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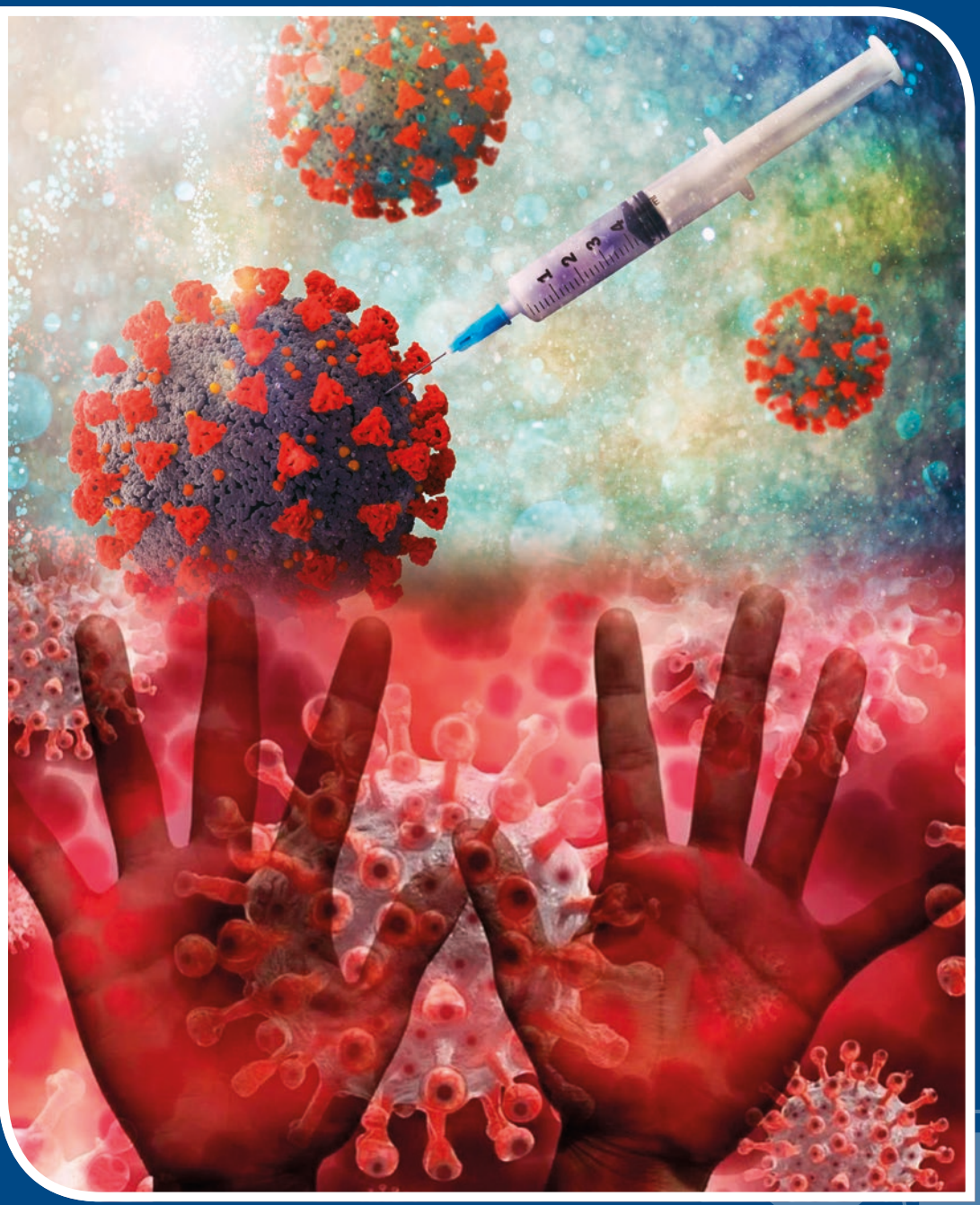

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COVID-19 & Monkeypox

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SLMA President

Prof. Samath D. Dharmaratne
MBBS (Colombo)
MSc (Community Medicine)
MD (Community Medicine)
President
Sri Lanka Medical Association

President's Message

Health Care System in danger of collapse

Dear SLMA Members,

Sri Lanka is still in 'crisis'. In the President's Messages in May, June and July newsletters, the 'crisis' affecting Sri Lanka, and its effects on the health care system and its contribution to the health status of the people of Sri Lanka, especially the children, were highlighted.

Has the 'crisis' to some extent abated? Fuel shortages have reduced with the introduction of the new QR Code method. Public servants were requested to report for work as usual. Schools are now in session daily. More and more vehicles are seen on the roads.

However, shortages in the health sector, especially of medicines, continues. Food prices are still high affecting accessibility and affordability with consequent food shortages. In supermarkets and other trading stores, shortages of products continue. Shortage of milk is still there with supermarkets limiting purchase of milk. The gas supply has not yet come back to normal.

In this background, COVID-19 has started to resurge, the '4th' wave, once again reporting deaths and disease morbidity. Monkeypox has started to spread in other parts of the world, India reported the first case of the disease recently. It might visit Sri Lanka one of these days!!!

We need tourists and with them diseases come as well.

There are constant problems facing the people of the country and this will affect the mental status of the population, leading to associated problems including suicides. This is one important aspect the Ministry of Health and other health sector organizations need to consider, address and prevent. The Expert Committee for Suicide Prevention of the SLMA has been addressing this and related issues and have initiated webinars to educate the public.

I would also like to take a minute to present the likely effects of the crisis on the health care system and the probable irreversible damage that it might cause. Hopefully, when at some point in time in the future, when this 'crisis' ends, the health care system would still be in a recoverable state.

Let me take a sentence I wrote in the July Newsletter, "What can we, the SLMA do? We need to meet, discuss, argue, and decide on a short-term and a long-term plan to 'Save the Health Care System of Sri Lanka'. This will save us, the people of Sri Lanka". I would like to highlight this again to keep us, the stakeholders of the health sector in Sri Lanka and abroad, informed of the danger that we are facing.

As I wrote in the July Newsletter, this is not the last message that will be in the Newsletter, on the effects of the 'crisis' on the health care sector and on the health of the people of Sri Lanka. You will hear more and more on this in future newsletters, until the 'crisis' is resolved and we as a country come back to normal.

Professor Samath D. Dharmaratne
President - SLMA

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Activities in Brief (16th July - 15th August)

SLMA Saturday Talks

16th July

'Are you failing to manage the Failing Heart' by Dr Dulaanga Rathnayake, Senior Registrar in Cardiology, Cardiology Unit, National Hospital Kandy.

23rd July

'Approach to a patient with fever'by Dr. Upul Dissanayake, Consultant Physician, NHSL, Colombo.

30th July

'Lower GI Bleeding' by Dr.MNM Nuzair, Consultant GI Surgeon, NHSL, Colombo

6th August

'Management of Leptospirosis in the Modern Era' by Dr Chamara Dalugama, Senior Lecturer in Medicine, Peradeniya/ Hony Consultant Physician, NHSL, Kandy.

13th August

'Acute Paraplegia - A Clinical Approach' Dr.Praveen Weeratunga, Dept of Clinical Medicine, University of Colombo, and Clinical Tutor, Queen's College, University of Oxford.

21st July

SLMA Expert Committee on Medical Rehabilitation organized a lecture on 'Goal Setting in Rehabilitation' by Dr Nilanthie Perera, Staff Specialist, Rehabilitation Medicine, Gold Coast, Australia.

