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Cover Story

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Tackling abnormal lipids in the primary care

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Looking after Our Own

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SRI LANKA MEDICAL ASSOCIATION

THEME: WHAT MAKES ME HAPPY?

SHOULD INCLUDE

Full Name
Age
Grade
School
Home address
Parent Contact Number

Drawings need to be certified by principal or class teacher as original creation of the child. The drawings should not be copied from internet or any other source.

Age : From **Pre-School to Grade 10** (Each Grade is recognised as a category)

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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

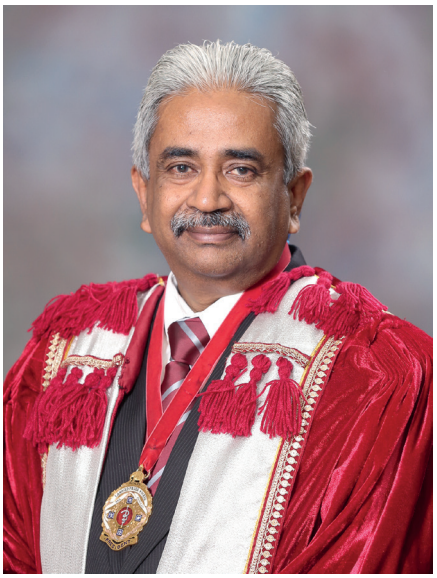
Dear SLMA Members,

The Sri Lanka Medical Association (SLMA) has been actively engaged in a range of activities in the first two months of this year. Clinical meetings, Expert Committee meetings, and follow-up actions have kept the Council members and staff engaged and occupied. However, the most significant among these activities is the proactive measure taken by the SLMA to address the dire issue that is currently affecting the healthcare sector, namely the acute shortage of essential medicines, reagents, and devices.

During the inaugural session of the Sri Lanka Medical Association's (SLMA) Council for 2023, an exhaustive discussion was held on the matter of insufficiencies of pharmaceuticals, reagents, and equipment. The President-elect and various Council members expounded upon the factual situation concerning drug availability and the severe improprieties that transpired during the Ministry of Health's drug procurement process. The Council arrived at a consensus that this predicament must take precedence as SLMA's foremost objective at the outset of the year.

Following such extensive deliberations, a decision was made to address His Excellency the President as an initial step. This action was followed by a press conference to generate public awareness and interest and to make aware of the gravity of the situation and the vital role the Public can play in mitigating its impact. We have received great feedback from the health fraternity as well as from the public.

The letter addressing SLMA's concerns was sent to HE President on the 16th of January 2023, detailing the urgency of the issue and possible remedial action that includes the importance of involving medical fraternity and representatives of Colleges when making deliberations



as well as action. The response was merely forwarding the letter to the Secretary of Health. Despite the concerted efforts of the SLMA and the Intercollegiate Committee to resolve the issue, no tangible progress has been made thus far. Apart from the said interventions, SLMA has officially corresponded with the Ministry of Health and its top officials on matters pertaining to medical supplies and related shortages on several occasions.

This prolonged shortage has become a significant concern for the SLMA and Colleges, affecting the healthcare system's ability to deliver essential services effectively. It will only deteriorate the health situation of the country and will harm the positive action as well as the excellence that had been achieved by the Public Health sector over the years. Moreover, the condition is affecting our medical and health care professionals working and dealing with the reality at the very point of delivery. Amidst deteriorating conditions and distress, they continue to serve their patients trying their best to deliver health care. Therefore, the crisis at hand is not only affecting at the patient level but to the health care system in its entirety and requires holistic action and responses in the months and years to come.

Parallelly to engaging with the Executive, Government and at Official capacities, the SLMA and the Intercollegiate Committee have also deliberated deeply in legal remedy in the form of public interest litigation. This will solely be at the interest of our own citizens and our medical and health care fraternity.

In conclusion, the shortage of medical supplies in Sri Lanka is a pressing issue that demands urgent attention and remedial action. The SLMA and the Intercollegiate Committee have been actively engaging with the Ministry of Health and raising public awareness. It is imperative that these efforts translate into tangible progress, as the healthcare system in Sri Lanka relies heavily on the availability of essential medical supplies to serve the people. Access to adequate healthcare is a fundamental right of every citizen, and it is the responsibility of the government and relevant stakeholders to ensure that this right is protected.

As an organization committed to the advancement of healthcare in Sri Lanka, the Sri Lanka Medical Association (SLMA) remains steadfast in its commitment to monitor, advocate, and support efforts aimed at addressing the critical shortage of essential medical supplies in the country. We call upon all stakeholders within the healthcare sector, as well as members of the public, to join us in our efforts to bring about positive change. It is only through our collective action that we can hope to achieve a healthcare system that is adequately equipped to meet the needs of its people and promote the overall health, prosperity, and equity of our society.

Dr Vinya Ariyaratne
President - SLMA

Activities in Brief
(24th December 2022 - 15th February 2023)

SLMA Saturday Talks

21st January

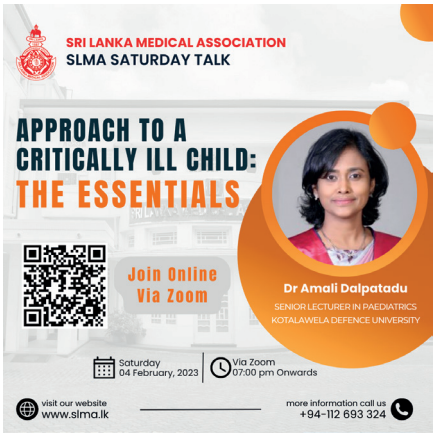
'Personalizing Treatment in Prostate Care' by Dr Nuradh Joseph, Consultant Oncologist, District General Hospital, Hambantota.

28th January

'Expect the Unexpected: Interesting cases in Obs & Gyn' by Dr Chinthaka Banagala, Senior Lecturer in Obsterrics & Gynaecollogy, General Sir John Kotalawela Defence University.

4th February

'Approach to a critically ill child: The essentials' by Dr Amali Dalpadatu, Senior Lecturer in Paediatrics, General Sir John Kotalawela Defence University.



11th February

'Methamphetamine (ICE) use: A burning issue' by Dr Chamara Wijesinghe, Lecturer, Department of Psychiatry, University of Kelaniya.

Other Activities

16th January

Dr Vinya Ariyaratne President, SLMA attended a discussion on the current issues faced by the Health system and the migration of Health Professionals and it impact on Health care on Derana 24, *'Big Focus'*.

17th January

The first clinical meeting for the year 2023 was held in collaboration with the Anatomical Society of Sri Lanka.

The topics of discussion and resource persons are as follows.

'Anatomical Basis for Evaluation of Common Neck Problems' by Dr Sithara Dissanayake, Senior Lecturer in Anatomy, Faculty of Medical Sciences, University of Sri Jayawardenapura, 'Applied Anatomy of the Eye & Orbit' by Professor Maduwanthi Dissananyake, Professor at the Dept. of Anatomy, Faculty of Medicine, Colombo & 'Human Anatomy Picture Quiz' Dr Sajith Edirisinghe, Senior Lecturer, Faculty of Medical Sciences, University of Sri Jayawardenapura.

