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Monthly theme:

COVID-19 related special care

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- **Word count:** about 2000
- **Number of references:** maximum 8 (preferably less)
- **Referencing style:** (preferably) vancouver
- **Images:** It is the responsibility of the author to get permission from the original author. Please give the reference to the original owner.
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Thank you.
Professor Hasini Banneheke,
Editor-in-Chief-SLMA@2021

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So..., this Country does not need Senior Citizens?

Death toll has been rising ever since the beginning of the 4th wave (or the 3rd wave according to authorities). Number of deaths reported is grouped according to age categories. Public health importance of that is to target the particular age group for priority in vaccination and other processes of prevention.

However, non-technical groups seem to have perceived this data in a different way. In the media, the presenters' gestures and tone imply that the higher number of deaths in the over 60 years age group is 'acceptable'. Possibly they seem to think that those deaths are inevitable. In fact most of those deaths could have been prevented, if the priority lists for vaccination prepared by the experts was adhered to.

So..., don't we need senior citizens? Can we just let them die? If we just leave aside their contribution to the country, in the past and at present, don't they have the same rights as other people to live? How can someone underestimate the value of an over 60 person's life? (Unless of course, they are thinking of guys and gals occupying, or have occupied, seats at that infamous edifice by Diyawanna Oya.)

In Sri Lanka, over 60 years age category consists of 12% of the total population (www.statistics.gov.lk) and nearly 30% of them directly contribute to the labour force, hence defined as an economically active population. Furthermore, the number of hours worked for a week by an over 40 years person on average is 8 to 10 hours a day. Thus, they contribute to country's economy in a big way directly. If someone is taking an economy-based approach in saving lives from COVID-19, then ladies, you are in trouble too! They may let you die, as the contribution to labour force by females is only 34% compared to 65.7% by males. Leaving aside the definitions and numbers, both these categories carry much of the burden on 'unpaid' basis and counted under 'not contributing to economy' group. Basically, their contributions are not appreciated or acknowledged at home or in the society or in government reports.

The following, written by a doctor (Dr.Lahiru Kodithuwakku), in the social media, explains this further.

"In countries like ours there is no such thing as retirement. Our parents only retire from office work, but they continue their duties to support their children and grandchildren. Behind each death of an over 60 age category, there is a grandparent who looked after the needs of a little one (filling up for the void of a parent at work or due to demise of a parent or intentional desertion), or a parent; man or woman who shoulders the economic burden of a child's family, or had mortgaged all property to teach their children. Even during this COVID-19 pandemic, the only school that kids have is their grandparents' school. So, if one thinks these 60-year-olds aren't contributing to the economy of the country, you are mistaken, because they're the ones who allow other countrymen could go out of the house to work."

All in all, first the vaccines were not ordered on time. Then there was popularization of tonics, 'peniyas', steam pots and holy water pots and what not, until those who promoted them succumbed to COVID-19 and faced near death experiences themselves. Thereafter, when the vaccines were brought to the country, the priority list was messed up (the Editorial in February 2020- Heads without 'science or conscience', the COVID-19 Vaccine and priority-list fiasco). Ultimately, the price for all of the above was mostly paid by the senior citizens who had devoted their lives for the motherland.

If those decision makers who do not have adequate knowledge to make decisions or aren't humble enough to listen to experts, continue to do what is best according to their judgment (or what is best for their own future), history will record this as an intentional massacre of the powerless, economically deprived people. The saddest part is that the decision makers do not seem to care while the receiving end is way too ignorant to understand the reality. Finally one day the medical fraternity will be blamed and perhaps even persecuted for all those lost lives.

It was Hubert Humphrey, the 38th Vice President of the United States (1965–69) who once said *"The moral test of a government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; those who are in the shadows of life, the sick, the needy and the handicapped"*.

Need we say more?

Editor-in-Chief
Professor Hasini Banneheke
MBBS, Pg Dip Med Micro, MD (Med Parasit)

President's Message

Dear Colleagues,

Sri Lanka Medical Association is the premier professional organization for doctors in Sri Lanka. The primary objective of the Sri Lanka medical Association is the professional development of doctors. Along with the broadening of the scope of the Medical Professionals over the years, accommodating a range of specialities, the SLMA is actively involved in a range of themes that are important for human beings. There are 6 Standing Committees and 21 Expert Committees and Working Groups within the SLMA accommodating all or most of the theme areas in the medical profession. Thereby SLMA is in a position to decide the medical aspects of many topics that are of interest to many and even controversial subjects of interest to people.

The most recently established committee of the SLMA is the SLMA Expert Committee on COVID-19. This committee includes representation from the Professional Colleges, and the Council of the SLMA. In addition, experts in relevant fields are invited for selected meetings.

Since January 2021 the SLMA Expert Committee on COVID-19 has been meeting regularly at least twice per month and has issued reports on our concerns in relation to COVID-19 infection regularly. SLMA's concern on COVID-19 is aptly illustrated by the number of letters written during this year. In all probability, 2021 should be the year that released the highest number of letters to His Excellency and media releases out of the 134 years of existence of the SLMA. The contribution of the SLMA Expert Committee on COVID 19 towards mitigation of COVID-19 infection is substantial and our efforts influenced greatly to flatten the epidemic curve of COVID-19 on several occasions. I am ever so thankful to this Committee for safeguarding the credibility of the Medical Profession at this critical juncture.

Out of all SLMA activities the leading event is the Anniversary International Medical Congress which we are planning to have as a virtual conference from 21st – 24th September 2021. There will be 14 symposia, 3 plenary lectures and 3 orations, consisting of a wide range of topics, included in the academic programme of the conference. In keeping with the theme of the year, "Professional Excellence Towards Holistic Health care", highlights would include an on-line quiz among teams of healthcare professionals. The quiz would strengthen the cooperation and interpersonal relationships of varying categories of healthcare professionals.

Let me invite all medical professionals to join the 134th Anniversary International Medical Congress from 21st – 24th September 2021 and to make use of the academic content maximally for their day to day professional work.

With the very best of wishes for a safe life.

Dr. Padma Gunaratne
MBBS, MD(SL), FRCP (Edin, Glasg, Lond), FCCP, Hon FRACP, FAAN, FWSO
President,
Sri Lanka Medical Association

IMPORTANT NOTICE

Any member of the SLMA who considers himself/herself suitable to guide the SLMA in the year 2023 as President is kindly requested to contact the SLMA Office to obtain the application for President Elect 2022. The applications should reach the honorary secretary on or before 20th October 2021.

COVID related activities during August - September 2021

By Dr. Sumithra Tissera, Hony. Secretary of the SLMA

10th & 29th August

Two meetings of the SLMA Expert Committee on COVID-19 were held to discuss issues related to the COVID-19 situation in the country and as to what recommendations should the SLMA give to the Government.

11th August

A letter was sent to HE President requesting to declare a very extensive mobility restriction amounting to a lockdown for a minimum of two weeks while maintaining essential services, to continue the programme for vaccination uninterrupted and to allocate vaccines that produce some immunity even with a single dose to all elders and to people with comorbidities.

13th, 16th & 23rd August

Media briefings were held with the participation of Dr. Padma Gunartne – President SLMA with Dr. Malkanthi Galhena – Consultant Family Physician to Educate Public on Home management of COVID_19, Drs Manilka Sumanathilaka – Vice President SLMA & Harsha Sathischandra to educate the Community on Public Health Measures, Drs Lak-Kumar Fernando – President AMS, Harsha Sathischandra – Representing the SLMA Inter-collegiate Committee & Nihal Abeysinghe – President College of Community Physicians on the need for travel restrictions and other preventive measures and finally with Dr. Ruvaiz Haniffa & Professor Indika Karunathilaka – Past Presidents SLMA & Drs Manilka Sumanathilaka – Vice President SLMA on SLMA DoC Call 247 initiative.

Many media releases were published in print media and TV appearances by Dr. Padma Gunaratne – President SLMA and other council members were conducted during the month of July.

16th August

SLMA DoC Call 247 with the collaboration of MoH, SLT Mobitel, Suwaseriya & other mobile partners were launched to provide much needed advice to patients being managed at home with COVID and on other COVID related health issues.

A large number of SLMA members and non members from Sri Lanka responded to a letter sent by the President SLMA requesting their services at this crucial moment.

The services are provided voluntarily by these dedicated medical professionals consisting of both medical officers and Consultants. Many newspaper articles appeared on the initiative. Within the first 3 weeks over 40000 calls have been attended to.

20th August

A letter was sent to Dr. Asela Gunawadena, Director General of Health Services (DGHS), requesting to make use of the services of qualified private sector doctors formally in order to implement the COVID Patient Home Isolation and Management Programme.

20th August

A media release in all three languages shared with the press requesting donations to SLMA COVID Sahana from philanthropists and well-wishers to purchase and distribute pulse oximeters to COVID-19 patients for self-monitoring while being managed at home and necessary equipment to COVID Treatment Centers.

1st september

A second letter was forwarded to HE President on mitigation of COVID-19 Pandemic with the following;

a. Report of the SLMA Expert Committee on COVID-19 giving recommendations on priorities for vaccination, the duration of the lockdown & exiting from the current lockdown

- The detail document on the 3rd dose in primary series for Vaccination against COVID 19

1st september

Donation of 250 Pulse oxymeters obtained through the SLMA COVID Sahana Fund was handed over to General Shavendra Silva, Head National Operation Centre for Prevention of COVID-19 Outbreak, Commander of the Sri Lanka Army & Acting Chief of Defence Staff in the presence of Dr. Asela Gunawardena, DGHS, Dr. Padma Gunaratne – President SLMA, Dr. Manilka Sumanathilaka – Vice President SLMA, Dr Ruvaiz Haniffa – Past President, SLMA, Professor Indika Karunathilaka – Past President SLMA, Professor MC Weerasinghe – Council Member, SLMA & Dr. Sajith Edirisinghe, Assistant Treasurer, SLMA.

Activities in August 2021 at a Glance

7th August

The SLMA Saturday Talk on 'Bilateral Lower Limb Weakness' was conducted by Dr. Arosha Dissananyake, Consultant Physician & Senior Lecturer in Medicine, University of Ruhuna.