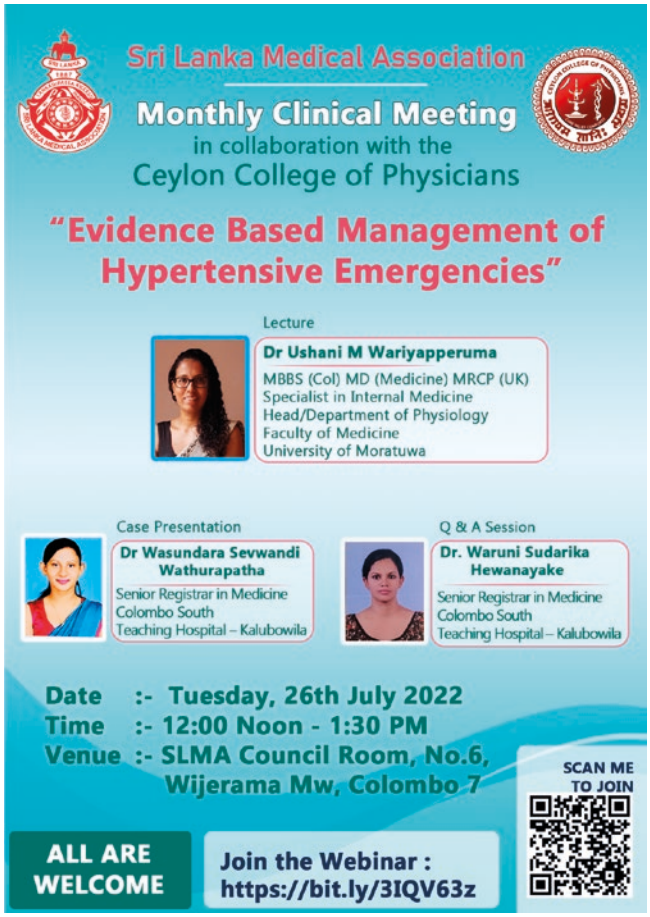
22nd July

Therapeutic Update on 'Migraine' by Dr Kumarangie K Vithanage, Consultant Neurologist/ Senior Lecturer in Physiology, Faculty of Medicine, University of Colombo was organized by the Medicinal Drugs Committee of SLMA.

26th July

A clinical meeting was conducted with the collaboration of the Ceylon College of Physicians on 'Evidence Based Management of Hypertensive Emergencies'.

The resource persons were Dr Ushani M Wariyapperuma, Specialist in Internal Medicine/ Head Department of Physiology, University of Moratuwa (Lecture), Dr Wasundara S Wathurapatha, Senior Registrar in Medicine, Colombo South Teaching Hospital, Kalubowilla (Case Presentation), and Dr Waruni S Hewanayake, Senior Registrar in Medicine, Colombo South Teaching Hospital, Kalubowilla (Q & A session).



5th August

A meeting with Ms. Madusha Dissanayake (Assistant Representative, UNFPA) and Ms Sarah Soysa (National Analyst, UNFPA) to discuss about UNFPA supporting financially/ technically through a symposium at the 135th Anniversary international Medical Congress.

Dr Surantha Perera (Vice President, SLMA) and Professor Ishan de Zoysa (Secretary, SLMA) participated on behalf of SLMA.

5th August (Morning)

Professor Samath D Dharmaratne, President, SLMA, participated on "Sharda' TV to discuss about the current economic/ political situation in the country and it effects on health care in Sri Lanka.

5th August (Evening)

A meeting was held with Ms. Alaka Singh, WHO Representative to Sri Lanka to discuss how SLMA can support WHO in uplifting the health status in SL and procuring technical/ financial support for SLMA activities in the year 2022.

Professor Samath D Dharmaratne, President, SLMA. Dr. Surantha Perera, Vice President, SLMA and Professor Ishan de Zoysa, Hon. Secretary, SLMA participated at the discussion.

Dr. Palitha Abeykoon, Past President, SLMA was also present at the meeting.

10th August

A webinar was organized by the SLMA 247 Team to update the medical professionals on 'COVID-19'.

The resource persons were Dr. Ananda Wijewickrama, Consultant Physician, IDH, Colombo, Dr. Shirani Chandrasiri, Consultant Microbiologist and Professor MC Weerasinghe, Consultant Community Physician, University of Colombo.

15th August

SLMA DoC Call 247 First Anniversary Celebrations held at the SLMA Auditorium with the participation of the SLMA council, Ministry & Suwaseriya Officials, DoC 247 Steering Committee and a few doctors who answer the calls from patients.

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COVID-19 Pandemic: the challenges and the way forward

Professor Neelika Malavige

MBBS (Col.), MRCP (UK), AFHEA, DPhil (Oxon),FRCP (Lond), FRCPath (UK), FNASSL
Professor in Immunology and Molecular Medicine,
Department of Immunology and Molecular Medicine,
Director, Centre for Dengue Research,
Faculty of Medical Sciences,
University of Sri Jayawardanapura.

Although it is 33 months since the onset of the COVID-19 pandemic, SARS-CoV-2 continues to evolve giving rise to new variants which are more immune evasive and have higher transmissibility [1]. The latest variant, the omicron sub-lineage BA.5 is causing a record number of infections around the world with an increase in hospitalizations, especially in developed countries with a higher proportion of elderly population [2]. Due to rapid development and introduction of different types of COVID-19 vaccines, boosters and also because of immunity due to natural SARS-CoV-2 infection, the mortality rates due to COVID-19 have declined in most countries [2]. However, it is very clear that COVID-19 is here to stay, with the SARS-CoV-2 virus continuously evolving and not necessarily giving rise to variants that would cause milder disease [3]. Therefore, it is important to anticipate and take timely and necessary actions to move forward, while living with COVID-19. However, there are many questions that need to be answered such as

1. What will be the characteristics of the next SARS-CoV-2 variant be and where will it come from?
2. How do we establish mechanisms to detect these as soon as they emerge in order to take timely action
3. What can we learn from the current epidemiology of COVID-19?
4. What sort of preventive measures should we continue with?
5. What should our testing strategy be? Who and when should we test?
6. When will there be new vaccines? Will vaccines ever prevent infection? Will we have to take boosters regularly? If so who should take them? Is it safe to take them so many times?

In order to start finding answers to these questions, we have to look back and learn lessons from what we have experienced in the past.

Differential mortality due to COVID-19 in different countries

Although the decline in mortality rates since January 2022 in many countries was attributed to omicron being a milder variant than the previous SARS-CoV-2 variants such as delta, it was shown that this was not the case. For instance, the omicron BA.2 sub-lineage caused more deaths than delta in the United States, in Hong Kong and in many other European countries [2]. Hong Kong reported one of the highest mortality rates due to BA.2, which was 37.8 deaths per million population during the height of the BA.2 wave [2]. In comparison, during the delta wave during July to October 2021 in Sri Lanka, the highest mortality rate reported was 9.49 per million population [2]. However, the reported mortality rates in different countries would depend on the reporting of deaths due to COVID-19 and a better indicator of deaths due to COVID-19, would be excess death rates during a particular period or a year [4, 5].

Although sub-Saharan Africa reported lower mortality rates throughout the COVID-19 pandemic, the ratio between the excess mortality rates and reported mortality rates is shown to be 14.2 [4]. In India this rate was 8.33, with some states reporting a ratio or 21.2 [4]. In USA the ratio between the excess mortality rates and reported mortality rates was 1.37, Western Europe 1.48, in the UK it was 0.97 and in Sri Lanka 0.86 [4]. Therefore, contrary to popular belief, based on statistics, Sri Lanka did not have a higher excess mortality compared to many countries in the region, and had comparable reporting rates to the United Kingdom. This is important, as during the BA.2 wave that occurred in Sri Lanka from January to early March 2022, our mortality rates were 0.85 per million individuals, compared to 4.03 per million individuals in Europe, 5.4 per million individuals in North America and 37.8 deaths per million in Hong Kong. This is an important fact, as it is evident that the hospitalization rates and mortality rates due the same SARS-CoV-2 variant differ greatly in different countries. Therefore, it is important to realize that a lethal and highly virulent variant in one country, may not have the same impact in a different country.

Risk factors for severe COVID-19 in different populations

Individual risk factors for COVID-19 are well known and many countries prioritized their vaccination programs and booster programs targeting the highly vulnerable populations such as the elderly, those with comorbidities and the immunosuppressed [6]. However, the risk factors for differential mortality rates and hospitalization rates in different populations are not clear. The extent of vaccination and natural infection in a population is one of the most important factors, and the reason for very high mortality rates in Hong Kong during the BA.2 wave, was in fact due to very low COVID-19 vaccination rates (<50%) in the older population [7]. Other important factors would be the demographic characteristics of the population. For instance, Japan has significantly higher mortality rates than for instance South Africa during the BA.5 wave, despite much lower vaccination rates in South Africa. This could also be attributed to the proportion of elderly individuals in a population, where the mean age of the population in South Africa is 27.6 years compared to 48.4 years in Japan. Apart from the above factors, climatic factors which influence virus transmission dynamics and the proportion of naturally infected individuals in a population could also impact the burden of disease due to a particular variant in a population. In addition, host immune factors which are currently under investigation include, prior exposure to seasonal coronaviruses inducing cross reactive immunity, the composition of the gut and respiratory microbiome, immunizations such as BCG and trained immunity (differences in how the innate immunity responds to pathogens)[8, 9].