18th January

A media seminar on the topic *'SLMA Past, Present & Future'* was organized by the SLMA Media Committee. The resource persons were; Dr Vinya Ariyaratne, President, SLMA, Dr Padma Gunaratne, Past President, SLMA (2021) and Dr Ananda Wijewickrame, President Elect, SLMA.

The session was moderated by Professor Indika Karunathilake, Past President, SLMA (2020)

19th January

A media seminar was organized by the SLMA Expert Committee on Prevention of Road Traffic Crashes to discuss about the increasing number of road traffic crashes, its consequences and prevention.

The panelists at this seminar were; Dr Vinya Ariyaratne, President, SLMA, Professor Samath D Dharmaratne, Chairman of the Committee, Mr Dilantha Malagamuwa, Brand Ambassador, 'Safe Lanka', Road Safety Project and Dr Ruwan Thushara Mitiwalage, Convener of the Committee.

24th January

A clinical meeting was held with the collaboration of the College of Community Physicians of Sri Lanka on the theme, 'Preventive Sector Services & Ways of Collaboration across Healthcare' services.

Dr Chitramali de Silva, Director, Maternal & Child Health, Family Health Bureau, Dr Iresha Jayawickrama, Consultant Community Physician, RDHS Office, Puttalam & Dr Bhanuja S Wijayatilaka, Consultant Community Physician, Directorate of Environment Health & Food Safety, MoH were the resource persons.

25th January

The SLMA Expert Committee on Suicide Prevention organized a public seminar for parents and teachers via zoom on *'How to improve child & adolescent Mental Wellbeing'*. Dr Dharshani Hettiarachchi, Consultant Child & Adolescent Psychiatrist, Teaching Hospital Karapitiya was the resource person.

27th January

The SLMA Expert Committee on Communicable Diseases organized a seminar to mark the World Leprosy Day on the topic *'Challenges in Eliminating Leprosy in Sri Lanka'*. The resource persons and the topics of lectures are as follows.

'Global and local situation of leprosy' by Dr Prasad Ranaweera, Director, Anti-Leprosy Campaign, *'Clinical diagnosis and treatment of leprosy'* by Dr Indira Kahawita, Consultant Dermatologist, Anti-Leprosy Campaign and *'Laboratory diagnosis of leprosy'* by Dr Chintha Karunasekara, Consultant Microbiologist, National Hospital for Respiratory Diseases, Welisara.

31st January

The first Regional Meeting for the year 2023 was held in collaboration with the National Dengue Control Unit (NDCU), MoH and the National Institute of Infectious Disease (IDH).

Dr Vinya Ariyaratne, President, SLMA & Dr Sudath Samaraweera, Director, NDCU welcomed the participants.

The resource persons and lectures delivered at this meeting are given below;

'Current country situation and notification of Dengue' by Dr Jagath Amarasekara, Consultant Community Physician, NDCU, *'Overview of management of*

Dengue Fever (DF) and Dengue Hemorrhagic Fever (DHF) in adults' by Dr Ananda Wijewickrama, Consultant Physician, National Institute of Infectious Diseases, *'Case Discussion'* by Dr Damayanthi Iddampitiya, Consultant Physician, National Institute of Infectious Diseases & *'Lessons learned from Dengue case reviews'* by Dr Srilal De Silva, Consultant Paediatrician, National Coordinator for Education and Training, Sri Lanka College of Paediatricians.

The meeting concluded with a interactive Q and A session.

Vote of thanks was delivered by Dr Sajith Edirisinghe, Secretary, SLMA.

7th February

A clinical meeting was held in collaboration with Sri Lanka College of Paedeatricians. Professor Pujitha Wickramasinghe, Senior Professor in Paediatrics, University of Colombo spoke on *'Management of Severe Acute Malnutrition'* and Professor Ishani Rodrigo, Professor of Paediatrics, General Sir John Kotelawala Defence University on *'Childhood Obesity: An Overview'*.

Dr Amali Dalpadatu, Senior Lecturer in Paediatrics, General Sir John Kotelawala Defence University conducted the case discussion and moderated the session.

9th February

A media seminar on the topic *'Non-availability of essential medicinal drugs in the health sector'* was organized by the SLMA Media Committee. The resource persons were; Dr Vinya Ariyaratne, President, SLMA, Professor Priyadarshani Galappatthy, Professor in Pharmacology, University of Colombo, Dr Anoma Perera, President, College of Anaesthesiologists & Intensivists of Sri Lanka and Dr Ananda Wijewickrame, Consultant Physician, National Institute of Infectious Diseases.

The session was moderated by Dr Pramitha Mahanama, Council Member, SLMA.

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Glutamine 1.8g	Helps to prevent further metabolic disturbances in COPD patients
11 vitamins & 5 minerals	Helps to exert potent anti-inflammatory and antioxidant effects, reduce lipid peroxidation, which are likely to be protectve in the progression of COPD

Enriched Nutrition for Easier Breathing & Improved Pulmonary Outcomes

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1. Collins, P., Yang, I., Chang, Y. and Vaughan, A., 2019. Nutritional support in chronic obstructive pulmonary disease (COPD): an evidence update. Journal of Thoracic Disease, 11(S17), pp.S2230-S2237. 2. Hanson, C., Bowser, E., Frankenfield, D. and Piemonte, T., 2020. Chronic Obstructive Pulmonary Disease: A 2019 Evidence Analysis Center Evidence-Based Practice Guideline. Journal of the Academy of Nutrition and Dietetics, 121(1), pp.139-165.e15. 3. Schols, A., Ferreira, I., Franssen, F., Gosker, H., Janssens, W., Muscaritoli, M., Pison, C., Rutten-van Mölken, M., Slinde, F., Steiner, M., Tkacova, R. and Singh, S., 2014. Nutritional assessment and therapy in COPD: a European Respiratory Society statement. European Respiratory Journal, 44(6), pp.1504-1520. 4. Hsieh MJ, Yang TM, Tsai YH. Nutritional supplementation in patients with chronic obstructive pulmonary disease. [Internet]. [cited 2021 Jan 7th]. Available from: https://www.researchgate.net/publication/291952250_Nutrition-al_supplementation_in_patients_with_chronic_obstructive_pulmonary_disease

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Is silence an ethical option?

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Senior Consultant, Global Health
The Geneva Learning Foundation
Former Senior Adviser, World Health Organization
Geneva, Switzerland

New Year 2023

Sri Lanka is still amidst an unprecedented economic and socio-political crisis. Factors underlying the crisis include abuse of the constitution, mismanagement of the economy and the state-owned enterprises, systemic corruption, violation of human rights, lack of accountability, impunity and politicisation of independent institutions [1].

The new year uplifted the credibility of the judiciary. The Supreme Court of Sri Lanka gave a historic ruling on the twelve Fundamental Rights applications invoking justice for the victims of the April 2019 Easter Sunday bomb attack. It killed at least 290 people and injured hundreds. The Court found a former President and four other senior government officials responsible for failing to prevent the attack and ordered them to pay compensation to the victims[2].