9th, 10th, 11th & 12th August

Poster presentation of the 134th Anniversary International Medical Congress was conducted with some participants coming to SLMA and others joining online. There were a total of 234 posters presented during the 4 days.

11th to 13th & 16th to 18th August

Fifth Pre-congress session on 'Stroke Unit Care for Physicians' was held as a series of lectures online with a half day workshop on skill development on the final day.

The resource persons for the sessions and the topics discussed were;

Burden of Stroke in Sri Lanka & the essentials for setting for stroke care – Dr. Senaka Bandusena, Consultant Neurologist, Principles of Stroke Recovery & Rehabilitation – Dr. Gamini Pathirana, Consultant Neurologist , Disabilities in Stroke & Rehabilitation Assessment - Dr. Gunendrika Kasthuriratne, Consultant Rheumatologist, Stroke Rehabilitation, How to

Do it?: Practical Approach – Dr. Harsha Gunasekara, Consultant Neurologist, Post Stroke Complications & Prognostication – Dr. Champika Gunawardena , Consultant Neurologist.

Nursing for Stroke – Ms. Sujatha Seneviratne, Senior Lecturer in Nursing & Midwifery & Ms. D Thushara Anuruddhika – Nursing Officer, Physiotherapy for Stroke – Dr. Nadeehsa Kalyani – Lecturer in Physiotherapy & Mr. BAP Lakmal – Senior Physiotherapist, Occupation Therapy for

Stroke – Mr. Nandana Welage, Senior Tutor, Occupational Therapy & Mr. HG Tharindu Dilshan, Occupational Therapist, Speech Therapy & Swallowing Assessment for Stroke – Dr. Shyamanine Hettiarachchi, Senior Lecturer in Speech Therapy & Ms. Prabani Dineshika – Senior Speech Therapist, Nutrition in Stroke – Dr. Renuka Jayatissa – Consultant Medical Nutritionist, Social Services for Stroke – Mr. Chandana Ranaweera, Director, Department of Social Services, Multi-disciplinary Stroke Care - Dr. Champika Gunawardena , Consultant Neurologist.

14th August

The SLMA Saturday Talk on 'Obstructive Jaundice' was conducted by Professor S Sivaganesh, Consultant Surgeon & Professor in Surgery, University of Colombo.

15th August

A joint webinar was organized by Doctors Cricket in Sri Lanka & SLMA on 'Should Athletes be Tested on their Fitness?'. The resource person was Dr. Chathuranga Ranasinghe – Senior Lecturer and Specialist in Sports & Exercise Medicine, University of Colombo.

19th August

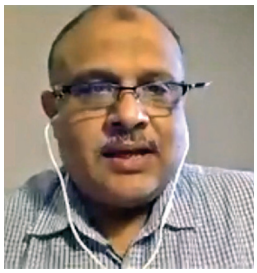
The SLMA Expert Committee on Rehabilitation organized a webinar on 'Considerations in the Management of the Neurogenic Bladder' by Dr. Ashani Couchman, Urological Surgeon, Australia.

21st August

The SLMA Saturday Talk on 'Bronchial Asthma in Children' was done by Professor Guwani Liyanage, Consultant Paedeatrician & Professor in Paediatrics, University of Sri Jayawardenapura.

25th August (Morning)

Seventh Pre Congress on 'Enriching Clinical Acumen with Communication Skills' was done with the following resource persons.



Professor Rasanayake Mudiyanse, Professor Guwani Liyanage, Dr Amali Dalpatadu, Dr. Sajith Edirisinghe, Dr Kapila Sooriyarachchi, Dr Kanthi Hettigoda, Dr S Krishnapradeep, Ms. Anuradha Rathanayaka, Dr. Nihal Weerasooriya, Dr. Anjali Wimalasiri, Dr. Athulya Amaratunga & Ms. Ramya K Ekanayake.

The Topics covered were on; Effective, efficient & supportive conversations, sharing information to serve the needs of the client, attuned with emotions when the news is bad, professional management of private & sensitive stories, empathy to resolve aggression & sooth the pain online.

25th August (Evening)

SLMA in partnership with Institute of Policy Studies Sri Lanka and Centre for Policy Impact in Global Health of the Duke University, US conducted a virtual Policy Dialogue on 'Planning for Universal Health Coverage Amidst the 4Ds of Health Transition'.

Drs Padma Gunaratne – President SLMA, Ruvaiz Haniffa – Past President, SLMA and Professor Samath Dharmaratne – President Elect SLMA were resource persons at this discussion.

Many experts (Sri Lankan and International) on the field of Health & Economics attended as resource and participants for the dialogue.

27th August (Evening)

Sixth Pre Congress 'Evidence Based Practice for Busy Clinicians: An Evidence Based Approach' was conducted successfully.

The topics and resource persons were;

Evidence Based Medicine in the era of COVID – Can we? – Professor Kumar Mendis, Appraising Evidence – Critical Appraisal & Points of Care Resource (POCR) – Professor Sharmila de Silva, Communicating with Patients: Shared Care – Dr. Shehan Silva, Acquiring Evidence – Google, PubMed, TRIP – Dr. Supun Vithana, Asking Structured Answerable Questions: PICO & 5S Pyramid – Dr. Marylou Dharmakaran.

28th August

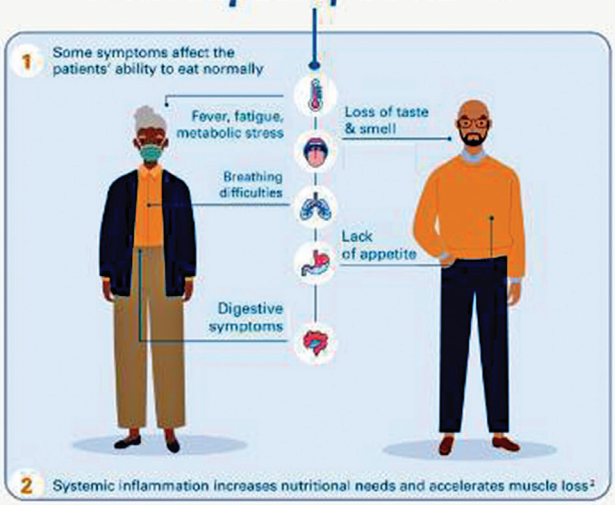
The SLMA Saturday Talk on 'Multiple Pregnancy' was done by Professor Athula Kaluarachchi, Consultant Obstetrician & Gynecologist and Professor in Obsterics & Gynaecology.

Why is nutritional care important for patients with COVID-19 across the healthcare continuum?

«Prevention, diagnosis and treatment of malnutrition should be routinely included in the management of COVID-19 patients.»[1] European Society for Clinical Nutrition and Metabolism (ESPEN)

Why are patients with COVID-19 at risk of malnutrition ?

1. The impact of COVID -19



2. The context of the pandemic

Reduced physical activity, and in some cases immobility due to bedrest

Impact of lockdown and social distancing measures, including limited support for meals provided by carers or healthcare services

Scientific experts highlight the need to integrate nutritional management in the care of patients with COVID-19

REFERENCES: 1. Barazzoni R, et al. Clin Nurt. 2020; 39(6):1631-1638, 2. Cederholm T, et al. Clin Nutr. 2019; 38(1):1-9

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The Spectrum of Neurological Complications of COVID-19

Dr.I. K. Goonerate,
Senior Lecture / Hony. Consultant Neurologist
Department of Clinical Medicine and Mental Health
Faculty of Medicine
University of Moratuwa
&
Dr.H. E. Jayaratne
Postgraduate Trainee in Family Medicine
Postgraduate Institute of Medicine
University of Colombo

SARS-CoV-2 presents primarily as a respiratory disease and has a wide spectrum of respiratory symptoms ranging from mild to severe. It affects several other organs, including injuries to the nervous system. The spectrum of reported neurologic effects of COVID-19 infection can be due to: systemic disease, immune-mediated symptoms, inflammatory-mediator related effects and symptoms due to direct viral damage. These effects can be broadly divided into two groups: non-specific neurological symptoms and specific neurological disorders/ syndromes.

Nonspecific neurological symptoms

A significant proportion of patients with SARS-CoV-2 infection are reported to manifest loss of smell (anosmia) and/or loss of taste (ageusia) as a presenting symptom. Isolated sudden onset anosmia without any other symptoms has also been reported. The mechanism of cellular entry by SARS-CoV-2 is through binding to the angiotensin-converting enzyme 2 (ACE-2) receptor. The loss of sense of smell suggests the possibility of direct targeting of the olfactory system by SARS-CoV-2. However, studies have demonstrated a high expression of ACE-2 in the olfactory epithelium and conversely an absence of ACE-2 expression in olfactory neurons.

Thus, this more likely indicates an indirect effect of SARS-CoV-2 infection, rather than the virus directly causing olfactory neuronal dysfunction.

Other non-specific neurological symptoms include dizziness and headache. These are considered to be manifestations of mild to moderate symptomatic infection, and are often observed early in the disease. In contrast, most specific neurological disorders/ syndromes are reported mainly in later stages and in severe disease.

Specific neurological disorders/ syndromes Stroke

A multicentre, multinational observational study that included hospitalized patients with SARS-CoV-2 infection from North and South America, Europe, Asia, and Oceania estimated an overall stroke risk of 0.5% (pooled risk: 0.9%).

This included ischaemic stroke, intracerebral hemorrhage, subarachnoid hemorrhage, and cerebral venous thrombosis of which the majority were ischaemic in nature (nearly 80%). The risk is quite similar to the risk of stroke following any other influenza infection.

Vascular complications of SARS-CoV-2 infection, are due to different pathophysiologic mechanisms which include: vasoconstriction and increased blood pressure through an imbalance of Angiotensin-Converting Enzyme (ACE) and ACE-2 activation, immune-mediated mechanisms including overexpression of cytokines; vasculitis and finally ischaemia secondary to hypoxaemia or hypotension.

Increased pro-inflammatory biomarkers, plus COVID-19-associated coagulopathy which is characterized by increased fibrinogen to fibrin ratio, degradation products and d-dimer levels, increases the risk of stroke- especially in patients with severe disease needing ventilatory support and in patients with comorbidities such as ischaemic heart disease, diabetes and hypertension.

