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SLMA President

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

Behavioural imprudence and the reputation of the noble profession

"Medicine is a sacred calling and he who makes it ridiculous is guilty of sacrilege" **– Sodhoff**

Quoted from the Guidelines on Ethical Conduct for Medical & Dental Practitioners Registered with the Sri Lanka Medical Council-July 2009

During the most recent times of life inside the Paradise Isle, the statement given above would have reminded you of quite a few who tarnish the good image of the medical profession even without feeling guilty about it, or for that matter, even caring a tuppence about it. The latest talk of the town is about a doctor who was arrested for sexual abuse of a child. I have no intention of discussing anything pertaining to that disgusting case, which is now a legal matter.

Sexual offences by doctors are reported from time to time. Such news items draw the attention of the general public and are often highlighted, and even sensationalised, in the media. In such instances, not only the alleged doctor but the entire profession face much embarrassment in front of society, at the hospital, and even in their own homes.

Medical ethics very specifically and pointedly prohibit sexual relationships with patients and their family members. Sri Lanka Medical Council (SLMC) categorizes such relationships as acts of serious professional misconduct. The SLMC's ethics guideline states that **"The public reputation of the medical profession requires that every member observes proper standards of personal behaviour, not only in professional activities but at all times.**

This is the reason why a doctor convicted of a criminal offence will have to face disciplinary proceedings even if the offence is not directly connected with the profession." SLMC ethics guideline draws attention to the doctors in three areas of personal behaviour that can lead to disciplinary proceedings. They include personal misuse or abuse of alcohol or other drugs, dishonesty (in particular improper financial transactions), and indecency (eg: violence).

A doctor has always been considered to be a 'role model' in society. Even 'The Hippocratic Oath', in its last section, emphasises on living an exemplary personal and professional life. R. L. Stevenson, a Scottish novelist, essayist, poet, and travel writer (1850-1894) has stated that "The physician is the flower of our civilization". When talking about medical ethics and etiquette, in an article published in the 'Journal of the Ceylon Branch of the British Medical Association' in 1948 (currently 'CMJ' of the 'SLMA'), Dr. E. M. Wijerama, who donated his magnificent house to the SLMA, had stated that **"everyone, on entering the profession incurs an obligation to uphold dignity and honour.** The practitioner should guard against whatever may injure the respectability of the profession."

Given the level of competition in the education system in Sri Lanka, it is very hard to secure a place to study medicine. Becoming a specialist is even harder. One has to spend over a decade-long period of their life to achieve these targets.

The miscreants of the profession who bring the very profession into disrepute for an unwholesome and unholy cause such as carnal desires will be deemed to suffer intense embarrassment, monetary losses, imprisonment, and erasure of registration to practice medicine, etc. But the worst part is the pain and the disgrace that one will cause the parents, families, and most especially children, to suffer as a result of such misdemeanours.

All of them have made enormous sacrifices for 'the doctor' to realise his/her dreams. Unfortunately, families of doctors never get the comfort they would even have dreamt of because of the commitments involved in the medical profession. Hence they do, at least, deserve not to get harmed.

The Sri Lanka Medical Council, though restricted by limited resources, should take a stricter stand on the various complaints against doctors. The medical ordinance gives only a limited range of power to the SLMC against errant doctors. In this regard, extensive amendments to the medical ordinance are long overdue. It is in the long-term interests of the entire profession that wrongdoers are dealt with adequately and expeditiously.

"Do not do anything today, that you know you will regret tomorrow, think before you act".

– Rashida Rowe

It could leave you with a lifetime of pain and regret !!

Editor-in-Chief
Professor Hasini Banneheke

President's Message

Dear Colleagues,

I am glad that I am writing this message at a time the Government of Sri Lanka has taken steps to relax many of its travel restrictions as well as authorization of much-awaited activities by the general public such as wedding receptions, attending religious places, and conferences, etc. While promoting engagement involving economic activities, the Government has well appreciated the benefits of an expedited vaccination programme during this period where we see some reduction of admissions to hospitals and has already commenced vaccination of public at an unprecedented pace using military personnel in the main.

Furthermore, previously ordered stocks of all varieties of vaccines, including Sinopharm, AstraZeneca, Pfizer, Sputnik V, and even Moderna have started arriving. While being quiet, the virus appears to be taking its own time and pace for transmission, and the health care professionals, with the knowledge that there could be another surge at any moment in the near future, try to compete with the virus by vaccinating as much of the population as possible.

In this context, it is important that we understand the reality that the COVID -19 outbreak is far from over and that out of many factors that would determine whether we will face another surge, the irresponsible and careless behaviour of the public with regard to public health measures, including failure to wear masks and avoiding gatherings, are likely to be equally and perhaps the most relevant considerations at the present time.

As a responsible professional organization, it is also important that the SLMA pays attention to the unprecedented disturbance in the schooling of children for nearly 2 years as well as the university students, incurred by the COVID-19 outbreak. There are many research studies published over the last two years confirming that children learn vastly less with remote learning than they do in-person at schools.

In addition to learning the subject matter, interpersonal relationships are essential for personality development and teamwork for children, which are crucial for the future development of our youth. As a measure to support the efforts taken by the Ministry of Education to commence schools early, SLMA organized the Webinar in July 2021 on "Vaccination of Children Against COVID-19" with the participation of a Consultant Paediatrician, Secretary to the Ministry of Education, and a WHO expert on immunization and vaccines. The webinar was well attended by many interested parties.