In 2023 fuel queues have disappeared, giving people a false sense of security. Most do not understand that Sri Lanka has an energy crisis and that the government is borrowing more money to provide fuel at subsidised prices, worsening the nation's debt. As the new year dawned, it was reported that the government was seeking Russian collaboration to build two new mini-nuclear power stations for Sri Lanka[3]. Nuclear power plants have massive security, financial, technical and health risks. Several nuclear accidents in developed countries with stringent security measures-Three-mile Island USA (1979), Chernobyl/Ukraine (1986) and Fukushima/Japan (2011) - highlight the risks of power generation using nuclear fission[4]. It is extremely difficult to establish the kind of high security and regulatory frameworks required for a nuclear power plant in Sri Lanka, particularly in the context of the current crisis. Nuclear power plant disasters though rare are catastrophic with a colossal impact on human health. Who will inform the government that nuclear energy is not a safe power source for Sri Lanka at the present juncture?

Regime change in 2022 and continuing suppression of dissent

In 2022, mass protests ('Aragalaya') erupted, demanding economic stability and a system-wide change in administration and the political system. The 'Aragalaya' united the Sri Lankan nation across religious and ethnic divisions, a fleeting nation-building moment. People's power brought about a regime change, prepared the way for a 'system change' and instituted a new government without a general election.

However, the new government continues to suppress dissent. Those who protest are arrested and detained under the Prevention of Terrorism Act (PTA). On 18 January 2023, the Sri Lankan parliament passed the draconian Bureau of Rehabilitation Bill, which gives the army, navy and air force authority to run so-called rehabilitation centres[5]. This legislation will allow the current regime to incarcerate youth and political opponents in military-operated detention camps. Only 29 MPs were in the 225-seat parliament for the vote, and 23 voted in favour of the bill. The Supreme Court had ruled the original version of the bill, which was presented to parliament in September 2022, to be "unconstitutional in its entirety,"

Abuse of the constitution

Abuse of the Constitution since independence paved the way for the present national crisis. It has been tinkered 21 times mainly to further political interests[1]. The 20th Amendment enacted in 2020 increased the President's power over parliament. It enabled the President to unilaterally make appointments to a host of essential offices: the highest judges, the Attorney General, the Governor of the central bank, the Treasury

1 Mendis Shanthi. 30 November 2022. Sri Lanka: tears and dreams of a fragile democracy. https://drive.google.com/file/d/1PKdZV_AhWI4GDDNu3PQWL9ZN7Hx1Xull/view?usp=share_link
2 https://www.ohchr.org/en/statements/2023/01/comment-un-human-rights-office-spokesperson-jeremy-laurence-sri-lanka-supreme
3 https://ceylontoday.lk/2022/12/31/russia-sl-hold-talks-on-two-mini-nuclear-power-plants/
4 https://www.newyorker.com/science/elements/how-safe-are-nuclear-power-plants
5 https://www.wsws.org/en/articles/2023/01/21/qphz-j21.html

Secretary and members of independent commissions. Nepotism, corruption, violation of human rights and impunity blossomed under the 20 th Amendment of the Constitution, ending in the present crisis. The public demand in early 2022 was for fundamental democratic reforms (system change), the core requirement of which is the abolition of the executive presidency.

On 21 October 2022, the parliament passed a new constitutional amendment which does not limit the far-reaching powers of the executive President. Under the 21st Amendment, the Constitutional Council, which is responsible to the parliament, will appoint senior personnel to nine commissions, including the public service, national police and elections. The Constitutional Council can also propose names for the chief justice, judges to the supreme court and the court of appeal. However, even with these superficial changes, the Constitutional Council has no absolute independence, as the President can significantly influence who is elected to this body.

Collapse of the economy

By 2022, decades of fiscal indiscipline of successive governments had left the economy in a fragile state with no resilience to withstand financial shocks. Moreover, the reckless borrowing for unproductive infrastructure projects, particularly between 2009-2015, swelled the foreign debt. Earnings from tourism took a nose-dive after the Easter Sunday Massacre in 2019 and the Covid 19 pandemic. Moreover, a spate of short-sighted government policies implemented between 2019-2022 (e.g. cutting taxes, ban on the import of synthetic fertiliser and financing non-essential infrastructure projects with debt), compounded by an ineffective Central Bank, led to the collapse of the economy in 2022[1]. In addition, the Presidential System of Government had suppressed dissent and enabled corruption and mismanagement of public enterprises, providing a spot-on backdrop for the economic crisis.

The gross debt of Sri Lanka in 2020 was USD 82 billion, USD 3740 per capita. Foreign currency reserves dropped from USD 7.6 billion in 2019 to only USD 50 million by July 2022[1]. Profound structural and constitutional reforms and anticorruption strategies are essential to turn the economy around. Economic reforms should rein in State expenditure, increase taxation revenue, and reduce the current account deficit by shifting the country to an export-oriented economy. However, such reforms can be realised only by a humane government with a strong mandate of the people. Only a general election will enable people to elect political leaders with integrity who can bring about the system change required for reforms.

Sustainable recovery of Sri Lanka

Sri Lanka is no longer performing well according to GDP per capita, the UNDP Human Development Index, Transparency International's Corruption Perception Index, and Freedom House's Freedom of the World Report[6]. The ability of the incumbent government to provide essential public goods is diminishing rapidly. If business as usual is allowed to continue with a weak and ineffective government, Sri Lanka would gradually transform into a failed Nation State joining those that failed or collapsed in the last ten years, such as Afghanistan, Angola, Burundi, the Congo, Lebanon, Liberia, Sierra Leone, Nigeria, Somalia, Sudan, Syria and Tajikistan.

Recovery should begin with a national dialogue so that people gain insight into underlying factors that have contributed to the economic, social and political upheaval. Recovery process must address the inherent problems of governance and human rights, end impunity and restore the rule of law. Short-sighted manoeuvres to safeguard the power base of the incumbent President and the parliament will only undermine sustainable recovery. Fundamental constitutional reforms, a system to ensure accountability and transparency, economic reforms, restructuring of State-Owned Enterprises, processes to empower civil society and a robust anticorruption framework are needed for sustainable recovery. Although the 17th bailout by the International Monetary Fund is essential, it will only save Sri Lanka if concrete steps are taken to address the deep-seated underlying causes of the crisis.

The role of doctors

The present crisis demonstrates how macroeconomic stability, social cohesion and political stability are intertwined and how they impact one another as well as the health and wellbeing of people. Moreover, the crisis has severely disrupted the effective delivery of preventive and curative health services at all healthcare system levels[7].

Decades of political dysfunction have fractured our democracy, and the present crisis provides an opportunity for healing. The society expects doctors to be apolitical. However, should doctors stand aloof from the ongoing political process while those who claim to represent us act in a way that threatens the health and human rights of our fellow human beings? As doctors, we have an ethical responsibility to contribute to political change that will benefit our patients, people and the country. Doctors are widely respected community members who can influence politics and policy more than they realise. The inadequate involvement of such a group in leadership can only be detrimental to Sri Lanka's sustainable recovery.