The aforesaid study on hospitalized patients with COVID-19, further reinforced this fact and concluded that the need for mechanical ventilation and the presence of ischaemic heart disease were predictive of stroke.

Encephalopathy

Clinical and EEG features suggestive of encephalopathy in the absence of inflammatory changes in cerebro-spinal fluid (CSF) are observed in patients with COVID-19. Acute encephalopathy can manifest as headache, delirium, altered consciousness, seizures and coma.

Septic shock, hypoxia, metabolic acidosis, acute kidney injury and liver dysfunction are systemic complications of severe disease, which contribute to toxic/metabolic encephalopathy. Systemic

inflammatory response syndrome causing immune mediated brain damage can also cause encephalopathy.

COVID-19 induces a dramatic increase in the release of cytokines, chemokines and complement leading to a cytokine storm and multi-organ dysfunction, which can cause inflammation in the brain and increased blood-brain barrier permeability.

Patients with severe COVID-19 have high levels of interleukin 1b, interferon gamma, granulocyte-colony stimulating factor, IFN-gamma-inducible protein-10, monocyte chemo attractant protein 1, macrophage inflammatory proteins 1 alpha, and tumor necrosis factor alpha. Thus, such patients with severe disease have a higher incidence of encephalopathy than patients with non-severe disease.

Encephalitis

The pathogenesis of COVID-19 encephalitis is thought to be due to direct viral invasion of the nervous system by either haematogenous spread or via the retrograde neuronal route. The virus can cross the blood–brain barrier, and increased blood-brain barrier permeability caused by cytokines can facilitate this process.

The sluggish movement of blood in the brain microcirculation helps the virus spike protein to bind with ACE-2 receptors in the capillary endothelium.

Infected leukocytes can be both a reservoir and a vector, augmenting haematogenous spread into the central nervous system. Apart from the aforesaid mechanisms SARS-CoV-2 can enter the brain via the olfactory nerve resulting in rapid trans-neuronal spread.

Common symptoms of encephalitis include headache, fever, vomiting, convulsions, focal neurological deficits, and deficits in consciousness. Inflammation can involve any part of the brain, especially the temporal lobe, white matter, frontal lobe and corpus callosum.

Although COVID-19 encephalitis is reported, it remains a rare complication limited to case reports and case series. Variability in clinical presentation of encephalitis and the spectrum of severity ranging from mild to severe could lead to under recognition of this neurological disorder.

Definitive evidence regarding direct neuroinvasiveness of SARS-CoV-2 includes SARS-CoV-2 RNA PCR positive tests in CSF, SARS-CoV-2-specific antibodies detected in CSF and SARS-CoV-2 RNA or antigen positive tests in brain tissue obtained at autopsy or biopsy. However only a minority (less than 25% of reported cases) have demonstrated neuro-invasion in COVID-19.

Isolation of SARS-CoV-2 in CSF can be challenging and thus low rates of positivity may be attributed to rapid CSF clearance of the virus, low titers or delayed sampling of CSF.

Guillain Barre Syndrome

There is evidence to suggest an association between SARS-CoV-2 infection and the development of Guillain–Barré Syndrome (GBS), which could be a post infectious neurological complication affecting the peripheral nervous system. It is not a common complication and restricted to case reports and case series.

The most common clinical manifestation is the classic GBS with predominance of the sensorimotor syndrome and the majority of patients having the acute inflammatory demyelinating polyneuropathy (AIDP) variant.

However, rare variants like Miller Fisher syndrome have also been reported. CSF albumino-cytological dissociation is present in the majority (approximately 70%), and CSF SARS-CoV-2 RNA is absent suggesting a post-infectious sequelae rather than a para-infectious one. More than 70% of patients have a good prognosis, following treatment with intravenous immunoglobulin.

Other rare neurological disorders/ syndromes

There is a spectrum of extremely rare neurological disorders that have been reported in association with COVID-19 which are confined to case reports. Since these are case reports, a cause and effect relationship is difficult to establish.

The neurological conditions reported thus far include: acute necrotizing hemorrhagic encephalopathy, acute disseminated encephalomyelitis (ADEM), acute myelitis, optic neuritis, trigeminal neuropathy and other isolated cranial nerve palsies, myopathy/ myositis and CNS vasculitis.

Conclusion

Awareness of neurological complications associated with severe infection in COVID-19, such as stroke, encephalopathy and encephalitis is paramount, as such involvement of the nervous system indicates a poor prognosis, requiring closer attention.

Neurological manifestations will remain uncommon in spite of the large number of people developing SARS-CoV-2 infection. The impact of the pandemic on the delivery of optimal care to patients with other neurological disorders poses the greater challenge, especially in an already resource-constrained setting such as in Sri Lanka.

Acknowledgement

We would like to thank Dr Tharuka Herath, Dr Nilanka Perera and Prof Udaya Ranawaka for their contribution on a paper on the same subject, which was the main source of the above content.

COVID-19: Approach to Patients with Severe and Critical COVID Disease

Dr. Harendra Cooray
Acting Consultant in Emergency Medicine
ETU Neurotrauma Centre
National Hospital of Sri Lanka

COVID-19 (coronavirus disease 2019) is a respiratory tract infection with a newly recognized coronavirus, SARS-CoV-2. It is thought to have originated as a zoonotic virus that has mutated or otherwise adapted in ways that allow it to cause human pathogenicity.

The illness of COVID-19 ranges in severity from asymptomatic or mild to severe. A significant proportion of patients with clinically evident infection develop severe disease, which may be complicated by acute respiratory distress syndrome (ARDS) and shock.

Mortality rate among diagnosed cases (case fatality rate) is generally about 3% globally but varies from country to country. The true overall mortality rate is uncertain, as the total number of cases (including undiagnosed persons with milder illness) is not known as a certainty.

Knowledge of this disease is incomplete and id constantly evolving. Moreover, coronaviruses are known to mutate and recombine often, presenting an ongoing challenge to our understanding and to clinical management.

In late 2020 and early 2021, several variants with potential impact on transmission, clinical disease, and immune protection were recognized. Several are characterized as "variants of concern" or "variants of interest" based on their capabilities to cause increased transmissibility, greater severity of disease, reduction in protective effect of antibodies generated by previous disease or vaccination, reduced efficacy of available treatments, or reduced sensitivity of testing modalities.

Severe illness

Adult patients meeting any of the following criteria:

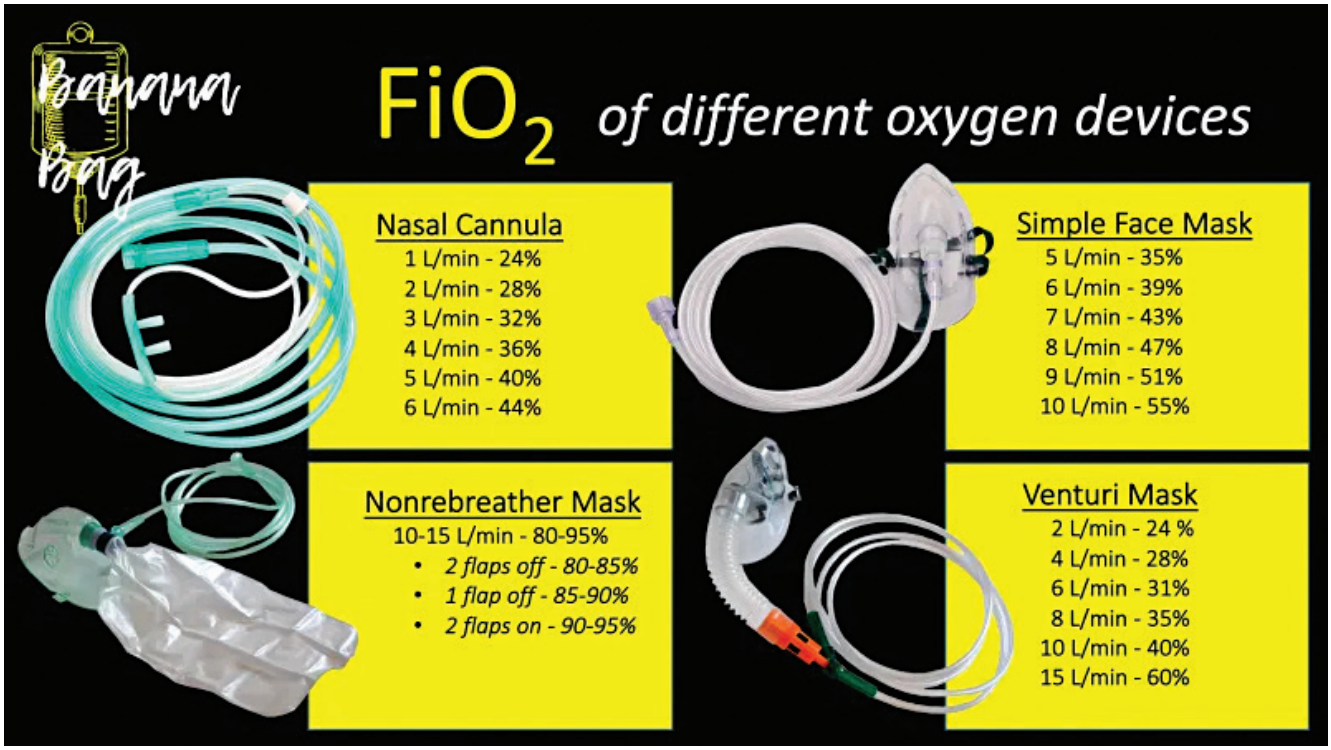
- Respiratory rate ≥ 30 breaths/min
- Oxygen saturation ≤ 92% at a rest state
- Arterial paartial pressure of oxygen (PaO2) divided by inspired oxygen fraction (FiO2) ≤ 300

Critical illness

Adult patient meeting any of the following criteria:

- Respiratory failure

Occurrence of severe respiratory failure (PaO2/FiO2 < 200), respiratory distress or acute respiratory distress syndrome (ARDS). This



includes patients deteriorating despite advanced forms of respiratory support (non-invasive ventilation (NIV), high-flow nasal oxygen (HFNO)) OR patients requiring mechanical ventilation.