During my President's Address in early 2021 titled "A drop out of the ocean of medical rehabilitation", I emphasized the need to improve many aspects of medical rehabilitation in Sri Lanka. As a foundation to conduct activities in relation to medical rehabilitation, I initiated the SLMA Expert Committee on Medical Rehabilitation in 2020. To emphasize the need to promote multidisciplinary team care, I selected "Professional Excellence Towards Holistic Healthcare" as the theme for all activities of the SLMA 2021. Over the course of the year, the SLMA was able to conduct many activities to strengthen knowledge and practices in relation to medical rehabilitation. After the Anniversary International Medical Congress the highlight of the year would be the conference on medical rehabilitation that will be held over two days from 29th July 2021 at the N D W Lionel Memorial Auditorium, Wijerama House, Wijerama Mawatha, Colombo 7. I invite all medical practitioners, nurses, allied health professionals, social service officers, and others with interest in rehabilitation to join the conference that will be held as a hybrid event.

Thank you and please do take all precautions to continue to stay safe.

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

COVID related activities during June – July 2021

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

2nd & 10th June

A letter was sent to HE President to continue with the lockdown measures for 2 more weeks beyond 14th June, as the case numbers were not seen to be decreasing, even with the current lockdown measures.

7th June

A letter was sent to Hon. Ms. Pavithra Vanniarachchi, Minister of Health requesting to provide COVID vaccines through the clinics to persons below 60 years with comorbidities as they regularly visited the relevant medical clinics in all hospitals around the country.

A media briefing was held at the SLMA Auditorium to discuss the current COVID-19 situation and community empowerment.

The resource persons at this briefing were Dr. Padma Gunaratne, President – SLMA, Dr. Manilka Sumanathilake, Vice President SLMA & Dr. Upul Dissananyake, Consultant Physician. NHSL, Colombo.

10th & 18th June

Meetings of the SLMA COVID committee were held to discuss on the issue related to the COVID-19 situation and the way forward.

19th June

A letter was sent to HE President on the measures to be taken when lifting the countrywide curfew on 21st June

22nd June

An exit strategy to lift mobility restrictions implemented to curb COVID-19 in Sri Lanka prepared by the SLMA & SMIC, with technical support from College of Community Physicians was handed over to Dr. Asela Gunawardena – DGHS, MoH, Dr. Sunil de Alwis, Additional Secretary, MoH & Dr. Samitha Ginige, Chief Epidemiologist. This was also shared with HE President, Minister of Health, Head COVID center & Secretary, MoH. SLMA President and many council members participated as resource persons on electronic media and also provided input for print media.

Activities in June and July 2021 at a Glance

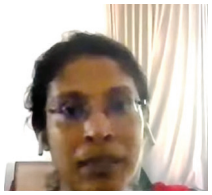
7th June

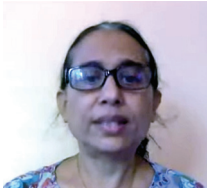
On behalf of the SLMA, Dr. Sajith attended the "Nugasevana" Programme on Rupavahini TV and discussed the hazards of plastics in the environment

11th June

A therapeutic update on 'COVID-19' was organized by the SLMA Expert Committee on Medicinal Drugs. Dr. Harsha Sathischandra, Specialist in Internal Medicine, NHSL spoke on 'Therapeutics for COVID' and Professor Neelika Malavige, Professor at the Department of Immunology & Molecular Medicine, University of Sri Jayawardenapura on 'Vaccines in COVID-19'.

It was attended by more than 600 persons who had so many questions to be clarified by the expert resource panel.



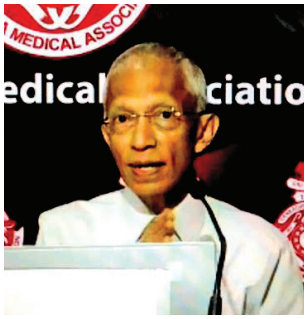
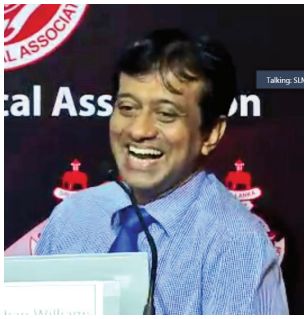
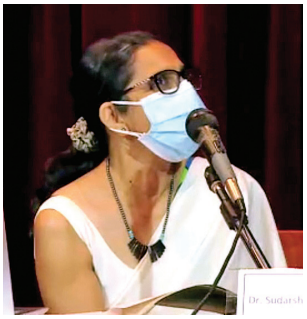


12th June

The tenth SLMA Saturday Talk on 'Antepartum Haemorrhage' was conducted by Professor Rasika Herath, Consultant Obstetrician & Gynaecologist & Professor in Obstetrics & Gynaecology, University of Kelaniya.

More than 900 students participated.

12th June – On behalf of SLMA, Dr. Sajith Wickramasingha attended Sirasa TV channel and discuss the hazards of plastics in the environment.


14th June

The first Pre-Congress session was held on 'Work-Life Balance for Doctors – Reclaiming of Control'. The resource persons at this seminar were Dr. Dulangi Dahanayake, Consultant Psychiatrist, NHSL, Colombo who spoke on 'Doctors as Parents: A Balancing Act', Professor Diyanath Samarasinghe, Consultant Psychiatrist on 'How the Profession can help us balance work & life issue', Professor Shehan Williams, Consultant Psychiatrist, NHSL, Colombo on 'Aging Wisely: How to mind your brain' & Professor Piyanjali Soyza, Clinical Psychologist, NHSL, Colombo on 'Identifying & Handling your emotions: mindfulness-based approach'.