There is a difference between pursuing party politics and speaking out on critical national issues such as the present economic and socio-political crisis. Admittedly, it is easy to be discouraged from speaking out because the current political situation in Sri Lanka is chaotic. The Government Medical Officers Association has raised concerns about shortages and escalating prices of medicines and allegations of malpractices and corruption in procurement procedures[8]. Should the Sri Lanka Medical Association and Professional Colleges jointly advocate for economic, social and political changes that can ameliorate suffering and uplift the health and wellbeing of the people of Sri Lanka?

6 https://freedomhouse.org/country/sri-lanka
7 SLMA Presidents Message. Healthcare system in danger of collapse. SLMA Newsletter August 2022
8 https://island.lk/health-crisis-gmoa-calls-for-who-intervention/

Tuberculosis in Sri Lanka: An old foe with new challenges

Dr Amitha Fernando
Consultant Respiratory Physician, NHSL

Dr Ruwanthi Jayasekara
Acting Consultant Respiratory Physician, NHSL

Tuberculosis:

Tuberculosis (TB) is an infectious disease caused by the bacillus *Mycobacterium tuberculosis*. It could affect any part of the body except the hair and the nails. It is spread by infectious droplets. Once infected with the bacillus, the bacteria can lie dormant for many years before the clinical features manifest. Once infected, the lifetime risk of developing the disease is 5-10% in an immunocompetent person

Tuberculosis one of the oldest diseases, remains a deadly killer in the world, and it happens to be the second leading cause of mortality due to an infectious disease. It is estimated that tuberculosis is the cause of death of 4000 people, each day.

Disease burden

Tuberculosis is prevalent in the whole world but the Southeast Asian region holds the highest disease burden. According to the Global TB report 2021, Sri Lanka is identified as a country with a low disease burden with 7000 to 9000 cases reported each year. The highest number of cases are from Colombo and the highest disease burden is in the economically productive age group, with a significant impact on productivity. The incidence of TB in Sri Lanka has remained static over the past several years though there is a gap of 3,000-4,000 patents remaining undetected, between the WHO estimated burden and the actual number of cases detected.

According to the Annual report on tuberculosis in Sri Lanka, in 2021, 6249 new TB cases were detected in that year. 4416 (70.6%) were pulmonary TB (PTB) cases and the rest 1833 (29.3%) were extra pulmonary TB (EPTB) cases. Of the 4416 PTB cases, 3483 (78.9%) were bacteriologically diagnosed, while 933 (21.1%) were clinically diagnosed.

The COVID-19 pandemic and its impact on tuberculosis

The case detection rate fell significantly with the covid pandemic and it is still struggling to pick up with the onslaught of the fuel crisis and economic crises hindering the community work of the public health inspectors, clinic attendance of patients and laboratory testing, among several other contributory factors. The COVID pandemic also brought previously unanticipated issues such as difficulties in conducting usual microscopic assessments with sputum being considered a potential infectious source of spreading COVID, raising a wave of fear in healthcare workers involved in this testing. There was restricted access to healthcare workers with lockdowns and restrictions on public transport, leading to delays in case detection. The efforts of the global combat processes to curtail tuberculosis have had a significant blow with the COVID pandemic. For the first time in years, deaths due to Tuberculosis have increased, leading to a reversal of years of gradual and persistent achievements.

Poorly controlled diabetes is a well-recognised risk factor for the development of tuberculosis. Patients who did not have access to medical care to optimise glycaemic control during the two year-long pandemic period, not only had an increased risk of developing the disease but also had a higher rate of being missed or being unscreened. Efforts were taken to provide medication to the doorstep, but monitoring of chronic disease control was hampered.

With the reported increased incidence of HIV in Sri Lanka, it is anticipated that people with HIV/TB co-infection would increase. This group is at risk of a higher complication rate. TB in an HIV patient is an AIDS defining condition. Untreated TB infection is one of the leading causes of death in people with HIV. There is a risk of progression in those with latent TB when they are immunocompromised. Therefore, it is vital that screening services carry on unhindered.

Furthermore, we must be alert to the burden of foreign migrant workers who are from high disease burden countries for tuberculosis. The volume of such workers has dramatically increased over the past five years. The risk of contracting multi drug resistant (MDR)

tuberculosis MDR also increases as the burden of MDR tuberculosis is higher in those countries. It is important to have screening pathways for these workers, especially at the time of immigration.

In the current economic crisis, with the growing risk of malnutrition and the increasing spread of substance abuse, we are faced with an onslaught of challenges in mitigating the risk of tuberculosis in these communities. This would involve not only identifying tuberculosis in the community but also identifying the root causes of spread of the disease and addressing those issues at ground level, with the help of community-based stake holders.

Control of the disease:

The NPTCCD is the national focal point for prevention and control of TB in the country. The services are provided through a well-established and functional network of 26 District Chest Clinics, 2 Sub Chest Clinics, 108 branch Clinics and 189 Disagnostic Microscopic Centres.

An untreated sputum-positive patient has the potential to infect 10-15 persons per year. According to the NPTCCD report of 2021, 39% of initial patients had sought treatment in the private sector; that being a very significant amount.

Recent information has also shown that patents with TB delay, on average for a full three weeks, before seeking medical help, and that they make much greater use of the private sector than previously thought. Unfortunately, it is reported that time taken to make a diagnosis of TB by private sector primary care is twice as long as government hospitals, and more than 6 times as long as the District Chest Clinics (DCCs)

Around 85% of tuberculosis patients who receive standard care get cured of the disease. Therefore, early identification and treatment of index cases remain the main modality of curtailing the disease spread. Moreover, it is of utmost importance that we screen for the disease at the outpatient departments of all hospitals. This practice must be extended to the primary care providers in the private sector as well.

It has been estimated that for every one USD invested to end TB, 43 USD is returned as the benefits accrued to a healthy functioning society.

Diagnosis and management

It is essential that the axiom 'a cough continuing for more than two weeks should be evaluated for tuberculosis' is put into practice scrupulously. Patients presenting with symptoms of persistent fever, night sweats, loss of weight, loss of appetite or symptoms related to an affected system, such as the CNS/ intestine, or presenting with local swelling with involvement of lymph nodes, should be assessed for TB.

Investigations to diagnose the disease would require the detection of acid-fast bacilli in sputum. Even a single positive sputum sample along with CXR changes suggestive of tuberculosis will be adequate to diagnose tuberculosis. GeneXpert TB on tissue samples is also used for the diagnosis of the disease. The correct procedure for sputum collection should be advised and implemented so that a patient would collect sputum after a vigorous cough following a deep inhalation, and not just give a sample of saliva. Three early morning samples are preferred. The first spot specimen is collected at the first visit as a supervised collection. The second sample is taken by the patient at home and the third sample is collected as a supervised spot sample again.

Xpert MTB/RIF is a nucleic acid amplification test which has a higher sensitivity and specificity for diagnosis, compared to sputum collection and it has the advantage of reporting on rifampicin resistance as well. Rifampicin is one of the first-line treatments fot TB. Line probe assay is another PCR-based method of detecting TB and identifies resistance to both rifampicin and isoniazid. This technology can identify MDR-TB from smear-positive sputum samples or culture isolates.

Depending on the past history of tuberculosis the patient will be grouped as new/ relapse/treatment after failure or treatment after loss to follow-up.