OR other signs of significant deterioration

- Hypotension or shock
- Impairment of consciousness &/or vital organ failure

Patients with severe respiratory distress, obstructed or absent breathing, central cyanosis, shock, seizures, or coma, require aggressive airway management (which may include intubation) and oxygen.

Oxygenation and ventilation

Begin supplemental oxygen therapy when oxygen saturation falls below 92%. Oxygen can be administered through nasal cannulae at 5 L/minute or face mask with reservoir bag at 10 to 15 L/minute. Titrate to reach SpO_2 of 94% or more initially. Once stable, target SpO_2 of 90% or higher in nonpregnant adults. It should ve maintained at 92% or higher in pregnant patients.

In most children the target SpO_2 is 92% or greater; for those who require urgent resuscitation (eg, those with apnoea or obstructed breathing, severe respiratory distress, central cyanosis, shock, seizures, or coma), a target SpO_2 of 94% or higher is recommended.

High-flow nasal oxygen or non-invasive ventilation has been used to achieve adequate oxygenation in some patients.

High-flow nasal oxygen is recommended by Surviving Sepsis Campaign and NIH (National Institute of Health) for patients with COVID-19 who develop hypoxaemic respiratory failure despite conventional oxygen therapy. There is some evidence that it averts the need for intubation and mechanical ventilation. Non-invasive positive pressure ventilation may be used if high-flow nasal oxygen is not available

However, there is concern that these techniques may result in higher risk of aerosolization of the virus. Additionally, sudden deterioration may require emergent intubation, which is associated with more risk to both patient and healthcare providers. Therefore, some authorities reserve these options for settings in which airborne-spread precautions can be taken and close monitoring provided.

High-flow nasal oxygen therapy

High-flow nasal oxygen (HFNO) therapy is a form of respiratory support where oxygen is delivered, often in conjunction with compressed air and humidification. It delivers high flow heated and humidified oxygen via large diameter nasal cannulae. Flow rates can be given up to 60 L/min with an oxygen/air blender supplying oxygen at 21–100%.

High-flow humidified oxygen should be considered when unable to maintain SaO2 ≥ 92% despite conventional oxygen delivery at > 6 L/min or an FiO2 of 0.4.

Non-invasive ventilation

Non-invasive ventilation (NIV), also known as non-invasive positive pressure ventilation (NIPPV) or bilevel positive airway pressure support (BiPAP), is a form of respiratory support. Bilevel positive pressure is delivered throughout the respiratory cycle by a firm-fitting nasal-face mask. The patient breathes spontaneously and triggers the device to each cycle.

A higher level of pressure is provided during the inspiratory phase to enhance ventilation, while a lower level of continuous positive pressure is delivered during the expiratory phase (also known as positive end-expiratory pressure or PEEP). Supplemental oxygen can also be delivered through the device.

Invasive mechanical ventilation & ECMO

Mechanical ventilation may become necessary for patients in whom oxygenation targets cannot be met with less invasive measures or who cannot maintain the work of breathing (eg, PaO_2/FIO_2 ratio of less than 300 mm Hg)

Although an optimal technique has not been fully defined,

COVID-19–specific recommendations are emerging

Extracorporeal membrane oxygenation has been used in severely ill patients, and it can be considered if resources and expertise are available.

Medications in clinical practice

A strategy has emerged by which drugs are selected according to the mechanism of action most likely to be effective against the dominant pathophysiology at various stages in the disease process. Thus, antivirals and monoclonal antibodies directed at viral components are most effective when used early in the course of infection to prevent cell entry and viral replication; anti-inflammatory drugs (e.g., dexamethasone) and immunomodulators are of most benefit during the hyperinflammatory response in later phases of severe disease.

Anti-viral: remdesivir

Remdesivir is an antiviral agent with significant in vitro activity against coronaviruses. Some evidence of efficacy in an animal model of MERS, and some evidence of efficacy in COVID 19 is currently available.

Preliminary and follow up results of the Adaptive COVID-19 Treatment Trial, a placebo-controlled randomized trial in 1062 patients, showed a statistically significant improvement in time to recovery and a non-significant trend in lower mortality. Several other trials remain active, as well.

On the basis of these and other data from clinical trials, the NIH (National Institute of Health) guideline recommends, and the Infectious Diseases Society of America and Surviving Sepsis Campaign guidelines suggest, remdesivir for use in hospitalized patients with COVID-19 who require supplemental oxygen.

In patients who require oxygen via high-flow device or non-invasive ventilation, NIH offers the option of remdesivir with dexamethasone or dexamethasone alone, because remdesivir appears to confer maximum benefit before the onset of more severe disease, in which dexamethasone alone is associated with markedly reduced mortality. NIH does not recommend routine use of remdesivir in patients who require mechanical ventilation or extracorporeal membrane oxygenation

Monoclonal antibodies against SARS-CoV-2 spike protein: casirivimab-imdevimab & sotrovimab

NIH guidelines recommend using these agents in outpatients with mild to moderate COVID-19 who are at high risk for clinical progression. They note that these should not be given to patients hospitalized for COVID-19 outside of a clinical trial.

Sotrovimab targets a highly conserved region in the receptor-binding domain of the SARS-CoV-2 spike protein.

Interim data from the ongoing COMET-ICE clinical trial show that in 583 patients with symptomatic COVID-19 and at least one comorbidity or age-related risk factor for progressing to severe disease who were randomized to receive sotrovimab or placebo, the risk of progression to severe disease was 85% lower in the sotrovimab arm.

Immunomodulators: tocilizumab, sarilumab & baricitinib

Immunomodulators are also being investigated for mitigation of cytokine release syndrome believed to be a factor in severe acute respiratory distress syndrome and shock in COVID-19 (eg, tocilizumab and sarilumab, both monoclonal antibodies against interleukin-6 receptor; Baricitinib and other Janus kinase inhibitors) Ocilizumab

Corticosteroids - dexamethasone

NIH COVID-19 treatment guideline recommends tocilizumab with dexamethasone alone or with remdesivir and dexamethasone in hospitalized patients on high-flow oxygen or non-invasive ventilation who have clinical or laboratory evidence of progressive disease

Surviving Sepsis Campaign guideline on managing critically ill adults with COVID-19 strongly recommends using corticosteroids (preferably dexamethasone) for up to 10 days in patients with severe or critical COVID-19

Venous thrombo embolism prophylaxis

Use of prophylactic doses of anticoagulants, preferably low molecular weight heparin (LMWH), (e.g. enoxaparin 40 mg once daily or dalteparin 5000 IU once daily), in adults with moderate, severe or critical COVID-19 or other indications, unless there is a contraindication such as a risk for major bleeding. Where the estimated glomerular filtration rate (eGFR) is less than 30 mL/min/1.73m2,

unfractionated heparin or clearance-adjusted doses of LMWH may be used (e.g. enoxaparin 20 mg once daily).

Complications of severe & critical COVID-19

Most common complication is acute respiratory distress syndrome.

Other significant problems include:

- Septic shock
- Acute kidney injury
- Myocardial injury
- Secondary bacterial and fungal infections
- Multi-organ failure
- Thrombotic events
- Guillain-Barré syndrome

Patients who require hospital admission often require prolonged inpatient stay (more than 20 days) and experience significant physical deconditioning Otherwise, short-term and long-term prognosis (eg, recovery of pulmonary function) remains to be seen with time.

Long COVID disease:

It is increasingly recognized that a substantial proportion of patients, including some who did not have severe manifestations of the acute infection, experience persistent symptoms and prolonged recovery.

"Long COVID" or "post-acute COVID-19" is most commonly characterized by the following symptoms persisting more than 3 weeks from onset of COVID-19.

- Low-grade fever, which may come and go
- Fatigue, which may be profound and may be sharply exacerbated by even mild exertion
- Joint and/or muscle pain
- Chest pain
- Cough
- Headache
- Cognitive dysfunction

It is not yet known whether recovery from infection is associated with protective immunity. Reinfection has been documented, and the risk of reinfection may be increased by exposure to variant strains that have emerged in the United Kingdom, South Africa, and Brazil, although data are limited.

Toxocariasis: A Neglected Disease

Dr Chamarika Jayanetti Weerasekera
Registrar in Medical Parasitology
Department of Parasitology
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University of Sri Jayewardenepura

It was recently reported in the news that the incidence of toxocariasis is increasing among children in Sri Lanka. Children being confined to their homes amidst the pandemic , and thereby spending more time with their four-legged pets may have contributed to this. This article aims to provide a brief outline of toxocariasis, which is also known as visceral larva migrans.

What is toxocariasis?

Toxocariasis is a parasitic disease predominantly caused by the zoonotic round worms , Toxocara canis and Toxocara cati. The definitive hosts of T.canis and T.cati are dogs and cats respectively; the adult worm dwells in the lumen of the small intestine of these definitive hosts.

The parasite eggs are excreted in the faeces of the host and are infective upon 2-4 weeks of maturation in the soil. Ingestion of eggs containing infective larvae commences a new life cycle. The humans are accidental dead-end hosts meaning that the larvae cannot develop into adult worms within the human body.

Humans acquire the disease via the ingestion of infective eggs present in contaminated soil or food. Ingestion of improperly cooked meat products of other dead-end hosts that might contain encapsulated larvae (eg beef) also aid in the transmission . 1 Upon reaching the small intestine, the outer wall of the egg breaks down, and the larvae penetrate the small intestinal mucosa and enter the circulation. The larvae migrate throughout the body and enter various organs and cause a widespread inflammatory reaction, hence the name visceral larva migrans.

Cutaneous larva migrans (CLM), on the other hand, is a completely different clinical entity caused by animal hook worms such as Ancylostoma caninum and Ancylostoma braziliense. The mode of transmission of CLM is via skin penetration by infective filariform larvae.

How common is toxocariasis?

Human infection with Toxocara species was initially reported in early 1950s by identification of the larval worms in biopsy specimens in various organs of children who exhibited multi system

disease, hence the name visceral larva migrans .2 Since then, parasites of these species have been reported in patients all over the world.

It is now estimated that the prevalence of toxocariasis is 40% or higher in different parts of the world .3 A seroprevalence of 62% was noted among patients with ophthalmic disease in Kandy in 2017 (Iddawela et al 2017). 4 A 29% sero-prevalence was noted in 2009 among children with asthma. 5

What are the risk factors?