Around 200 persons joined online.



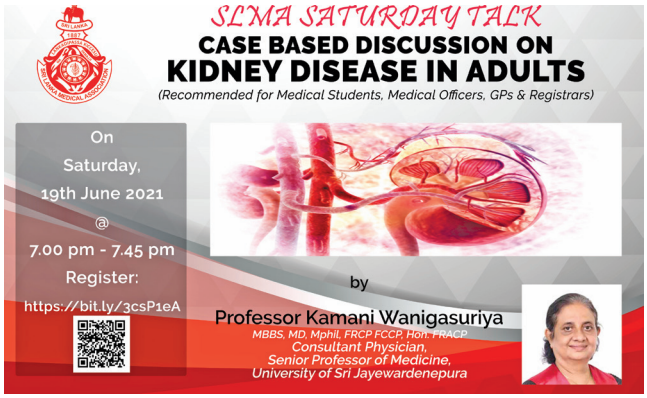

16th June

A letter was forwarded to Hon. Mahinda Rajapakse, Prime Minister and Finance Minister by Dr. Padma Gunaratne – President SLMA and Professor Narada Wanasurinya – Chairman, SLMA Expert Committee on Tobacco, Alcohol & Illicit Drugs requesting to stop the online sale of liquor. A similar letter was sent to General Shavendra Silva, Head, National Operations Centre for Prevention of COVID-19 Outbreak (NOCPCO). The SLMA letter opposing the online sale was given wide publicity and as a result the decision to allow online sale of alcohol was withdrawn by the Ministry of Finance.

17th June

The SLMA Expert Committee on Rehabilitation organized a webinar on 'New Frontiers on Health: Healthy Ageing' by Professor Nathan Vytialingam, Dean School of Occupational Therapy, Perdana University, Malaysia.

A lively discussion followed the lecture which was attended by more than 100 participants.



19th June

The eleventh SLMA Saturday Talk on 'Kidney Disease in Adults' was done by Professor Kamini Wanigasuriya, Consultant Physician & Senior Professor of Medicine, University of Sri Jayewardenepura.

Around 1000 students attended the case discussion.

23rd June

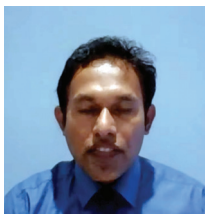
The Proposed Exit Strategy for the 'Lockdown of the COVID-19 Third Wave in Sri Lanka' prepared by the SLMA and Intercollegiate Committee in collaboration with the College of Community Physicians of Sri Lanka was presented to Dr. Asela Gunawardana, Director General of Health Services, Dr. Samitha Ginige, Chief Epidemiologist, MoH and to Dr. Sunil De Alwis, Additional Secretary, MoH.

26th June

The twelfth SLMA Saturday Talk on 'Peripheral Vascular Disease' was done by Dr. Rezni Cassim, Consultant Vascular & Transplant Surgeon & Senior Lecturer, University of Colombo.

The session was attended by more than 1000 students.

30th June

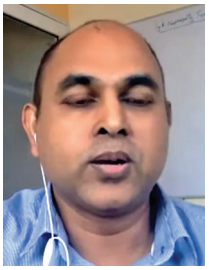


The second Pre Congress Workshop was held on 'Five minutes assessment & interventional inputs for patients with alcohol, tobacco, cannabis, non-prescribed medications & other psychoactive substances'.

It was conducted as an interactive session with maximum audience engagement.

The resource persons were Dr. Mahesh Rajasuriya, Dr. Jayamal de Silva, Dr. Dhanuja Mahesh, Dr. Manoj Fernando, Dr. Medhani Hewagama & Dr. Prasangika Seneviratne.

2nd July



A therapeutic update on 'Acute Kidney Injury' was organized by the SLMA Expert Committee on Medicinal Drugs.

Professor Eranga Wijewickrma, Consultant Nephrologist and Professor in Clinical Medicine, University of Colombo was the resource person.

More than 200 persons participated in the session.

Achieve Weight Management Goals to Improve Liver Health*

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

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

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

VLCD Intervention 1 – 8 Week
3 OPTIFAST MEALS

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

Weight Maintenance 13 – 32 Week
Food Based Diet

• Mean Weight Loss – 10.3kg

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

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

OTHER BENEFITS

LIVER HEALTH

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

METABOLIC CONTROL

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

CARDIOVASCULAR HEALTH

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

QUALITY OF LIFE

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

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

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Minding your plate to get protected from COVID-19

Dr.Renuka Jayatissa
Head, Department of Nutrition
Medical Research Institute
Ministry of Health, Colombo
&
Dr.Malika Udagedara
Registrar, Clinical Nutrition
National Hospital, Sri Lanka

Proper nutrition and hydration are vital part of life. People who eat healthier and consume well balanced diet tend to have strong immune system and reduced risk of chronic disease and infectious diseases. Currently there is no evidence to support that a specific food or nutrient provides protection against Covid-19.

But eating a well balanced diet will fulfill the requirements of vitamin, mineral, dietary fibre, protein and antioxidants of the body. Anti-oxidants and immuno-nutrients are crucial for strengthening defense mechanisms against tissue damage that occur due to pro-inflammatory cytokines (such as IL-6, IL 1, TNF alpha).