The place of Mantoux testing is only an ancillary investigation in the diagnosis of Tb. A positive test only indicates infection and not the presence of active disease or the extent of the disease. Mantoux test/ tuberculin skin test and interferon gamma release assay are the two tests that are used to diagnose latent tuberculosis.

Management of tuberculosis consists of medication with a combination of four drugs which are adjusted according to body weight and according to liver and renal impairment. The four main drugs are rifampicin, isoniazid, ethambutol and pyrazinamide; administered as a combination. The four-drug combination is administered for two months after which the next four months are continued on rifampicin and isoniazid for pulmonary tuberculosis and most other extra-pulmonary tuberculosis. The involvement of multiple sites, the involvement of the central nervous system and the bones would require a longer duration of treatment.

The way forward...

The way forward in the current context would be to explore cost-effective and efficient ways of screening population groups at risk. Recently a pilot project was conducted in the Colombo Municipal Area by the DTCO/ Central Chest Clinic Colombo, where mobile CXR was performed in a high disease burden area, which led to identifying many cases of potential tuberculosis. These people would be in the community untreated and would be sources of spreading the disease. Screening people for tuberculosis is associated with a stigma, which is a hindrance to effective screening. This leads to poor volunteering for sputum sampling, especially among the working-class male population where the disease is more evident. Therefore, screening methods must be designed to be socially acceptable so that they will be taken up by more people. Microscopy centres in OPDs in main hospitals should be strengthened to increase testing. There should be education among the Private Medical Practitioners as a recent study has shown that many people had sought healthcare a few times before being screened for tuberculosis. It is also important to have sputum screening centres attached to outpatient departments in main hospitals, as thousands of patients can be screened. This relieves them from an additional hospital visit and makes the tracing of diseased individuals more effective. Contact tracing has also taken a step forward by including adults and risk groups and not only children, as was the practice before.

All in all, tuberculosis is a disease that can be curtailed. Cost-effective practical ways to increase screening and detection of index cases and adequate treatment of identified patients should be a priority, especially in view of the current status of our country.

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Dr Lucas wins 3 golds and 3 silver at the New Zealand World Masters Games

Dr Gerard Nimal Lucas won 3 gold medals and 3 silver medals in the table tennis event at the New Zealand Masters Games held in the Jubilee Stadium, Wanganui, New Zealand from 8th to 12th February 2023. He was the sole participant from Sri Lanka.

Dr Lucas won gold medals in the over 75 Men's Singles, over 75 Men's Doubles (partnered by Robert Dunn) and the over 70 Team Event (partnered by Derek Adamson). He won silver medals in the over 70 Men's Singles, over 70 Men's Doubles (partnered by Robert Dunn) and the over 70 Mixed Doubles (partnered by Kerry Allen. He was partnered by New Zealand players in the Men's Doubles, Mixed Doubles and Team Events.

Tackling abnormal lipids in the primary care

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Honorary Consultant Physician, Teaching Hospital, Peradeniya
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Mrs Kanthi, a 45-year-old preschool teacher presented to her general practitioner for a 'body check-up' stating that her brother recently suffered a stroke. She wants to know whether she has got any risk factors for such a vascular event.

Let's discuss this case step by step

1. Is a lipid profile indicated in this patient?

Certainly yes. Currently, a lipid profile is recommended for anyone more than 20 years of age. She is having a significant family history of atherosclerotic cardiovascular disease, so it is recommended to do a lipid profile

2. How would you advise on doing a lipid profile?

A fasting lipid profile is preferred to a non-fasting lipid profile in the assessment as it gives a more accurate assessment of triglycerides and LDL cholesterol. The patient is advised for overnight fasting (minimum 12 hours) prior to collecting blood for the lipid profile

3. How would you interpret her lipid profile results?

Interpretation of a lipid profile result is more complex than interpreting a fasting blood sugar or HbA1c. It should be always individualized, and many factors need to be considered together.

a. Cardiovascular risk (Low risk, moderate risk or high risk)

b. Treatment target (Primary prophylaxis or secondary prophylaxis) and Treatment goals (Desired LDL-C level)

a. Assessment of cardiovascular risk (Low risk, moderate risk, or high risk)

Cardiovascular risk means the likelihood of a person developing an atherosclerotic cardiovascular event over a defined period of time. But in patients with already documented atherosclerotic cardiology vascular disease, blood cholesterol ≥ 309 mg/dL (8 mmol/l), diabetes mellitus with renal disease and advanced CKD this risk assessment is not indicated as they anyway warrant lipid therapy.

How to assess the 10-year atherosclerotic cardiovascular disease (ASCVD) risk-

1. Risk estimation charts are available (WHO cardiovascular charts)
2. Select the region-specific chart (South-East Asia)
3. Laboratory and non-laboratory-based charts are available (depending on total cholesterol and presence of diabetes)
4. Select the chart depending on the presence or absence of diabetes
5. Select male or female tables
6. Select smoker or non-smoker boxes
7. Select the age group box
8. Within this box find the nearest cell where the individual systolic blood pressure (mmHg) and the total blood cholesterol level (mmol/L) cross
9. The colour of the determines the 10 hear cardiovascular risk (<5% to >30%)

b. Treatment target (Primary prophylaxis or secondary prophylaxis) and treatment goals

i. Primary prophylaxis

High risk	(ASCVD risk >20%)	- LDL target <70 mg/dL
Moderate risk	(ASCVD risk 10-20%)	- LDL target <100 mg/dL
Low risk	(ASCVD risk 10-20%)	- LDL target < 116 mg/dL

ii. Secondary prophylaxis

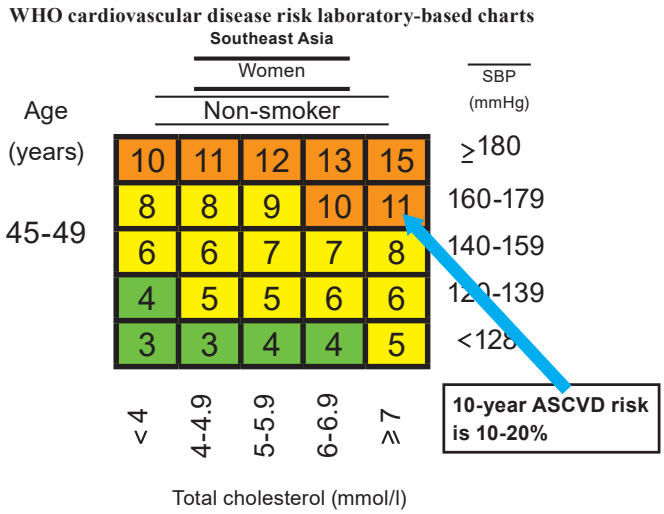
Established ASCVD	- LDL target <55 mg/dL
ASCVD with second event within 2years	- LDL target <40mg/dL

These are the findings of our patient - Mrs Kanthi

Non-smoker
Systolic Blood pressure 165 mmHg
HbA1c 7.0%

Lipid profile

Total Cholesterol	275 mg/dL (7.2 mmol/L)
LDL- Cholesterol	182mg/dL (4.7 mmol/L)
TG-	178mg/dL (2 mmol/L)
HDL- Cholesterol	48 mg/dL(1.2 mmol/L)



Mrs Kanthi's 10-year ASCVD risk is 10%-20% and she does not have established atherosclerotic disease. So, she needs primary prophylaxis with a treatment goal to reduce LDL to less than 100mmol/L

4. How would you advise on lifestyle modifications for the patient?

4.1 Diet

Healthy eating is pivotal in the control of high lipids. The general recommendation is to have a diet low in saturated fat (cheese, butter, ghee, animal fat) and more in unsaturated fat (Olive, peanut, and canola oils, avocados, and nuts such as almonds, and hazelnuts).