The way forward

It is evident that COVID-19 is here to stay and will continue to cause outbreaks due to new variants, which are likely to be more transmissible as they will evolve the further evade host immunity, while not necessarily be less virulent. COVID-19 vaccines were the 'game changer' in reducing mortality, while the elderly and the immunosuppressed are likely to need additional booster doses, to maintain a high level of protective immunity. However, it is clear that while the current vaccines reduce disease severity, they are not very effective in preventing infection. Therefore, the long-term strategy to prevent infection with future SARS-CoV-2 variants, and also potential new bat coronaviruses that may give rise to a similar pandemic is to develop a pan Sarbecovirus vaccine [10, 11]. A pan Sarbecovirus vaccine should ideally provide immunity against the group of beta coronaviruses, which include most of the bat coronaviruses and the SARS-CoV-1 and SARS-CoV-2 viruses and their potential future variants. However, this is easier said that done, and there is a global effort to develop such a vaccine as soon as possible.

During the transition from the pandemic to the endemic change, our approach to controlling COVID-19 needs to change. Currently, many countries are in the transition stage (transition from pandemic to endemic stage), with some already in the endemic stage [12]. We will have to change our testing strategy accordingly, to suit the needs. For instance, during the beginning of the pandemic, mass testing was carried out to identify all infected individuals, in order to quarantine them with the view of eliminating infection or trying to control the spread as much as possible. During the transition stage, testing is required to control the spread of infection as much as possible until adequate vaccination coverage is achieved and booster doses given to all high risk populations [12]. In the endemic stage, testing is required for those who have symptomatic infection for surveillance activities and where it is clinically relevant [12]. Mass testing at this stage, serves no purpose.

However, the virus keeps outsmarting us and continues to evolve at a rapid rate. Therefore, it is important that we do not forget this silent threat, just because we have high vaccination coverage, relatively low mortality rates and hospitalization rates. The virus has shown to evolve in immunosuppressed hosts and the virus also does infect many animal hosts. Therefore, a very different form of the virus could emerge from a reverse spill over event (animals infected with SARS-CoV-2 from a human host, reinfecting a human host with the animal virus) or from a immunosuppressed host. To avoid such unpleasant surprises in future, it is important that we ramp up our genomic sequencing to include active surveillance of all such potential sources, even when the case numbers are lower. We have had enough unpleasant surprises and it is better to be ready than sorry.

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To all SLMA Members,

The SLMA elects a President-Elect at its Annual General Meeting every year in December to take over as President thereafter.

The Past Presidents receive proposals of suitable persons and make their recommendations to the Council for Council nomination.

Applications are hereby invited for the post of President-Elect for 2023 from SLMA Life Members of over five (5) years duration, proposed and seconded by SLMA Life Members.

Application forms may be obtained from the SLMA Office during working hours.

Applications will be accepted till the last day of September.

Dr Lakshman Ranasinghe
Past Presidents' Representative
Date: 25th August 2022

Monkeypox: Is the risk real?

Dr. Jude Jayamaha

MBBS, MD (Med. Virology)
Consultant Medical Virologist
National Influenza Centre
Medical Research Institute

Dr. Chinthana Perera

Consultant Epidemiologist
MBBS (Colombo), MSc,
MD(Community Medicine)
Epidemiology Unit
Ministry of Health

Key facts about Monkeypox

- It is caused by the monkeypox virus, a member of the Orthopoxvirus genus in the family Poxviridae.
- It is a viral zoonotic disease that occurs primarily in tropical rainforest areas of Central and West Africa and is occasionally exported to other regions.
- The disease typically presents with fever, rash and swollen lymph nodes and may lead to a range of medical complications.
- It is usually a self-limited disease with symptoms lasting from 2 to 4 weeks. Severe cases can occur. In recent times, the case fatality ratio has been around 3-6%.
- Monkeypox virus is transmitted from one person to another by close contact with lesions, body fluids, respiratory droplets and contaminated material such as bedding.
- The clinical presentation of monkeypox resembles that of smallpox, is less contagious than smallpox and causes a less severe illness.
- Clinical suspicion is confirmed by a real-time PCR assay which is available at MRI.

Introduction

Monkeypox is a viral zoonosis that has emerged as the most important orthopoxvirus for public health with the eradication of smallpox in 1980. Monkeypox was discovered in 1958 when a pox-like disease occurred in colonies of monkeys kept for research. Despite being named "monkeypox," the source of the disease remains unknown. [1] Human monkeypox was first identified in humans in 1970 in the Democratic Republic of Congo. Since then, most cases have been reported from rural, rainforest regions of the Congo Basin, mainly in the Democratic Republic of the Congo and across Central and West Africa. [2]

An ongoing outbreak of monkeypox was confirmed in May 2022, by identifying the initial cluster of cases in the United Kingdom, where the first case was detected on 6th May, 2022 in an individual with travel links to Nigeria. From May 2022 onwards, cases were reported from an increasing number of countries and regions, predominantly in Europe. On July 23, the monkeypox outbreak was declared a Public Health Emergency of International Concern (PHEIC) by the WHO which is the highest level of alert and one which there is a call to action in response to an international health risk.

The natural host of the monkeypox virus

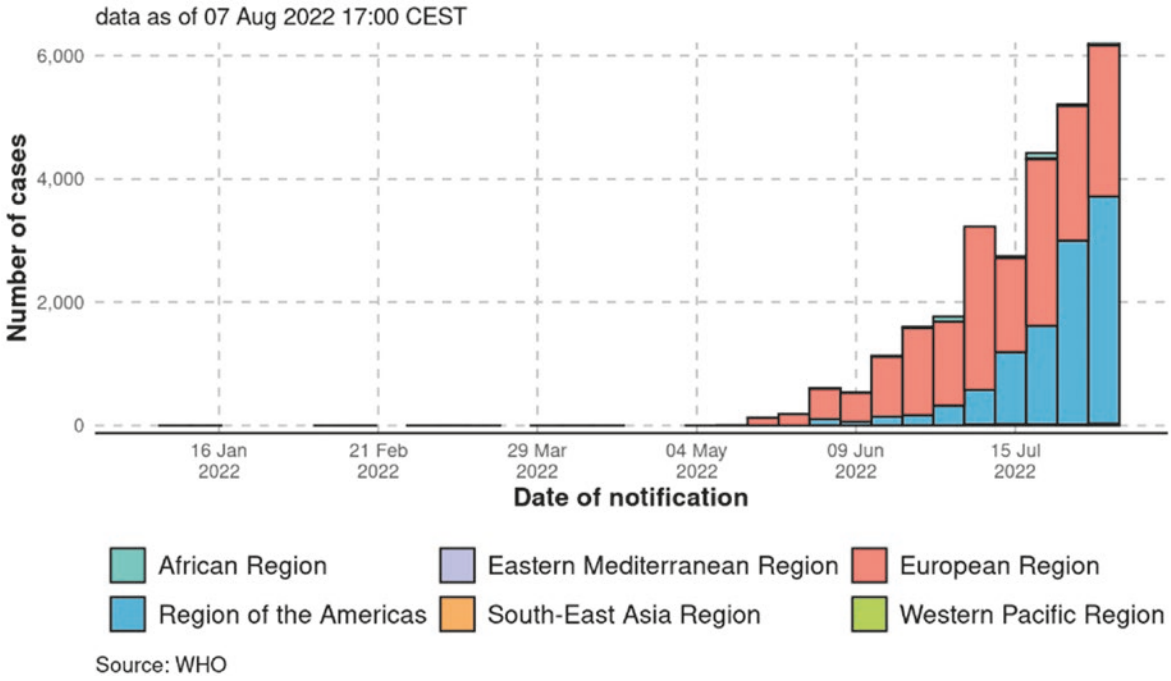
Various animal species are susceptible to the monkeypox virus, including rope squirrels, tree squirrels, Gambian pouched rats, dormice, non-human primates, and other species. But, further studies are needed to identify the exact reservoir(s) and how virus circulation is maintained in nature.