It is always advisable to use fresh, unprocessed food. The exact make-up of a diversified, balanced, and healthy diet will vary depending on individual characteristics (e.g. age, gender, lifestyle, and degree of physical activity), cultural context, locally available foods, and dietary customs. Gut dysbiosis is a feature of disease including many infectious diseases and has been described in COVID-19 as well. Dietary approaches to achieve a healthy microbiota can also benefit the immune system.

There is evidence that probiotic bacteria, particularly some lactobacilli and bifidobacteria can modify the microbiota, modulate the immune response, and protect against infections including respiratory tract infections. More recent evidence also shows gut microbiome is involved in the magnitude of severity in Covid 19 infection, possibly via host immune response modulation.

1. Eat fresh and unprocessed foods every day

- Eat fruits, vegetables, legumes (e.g. lentils, beans), nuts and whole grains (e.g. less processed rice, millet, wheat, brown rice or starchy tubers or roots such as potato, sweet potato, yam, manioc), and foods from animal sources (e.g. meat, fish, eggs and milk).
- Daily, eat: 2 cups of fruit (4 servings), 2.5 cups of vegetables (5 servings), 180 g of grains, and 160 g of meat and beans (red meat can be eaten 1-2 times per week, and poultry 2-3 times per week).
- For snacks, choose raw vegetables and fresh fruit rather than foods that are high in sugar, fat or salt.
- Do not overcook vegetables and fruit as this can lead to loss of important vitamins. Use steaming and pressure cooker in cooking.

2. Drink enough water every day

- Water is essential for life. Water helps to regulate your body temperature, transport nutrients, gets rid of waste, etc...
- Drink 8-10 cups of water every day.
- Water is the best choice, but you can also consume other drinks, fruits and vegetables that contain water, herbal drinks, king coconut and tea.

3. Eat moderate amounts of fat and oil

- Consume unsaturated fats (e.g. found in fish, avocado, nuts, olive oil, soy, canola, sunflower and corn oils) rather than saturated fats (e.g. found in fatty meat, butter, palm and coconut oils, cream, cheese, ghee and lard).
- Choose white meat (e.g. poultry) and fish, which are generally low in fat, rather than red meat.
- Avoid processed meats because they are high in fat and salt.
- Consume low-fat or reduced-fat versions of milk and dairy products.
- Avoid industrially produced trans fats. These are often found in processed food, fast food, snack food, fried food, frozen pizza, pastries, margarines and spreads.

4. Eat less salt and sugar

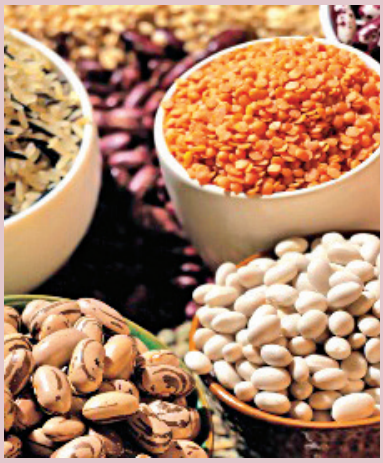
- When cooking and preparing food, use small amounts of salt and condiments with high salt.
- Use salt alternatives such as herbs and spices.
- Limit your daily intake of salt to less than 5 g (approximately 1 teaspoon) and always use iodized salt
- Avoid snacks with high salt and sugar
- Limit intake of high sugar drinks, sodas and soft drinks (artificial fruit juices, flavoured milk and yoghurt)
- Replace sugary snacks with cut fruits, herbal drinks, king coconut and aggala.

Add antioxidants to your daily diet

Vitamin A rich food

Pumpkin, carrot, yellow sweet potato, green leafy vegetables, papaya, passion fruit and dates (2 per day)

Vitamin B rich food



Parboiled rice, barley, semolina, dhal, cowpea, green gram, sesame, dark green vegetables, peanuts, yeast extract (1 teaspoon/day)

Zn, Iron, Selenium rich food

Fish, meat, sesame, koonissa, pulses, eggs

Vitamin C rich food

Guava, nelli, jambola, papaya, oranges

Healthy gut microbiota

Many plant foods, fiber, and fermented foods (such as diya bath, hoppers, dosa, pickles, curd, etc) play a role in creating and maintaining a healthy gut microbiota.

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Adverse events occur not due to bad people, but due to bad systems

Timely and accurate reporting leads to;

- Generation of "**alerts**"
- Dissemination of "**lessons learnt**"
- Improvement of patient and Health worker **safety**

To Err is Human; Reporting is safe, NO blame, NO fault finding

Report adverse events to quality management unit in your institution.

For more details contact;

Directorate of Healthcare Quality and Safety

Premises of Castle Street Hospital for Women,

Castle Street,

Colombo 8 – Sri Lanka

Tel : 0112678598

Fax : 0112698602

Diabetes and Covid-19: Clashing of two giant pandemics

Dr Kavinga Gamage
Senior Registrar in Endocrinology
National Hospital of Sri Lanka

Dr Manilka Sumanatilleke
Consultant Endocrinologist
National Hospital of Sri Lanka

Introduction

After being first described in Hubei Province China, in 2019, COVID-19 infection has now become a pandemic, with increasing mortality and morbidity turning the world 'upside down'.

Emerging highly virulent strains of the virus is aggravating the situation. These include the most recent variants of concern such as alpha (B.1.1.7), beta(B.1.351), delta(B.1.617.2) and lambda(C.37). In the majority of patients SARS CoV-2 viral infection is an asymptomatic to mild infection. However, in some it leads to severe or critical disease. Severe disease is classified as individuals who have SpO2 <94% on room air at sea level, a ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mm Hg, respiratory frequency >30 breaths/min, or lung infiltrates >50%. Critical Illness is classified as individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction, according to the National Institute of Health Classification system for SARS CoV -2(1).

