 31st July 2023

Dr. Thistle Jayawardena SLMA Research Grant for Intensive and Critical Care: This grant is offered for a research project with relevance to the advancement of ***Intensive and Critical Care*** in Sri Lanka from *SLMA Members*. The maximum financial value of the grant is LKR 100,000.00.

Closing date: 31st July 2023

Five hard copies of the research proposal/ publication should be submitted with the application.

For further details please contact:

Dr. Sajith Edirisinghe
The Honorary Secretary, SLMA
"Wijerama House", 6, Wijerama Mawatha,
Colombo 7
Telephone: 011-2693324, Email: office@slma.lk

Continuing pioneer work: Palliative Care Team Building in Kandy District

Dr Udayangani Ramadasa - Chairperson
Dr Sankha Randenikumara - Outgoing Honorary Secretary
Palliative and End-of-Life Care Task Force, SLMA

The Palliative and End-of-Life Care Task Force (PCTF) of Sri Lanka Medical Association (SLMA) was established in December 2016 under the Non-communicable Diseases Expert committee and later became an independent expert committee of SLMA. The prime objective of the PCTF is to be the umbrella body to the all organisations, institutes and personalities who provide palliative care in Sri Lanka, specifically by advocating to implement a sustainable palliative care service in Sri Lanka by collaborating with the Ministry of Health (MoH), developing guidelines and common protocols for symptom control which are important in optimising quality of care and best clinical practices. From the beginning multiple stakeholders from various disciplines and professions such as healthcare workers from different levels, social workers, NGO representatives, journalists and lawyers were contributing to the PCTF. One of the very early achievements of the PCTF was the launching of the first textbook for palliative care in Sri Lanka 'Palliative Care Manual for Management of Non-cancer Patients- A Guide for Healthcare Professionals' in October 2017. This was not only useful as a training guide, but also was the only comprehensive reading material for postgraduate students. Later in 2021 the 'Palliative Care Manual for Healthcare Professionals of Sri Lanka' was launched as a comprehensive second edition of the same book including management of both cancer and non-cancer diseases and the 'Practice Guidelines for End-of-life Care.

As identified by the National Strategic Framework for Palliative Care Development in Sri Lanka 2019-2023 regular in-service training programmes on palliative care for health care staff is a need. This was pioneered by the PCTF, SLMA by organising a two-day workshop for the palliative care team building in Western province hospitals, which was held in September 2019 as. This successful workshop laid the foundation to arrange such training programmes also by the MoH.

PCTF, SLMA collaborated with the National Cancer Control Programme (NCCP) of MoH to conduct a three-day training programme for 52 medical officers from 11th to 13th October 2022 and a separate three-day training programme for 61 nursing officers from 14th to16th March 2023 in Kandy district. Regional Director of Health services organised this training programme and hard copies to each hospital and the soft copies to each participant of 'Palliative Care Manual for Health Care Professionals in Sri Lanka' (2nd Edition), 'Practice Guidelines in End of Life Care' and 'Palliative Care for Cancer Patients in Primary Care' were distributed prior to the programme.

Basic concepts of Palliative care, identification of palliative care needs, communication, pain and other physical symptom control, provision of holistic care including social, psychological and spiritual care, clinical case scenarios related to different systems, end of life care and caring of a terminally ill patient, ethical and legal aspects were discussed. Hands on training of procedures for nursing officers were done visiting trained experts to Kandy. There was a separate lecture on assessment of palliative patients; A clinical cases-based discussion was done for the same group of medical officers on 19th December 2022 as a component of continuation of palliative care training.

PCTF hopes to have more collaborative programmes with MoH to train and build palliative care teams all over the island.

Organ donation and transplantation foundation

Mobile - +94 770 344 344
E mail - odtf.lk@gmail.com
Website - www.odtfsrilanka.com

Organ transplantation is one of the greatest advances of modern medicine. For people in end stage organ failure, organ transplantation truly is a matter of life and death. The demand for organ transplantation has rapidly grown in the past decade in all parts of the world due to increased incidence of vital organ failure, however due to the unavailability of adequate organs for transplantation has resulted in a major organ shortage crisis.

This is the reason, promoting deceased organ donation has to be given the prominence it deserves. **Organ donation is a life-giving and life-enhancing act. One deceased donor could save up to eight lives and transform the lives of up to 50 other people thanks to organ and tissue donation.**

One must not forget that organ donation not only changes the life of the recipient, it also changes the lives of their loved ones, families, friends and colleagues. In addition, the entire act of donation helps the bereaving family knowing their loved one has saved and enhanced the lives of many other human beings.

In Sri Lanka as in rest of the world, the population in end organ failure is growing rapidly. Although living-donation is possible for kidney and liver, it is not possible for many other organ failures. Recognizing this growing need we (a group of clinicians) decided to formulate the organ transplant unit at SJGH in February 2016. Since its inception we have carried out many programmes to uplift organ donation and transplantation in the country.

Although the journey thus far has been long and tortuous, our enthusiasm and determination to see this grow into a successful national program has only picked up momentum. It is with this in mind that Organ Donation and Transplantation Trust Fund came to being.

A database is maintained for organ donors who will also receive a donor registration card. As a Trust Fund, we also initiate in assisting those financially deprived in this regard, through an approval Committee. Support towards this worthy cause in any way is much appreciated.

Our sincere expectations that the concept of organ donation will take Centre stage in the hearts of the masses of Sri Lanka positively in all spheres.

Co-conveners

Dr. Niroshan Seneviratne Consultant Urologist & Transplant Surgeon

Dr. Chintana Galahitiyawa Consultant Nephrologist

What is Brain Death?

Where a person no longer has activity in their brain stem due to a severe brain injury

Have permanently lost the potential for consciousness and the capacity to breath

What can you donate?

One diseases organ donor can donate -

Heart	Intestine
Liver	Pancreas
Lungs	Kidney

Can save Eight (8) Lives

Tissues including cornea, tendons and long bones, etc. to benefit fifty (50) more people

Who can donate?

Anybody who is pronounced brain dead can be a donor

For more information, please contact;

1. Organ Transplant Unit, Sri Jayewardenepura General Hospital
2. FB - http://www.facebook.com/OrganDonorDaySL/
3. E mail - outsjgh@gmail.com

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