Outbreaks

Since 1970, human cases of monkeypox have been reported in 11 African countries mainly affecting countries in West and Central Africa., The spread to other areas in the world made it a disease of global public health importance. In 2003, the first monkeypox outbreak outside Africa was reported in the United States of America and that was linked to contact with infected pet prairie dogs. These pets had been kept with Gambian pouched rats and dormice that had been imported into the United States of America from Ghana. Monkeypox has also been reported in Israel, United Kingdom, Singapore and United States of America from 2018 to 2021. [2]

In May 2022, multiple cases of monkeypox were identified in several non-endemic countries. Studies are currently underway to further understand the epidemiology, sources of infection, and transmission patterns. From 1st January to 11th August 2022, 32,760 laboratory-confirmed cases of monkeypox and 12 deaths have been reported to WHO from 91 Member States across all six WHO regions. A high proportion of these cases have been reported from countries without previously documented monkeypox transmission. [3]

The number of weekly reported new cases globally has increased by 19.3% in week 31 (01 Aug - 07 Aug) (n = 6,217 cases) compared to week 30 (25 Jul - 31 Jul) (n = 5,213 cases). The majority of cases reported in the past 4 weeks were notified from the European Region (49.8%) and the Region of the Americas (49%). [3]



Source: WHO

With the available data, out of reported cases of monkeypox, 98.7% (18692/18944) are males and the median age of reported cases is 36 years (IQR: 30-43). Males between 18-44 years of age have accounted for 76.8% of the cases and out of age available cases, 0.5% of all the cases are aged between 0-17 years. Of all reported types of transmission, sexual encounter was reported most commonly, with 82 of 111 (73.9%) of all reported transmission events. [3]

Is it deadly?

Monkeypox is usually a self-limited disease with symptoms lasting from 2 to 4 weeks. Severe cases occur more commonly among children and are related to the extent of virus exposure, patient health status and nature of complications. Underlying immune deficiencies may lead to worse outcomes. The case fatality ratio of monkeypox has historically ranged from 0 to 11 % in the general population and has been higher among young children. In recent times, deaths (case fatality ratio) being around 3-6%. Complications of monkeypox can include secondary infections, bronchopneumonia, sepsis, encephalitis, and infection of the cornea with ensuing loss of vision. The extent to which asymptomatic infection may occur is unknown. [2]

Transmission

Animal-to-human (zoonotic) transmission can occur from direct contact with the blood, body fluids, or cutaneous or mucosal lesions of infected animals. Eating inadequately cooked meat and other animal products of infected animals is a possible risk factor. People living in or near forest areas may have indirect or low-level exposure to infected animals. Direct contact with the blood, body fluids, cutaneous or mucosal lesions of infected animals, can result in animal-to-human (zoonotic) transmission. Eating undercooked meat and other diseased animal products is a possible risk factor.

Close contact with respiratory secretions, skin sores on an infected person, or recently contaminated objects can cause human-to-human transmission. Transmission via droplet respiratory particles usually requires prolonged face-to-face contact, therefore health workers, household members and other close contacts of active cases are at a greater risk. Transmission can also occur via the placenta from mother to fetus (which can lead to congenital monkeypox) or during close contact during and after birth. It is unclear if monkeypox can be transmitted specifically through sexual transmission routes. [1]

Signs and symptoms

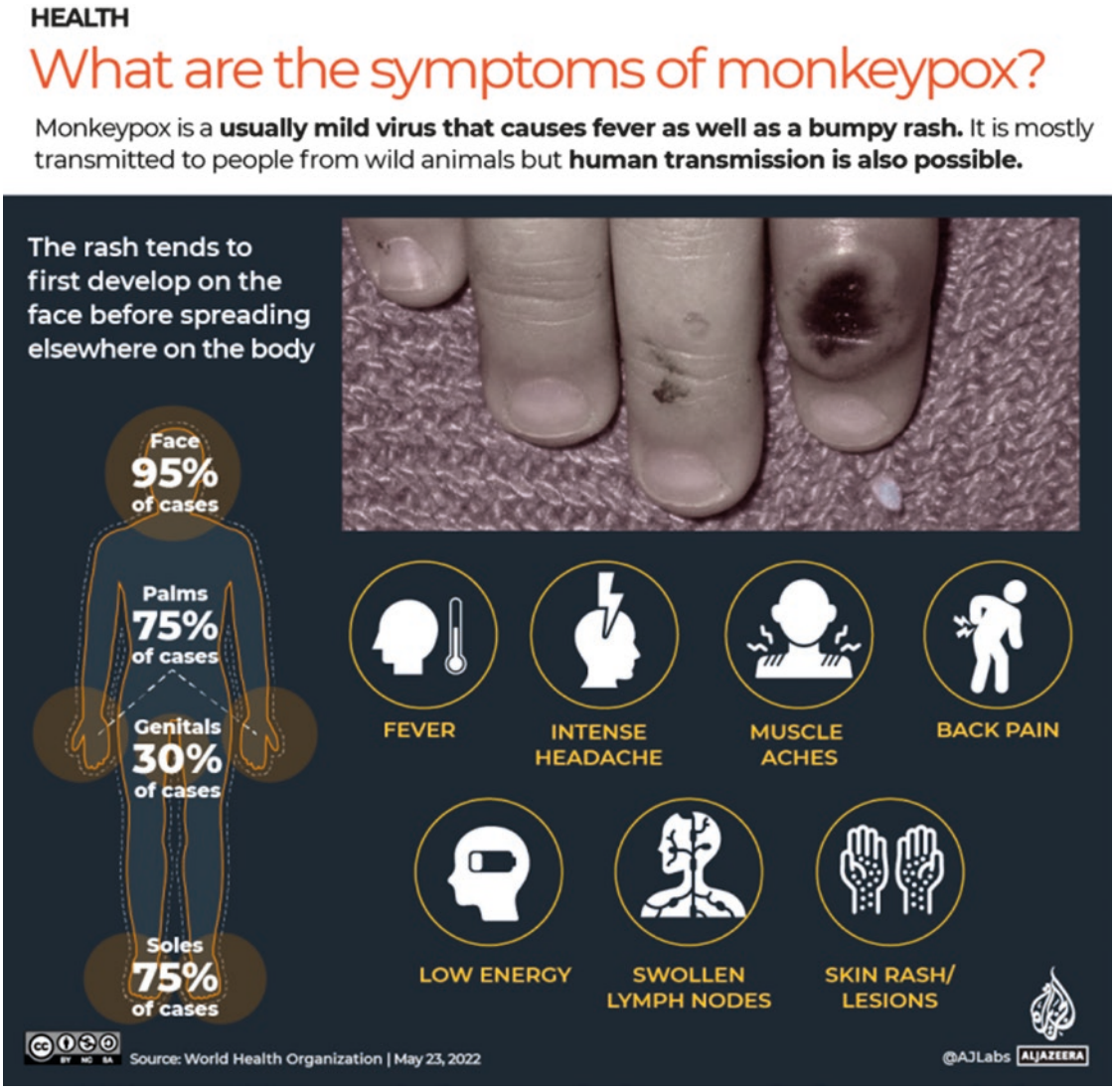
The incubation period (interval from infection to onset of symptoms) of monkeypox is usually from 6 to 13 days but can range from 5 to 21 days.

The infection can be divided into two periods:

- the invasion period (lasts between 0–5 days)

characterized by fever, intense headache, lymphadenopathy, back pain, myalgia and intense asthenia (lack of energy). Lymphadenopathy is a distinctive feature of monkeypox compared to other diseases that may initially appear similar (chickenpox, measles, smallpox)

- the skin eruption usually begins within 1–3 days of appearance of fever. The rash tends to be more concentrated on the face and extremities rather than on the trunk. It affects the face (in 95% of cases), and palms of the hands and soles of the feet (in 75% of cases). Also affected are oral mucous membranes (in 70% of cases), genitalia (30%), and conjunctivae (20%), as well as the cornea. The rash evolves sequentially from macules (lesions with a flat base) to papules (slightly raised firm lesions), vesicles (lesions filled with clear fluid), pustules (lesions filled with yellowish fluid), and crusts which dry up and fall off. The number of lesions varies from a few to several thousand. In severe cases, lesions can coalesce until large sections of skin slough off. [4]



Monkeypox is usually a self-limited disease with the symptoms lasting from 2 to 4 weeks. Severe cases occur more commonly among children and are related to the extent of virus exposure, patient health status and nature of complications. Underlying immune deficiencies may lead to worse outcomes. Although vaccination against smallpox was protective in the past, today persons younger than 40 to 50 years of age (depending on the country) may be more susceptible to monkeypox due to cessation of smallpox vaccination campaigns globally after eradication of the disease. Complications of monkeypox can include secondary infections, bronchopneumonia, sepsis, encephalitis, and infection of the cornea with ensuing loss of vision. The extent to which asymptomatic infection may occur is unknown.