Pathophysiology of Covid 19 infection

SARS CoV2 virus enters by binding to the epithelial cells of the respiratory tract.

The virion contains an envelope which is coated by spike (S) glycoprotein, envelope (E), and membrane (M) proteins. The S1 subunit of the S protein binds to angiotensin converting enzyme 2 (ACE2) on the cell surface and allows the entry to the host cell.

The viral genome is thereafter released, leading to viral replication, assembly and viral release from the infected cell(2). (figure 1)

ACE2 is expressed in upper respiratory tract, type 1 and 2 alveolar epithelial cells in the lungs, kidney, pancreas, endothelium and the heart.

Therefore, SARS CoV-2 affects the alveolar epithelial cells of both upper and lower respiratory tract. Angiotensin converting enzyme

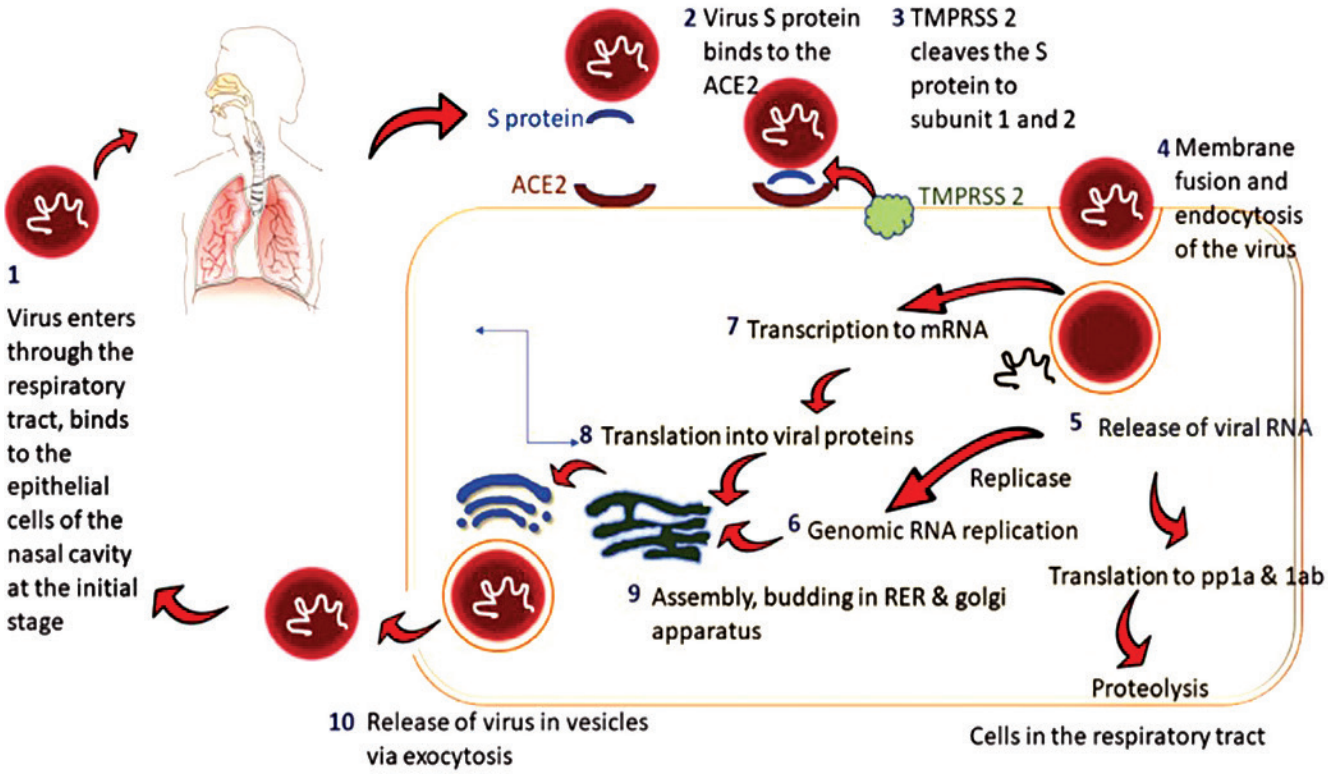

Figure 1. Pathogenesis of Covid-19

inhibitors (ACEi) and Angiotensin receptor blockers (ARB) are known to increase the ACE2 levels. However the resultant increase in Angiotensin(1-7) has a protective effect on Covid -19.

Infected cells undergo apoptosis and induce an inflammatory response. The release of massive amounts of pro-inflammatory cytokines leads to a 'cytokine storm', a dreaded complication that can lead to multiorgan dysfunction. Among the inflammatory mediators, IL-6 has been shown to co-relate with the mortality secondary to Covid 19 infection(3).

How does diabetes increase the susceptibility of severe COVID-19 infection?

It is now known that diabetes, severe obesity and hypertension leads to increased susceptibility to complications of Covid 19 infection and increases the risk of severe disease. Sri Lankan data published by the Epidemiology Unit also confirms this as diabetes is the comorbidity that is most associated (55% of all deaths) with severe Covid 19 infection in Sri Lanka (figure 2).

CORONADO study

CORONADO study(4) analysed the outcomes of diabetic patients admitted to hospital with COVID-19 in France. Results of this observational study showed 20.6% death rates among patients with diabetes within 28 days of admission. Routine use of metformin and longer time since onset of symptoms to admission appeared to be protective.