Coconut oil is the most consumed source of oil in Sri Lanka. Current evidence shows that it increases total cholesterol, LDL cholesterol and HDL cholesterol. Although it increases HDL, the effect is greater on total and LDL cholesterol and the effect on cardio-metabolic health is negative in comparison to other vegetable oils such as soybean, corn, or sunflower.

More wholegrain (red rice, brown rice) should be included than refined rice. More fruits and vegetables are to be included in the diet. Fish are low in saturated fat and contains omega-3 fatty acids which promote cardiovascular health.

4.2 Weight

Reduction in caloric intake and increasing physical activity will bring down the body weight. Weight reduction improves dyslipidaemia

4.3 Physical activity

Moderate-intensity physical activities (running, jogging, gardening, swimming etc) should be encouraged at least 30 minutes a day for 5 days a week

4.4 Smoking cession

In every clinic encounter patient should be asked about smoking and given strong personalized advice to quit smoking. The patient's willingness to quit smoking needs to be assessed and if needed should be assisted with behavioural counselling and/or pharmacotherapy.

4.5 Alcohol

For patients with hypertriglyceridemia, even a very small amount of alcohol can have a significant effect to raise triglyceride levels. But for others alcohol in moderation can improve the lipid profile by raising HDL cholesterol. Local guidelines recommend avoiding alcohol in keeping with the recommendation of the Sri Lankan No alcohol policy considering other detrimental effects on the physical, mental and social well-being of the individual.

5. How would you manage the patient pharmacologically?

Different categories of anti-lipid medications are available Statins are the most available and first-line recommended medication.

The other available classes of medications include fibrates, ezetimibe and bile acid sequestrants. There are newer anti-lipid medications such as PCSK 9 inhibitors, but not widely available in the country.

General guidance in starting lipid-lowering therapy

1. Statins to be prescribed up to the highest tolerated dose to reach the goals for the specific level of risk.

	Low-Intensity	Moderate-Intensity	High-Intensity
LDL-C Lowering	<30%	30-49%	>50%
Statin	Simvastatin 10mg	Atorvastatin 10-20mg Rosuvastatin 5-10mg Simvastatin 20-40mg	Atorvastatin 40-80mg Rosuvastatin 20mg

2. If goals are not achieved with the maximum dose combination with ezetimibe or bile acid sequestrant (cholestyramine) recommended.

3. If statin is not tolerated at all cholesterol absorption inhibitors (ezetimibe) should be considered.

6. Troubleshooting common clinical problems in practice

Q- Do I have to do CPK level before I start statin in my patient?

Ans- Routine monitoring of creatinine kinase levels before starting statin therapy or on asymptomatic patients on statin therapy is not recommended. But while on stain therapy if the patient develops muscle symptoms statin needs to be stopped and CPK levels should be monitored promptly as there is a risk of severe myositis and rhabdomyolysis

Q- What to do if the liver transaminases are high?

Ans- Mild elevation of liver enzymes up to 3 times the normal upper limit is not uncommon. It can be associated with ethanol use or non-alcoholic fatty liver disease. Statin use and the associated decrease in LDL cholesterol are of utmost importance for the primary and secondary prevention of atherosclerotic cardiovascular disease. So primary care physicians should not withhold statin therapy from patients whose liver enzyme elevations with no clinical relevance or could be attributed to other conditions like fatty liver. But it recommended starting statins at a lower dose and monitoring liver enzymes in 2 weeks and in one month and if liver enzyme elevations remain stable to continue with statin therapy.

The common definition of clinically significant transaminitis is a rise of three times the upper limit normal of liver enzymes on two occasions, usually measured within a short interval of days to a few weeks. But importantly progression to fulminant liver failure is exceedingly rare with statins. Reversal of transaminase elevation is frequently noted with a reduction of dose; thus, a patient who develops increased transaminase levels should be monitored with a second liver function evaluation to confirm the finding and be followed thereafter with frequent liver function tests until the abnormality returns to normal. If the transaminases remain persistently elevated 3 times the upper limit, statin therapy should be discontinued.

Q- I have read that statin therapy increases the risk of new-onset diabetes mellitus. Is it significant?

Ans- There is a slight rise in blood sugars with statin therapy which is a dose-dependent response. But clearly, the benefits of the statins outweigh the risks. Therefore, the statin should **not** be stopped if an increase in blood sugar is noted

Q- Will statins have adverse effects on the renal functions of my patient?

Ans- This is a common misconception. Although there is a mild increase in proteinuria noted in statin groups that is no statistical significance between the placebo group. There is no evidence that statins would adversely affect the renal functions

Q- How often should I repeat the lipid profile in my patient?

Ans- Lipid profile needs to be repeated in 3 months when a statin is initiated, or the dose is changed. Initial 3-6 monthly lipid profiles while titrating the drugs will ensure treatment targets are met

Q- What to do if my patient is not tolerating statins?

Ans- Some patients may not tolerate high-intensity statins. Initial strategies would be to stop the statin and re-challenge when the symptoms have resolved. Alternatively, the dose can be reduced, or statins can be used on alternative days. Some patients develop this statin intolerance as a class effect so that one class of statin can be replaced with another class E.g. Rosuvastatin replaced with atorvastatin. If not tolerating statins at all ezetimibe monotherapy or bile acid sequestrants such as cholestyramine can be attempted

Q- What is the association between high lipids and hypothyroidism

Ans- Hypothyroidism can lead to raised blood levels of total cholesterol, LDL-C, and elevated TG levels. It is recommended to screen every patient with dyslipidaemia for hypothyroidism with a serum TSH. In instances where patients have severe hypothyroidism, treatment with thyroxine alone would normalize the lipid profile. There is

a reported higher risk of statin-induced myopathy and rhabdomyolysis in patients with hypothyroidism. So, it is best if hypothyroidism is treated first before starting statins unless there are compelling indications such as acute atherosclerotic vascular diseases like myocardial infarction or stroke

Q- Can I use statins in pregnant and lactating females?

Ans- Routine use of statins in pregnant and lactating categories should be avoided. But in complicated cases such as established ASCVD risks and benefits should be carefully weighed. Primary care practitioners should refer the patient to a physician/endocrinologist/ cardiologist for expert opinion to decide on statin therapy.

A LESSON FROM HISTORY

The camels are coming on the horizon

The founder of Dubai, Shahiq Rashid, was once asked about what the future holds for Dubai.