There are several factors that are associated with higher rates of toxocariasis. Ownership of a dog, especially a puppy (as the puppies tend to excrete more eggs) is a major factor.1,3,6 Children and adolescents are more likely to get infected as they play outdoors as well as with their pets.

Younger children are also less likely to practice proper hand hygiene. The prevalence is more in impoverished communities due to the poor hygienic practices. Also, toxocariasis is more prevalent in the tropics as the eggs tend to survive better in hot , humid climates. 3

What are the clinical manifestations?

In most infections larvae are destroyed causing little damage to the host, but in some larvae can survive for many years and eventually cause lesions during their wanderings. The clinical manifestations are according to which organ is involved.

Generally, four main clinical forms of the disease are recognised – visceral larva migrans and ocular toxocariasis, covert / common toxocariasis and neural toxocariasis .1

Visceral larval migrans (VLM)

This is mostly seen in children 2 – 7 years as a result of larval migration through the viscera. 4The liver is the most affected with formation of granulomatous lesions and hepatitis.

Symptoms include fever, anorexia, abdominal pain, vomiting diarrhoea, and weight loss. Hepatomegaly is usually observed in the examination. Pulmonary symptoms such as wheezing, dyspnoea and cough are also common. Less commonly heart, kidneys and muscles may be involved leading to myocarditis, nephritis, and arthritis. Most recover spontaneously within two years but some succumb to the disease.6

Ocular toxocariasis

Usually affects children aged 5 – 10 years.4 The manifestations are often unilateral blurred/cloudy vision, sensitivity to light and painful eye. Retinal lesions can be caused by the migrating larva subsequently resulting in degeneration of the retina. Visual acuity may be reduced, and central vision may be lost. Strabismus is often the presenting symptom. Ocular lesions may cause severe loss of vision or even complete loss of sight in the affected eye.

Covert toxocariasis

Non-specific signs and symptoms are seen in children and adults with this clinical entity. 4,6 These include abdominal pain, headache, fever , cough, and cervical lymph node enlargement. Eosinophilia and positive Toxocara serology are common associations.

Neural toxocariasis

Invasion of the brain and spinal cord by the Toxocara larvae lead to this severe form of disease. Headache, fever, epileptic seizures, paresis, and incontinence are observed. 4

How is the disease diagnosed?

The non-specific nature of the signa and symptoms may confound the diagnosis, and if missed may lead to severe morbidity.4 The diagnosis is based on the history (age, presence of a pet, playing outdoors etc), examination (cervical lymphadenopathy, hepatomegaly etc) and investigations (leucocytosis and eosinophilia). The parasitic aetiology should be confirmed by investigations whenever possible.

What are the differential diagnoses?

Other parasitic differential diagnoses to VLM include larval ascariasis (shorter duration), strongyloidiasis (longer duration) and tropical pulmonary eosinophilia (pronounced pulmonary symptoms mostly in adults). 6 Ocular toxocariasis should be excluded from retinal tumour (retinoblastoma) and other infective causes such as toxoplasmosis, angiostrongyliasis, cysticercosis, dirofilariasis, Lyme borreliosis and cytomegaly virus infections. 4

What are the investigations to confirm the diagnosis?

As mentioned above, leucocytosis and eosinophilia are consistent in VLM.6 Ultrasound scan of the abdomen may reveal hypoechoic lesions of the liver and is indeed more preferable to liver biopsy. 6

Magnetic resonance imaging (MRI) and computed tomography (CT) are also useful imaging modalities.4 Fundus photography, fluorescein angiography, ophthalmic ultrasound and optical coherence tomography are useful in the diagnosis and evaluation of ocular toxocariasis.4

Serology is the widely used investigation to detect anti Toxocara IgG antibodies by means of ELISA. 5 The sensitivity for ocular toxocariasis is lower than for VLM.6However, it is difficult to distinguish between past and present infections and is not useful to evaluate the success of treatment.

Demonstration of larvae in tissue biopsy or ocular fluids is the gold standard for the confirmation but is very difficult and hardly achieved.4 Biopsy samples taken for histopathology (usually for some other purpose) may reveal the presence of larvae/ portions of larvae within a granuloma.

Molecular diagnostics are also emerging as promising diagnostic tools. 6 : While being highly sensitive with a lesser turnaround time, identification up to the species level can also be achieved."

It is important to note that toxocariasis cannot be diagnosed by examining a faecal sample of a patient. Toxocara species do not develop into adults within the human!

What is the treatment?

Anti-helminthics and anti-inflammatory medication are the mainstay of treatment.4 Toxocariasis can be treated with albendazole and mebendazole given twice daily for 5 days. Albendazole is preferred due to the better absorption.

Diethylcarbamazine and thiabendazole were used in the past but are no longer recommended. Systemic corticosteroids have a place in ocular toxocariasis .

What are the preventive measures?

The One Health concept , where the well being of other animals and environment is important for our own well being is aptly demonstrated in the prevention of toxocariasis.

The initial contamination of the environment should be prevented to interrupt the transmission of Toxocara eggs to the humans. This includes regular and frequent deworming of household pets from a younger age and safely collect and hygienically dispose of pet faeces before the eggs become infective.

Promotion of handwashing after playing with pets or playing outdoors, regularly cleaning children's play areas and keeping pets out of outdoor play areas also help in the reduction of transmission. 3,4,6

What is the way forward?

Despite the many advances made in the past few decades, toxocariasis remains a significant challenge to the public health as it is still under-diagnosed and largely neglected.

Increased surveillance, increased awareness and increase in diagnostic facilities , especially molecular diagnostics and development of effective vaccines for the animals are much needed to keep this disease at bay.

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SRI LANKA MEDICAL ASSOCIATION

THANK YOU!

Dear Colleagues,

"You have not lived today until you have done something for someone who can never repay you."

The Poetry of John Bunyan – Volume II

I am absolutely delighted to convey my heartfelt gratitude to all medical professionals who joined hands in hundreds with the Sri Lanka Medical Association by volunteering for the Doc Call 247 Consultations for care of the COVID-19 patients.

DOC Call 247 was a tremendous success in saving lives of COVID-19 infected patients and for providing that much needed advice to people who needed it so badly.

Your response to our invitation was remarkable and you are the absolute personification of the quotation provided at the beginning of this note.

The SLMA salutes all of you for the yeoman service so selflessly provided during this catastrophic pandemic.

Dr Padma Gunaratne
President
Sri Lanka Medical Association

Majority of Maternal and New-Born Deaths Can be Prevented through Provision of Safe and Quality Care!

"Act now for safe and respectful childbirth!"

World Patient Safety Day 17 September 2021

Directorate of Healthcare Quality and Safety

Premises of Castle Street Hospital for Women,
Castle Street,
Colombo 8 - Sri Lanka
Tel : 0112 678 598
Fax : 0112 698 602

The SLMA Young Members' Forum

The Sri Lanka Medical Association recently established a forum for its young members as a new committee and a working group. It functions under the guidance of the President and the Council.

The main purpose of initiating this forum is to promote the engagement of young doctors and medical students in the activities of the SLMA. Other objectives include improving soft life-skills among young doctors and medical students, promoting healthy living among doctors and public and further promoting environmental health and Conservation in Sri Lanka.

The membership of the Young Members' Forum is open to all the SLMA members who are less than 40 years of age. The committee comprises a chair, two convenors and twenty committee members, appointed for a period of one year. There will be regular meetings and various academic and social events for professionals and the general public.

We are happy to invite all the eligible SLMA members to join us!

Drop an email to office@slma.lk stating your desire to join.

Sankha Randenikumara
Chair
The SLMA Young Members' Forum

" Few members of the SLMA Young Members' Forum with the Editor-in-Chief of the newsletter"

Pandemic Woes

Nearly two years have so far gone
Yet end of the pandemic not in sight
To catch the virus many are still prone
Keeping it in check, an ongoing fight

How sad millions of lives already lost
And millions more suffering with fright
To people and nations, a terrible cost
End of the tunnel, hoping to see light

For children two years lost at school
Just idling at home, parents in distress
Only for a few, online learning a tool
To all concerned causing much stress

Working from home not an easy task
Sitting at the screen, straining the eye
With household chores, a hefty ask
Lost in darkness, awaiting a brighter sky

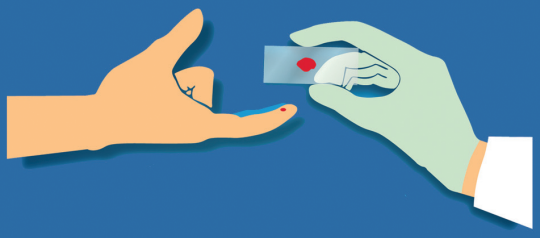
Mostly affected, the daily wage earner
With many hungry kids crying at home
Eagerly wishing for some relief sooner
Looking for charity in whatever form

Healthcare workers stretched to the limit
Hospital facilities getting over-burdened
Armed forces keenly fulfilling their remit
Let's hope their attitude is not hardened.

Vaccination is for longer term prevention
Public health precautions, immediate need
Deserving everyone's undivided attention
Well intended advice all should heed

It appears the response is bungled
No coordination, no firm strategy
Leaders confused, words fumbled
Some profiteering, it's a tragedy!

Dr. Sarath Gamini De Silva
Consultant Physician



Reduce the Delay in diagnosing imported Malaria

If a malaria patient is left untreated

- Risk of complications & death of the individual increases
- Could lead to re-introduction of malaria in Sri Lanka

Malaria should be suspected in all fever patients with a travel history to a malaria endemic country …..!!

Common causes for delay in diagnosis:

- Forgotten disease
- Atypical presentations
- Mimic other common febrile diseases with thrombocytopenia

Anti Malaria Campaign Headquarters
Public Health Complex, 3rd Floor, 555/5,
Elvitigala Mawatha, Colombo 05, Sri Lanka.

94 (112) 588947 | Director
94 (112) 369873 | Medical Officers
94 (112) 588408 | General Line
071 2841767 | Hotline
antimalariacampaignsl@gmail.com

Call 24/7 **HOTLINE** for free advice on prophylaxis, malaria prevention and notification of malaria suspects

011 7 626 626

www.malariacampaign.gov.lk

SLMA DOC CALL 247 – Professional Service Within Reach

Prof. Chandrika Wijeyaratne
MBBS, M.D. Internal Medicine, Doctor of Medicine (Colombo), FRCP
Vice Chancellor, University of Colombo
Senior Professor - Reproductive Medicine, Faculty of Medicine, Colombo.