Increasing age, history of microvascular complications, insulin use and dyspnoea on admission were noted as factors increasing risk of death. Hospital discharge rates were 50.6% by 28 days from admission and same factors mentioned above appeared protective and harmful respectively. Interestingly this study showed that long term blood sugar control which is assessed from HbA1c did not have an impact on death rates or hospital discharge rates. However, higher blood glucose levels on admission were associated with higher death rates and delayed discharge.

COVID-19 confirmed deaths by co-morbidities

Co-morbidities	Total							
	<30 Yrs		30-60 Yrs		>60 Yrs		Total	
Total Number with Co-morbidities	**11**	**58%**	**312**	**83%**	**924**	**85%**	**1247**	**84%**
Diabetes Mellitus	1	9%	174	56%	507	55%	682	55%
Hypertension	0	0%	118	38%	516	56%	634	51%
Ischemic Heart Disease	0	0%	44	14%	218	24%	262	21%
Chronic Kidney Disease	0	0%	72	23%	169	18%	241	19%
Bronchial Asthma	0	0%	30	10%	111	12%	141	11%
Cerebro Vascular Accident	0	0%	7	2%	63	7%	70	6%
Chronic Obstructive Pulmonary Disease	0	0%	9	3%	59	6%	68	5%
Chronic Liver Cell Disease	1	9%	10	3%	27	3%	38	3%
Dyslipidemia	0	0%	19	6%	80	9%	99	8%
Cancer	3	27%	34	11%	58	6%	95	8%
Tuberculosis	1	9%	18	6%	12	1%	31	2%
Other	7	64%	62	20%	171	19%	240	19%
Co-morbidities reported as "No"	**8**	**42%**	**59**	**16%**	**149**	**14%**	**216**	**15%**
Co-morbidity status "Not known"	**0**	**0%**	**6**	**2%**	**15**	**1%**	**21**	**1%**
Total	**19**	**1%**	**377**	**25%**	**1088**	**73%**	**1484**	**100%**

Figure 2: comorbidities and their association with deaths, Sri Lankan Situation. Covid -19 Epidemiology report from 27.01.2020- 31.05.2021, Epidemiology unit

Mechanism of increasing severity of Covid 19 infection

Diabetes increases the risk of any type of infection. This may be partly related to the decreased T cell mediated immune response and impaired neutrophil function. However, it is shown that once appropriate measures of infection prevention strategies are used, diabetes does not increase the susceptibility of acquiring COVID-19.

The increased prevalence of silent or overt cardiovascular disease, may also predispose to increased mortality in diabetics. Diabetes and plasma glucose levels have shown to be independent risk factors for severe Covid 19 infection.

Potential mechanisms that may increase the risk of complications of COVID-19 infection in diabetics may include(5),

1. higher affinity cellular binding and efficient virus entry
2. decreased viral clearance
3. diminished T cell function
4. increased susceptibility to hyperinflammation and cytokine storm syndrome
5. presence of cardiovascular disease

The higher basal levels of proinflammatory cytokines in patients with diabetes predisposed to increased risk of 'cytokine storm' and ARDS. (figure 3)

Glycaemic control and risk of severe COVID-19

Both hyperglycaemia and hypoglycaemia have shown to be associated with poor outcome in patients with diabetes and COVID-19. It is found that those with poor glycaemic control have reduced lymphocyte counts and increased neutrophil counts, C reactive protein, LDH and Interleukin 6 levels (6) leading to impaired immune response, increasing risk of severe disease.

Well controlled blood glucose, maintaining reduced glycaemic variability during hospital admission has shown to reduce mortality in diabetic patients compared to those with poor control. Higher admission glucose as well as hyperglycaemia during the hospital stay has been associated with increased risk of mortality.

Additionally, those with chronically elevated blood glucose levels have higher prevalence of micro and macrovascular disease with associated endothelial dysfunction. Since COVID-19 perse increases the risk of thrombotic events, the combination of these two would increase the risk of thrombosis and higher mortality rates.

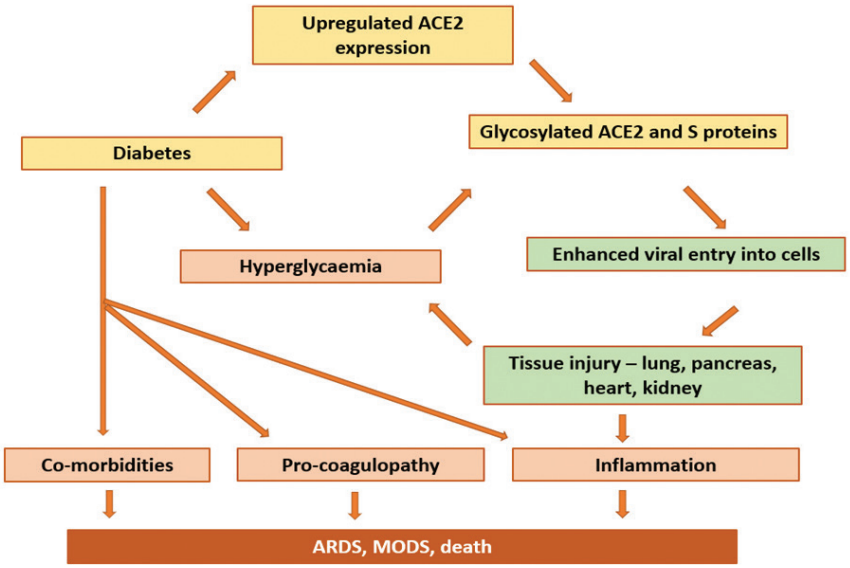

Figure 3 Mechanism of diabetes increasing the risk of severe Covid 19 infection

Measures to prevent acquiring COVID-19

Patients with diabetes should be given appropriate advice to prevent acquiring the infection and measures to be taken once infected(7).