He said that his grandfather rode a camel, his father went on a camel and he, the maker of Dubai, rides a Mercedes Benz. His son goes in a Land Rover, and the grandson will ride in a Lamborghini. However, his great-grandson will have to ride a camel again.

When he was asked why? he went on to say that hard times create strong men, and strong men create easy times. Easy times create weak men. These weak men create difficult times. We need to create warriors and not parasites. The historical reality is that the Greeks, the Egyptians, the Romans and even the British, all those empires, rose and perished within a short span of 240 years. They were not conquered by external enemies; they were destroyed from within.

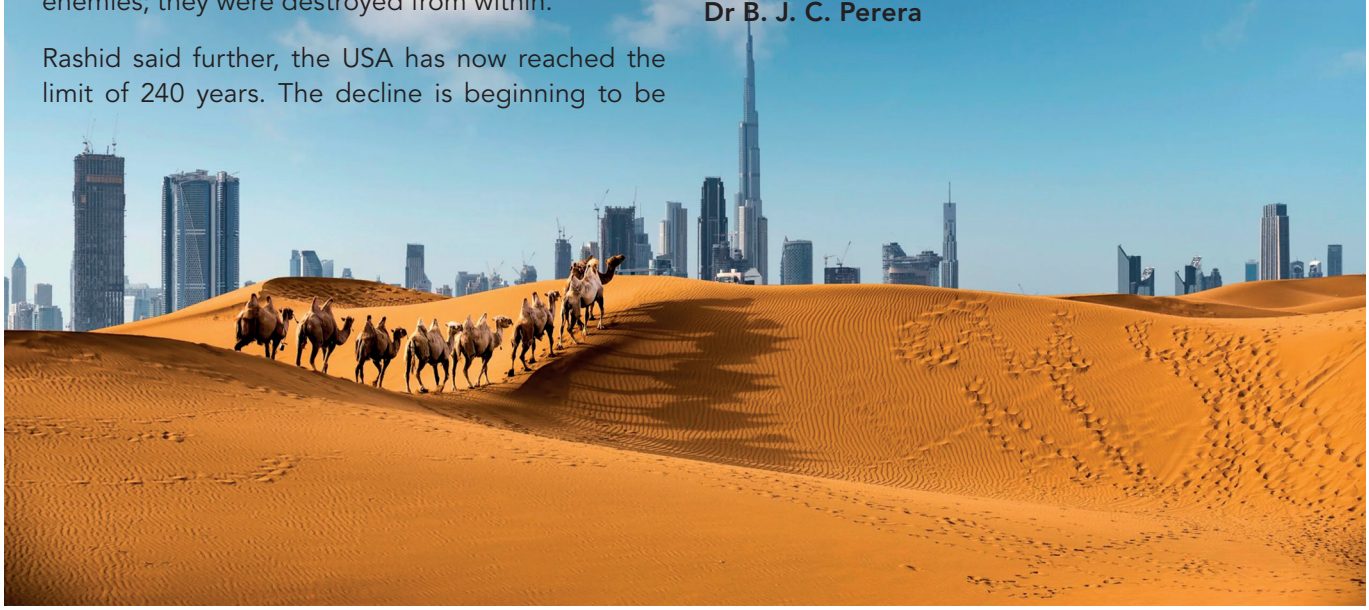
Rashid said further, the USA has now reached the limit of 240 years. The decline is beginning to be visible and even accelerating. They are past the Mercedes and Land Rover years. The camels are now on the horizon.

The greatest generation consisted of 18-year-old 'children' who stormed the beaches of Normandy. Now two generations later, some children want to hide in a safe room when words hurt their feelings. They want free stuff from the government because they think that they are entitled to it.

Watch out. History has a funny way of repeating itself.

From an e-mail sent by:
Professor Sanath P. Lamabadusuriya.

Transcribed and sent by:
Dr B. J. C. Perera



Looking after Our Own

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A recent study that I read in the Indian Journal of Ophthalmology drew my attention to the sobering fact that the life expectancy of doctors in that country is less than that of the average person - 59 years as compared to 67.9 years.(1)

While the Covid pandemic and the economic mismanagement of Sri Lanka by our elected rulers has led in the past year to the near collapse of our once reputed health system, this review article from India - drawing conclusions from a 2010 study conducted by the Indian Medical Association (IMA) in Maharashtra and another study conducted in Kerala by the research cell of the IMA – gave me some serious food for thought.

Unfortunately, I could find no research in the literature about doctors' health in our own country – although there are a few studies from the UK, USA and Australia which did not really strike me as based on good methodology. The one quotation I found in an Australian article was this - from Dr John Cummins, the chief medical officer of an Australian Insurance Company - who stated: *"Most doctors do not outlive the general population. Are you as a doctor taking care of yourself properly?"*

Given the ethnic, culinary and cultural similarities between Sri Lanka and India, I am sure that the Indian studies could be extrapolated to our own county,

There were several reasons adduced by the authors Pandey and Sharma (1) to try and explain the strange fact that members of the medical profession in that country (who would be expected, with their superior knowledge of medical conditions, to be healthier and have longer lives) were actually less healthy and dying earlier than the average person!

I am always intrigued by the safety video shown by all airlines to their passengers before take-off. In addition to explaining all about stowing luggage in the overhead compartments or beneath one's seat and how to fasten one's seat belt properly, these safety videos explain to passengers what they should do in the case of an emergency. What I find most significant is the clear advice given about what to do if cabin pressure drops. Passengers are unambiguously told **"When Oxygen masks drop down in front of you, put the mask on yourself BEFORE you attempt to help and put a mask on anyone else".**

The message is clear: you cannot help others if you don't take care of yourself first.

But how many of us doctors take this advice seriously?

To be a doctor is a great privilege. We usually have job security, we are given respect by society and we earn a reasonable wage from our labours. But just as we belong to a privileged profession we also work in a stressful profession. We are so busy looking after our patients – working long hours, skipping regular meals, not having enough time to include some decent exercise in our lives – that we do not really make the effort to look after ourselves. Moreover, dealing as we often do with situations where human lives are at stake, having to make critical decisions in minutes, facing the reality of patients under our care dying – all this puts us under mental stress. It has been shown from data in the US and Europe (2) that the suicide rate among doctors is higher than in the general population.

Working as doctors we sometimes forget that we are not some immortal specially gifted gods (even though at times some of our patients treat us as re-incarnations of Hippocrates or Susruta!). We must never lose sight of the basic fact that we are simply human beings who are working as doctors – and that we too are subject to all the physical and mental ills to which human beings are vulnerable.

So what can we do as individuals to improve our own health?

Firstly, recognise that we are as vulnerable to illness as our patients. Therefore making it a priority to prevent ill health and to recognise signs of illness in ourselves is vital. We may be very good at recognising these signs in others – but we tend to overlook or deny clinical warning signs in ourselves.

Secondly, don't feel shy to consult another doctor. There is still a stigma in our profession to seeking medical help. In many cases, we treat ourselves – probably a practical thing that even our non-medically trained patients do if the problem is a simple headache, a shaving cut or a sprained ankle. However, treating oneself is NOT a good thing to do if we have persistent headaches - or

something like atypical angina which we put down to reflux and for which we keep taking antacids until the inevitable heart attack occurs.