A Personalized Care System "Twenty-four – Seven"

At a time when the exponential escalation of the COVID-19 pandemic and its variants were creating havoc in all parts of the country and thereby affecting families and communities while overwhelming the health system, it was very appropriate that groups of doctors met up professionally at the SLMA in their volunteer capacity to create this "247" service, which implies that a doctor is available "twenty-four hours a day, seven days a week".

This digital service, which connects up doctors to join hands and work as one team – as one family, can help identify red flag symptoms, identify and reassure those who can be managed at home and help those who should be admitted for hospital care. Furthermore, this service enables us to arrange and track ambulances as well as inform the visiting physician and other consultants receiving the patients upon necessity. This enables the medical community to provide a service with the best possible holistic care approach within the constraints of the prevailing national crisis.

A Rewarding Experience to Both Doctors and Patients

SLMA DOC CALL 247 is a free service dedicated to provide guidance and support to patients who are diagnosed or suspected of having COVID 19 infection.

By volunteering to this service, the doctors get the opportunity of relieving the distress of many helpless patients by just listening to their story or by providing correct information necessary for them to successfully get through the illness. In addition, during these calls, many lives are saved by identifying critical patients and guiding them to hospitals without delay.

I am happy to be a volunteer of this program. Trust me! Every call is a very unique experience.

Prof. Sudharshani Wasalathanthri
MBBS, PhD
Professor, Department of Physiology,
Faculty of Medicine, University of Colombo

Dr. Sarath Gamini De Silva
MBBS (Col), LRCP(Lon), MRCS(Eng), MD(Col), FRCP(Lon), FRACP(Hony.), FCCP
Consultant Physician, Colombo

A Fulfilling Service

By answering many 247 calls over the past few days, I realized that many people are aware of the recommended drugs and doses, but they actually needed medical guidance for clearing up the COVID related doubts and uncertainties causing much anxiety. This platform provides that opportunity of getting professional advice. Whole families falling ill with a pandemic illness that had caused many deaths worldwide has been a frightening experience bravely faced by our countrymen.

Through 247, I was able to help many people to find solutions for their genuine concerns as well as answer mundane questions related to daily living. I find this to be an extremely fulfilling experience for a doctor. This kind of service may be continued in a more organised manner even after the pandemic is over.

Keeping Afloat in a Sea of Traditional Medicine

Dr. Sarath Gamini De Silva
Consultant Physician

I have been a participant in the SLMA 247 COVID relief service for several weeks. The enormous relief provided to anxious individuals suffering from this dreaded disease, often several affected in the same household, managed at home often with no one else to seek help from, is admirable. The anguish of their families was palpable. The WhatsApp communications between the participant doctors has been an educational experience for me. Many, specially the younger doctors, appear to be surprised and annoyed that patients keep asking about bathing, drinking king coconut water, allergies to sour plantains etc, even in the 21st century! In fact I was surprised that a doctor said, I hope in jest, he has a notice displayed at his clinic asking patients not to ask about bathing. Yet another senior doctor admits to getting irritated and refusing to answer questions about such mundane matters. These instances expose a significant lack of knowledge about the cultural landscape of the society we are practising in. In this article the terms native, traditional and Ayurveda have been used with similar meaning as much as Western and allopathic mean the same.

Before allopathic medicine was introduced during colonial times, Sri Lankans over many generations have been well served by native physicians of all kinds for thousands of years. These practitioners did not have any formal training, inheriting the art from their ancestors by word of mouth or through Ola leaf manuscripts. The latter were considered family treasures passed on from father to son. All diseases were attributed to disturbances in gases (*vathaya*), bile (*pitha*) and phlegm (*sema*). Various items of food, habits of daily living like bathing and changes in the weather were blamed for such disturbances. Obviously bacteria, viruses and other pathogens were unknown entities then.

No wonder there was no research or new ways of treatment introduced from time to time as we are used to seeing in allopathic medicine nowadays. On the other hand probably the disease pattern too was fairly uniform and static as there were no drastic changes in the lifestyle or environment over the years. With a down to earth lifestyle, consuming unprocessed fresh food, mostly vegetarian, and physical work from dawn to dusk, "modern diseases" like vascular disorders must have been quite uncommon. There was the practically convenient acceptance that the remedy is generally found in the same locality as the malady, leading to the use of material of plant origin as the basis of medication. In history we hear of people dying of snake bites, consuming poisonous foods, at child birth or with wounds in battle and the like. There are hardly any historical accounts of people collapsing with chest pain, paralysis or sudden loss of consciousness. For whatever reason, the average lifespan was relatively low.

Even with the increasing popularity and positive outcomes of allopathic medicine, with new diseases being identified and new medications and other methods of treatment being introduced after extensive research, native or traditional medicine thrives to this day. The older generation still believes in their positive effects much more than Western medicine which many consider as foreign. Various decoctions (*kasayas*), local applications (oils and *paththus*), and rituals like thovils are still in vogue, wide spread in the society. When considering the laborious efforts needed in their preparation and application, compared to the ease of swallowing a ready-made allopathic pill or syrup, the faith people have in them becomes evident.

In our own childhood most of us would have swallowed gallons of coriander and various *kalkas* and *gulis* for respiratory and other illnesses. During school holidays we had a dose of *aralu* to induce a profuse diarrhea, which was supposed to cleanse the bowels. Every time the body temperature went up the first step was to stop taking solid food, even in the absence of bowel disturbances. Such starvation meant that on recovery it took a further few days to get the energy back and return to school or work. All medicinal products and other rituals are given credit for recovery from an illness which was self limiting anyway. In general bathing was discouraged after dusk or for several days after recovery from an illness, and we did not drink king coconut water or cooled fluids after bathing. So many food items like tomatoes, pumpkin, sour (*ambul*) plantains, eggs and milk were taboo for fear of causing certain disorders.

Having studied the sciences and being trained in allopathic medicine, we may be inclined to ridicule and discard all these be-

liefs and practices as irrational. Many of these treatment modalities may not stand up to scientific assessment we rely on now. But it is well established that many illnesses have a psycho-somatic basis and the trust one has on a treatment procedure will help in achieving a cure to a great extent. Native medicine has the advantage of the faith patriotic people have as one of their own which has come down many generations. They make the somewhat sensible argument that we have survived many illnesses long before Western medicine was introduced, notwithstanding the fact that many of the modern day diseases were probably nonexistent or not recognised then. Many still believe that allopathic medicine will temporarily suppress chronic illnesses like polyarthritis while traditional medicine may achieve a permanent cure. It remains popular in the treatment of strokes and fractures despite the resulting deformities and disabilities seen often. Many Western countries, birth place of allopathy, themselves have their own flourishing systems of traditional medicine. It is well known that among others, many Germans visit Sri Lanka in considerable numbers seeking Ayurvedic treatment, and Sri Lankan owned businesses dealing with Ayurveda and other forms of traditional medicine are flourishing in Western countries.

It is an interesting phenomenon that people tend to turn more towards traditional medicine as they are getting increasingly disillusioned with all that is modern. This is despite allopathic medicine advancing in leaps and bounds with inventions and innovations. This was amply illustrated recently when thousands of people queued up to obtain a decoction of dubious origins for COVID, an infection hitherto unknown to Western medicine let alone to native practitioners. The fact that a group of doctors and other healthcare workers from a leading Teaching Hospital in the forefront of treating COVID patients sent an emissary to buy a large quantity of the decoction for their personal use exemplifies the depth of this reality. State sponsorship of such products complicates the matter further.

Yet another issue is the heavily promoted herbal medicines and nutraceuticals. These are not subjected to stringent regulatory procedures that apply to authentic Western drugs. Being combinations of multiple herbs, it is doubtful whether there is any standardization done about their composition. Unfortunately doctors get information about these formulations only from the sales representatives promoting them. They are highly priced as well. It should be kept in mind that it is a punishable offence for doctors registered with the Sri Lanka Medical Council to prescribe drugs of other systems of medicine which they are not trained in.

Very often the patients request clarification whether they can use traditional medicine along with drugs the doctor has prescribed. My practice is to allow any external applications like oils, paththus, massages etc that may give symptomatic relief. I stress that it is the physiotherapy that goes with such therapies that is more important. I discourage swallowing of any other medicines, apart from well established substances like coriander, explaining the possibility of drug interaction. To dismiss the traditional medicine altogether will not be to the satisfaction of the patient. One should note the value of complementary medicine when several systems of medicine are prevalent in the society simultaneously.

It is well known that large numbers of practitioners of traditional medicine prescribe allopathic drugs, especially antibiotics. Sri Lankans celebrated for their high literacy swallow such medicine without any hesitation. This is beyond our control in the apparent absence of any legal provisions to undertake punitive action. It appears that the Ayurvedic Medical Council is not interested or is powerless to rectify the situation. I subtly indicate to the patient that this practice is not acceptable. There were a few instances where patients believed that probably such offenders are trained in both systems! Such is the level of ignorance we have to contend with.

It is important for the present generation of doctors trained in allopathic medicine to realise that they have to ***keep afloat in a sea of traditional medicine***. The situation may be experienced more by those practising in semi-urban or rural areas where there is more faith prevalent among the people in other systems of medicine and rituals, and where practitioners of such abound. When patients seek clarification based on traditional beliefs, they deserve a patient hearing. Obviously one should try and explain the true facts without any sense of sarcasm or ridicule, gently addressing the various misconceptions. Some knowledge in humanities as imparted to the students in the Colombo Medical School will help in this respect.

For further information please see my article; ***"Native Medicine and its Relevance Today"***, in the SLMA Newsletter of February 2021 or Pg 86-90 in my book "*Essays on Random Topics; the Common Sense of a Physician*".