Diabetic patients should be prioritized for vaccination and should minimize their exposure to SARS CoV-2 virus. However, isolation processes will have a significant impact on patients' lives and may disrupt the lifestyle of an individual. Patients need to be educated on continuing a healthy lifestyle, but access to healthy food would be a concern as well as activities such as walking indoors.

Stationary high intensity activities will be required as an alternative to outdoor walking and usage of gym and sports centres. It should be emphasized that the energy requirements will drop with further reduction of activities.

Therefore they should pay attention to consumption of foods with low glycaemic index, avoiding fried food and added fat, and increasing use of green leafy vegetables. Regular glucose monitoring needs to be done with extra attention, and routine clinic visits should not be missed.

Authorities should arrange clinic visits with facilities for social distancing and should ensure continuous supply of antidiabetic medicines for the patients. Overcrowding of the clinics is a matter of concern in Sri Lanka and needs to be suitably managed to prevent patients from getting unnecessarily exposed. In appropriate situations, usage of telemedicine or telephone advise might be useful to prevent overcrowding of clinics. Dispensing medicine for a longer period will reduce the congestion in clinics.

Type 1 diabetic patient should specially be vigilant of symptoms of ketoacidosis. Pregnant mothers with diabetes need to have continuous care avoiding pregnancy related complications. The fear of Covid -19 should not be a reason for delay in seeking health care advise in the case of new onset symptoms of diabetes or features of worsening glycaemic control.

Managing diabetic patients with Covid 19

Presentation in diabetics may vary. They are prone to have increased risk of pneumonia and severe disease and higher prevalence of abnormal CT findings compared to euglycemic patients. Sometimes they tend to have very minimal symptoms initially which deteriorates rapidly resulting in home deaths and death on admission in certain instances.

Patients need to immediately notify the relevant health care workers with the onset of symptoms for diagnostic evaluation, severity assessment and direction to the relevant health care facility. SGLT2 inhibitors need to be stopped during moderate to severe infection due to the risk of euglycemic ketoacidosis and dehydration. If the patient is given care at home, the glucose levels need to be closely monitored. Regular oxygen saturation monitoring would be beneficial.

Rest of the routine medications can be continued in case of mild disease. It will require conversion to insulin in case of more severe disease. Metformin needs to be stopped in acute severe illness due to risk of lactic acidosis as severe and critically ill patients are at higher risk of lactic acidosis due to hypoxia. Those who are on insulin need close blood glucose monitoring as stress might worsen glycaemic control or poor oral intake might predispose to hypoglycaemia.

ACEi or ARBs can be continued in those who had already been on these agents unless a clear contraindication arises such as hypotension or hyperkalaemia. Observational studies have shown beneficial effects of statins, demonstrating protection against infection(8). Nevertheless, precautions should be taken, considering possible drug interactions, risk of transaminitis and rhabdomyolysis.

Stress management is important during this Covid 19 outbreak. Travel restrictions, financial matters, lack of access to health care due to travel restrictions will worsen the stress in patients and may have a negative impact on healthy lifestyle and glycaemic control. In order to reduce stress, the WHO recommends on talking to a trusted person, trying to contact through email or phone or virtual methods and acquiring information from trusted sources and advises on minimizing reading and listening to news that can cause distress. Should advise on avoiding smoking and consumption of alcohol as a coping mechanism.

Current requirements

With the raging numbers of covid 19 infections in Sri Lanka, patients with diabetis are affected more severely with increased risk of complications and death. This consequently adds fear of attending clinics and delays in seeking health care advise worsening the situation.

To ameliorate this status quo, measures should be taken by the government as well as the health professionals ensuring continuous supply of medications, uninterrupted monitoring and prevention of progression into complications maintaining standards of care.

A policy decision to provide priority for diabetics for vaccination should be given serious thought.

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Overweight and Obesity: A Rising Epidemic

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The World Health Organization (WHO) defines overweight and obesity as abnormal or excessive fat accumulation that may impair health. These are considered to have reached epidemic proportions with 39% of adults being either overweight or obese, globally. The worldwide prevalence of obesity among adults has tripled between 1975 and 2016 and, more alarmingly, quadrupled among children and adolescents aged 5 to 19 (Obesity and overweight 2021).

In 1994, the prevalence of obesity in Sri Lanka was found to be 21% among diabetic patients and 10.5% among non-diabetic (Fernando et al. 1994). A recent study done in 2010 reveals the prevalence of overweight and obesity to have reached 34.4%, a startling rise from that encountered less than two decades ago (Katulanda et al. 2010). This is in addition to the burden of infectious diseases and malnutrition faced by developing countries such as ours. Hence, Sri Lanka is currently facing a "double burden" of disease (Min et al. 2018).

Overweight and obesity are not regarded as disease conditions in themselves. However, they are associated with a host of physical, medical, and social implications, especially from a medical standpoint, the rising burden of associated non-communicable disease burden.