The case fatality ratio of monkeypox has historically ranged from 0 to 11 % in the general population and has been higher among young

children. In recent times, the case fatality ratio has been around 3–6%.[2]

Diagnosis

The clinical differential diagnosis that must be considered includes other rash illnesses, such as chickenpox, measles, bacterial skin infections, scabies, syphilis, and medication-associated allergies. Lymphadenopathy during the prodromal stage of illness can be a clinical feature to distinguish monkeypox from chickenpox or smallpox.

If monkeypox is suspected, health workers should collect an appropriate sample and have it transported safely to a laboratory with appropriate capabilities. Confirmation of monkeypox depends on the type and quality of the specimen and the type of laboratory test. Thus, specimens should be TRIPLE packaged and shipped in accordance with national and international requirements. Polymerase chain reaction (PCR) is the preferred laboratory test given its accuracy and sensitivity. For this, optimal diagnostic samples for monkeypox are from skin lesions – the roof or fluid from vesicles and pustules, and dry crusts. PCR blood tests are usually inconclusive because of the short duration of viraemia relative to the timing of specimen collection after symptoms begin and should not be routinely collected from patients. [4]

As orthopoxviruses are serologically cross-reactive, antigen and antibody detection methods do not provide monkeypox-specific confirmation. Serology and antigen detection methods are therefore not recommended for diagnosis or case investigation in areas of resource limitation. Additionally, recent or remote vaccination with a vaccinia-based vaccine (e.g. anyone vaccinated before smallpox eradication, or more recently vaccinated due to higher risk such as orthopoxvirus laboratory personnel) might lead to false positive results. [2]).

Treatment

Treatment is mainly supportive. Clinical care for monkeypox should be fully optimized to alleviate symptoms, manage complications and prevent long-term sequelae. Patients should be offered fluids and food to maintain adequate nutritional status. Secondary bacterial infections should be treated as indicated. An antiviral agent known as tecovirimat that was developed for smallpox was licensed for monkeypox in 2022 based on data in animal and human studies. It is not yet widely available.

Prevention of monkeypox

- Ministry of Health, Sri Lanka has taken measures to make the general public and the medical staff be informed and be aware of the disease. Surveillance activities for identification and notification of monkeypox cases have been strengthened and a circular has been issued on "Surveillance, notification, investigation, and laboratory testing of cases of monkeypox virus. (https://www.epid.gov.lk/web/index.php?option=com_content&view=article&id=230&lang=en)
- As monkeypox is a zoonotic disease it is important to work collaboratively under one health approach, with the other sectors important for the prevention of an outbreak. These matters have been discussed and information shared at the National Avian/ Pandemic Influenza Committee meeting for further action.
- All healthcare institutions have been informed to report immediately to the Chief Epidemiologist, Epidemiology Unit once a suspected case of monkeypox is identified.
- The Ministry of Health has given directives to the curative and preventive institutions for case identification, notification, and management of cases. The laboratory facilities have been improved and monkeypox testing capacity has been established at the Medical Research Institute.
- Practising standard infection control precautions for people who contact infected persons closely include:-
    - Health workers caring for patients with suspected or confirmed monkeypox virus infection
    - People handling specimens
- Preventing unprotected contact with wild animals, especially those that are sick or dead
- Restricting importation of rodents and non-human primates

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Being your most Resilient Self

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We are well aware that 2022 is posing a most challenging time for all of us in Sri Lanka, with a most unexpected and unprecedented socio-economic and political upheaval. Large-scale stressors such as these are characterized by a high degree of uncertainty and ambiguity – which could mentally sway even the strongest amongst us.

Psychological resilience is the ability to cope with a crisis in a healthy wholesome way, and to return to the pre-crisis state quickly, or even better, to become a more resilient person, thanks to the conflict. Learning strategies to maintain and/or increase our psychological resilience is most useful. It would help us make wise decisions in both our personal and professional lives. When we take wise decisions, it prevents new problems because we have conducted ourselves in a wholesome manner to start with. Wise decisions also help maintain relationships that could have gotten sour due to, say, conflicting opinions each of us has on the current situation. Other than a healthy resilient mind being wise in nature, it is also happier – and, all of us, I am sure you would agree, ultimately are seeking happiness.

There are many ways to increase psychological resilience, including mobilizing existing healthy coping strategies that you have utilized in previous difficult situations, such as at the conclusion of a challenging relationship. These may include a program of exercise or pursuing artistic interests. There are also other ways to grow resilience:

- Having an attitude of acceptance WHILST doing your part to change the situation: Accepting the current reality of the country is essential if we are to cope with it. This involves abstaining from complaining and embracing a difficult but real life situation. However, complaining is different from making an objective assessment of the situation. The latter is useful and is a feature of the resilient mind.
- This attitude of acceptance however does not mean that we *don't* take constructive action to change the situation for ourselves or the country. In fact, a wholesome mind would do just that – be involved in changing the current status quo, for the better. However, being an agent of systemic change must be done after wise deliberation, whilst keeping the good of the masses in mind. It involves acting on the areas that you could act on, rather than dabbling in areas you are not skilled at. For instance, if you would like more honesty and transparency in the system, you could start with being more honest and transparent in your daily activities, *whilst* being involved in group activities to bring about such change in the larger context. Being an activist with a wholesome attitude increases your sense of purpose in the world, which in turn contributes to an increase in your self-esteem.
- Living in the present: Living in the present, coupled with the strategy indicated above, is a most powerful way to increase resilience.

  Living in the present involves training your mind to dwell on the present instead of wandering to the past, future, or to a fantasy world of your own creation. The act of living in the present requires practice. It is cultivated by keeping your mind on the physical activity you are doing at any given moment - if you are washing your dog, keep your mind on the activity of washing it; if you are cutting a mango, keep your mind on the process of cutting, etc. Every time the mind wanders from the activity you are doing, gently

bring it back to the activity - do this every time.

Remember, practice makes perfect. A mind dwelling in the present is like a well-thatched roof - it doesn't leak the 'rain' of sadness, confusion, fear, irritability, etc, into the depths of your mind. If you feel a difficult emotion such as fear, anger, irritability, or jealousy arise, know that it has arisen and re-focus your mind on the activity you are doing. Let the emotion be and move your focus from it back to the activity at hand. With time, you would realize that positive emotions are like the upside of a wave whilst difficult emotions are like a trough – and that *both* these types are a part of human life. And, that they come and go. By practicing living in the present, you would 'embrace' the varied emotions felt rather than being carried away with them.

Because by living in the present, we aren't swayed by our varied emotions and thoughts, but rather are aware of it - it gives us a window of opportunity to re-think and possibly prevent any negative behaviors that we may consider doing. It gives us a moment to consider if whatever we are attempting to do would have a negative impact. This is indeed useful as we could prevent new problems that may arise due to unwholesome behavior.

- Finding meaning: Some of us have heard of Dr Victor Frankl, the renowned Austrian Psychiatrist. He, being born Jewish, was imprisoned by the Nazi regime for years, in a concentration camp. Dr Frankl, in his memoirs of life in a concentration camp, recounts that the strategy that kept afloat his will to live during a most inhuman time in human history was him finding a larger meaning for his life than dwelling on the everyday atrocities around him. Hence, he focused on noting the goodness in the people around him, which gave him hope for humankind. This of course did not mean he was in blissful denial of the challenges around him. Rather, whilst acknowledging these, he made it a point to note and focus on the positives too – for instance, the Nazi soldier, who was kind to the prisoners, when he was not being watched by other soldiers; the fellow prisoner who forewent his food for another who was dying in the dormitory, etc. These positive experiences made him determined to live through life in a concentration camp and increased his willpower to help others in life.

  So, finding meaning in life means contributing in a wholesome way to something larger than yourself. For instance, forming a group that liaises with medical colleagues overseas to bring-in essential medicines to the country when these are lacking. These kinds of endeavors certainly take much effort and energy, but also give a larger meaning to life and hence sustains our will to overcome challenges.