Preserving repatriated Wanniya-Laeto Remains from the University of Edinburgh at Dambana- Mahiyanganaya

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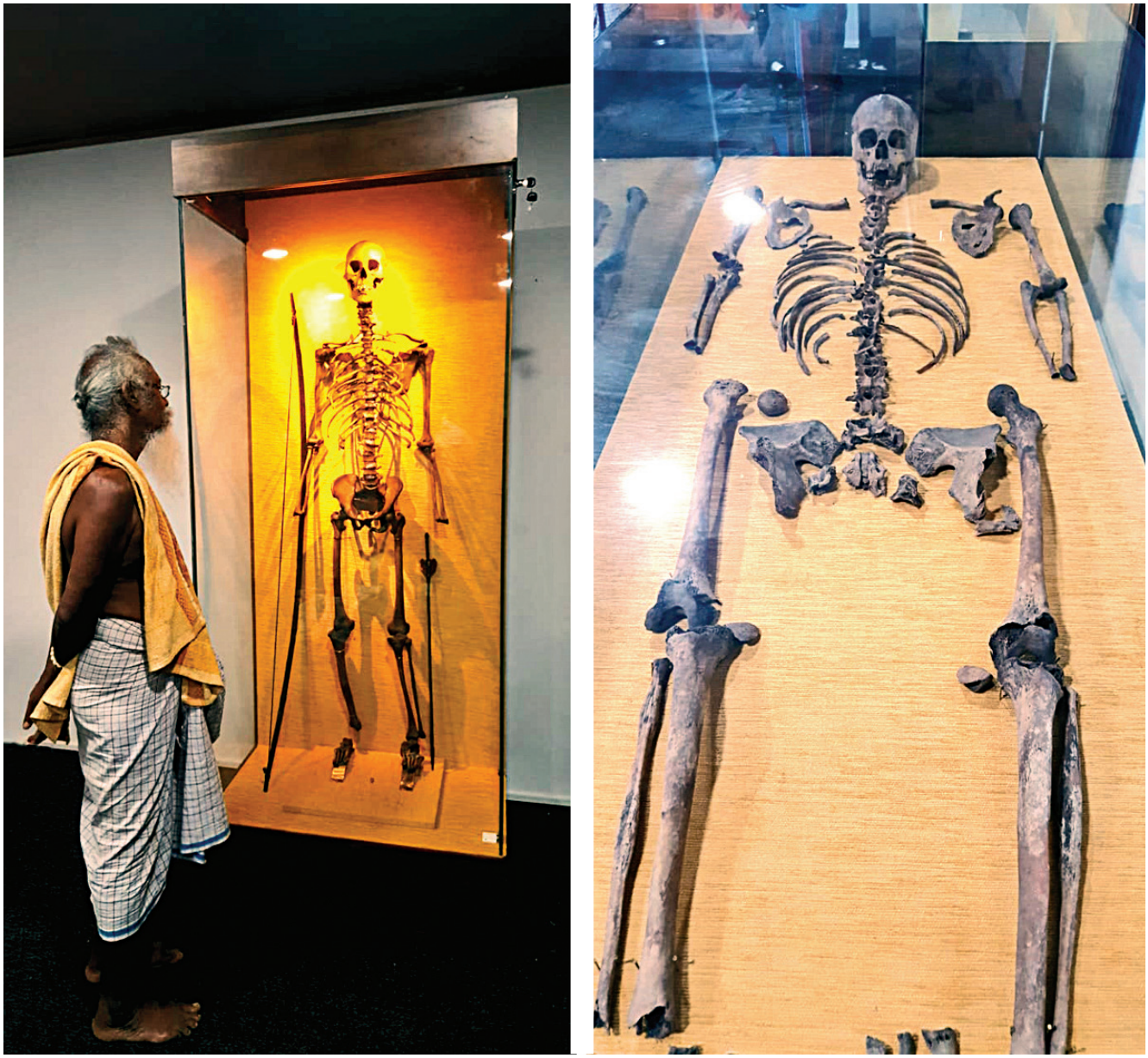
Uruwaruge Wainnya-laeto
Wariga Maha Gedara, Kotabakina Dambana

1. Preserving the remains of Wanniya-Laeto repatriated from the University of Edinburgh-UK: Now kept in Dambana-Mahiyanganaya-Sri Lanka
2. Repatriation of Wanniya-Laeto from The University of Edinburgh-UK to Dambana- Mahiyanganaya-Sri Lanka
3. From Edinburgh-UK to Dambana- Mahiyanganaya-Sri Lanka: preservation of repatriated Wanniya-Laeto
4. Wanniya-Laeto repatriated from Edinburgh-UK to Dambana-Mahiyanganaya-Sri Lanka: Assembled and Preserved

Uruwaruge Heenbanda
Wariga Maha Gedara, Kotabakina Dambana

The 'Veddas' or Wanniya-Laeto are Sri Lanka's Indigenous inhabitants, whose language is commonly referred to as 'Vedda' (Seligmann and Seligmann, 1911). The Wainnya-Laeto inhabited Sri Lanka prior to the arrival of Sinhala and Tamil-speaking populations (Seligmann and Seligmann, 1911) and have even been proposed as having an affinity to the earliest 'Microlithic' human settlers of the island who arrived during the Late Pleistocene (Deraniyagala, 1998).

The term 'Vedda' comes from the Tamil word for hunting and the Wanniya-Laeto take pride in



Uruwaruge Wainnya-Laeto observes the assembled full skeletons *(Figure 02)*

their traditional forest foraging lifestyle (M.W. De Silva Sugathapala, 1972, C.R. De Silva, 1990; Bandaranayake, 1985). In the 19th and 20th centuries, Wanniya-Laeto communities were recorded as being widespread across the Wet and Intermediate rainforests of the islands, as well as in the Dry Zone (Seligmann and Seligmann, 1911; Knox, 1981), and several Wanniya-Laeto communities still retain their traditional knowledge and culture in Sri Lanka today.

A series of skeletons of Wanniya-Laeto (labelled 'Veddah') remains, which were taken from Sri Lanka during the British colonial period, had been stored in the University of Edinburgh's anatomical collection for more than 100 years. According to the request made by Uruwaruge Wanniya-Laeto, the skeletal remains have now been repatriated following a unique research collaboration between the Wanniya-Laeto , the Max Planck Institute for the Science of Human History, and the Anatomy Department at the University of Edinburgh.

On 22nd November 2019, the University of Edinburgh safely returned the skeletal remains, which are more than 200 years old, to the rightful custody of the Wanniya-Laeto community of Dambana at the Playfair Library, University of Edinburgh.

This was initiated by Dr. Oshan Wedage, Senior Lecturer, Department of Archaeology, Faculty of Humanities and Social Sciences, University of Sri Jayewardenepura (USJ) and Dr. Patrick Roberts of the Max Planck Institute of the Science of Human History (MPI-SHH). There were nine skulls, two of which were also part of near complete skeletons. These human remains were safely brought to Sri Lanka in November 2019.

The Department of Archaeology, Ministry of Cultural Affairs of Sri Lanka made a request to the Department of Anatomy, Faculty of Medical Sciences, USJ to as-

Senior Prof S.G Yasewardene, Dr. Sajith Edirisinghe, and Dr. Oshan Wedage with Uruwaruge Wainnya-Laeto after assembling the skeletons *(Figure 03)*

semble and preserve these skeletons.

As a response to the national request, Senior Prof S.G Yasewardene, Chair and Professor of Anatomy, Department of Anatomy, and Dr. Sajith Edirisinghe, Lecturer and Clinical Geneticist, Department of Anatomy representing Faculty of Medical Science, USJ visited the cultural heritage museum in Dambana village- Wariga Maha Gedara (වරිග මහගෙදර), Mahiyanganaya on 4th and 5th August 2021 to help preserve the skeletons for future generations.

The skeletons were preserved in glass cabinets without causing any damage to the bones using special techniques of bone articulation. The bones were kept in a separate room especially designed with air conditioning facilities at Wariga Maha Gedara museum to minimise the atmospheric humidity surrounding them.

The main objective of preserving these ancient skulls and skeletons is to protect them for future generations as part of an exhibition highlighting the culture of the Wanniya-Laeto and the impacts of colonialism on these societies.

Their preservation also offers the possibility for potential future molecular biology research, including DNA studies and sequencing to understand the lineage of modern humans and reveal the deep history of inequality among different populations and among individuals within a population. However, it is important to note that the future of the human remains, and their display or burial, is completely in the hands of the Wanniya-Laeto Traditional Elders and their decision-making bodies. The museum section of the preserved skeletons was ceremonially opened for public display at Wariga Maha Gedara, Mahiyanganaya on 9th August 2021, with the International Day of the World's Indigenous Peoples celebration. These skeletal remains could help to develop and provide new lines of evidence for investigating Sri Lanka's indigenous inhabitants in the future, while also providing a permanent memorial to their cultural heritage.

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That Fateful Day

The article "Recalling that narrow escape" of the Parliament terrorist grenade attack of '87, published in the Sunday Times of 15th August 2021 prompted me to write my own personal recollection of details of that fateful day…

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Eighteenth of August 1987 began like any other Tuesday, when I provided Anaesthesia for a busy surgical list for Dr Yoheswaran in theatre five at the Sri Jayawardanepura General Hospital. We had come to the end of the second case - a vesicolithotomy (removal of a bladder stone) - and just as we walked into the corridor within the theatre complex, an announcement was made over the PA system "Dr Yoheswaran please come to the ETU immediately". Yoga remarked "That's a strange request – I wonder what it's all about?" I opined perhaps a VIP patient must have come to the ETU to see him. We continued to walk toward the theatre door when the announcement was repeated. Yoga asked "Should I change out of my theatre clothes?" and Dr Kenneth Perera who was there said "Just go as you are and see what they want." Yoga walked out of the theatre sliding doors and entered the lift just outside to go to the ground floor.

Barely minutes after Yoga left, I got an irresistible urge to run down to the ETU. I felt that someone needed me desperately – call this compulsive feeling: Extra Sensory Perception, Thought Transference, or what you like. Being a Christian I believe that it was Divine Direction. I ran out in my theatre scrubs and shoes, without even putting on my white coat or changing my theatre shoes, a thing I would do only when summoned for a Cardiac Arrest. I remember running down the single flight of stairs without waiting to summon the lift, running as fast as I could pushing at least three people bodily out of my way. I had a hazy impression of surprised faces as I rushed past them down the stairs, past the Physiotherapy Department, Corridor, Out Patient Department, and through the swing doors of the Emergency Treatment Unit.