I recall a very senior lawyer once telling me *"A lawyer who tries to advocate his own case in court has a fool for a client and a fool for a lawyer"*. The same is true for doctors who try to treat themselves.

Ideally we should find a colleague, preferably a good GP or a general physician (if we can find such a non super-specialised physician these days!) whom we can trust, and consult them once a year for a thorough check-up. They should be colleagues whom we can then (because they know us as patients) be able to consult at short notice if we develop any new symptoms. Such a consultation should not be a quick word as you pass each other in the corridor of the hospital or in the car park of the Channelled Consultation Centre – but a proper consultation in a consulting room as would be done for a real patient.

Thirdly – and this is easy for me to write but realistically it is not something that many of us (myself included) would find easy to do. All of us get stressed, and there are times when even we invincible and indestructible doctors find things becoming overwhelming. The stigma attached to mental disease in our own country and particularly among our profession is still high, and this dissuades many of us from seeking help for 'Mental dis-ease' – when the mind and emotions are not at ease.

We **must** be open to seeking help. It has been said that a burden shared is a burden halved. So if things get too much, arrange a consultation with a trusted colleague who can listen to you, hear your concerns empathetically, take an objective view and either counsel you themselves or advise you where to go if you need specialised help. If a doctor is in a state of depression and resorts to attempting suicide, chances are that they will successfully commit suicide – because they have the specialised knowledge and access to the necessary medications with which to kill themselves.

Fourthly, take time to look after yourself.. One of the best bits of advice I received when I was younger was from my friend Dr Buddy Reid, surgeon and national cricketer, who first told me about the Rule of Threes: **Set aside three hours every week, three days every month and three weeks every year to take time off your routine work.** Use this time away from your medical work to do something you really enjoy – listening to music, reading a book, playing a game or spending quality time with your loved ones.

The primary reason behind the premature death and poor health of our profession is doctors like us neglecting our own health. Compared to most of the patients we look after, we have a better knowledge and understanding of how the body and mind work - so we must not neglect our own health for the sake of an abnormal work ethic.

We will do no good for our patients if we do not prioritise our own health.

The Latin phrase aptly expresses this idea very nicely: **Medice, cura te ipsum** meaning 'Physician, heal thyself".

We as doctors need to care for ourselves so that we may better care for others.

Acknowledgements

I am grateful to my colleagues Prof Kumara Mendis and Dr Chitra Wijesinha for helpful advice and assistance during the preparation of this article.

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Dual Practice: is it time to change?

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Doctors working in the public sector engaging in private practice is an example of dual practice. The benefits of dual practice are many. The doctors, the patients and the healthcare system benefit from this. But, like everything else in life, this dual practice has drawbacks.

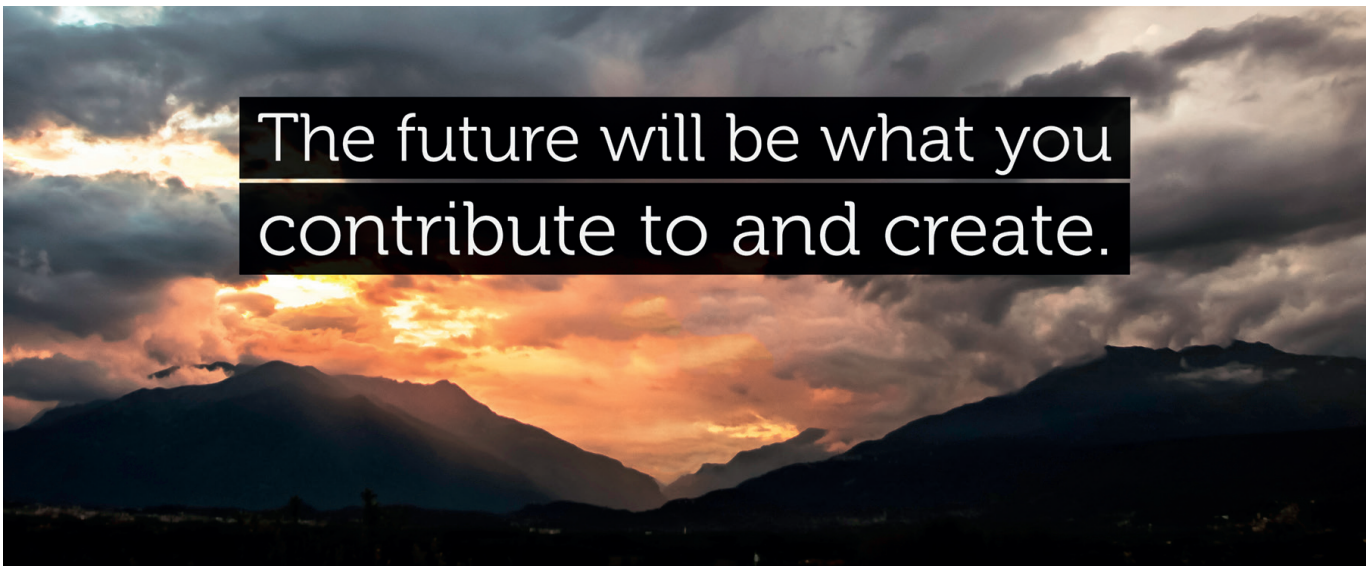
An obvious benefit for the doctors engaging in dual practice is the additional income to supplement their inadequate public sector pay. Medical specialists who treat a restricted group of highly selected patients in the public sector feel rewarded by dealing with a broader spectrum of clinical conditions and patients in relatively early stages of illness. Non-specialist doctors working in various roles in the public sector feel rewarded by working as family physicians/ general practitioners in their spare time. Patients who use the private sector can consult specialists and general practitioners at a convenient time, and they have access to the doctor of their choice. It is claimed that the healthcare system is able to retain doctors in the public sector as the doctors can supplement their income by engaging in private practice.

We have only 24 hours in a day; therefore, the time spent on dual practice by a doctor is time not spent on something else, such as pursuing hobbies, participating in professional development activities, or enjoying quality time with family & friends. Some of us can balance these conflicting demands on our time, but most have to miss out on something.

How about the choice and convenience enjoyed by the patients consulting, in the private sector, doctors involved in dual practice? In reality, patients rarely have the information necessary to make an informed choice in selecting a doctor. And is it not possible to revise the working hours of the outpatient departments and clinics in public hospitals to times convenient to patients?

Dual practice enables the elite, who cannot be expected to cope with the less-than-ideal conditions in the public sector facilities, to access specialists working in the public sector. What should be our response to this; is it to continue with dual practice or to improve the conditions in the public sector facilities to reduce inequities in accessing healthcare? For younger doctors, dual practice has always been there, but that is not true. Medical specialists had the privilege of dual practice even during colonial times. However, the authorities abolished dual practice during the early seventies of the last century, and some medical specialists opted to leave government service. The reintroduction of dual practice a few years later included the privilege of dual practice for both specialists and non-specialists.

The harmful effects of dual practice on doctors, patients, and the health system outweigh its limited benefits. The current political and economic crisis is an opportunity to make significant changes in our health system. We should work together to implement changes that would make the abolition of dual practice acceptable to all.



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