- Having a mindset of gratitude: This involves identifying the positives in your life. Twice or thrice a week, identify things you are grateful for – these do not have to be massive achievements such as a promotion, passing an examination, or getting involved with a new partner, as such massive achievements are not common in human life. Rather, you could note *simple* things in your life that you could be grateful for – the security officer who patiently helped you park your car or the young man at the corner shop that was pleasant to you, etc. By reflecting on these before you go to sleep, you inculcate a positive frame of mind and hence would wake up with a positive attitude.

  You could add a further component to this practice of gratitude – you could contemplate what in you brought about the situation that you are grateful for. For instance, in the above examples, maybe the security officer/young man at the shop was so helpful because the last time you encountered them, you treated them humanely? – tap yourself on the back at your own kindness which in turn brought you good things in life.

- Connect with friends – Wholesome friendships are a great boon, particularly during challenging times. Friends give us care (such as showing you love and kindness when your mind is not in the healthiest place), resources (such as money, or picking up our child from school when you haven't sufficient fuel in your car), and advice (because, when we are challenged, we are less capable of taking wise decisions. A sincere friend could direct us in the correct path when we are floundering). Identify sincere friends who mean well to you - such people are of course rare in the increasingly competitive world we live in. Reach out to them in their need as well as in your need. Don't be shy to seek help from them. When we are particularly challenged, we may even forget whom we could reach out to – open your phone's contact list and scroll through. You may come across a name who you know is a sincere person. Call/text him/her, connect, and have a chat. It will uplift you.

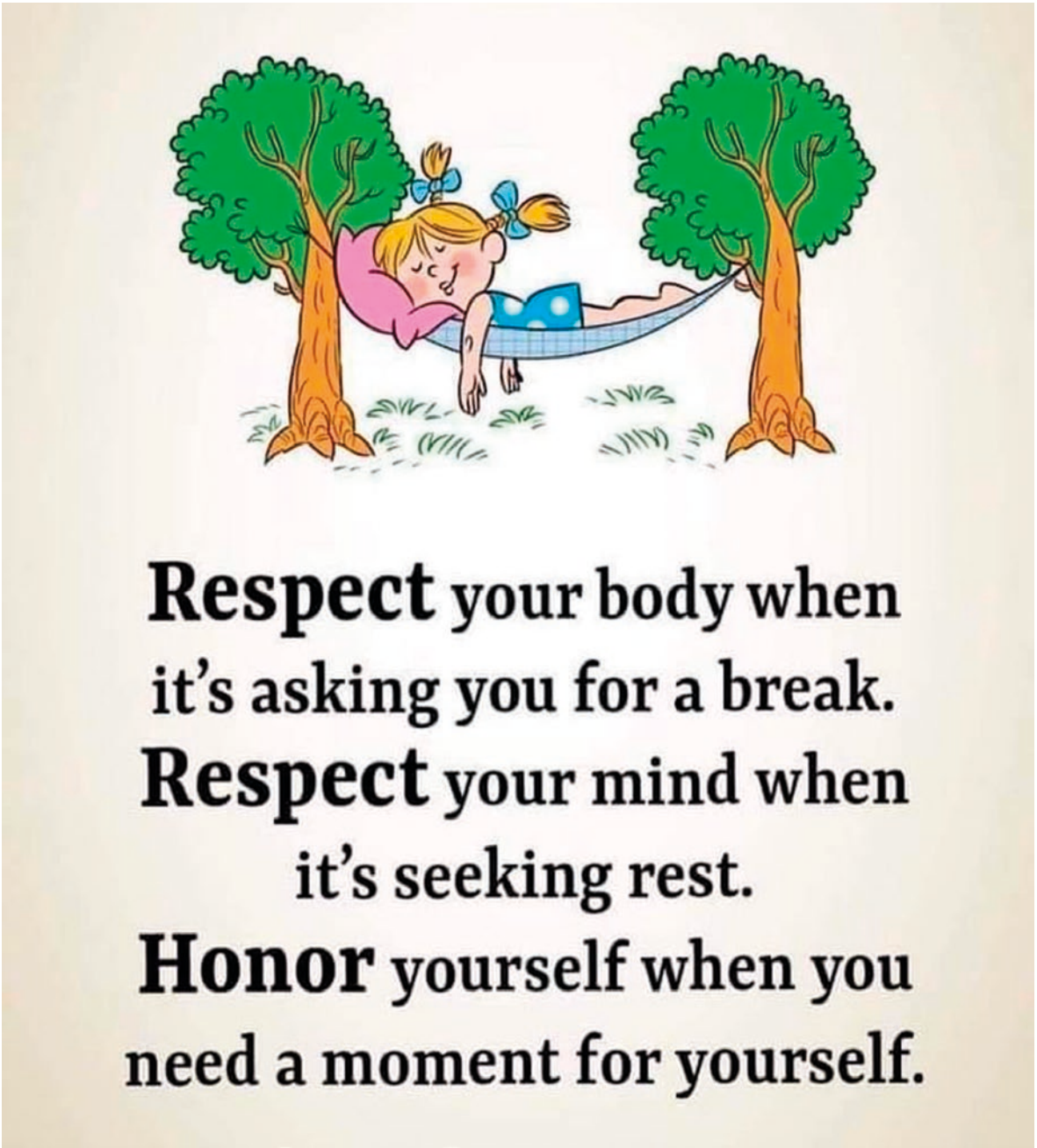
  Whilst we would all love to attract great sincere friendships into our life, at times, we forget to cultivate in us that

which draws wonderful people towards us. As magnets attract each other, we attract humane people to the extent that we have humane qualities within us – patience, wholesome speech, authenticity, kindness, setting appropriate boundaries, etc. Therefore, let us further develop our humaneness to attract the types of people we want to be in relationships with.

- Box breathing - Box breathing is a powerful, yet simple, relaxation technique that aims to return breathing to its normal rhythm. This breathing exercise may help to clear the mind, relax the body, and improve focus when you are feeling particularly challenged. Box breathing, also known as four-square breathing, involves exhaling to a count of four, holding your lungs empty for a four-count, inhaling at the same pace, and holding air in your lungs for a count of four before exhaling and beginning the count anew.

In addition to these mechanisms if you are feeling overwhelmed or unable to cope, seeking help from a friend, family member or professional is often beneficial.

If you like to listen to an audio recording on this topic, done at the SLMA, I invite you to listen to it at: https://www.youtube.com/watch?v=t2z5FSn70H0&t=161s



Dealing with Anxiety

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Anxiety is an emotion that all of us could experience from time to time when we perceive a threat to ourselves or our loved ones. "Stressed out", "unable to relax", "worry", "tense and nervous" are some of the words used to describe anxiety.

At certain times this anxiety can be helpful, for example when we need to perform well or cope with an emergency. Anxiety becomes unhelpful or enters into a disease state when it is prolonged (chronic) as it can lead to various physical problems such as gastritis, chronic headaches, high blood pressure, rheumatic conditions, just to name a few. Anxiety is also troublesome, particularly when it is very intense. Powerful anxiety is strongly linked to physical symptoms such as palpitations, tremors, numbness, dizziness etc. Anxious people tend to worry about these symptoms, which further increase their anxiety. This can stop them from doing what they have to do or like to do. Therefore, anxiety can affect us in four ways:-

- the way we feel,
- the way we think,
- the way our body works,

  and
- our behaviour

What causes anxiety?

- Certain medical conditions and misuse of substances can cause anxiety
- Ongoing stressors or a stressful event at home or the work place can cause anxiety
- Anxious personality traits in some people can cause them to worry a lot
- Other concurrent mental health conditions like depression can affect anxiety levels
- Early negative experiences can cause some people to feel anxious and insecure

Self-help techniques which will be discussed in this article can be helpful in mild to moderate anxiety. However, severe anxiety associated with functional impairment, affecting occupational and recreational activities, may require medical attention as more specific types of psychotherapy techniques and medication can be offered.

How do I manage my anxiety?

- **Tracking anxiety and relaxation techniques**

Anxiety can be managed in many ways. For mild to moderate anxiety self-help methods such as maintaining an anxiety diary will make a person more aware of situations that make them anxious or situations that they have been avoiding to circumvent feeling anxious. This enables the person to focus on a problem-solving approach rather than to let their anxiety spin out of control.

In order to reduce the physical symptoms of anxiety, identifying early signs of tension and practicing relaxation techniques can prevent the anxiety from worsening further. Exercise, listening to music, yoga are some methods people find relaxing. Relaxation is like any other skill which needs to be learned and mastered. Deep muscle relaxation and controlled breathing are other methods of relaxation that can be learnt and used during times of stress.