I came to a halt near a trolley around which several people were standing apparently frozen into immobility with shock. I saw a well-built figure in blood-spattered white clothes, lying semi-prone on the left lateral side with his right arm hanging over the side of the trolley. I instinctively reached for the hand and groped for the radial pulse – it was imperceptible. When I looked down at the figure lying so still, taking an occasional gasping breath, and a glazed look in his eyes, to my shock I recognised it was Lalith Athulathmudali. I felt as if I had been hit in my solar plexus. My first thought was that it was my husband Mahendra Amarasekera's beloved "Sir" (Lalith had been his Lecturer in Jurisprudence in Law College, and he had moved closely with him ever since)

I said "quick get me a cannula", and grabbed a green Venflon cannula that was being held by an E.T.U. doctor, and inserted into a vein at the back of the right hand. The circulation was so poor that there was no "flush back" to indicate that I was actually in the vein, but I knew I was in – I couldn't afford to miss! I connected a normal saline drip to the cannula and opened it fully.

I realized that it was not good enough and asked for a "Haemacel" – a blood substitute and started squeezing the plastic bottle with both hands so that the fluid was literally pouring into the vein. When about half the bottle was transfused, I could feel the pulse coming back – thready at first, and then stronger - what a relief! I looked up at Dr Rangith Attapattu who was standing there and said "It's alright now Sir". I started another drip on the left arm and sent blood for cross-matching. The blood pressure was only 80mm Hg at first, but soon came up to 90mm Hg.

Yoga did a quick assessment of the injuries. There were shrapnel wounds on both legs, back of chest and buttocks, and an alarming entry wound just below the left nipple. We were relieved to confirm that it was not a penetrating chest injury on examination. It was also a relief to see clear urine on catheterization, indicating that the

kidneys were functioning and not damaged.

Suddenly Lalith opened his eyes and asked me "What is my pressure? Is it low?" and I replied "It's a little low Sir but not bad" Then he said "I normally have low pressure ask my GP she will tell you" When I asked him if he could remember the actual value he said "about 60". I told him that he must be thinking of his pulse rate and not blood pressure. I asked him if he knows his blood group and he replied "The common one". A Blood Bank doctor rushed up with a bag of blood. I asked if it had been cross-matched and when she said "no" I said, "please do an emergency cross-match and bring it, I don't want to take the risk of giving uncross-matched blood, I can hold his pressure till then".

Yoga was puzzled by the initial state of collapse. He concluded that it was "neurogenic shock" as there was no evidence of any internal bleeding at this stage... Kenneth came down from the theatre and he gave some Morphine Intravenously. We then started wheeling the trolley out of the ETU Lalith asked "Where are you taking me taking me?" and I replied, "First to the X-Ray department and then to the Intensive Care Unit for observation". Once the Minster was lifted onto the X-Ray table everybody hastily left the room before the films were taken. I stayed back as I did not want to leave him alone when his condition was far from being stable. I said "I don't think you can remember me, Sir, I'm..." before I could complete the sentence he smiled and said "I know, you are Mahendra's wife" I was rather surprised as I had only met him twice before the last occasion being two years ago, at Mahendra's induction as the President of the Rotary Club of Mt Lavinia- at the Mt Lavinia Hotel, when the Minister was the Chief Guest.

He was rather concerned about an injury to his left thumb, so I got them to take an X-Ray of his left hand as well. It was only later that I learned that Lalith was left-handed. One pint of blood had been cross-matched by now and brought to the X-ray room, and I started the transfusion.

We took him to the I.C.U. and Yoga assisted by nurses from the theatre started cleaning and dressing the wounds. Lalith said that his chest was hurting and I assured him that there was no injury to his heart and that any pain he was feeling was due to a superficial shrapnel wound. He then said, "I feel rather sleepy – can I close my eyes?" I told him that had been given some Morphine and that's why he is feeling sleepy. I said "Go ahead and sleep – we will look after you" No grumble or moan escaped his lips though he must have been in pain – particularly when the wounds were being cleaned and dressed.

We got the X-Ray films and to our horror, we noticed several shrapnel that had obviously penetrated the abdomen. There was one that was near the 1st Lumbar vertebra, dangerously close to the Aorta. The blood pressure, which had been steady between 90–100mmHg, started dropping. Yoga examined Lalith's abdomen repeatedly. At first, the Minister said had no pain only discomfort, a little later he admitted that he felt pain. Yoga was able to elicit "rebound tenderness" which is evidence of peritoneal irritation. The blood pressure had fallen to 80mm Hg by now. Yoga asked Dr Premarartne another surgeon at SJGH to examine the Minister and give his opinion. He agreed with

Surgery in progress (Dr Yoheswaran in the foreground)

Yoga's findings. Despite differing opinions expressed by others present (wait and see) Yoga made the correct decision to proceed to do a laparotomy. He explained it to Lalith who showed no fear at all. He asked "You have to open me? go ahead" Then he asked, "Will you do it under Local or General Anaesthesia?" I explained to him that we have to give him a General Anaesthetic. I said "It's better for you to be asleep during the operation Sir"

Suddenly his wife Srimani was there. She stayed quietly by Lalith's side, not getting in the way, outwardly calm, though she must have been so distraught, as indeed we all were. We took Lalith to the Operating Theatre and having lifted him onto the table connected him to the monitors and started inducing anaesthesia. Kenneth injected "Pentothal" through one of the cannulae while I held an oxygen mask over Lalith's face. As the anaesthetic began to take effect, Lalith slowly drifted off to sleep. I secured his airway and connected him to the anaesthetic ventilator.

Yoga began the surgery and when he opened the abdomen there was a total of 4000 ml of blood in the peritoneal cavity. Yoga and Premaratne first removed the ruptured spleen that was bleeding briskly.

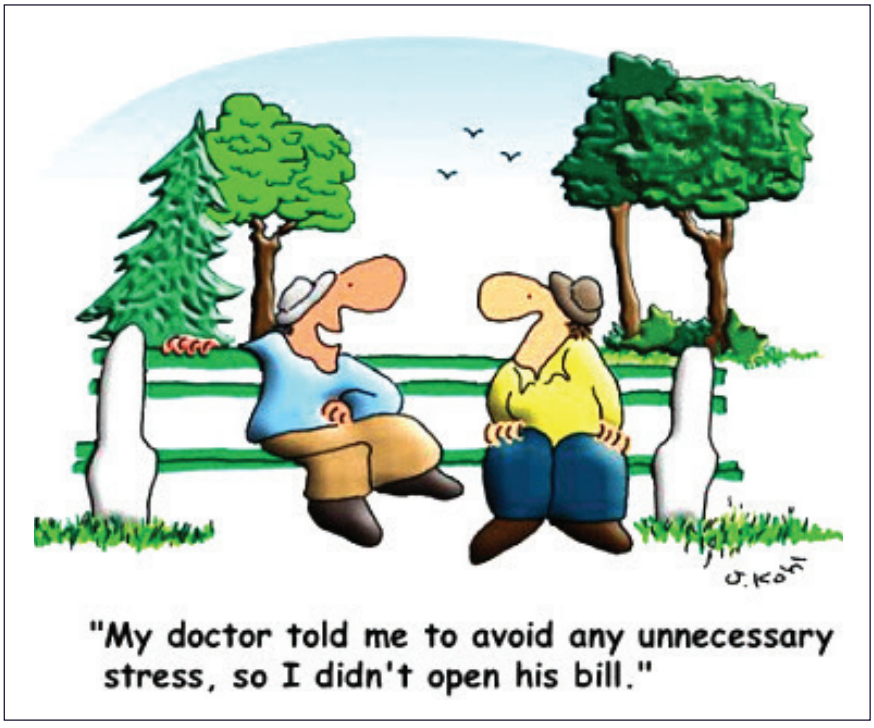
Then they proceeded to look carefully for less obvious but equally life-threatening injuries. There were several perforations of the bowel which were meticulously sutured by Yoga. He found a haematoma near the pancreas, which after much deliberation, decided to leave alone. Finally the difficult but correct decision to perform a "temporary de-functioning colostomy". The whole procedure took 4 ½ hours and we had to transfuse 11 pints of blood in all. Though we did have a few anxious moments, Lalith's condition remained remarkably steady throughout the procedure. Once the surgery was over we took him back to the I.C.U.

The time was about 4.00 p.m. One by one the others left – but I did not want to leave. I know only too well the problems that could follow major surgery and massive transfusion. I took a blood sample and sent it to the lab to check the clotting profile. My fears were justified when I saw the reports. The Haematologist and I got down "Fresh Frozen Plasma" and "Platelet Concentrate" urgently from the Central Blood Bank in Colombo to counteract the effects of the massive transfusion.

I was still standing by the bed with Srimani when Lalith opened his eyes and asked "Was it worth it?" and I replied with a heartfelt "Yes Sir"– had we not opened him up, or even delayed the operation, the result would have been disastrous. Then he asked "How are the other injured? Am I the worst injured?" I saw Lalith's Chief of Security Muthubanda making frantic negative signals, conveying to us not to say anything about Keerthi Abeywickrama who was killed in the blast. Srimani said, "The others are alright, Percy Samaraweera is also here, he also had an operation." I was touched by Lalith's concern for others in spite of being mortally wounded himself. He slowly drifted back to sleep again.

I arranged for a hospital vehicle to bring Yoga back for a night round, and left specific instructions with the SHO Anaesthesia on duty to call me at the slightest change in Laliths's condition and then drove home. It was pitch dark and pouring with rain. I was rather nervous driving alone and was relieved when Srimani instructed Lalith's Security to escort me.

I got home at about 8.00 p.m. mentally, physically, and emotionally exhausted. I tried to eat but had no appetite, though I had not eaten anything the whole day. I tried to sleep, but sleep evaded me. I stayed awake for hours – my whole being lifted up in earnest prayer for Lalith, asking God to heal him. We had done our utmost, - all that was humanly possible. But healing comes from God. And thank God that my prayers and that of many thousands of others were answered, that fateful day.



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THE PALACE
LIFESTYLE RESIDENCIES

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