- **Controlling thoughts related to anxiety**

Thoughts play a key role in perpetuating and setting up a vicious cycle of anxiety. If one feels, worrisome thoughts are going round and round in circles, without leading to any solutions a useful technique is to set a time during the day to manage worries. This is called dedicating a "worry time". A convenient time is set each day for 20-30 minutes for quiet problem solving. Throughout the day each time a person finds himself worrying, they are asked to tell themselves they will come back to worrying during their "worry time". This way when worry comes to their head any time of the day they can plan to think about them only during their worry time. Once this decision is made the focus can shift back to the here and now. During worry time the person is asked to think how to manage worries by prioritizing their worries, using a solution focused approach. This is called the "worry tree approach".

- **Handling uncertainty**

People who worry prefer to have 100% certainty in what they do and what will happen in the future. When they do not have this 100% assurance, they are likely to worry about it, even when there is nothing to fear. It is helpful for "worriers" to accept uncertainty as part of life. To become more comfortable with uncertainty it is helpful to change behaviour to act "as if" you are

comfortable with it. For example, trying to be more spontaneous, reduce the tendency to "over plan", letting go of control of some events and allowing others to plan things for you, are some helpful techniques.

- **Challenging beliefs about worry**

People who worry believe that worrying is beneficial, helpful, and valuable to them and are reluctant to give up worrying. They harbour beliefs such as "worrying prevents bad things from happening", "worrying prepares me from feeling bad later", "worrying motivates me" etc. To change these beliefs, they can challenge them by looking at evidence for and against the beliefs or experiment with them by setting up a worrying experiment, to see if worrying really is beneficial. In order to change their beliefs that worrying has positive benefits, it is important that they persist with both challenging and experimenting with their beliefs, until the evidence for the belief is weak, evidence against their belief is strong and proving to oneself that worrying does not bring the positive benefits one predicted would happen. This system of cognitive restructuring proves to the patient that worrying is unhelpful, useless and is of no value.

- **Mindfulness**

Mindfulness techniques are very popular in Asian cultures. This is a form of meditation that focuses on the here and now. It gives value to the present moment. It involves observing what is happening in the environment with a calm, non-judgemental stance. Allowing thoughts and feelings to pass by without getting caught up in them. It is sometimes described as a "Teflon mind" meaning 'non- stick'! The aim is to concentrate on the present and not the past and not the future. As we know worrying about the past (something we have lost control over) and worrying about the future (something we have no control of) is a major problem for anxious people. Meditation requires a lot of practice and is a discipline one needs to master.

- **Changing behaviour related to anxiety**

People often get into the habit of avoiding tasks and situations that make them anxious. Avoidance behaviours help to maintain anxiety in the long term. Recognizing situations that are avoided, making a list of them, starting off with easy tasks first and then gradually learning to tolerate more difficult situations is what is known as systematic desensitization. It is important that one stays long enough in each situation so that anxiety can reach its peak, after which it goes away gradually. People worry that if they stay in the situation, the anxiety will keep getting worse. However, this is not the case, patients can be reassured that it will start to come down.

- **Role of medication**

Medication is sometimes used when anxiety is severe or when it has started to interfere with one's quality of life. Medication can be very effective when used judiciously. Selective Serotonin Reuptake Inhibitors – SSRIs (e.g. sertraline, escitalopram, citalopram) have broad spectrum efficacy in both short-term and long term management of anxiety disorders. They are generally well tolerated, with some patients complaining of side-effects such as transient increase in anxiety, insomnia, nausea and sexual dysfunction. Serotonin Norepinephrine Reuptake Inhibitors- SNRIs (e.g. venlafaxine, duloxetine) are considered second line options. Other antidepressants such as tri-cyclic antidepressants, agomelatine, should generally be reserved for when patients have not responded, or are intolerant of SSRIs or SNRIs. Benzodiazepines such as alprazolam, clonazepam are prescribed on a short-term basis to alleviate anxiety. However long term treatment is not recommended as they are known to cause cognitive impairment, tolerance and dependence.

This article mainly deals with generalized anxiety; however there are more explicit types of anxiety such as specific anxiety disorders (fear of heights, fear of spiders etc.) social anxiety, agoraphobia, post-traumatic stress disorder (PTSD) etc. They all share common features of generalized anxiety but occur at specific times with specific triggers.

When should a primary care doctor refer a patient for specialist assessment?

Mild to moderate anxiety respond to the above listed techniques in the majority however, very severe anxiety with functional impairment, or anxiety not responding to above remedies, may benefit from a specialist assessment. A specialist assessment will entail an evaluation of diagnosis and any comorbid conditions, contributory factors, deciding on specific psychotherapeutic options and medication combinations.

Summary

This article has explored an uncomfortable emotion. While anxiety can be detrimental to our happiness it can also be exploited to function as a positive emotion; it can be made to energize us to perform better. However, for some of us it has been the bane of our existence and therefore, recognizing prolonged or severe anxiety is important. Many different strategies to manage anxiety are discussed in this article. It is important that one experiments

with different strategies, to find out what works best for them. Medication is reserved for severe anxiety and for individuals with functional impairment. Conquering anxiety will enable a person to be happy and productive and be rest assured as Charlie Chaplin said "Nothing is permanent in this world – not even our fears".

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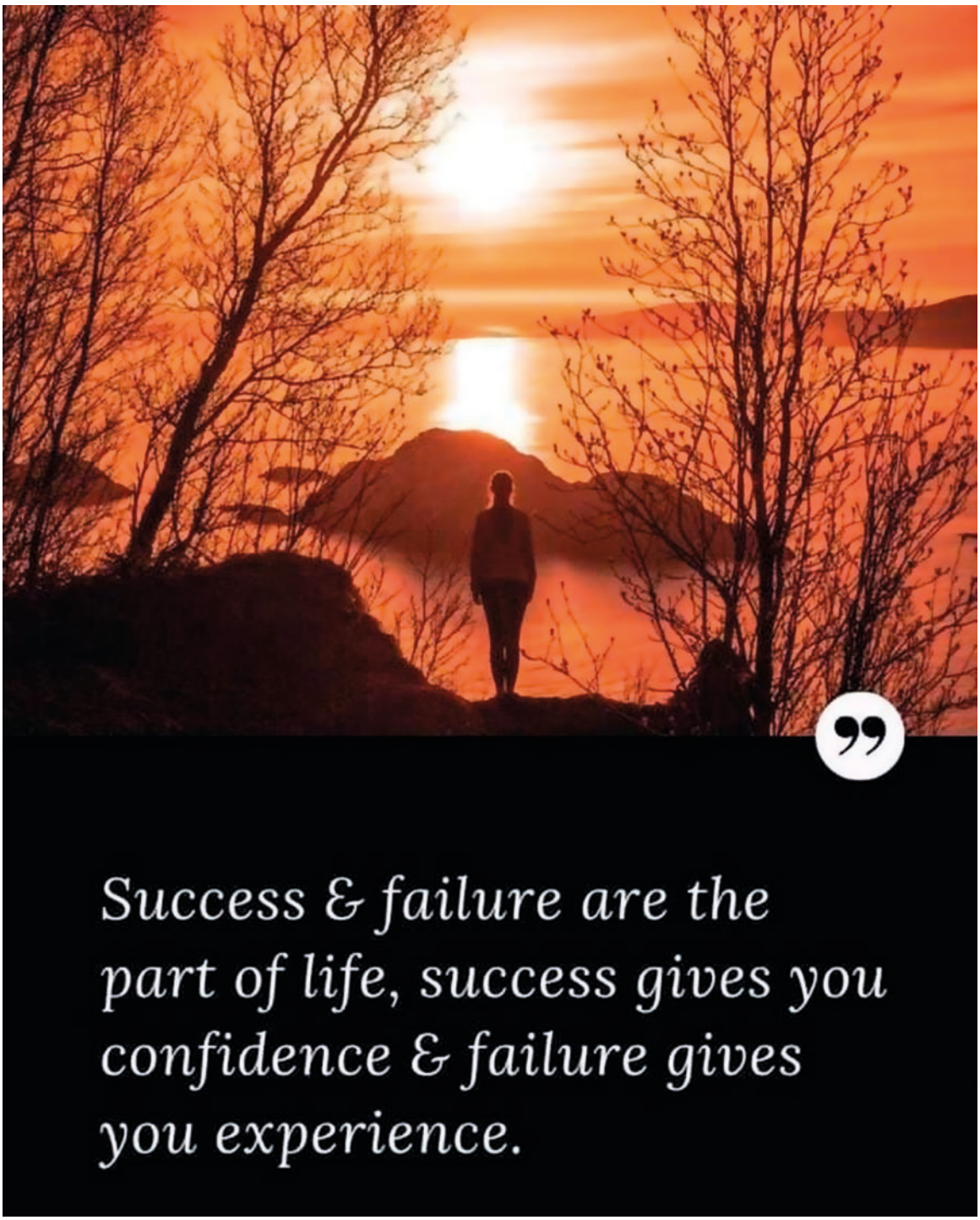

To treat or not to treat: Do physicians have a choice?

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"No matter how efficient medicine becomes, no matter how computerized, automated, algorithmed, wireless, evidence-based, or 'QA'ed' it becomes, medicine will always boil down to one doctor with one patient, in one room, with one story."

- Danielle Ofri, MD PhD

The doctor-patient relationship arises from the need to care for and relieve suffering of patients. It is a relationship based on mutual respect and trust (1). Patients seek the help of doctors to get advice and treatment for their illnesses and expect their welfare to be placed above all else by doctors.

Doctors are usually guided by science when it is related to technicalities and by their conscience or what is generally considered as right when it comes to decision making more than by any legal constraints. Many codes of conduct for physicians allow them considerable, but not unlimited, freedom to practice in keeping with well-considered, deeply held beliefs that are central to their self-identities (1,2). While these appear unambiguous and provide guidance to physicians, there is potential for conflicts when contentious issues arise.

In healthcare systems where there is a strict referral policy, the patients may not get the doctor of their choice to treat their ailments. While this is true for the Sri Lankan public sector hospitals, the absence of a proper referral system in the private sector allows the patients the freedom to decide on the doctor they would like to seek treatment from. Despite some patients having this 'right' to select the doctor of their choice, can a doctor refuse treatment to patients who seek his or her help? And if so, on what basis can he do so?

Countries may differ in their views on when a physician is allowed to refuse treatment based on their healthcare systems and legal requirements. For example, abortions and assisted suicide are legal in some countries while even a Do-Not-Resuscitate (DNR) order is not so in Sri Lanka (1). To avoid litigations, the physicians must be aware of the legal implications of their actions based on where they practice.

This article attempts to look at some instances where a physician might refuse treatment based on guidance issued by the governing bodies in Sri Lanka (1) and America (2).

While refusal to treat is not an easy decision to make at any time, it is unethical to do so if a patient is critically ill and his life is in danger (1,2). In such instances a physician is expected to provide all lifesaving care to the patient, irrespective of his personal beliefs or prejudices (1,2). The physician is not obliged to continue the care provided initially to save the patient's life if it conflicts with his beliefs and can transfer such care of the patient to a suitably qualified person once the emergency is managed.

When can a physician refuse treatment?

It is generally agreed that a physician should refuse/avoid treating those with whom they have a close personal relationship as it can prevent him or her from being objective (1,2). The physician being a family member can also prevent the patient from discussing/disclosing important private details which may have an impact on the patient's management (2). It is also agreed that a physician may not refuse treatment to a family member in an emergency, especially if he is the only person around and the patient's life is at risk (1,2).

In providing care, physicians are expected to recognize the limits of their competence (1). Providing required treatment/procedures that are not within the area of expertise or scope of practice of the physician could be harmful to and not in the best interest of the patient (2). In such instances the physicians should refuse to provide such care but must advise the patient on how best to proceed, with appropriate referrals as needed.

Among the most important functions of a physician is to avoid doing harm and a physician can refuse treatment considered harmful or useless and when it conflicts with good medical practice (2). For example, a patient's request for antibiotics for a viral upper respiratory infection could be refused by the physician as it is incorrect scientifically and has the potential to cause harm by inducing the development of resistant organisms. It is important to remember that while the 'customer may always be right',

the patient is neither a customer nor a client but someone who has sought help/advice from a person who is qualified and capable of providing it.

Violent or abusive patients can cause harm to physicians, their staff and other patients in the clinics or wards and the physician is within his rights to refuse treatment to such patients (1,2). However, this disruptive/violent behaviour could be the result of a mental health issue and the patient may need urgent medical attention. In such instances the physician must provide immediate care, with appropriate restraints if needed, to prevent or minimize harm.

The term 'Conscientious Objection (CO)' mentioned in the American Medical Association (AMA) (2,3) guidance refers to the refusal to perform a legal role or responsibility because of personal beliefs (1,2). This right to Conscientious Objection can be applied by physicians and refuse treatment to patients, if what is expected from them is incompatible with the physician's religious or moral beliefs (1,2) – e.g. abortions, assisted suicides etc. In such instances these conflicts may affect the advice or treatment provided (1). However, even in such instances, the patient should receive a timely referral to an alternative provider if it is legally permissible as the doctor's refusal to provide care can easily infringe on the patient's rights to obtain appropriate care (1,2,4). A physician's personal or religious beliefs should not interfere with his duty to promote the patient's wellness to the best of his professional ability.

There are instances where a patient's medical condition may put a physician at risk e.g., highly infectious diseases like Covid-19, TB etc. However, this is not a reason to refuse treatment and the physician is expected to take all available steps to minimize the risks to himself before providing treatment (1,2).

Physicians **cannot** refuse treatment to a patient based on gender, race, religious beliefs, moral convictions, or sexual orientation (1,2).

When can a doctor-patient relationship be ended?

Generally, the relationship is entered into by mutual consent between physician and patient and this relationship exists until a physician serves the patient's medical needs.

A limited patient-physician relationship /agreement may exist when the doctor is expected to provide only limited care, for example, a surgical procedure on a medical patient (2). In certain instances, such as when providing medical care to a prisoner on a court order, this limited patient-physician relationship maybe created even without the patient's explicit agreement (2). Whatever the reason, the physician's duty ends once the task undertaken has been discharged.

Can a physician refuse to treat a patient when he has accepted the responsibility for the patient's care?

A contentious issue is whether a physician can refuse to treat or terminate ongoing care, after he has accepted to do so. The matter is more complex than refusing before accepting care as the patient has come to be dependent on the physician and has the right to expect that his physician will not discontinue treating him when it is still indicated.

The AMA guidance states that physicians should not decline patients for whom they have accepted a contractual obligation to provide care (2). Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially if it is of long standing. This obligation is more when there is imminent risk of foreseeable harm to the patient or when the delay in access to treatment would adversely affect the patient's physical or emotional well-being significantly.

In the rare instance where the trust between a physician and his patient breaks down, the physician may wish to end the professional relationship. In such instances, he must inform the patient of his decision, the reasons for doing so, and must give the patient sufficient time and reasonable assistance to make alternate arrangements (2).

When contemplating refusal of treatment to patients the physicians must take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and adversely affect patient or public trust. They should also be mindful of the burden their actions may place on fellow professionals (2).

In summary, while the patient's goals and values should dictate treatment, it is the physician's duty to suggest possible ways that are compatible with those values and review options to determine the best path toward achieving those goals. The physician's primary obligation remains at all times as, "to do no harm", and overrides patient's autonomy in emergencies. This obligation must be ensured even when taking that difficult but at times unavoidable decision to refuse treatment to a patient. When refusing to treat or ending a professional relationship; the physician, if challenged, must be ready to justify his decision (1).

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CORRECTION

SLMA ANNOUNCEMENT

The Expert Committee on Snakebite
is pleased to Announce
that the revised
Guidelines for the Management of Snakebite in Hospital
is now available on the SLMA Website.

Access it through <slma.lk/sbc/>

From the Homepage
you can click on buttons to take you to:
History (of the Expert Committee);
Guidelines; Prevention & First Aid; Hotline
and a list of the current **Committee members**.
Included are links to download two e-books:
Management Guidelines &
a Gallery of Venomous Snakes.

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SCIENCE BASED NUTRITION

8 GOLDEN RULES FOR HEALTHY KIDNEYS*

1 Keep fit be active

2 Eat a healthy diet

3 Check & control your blood sugar

4 Check & control your blood pressure

5 Take appropiate fluid intake

6 Don't smoke

7 Don't take over-the-counter pills regular basis

8 Get your kidney function checked

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* https://www.worldkidneyday.org/facts/take-care-of-your-kidneys/8-golden-rules/

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