They have been shown to have direct or indirect causal relationships with ischemic heart disease, type 2 diabetes mellitus, hyperlipidaemia, stroke, hypertension, obstructive sleep apnoea, increased risk of cancer, menstrual abnormalities, osteoarthritis, and also, social and psychological disturbances (Fiori et al. 2018). On a timely note, obesity prevalence was also significantly associated with both the infection and mortality rate of COVID-19 (Jayawardena et al. 2020).

The development of overweight and obesity has a multifactorial aetiology. Although traditionally attributed to individual factors leading to excess calorie intake compared to expenditure, recent studies have proposed the concept of an 'obesogenic environment'. It is the sum of influences that the surroundings, opportunities, or conditions of life have on promoting obesity in individuals or populations (Townshend and Lake 2017).

	WHO general population BMI classifications	WHO asian BMI classifications
Underweight	<18.5kg/m^2	<18.5kg/m^2
Ideal	18.5-24.9kg/m^2	18.5-23kg/m^2
Overweight	25.0-29.9kg/m^2	23-27.5kg/m^2
Obese	≥30kg/m^2	>27.5kg/m^2

Figure 01 – BMI classifications (Source – World Health Organization)

LIFESTYLE FACTORS

Food patterns

Diet is the foremost factor that comes to mind when considering overweight and obesity. This is a vital factor since certain dietary patterns are considered more likely to lead to weight gain compared to others.

According to the WHO, a healthy diet should ideally consist of fruits, vegetables, legumes, nuts, and whole grains. Free sugars should make up less than 10% of the total energy intake and fats less than 30%. It also recommends reducing and replacing both saturated fats and trans-fats with unsaturated fats.

The easy accessibility to prepared meals including snacks and fast food and time constraints caused by busy lifestyles have pushed people towards consuming more and more calorie-dense food that can be easily purchased commercially. The tipping of the balance in favour of fast food and soft drinks as opposed to fruits and vegetables has contributed to this rising epidemic. In addition, skipping breakfast, eating meals outside the home, frequently visiting restaurants, and the habit of 'TV dinners' play a role in excess weight gain in modern society.

Physical Inactivity

WHO recommends at least 150–300 minutes of moderate-intensity or at least 75–150 minutes of vigorous-intensity aerobic physical activity throughout the week to maintain good health. The lack of adequate physical activity is known to be associated with obesity, cardiovascular disease, type 2 diabetes mellitus, metabolic syndrome, and cancer as well as

all-cause mortality and mortality from cardiovascular disease and cancer.

However, a quarter of the world's adult population does not meet the required level of physical activity. A sedentary lifestyle has become the norm among most of the population across all age groups. The demands of educational activities in childhood and youth, occupational responsibilities during adulthood, and illness and disability in old age all promote inactivity.

The lockdown period implemented following the outbreak of the Covid19 pandemic further escalated this issue. The restriction of normal activities led to a rise in the level of inactivity with a reduction of exercise and an increase in sitting time and screen time.

Sleep

A joint consensus statement issued by the American Academy of Sleep Medicine and Sleep Research Society states that adults between the ages of 18 – 60 require at least 7 hours of sleep per night. This requirement further increases for individuals on either side of this age range. Apart from the duration, the quality should also be sufficient if one is to maintain good health.

Insufficient sleep has been linked to the development and progression of a number of chronic diseases including diabetes, cardiovascular disease, and depression. It is also implicated in the development of obesity in individuals.

Sleep deprivation leads to increased food intake, decreased energy expenditure, and inappropriate plasma levels of appetite-regulating hormones, such as leptin and ghrelin. Dysregulation of orexin, an important homeostatic mediator of metabolism and maintenance of sleep/wake states, is shown to be linked to narcolepsy, obesity, and age-related disorders (Nixon et al. 2015).

Irregular sleep patterns are also associated with obesity, in addition to reduced sleep duration. The study by Patel et al. revealed that variability in sleep time at night and daytime napping correlates with obesity independent of the mean sleep duration (Patel et al. 2014).

SOCIO-DEMOGRAPHIC FACTORS

Studies done in Sri Lanka and elsewhere have shown certain demographic groups to be more prone to develop obesity. Female gender, advanced age, urban residence, higher educational attainment, higher income level, and higher socioeconomic status have

Figure 02 - Leading an active lifestyle and engaging in exercise are both effective ways of increasing physical activity. (Source - The European Food Information Council)

a significant association with overweight and obesity (Katulanda et al. 2010; Katulanda et al. 2012).

Apart from female gender and age, the source of all the other factors mentioned above can be attributed to the transition of a country from developing to developed. Accompanying this transition, an epidemiological transition occurs where a country moves from a predominantly infectious disease phase to a chronic disease phase. This transition occurred 3 or 4 decades back in the developed economies in North America and Europe and is currently occurring in the rest of the world.

SECONDARY CAUSES OF OBESITY

Obesity is primarily attributed to an imbalance between calorie intake and the output caused by the factors discussed above. However, there exists another group of causative factors where obesity develops secondary to a medical illness, genetic abnormality, or an iatrogenic cause such as medications (Table 1).

Table 1. Secondary causes of obesity

Endocrine causes
- Hypothyroidism
- Polycystic Ovarian Syndrome
- Cushing's syndrome
- Hypothalamic obesity
- Insulinoma

Genetic causes
- Monogenic obesity
  - Leptin and leptin receptor deficiency
  - POMC deficiency
- Syndromic obesity
  - Prader–Willi syndrome
  - Bardet–Biedl syndrome
  - Beckwith–Wiedemann syndrome

Drugs
- Anti-diabetic – insulin, sulphonylureas, thiazolidinediones
- Centrally acting medications - Antipsychotics, antidepressants, antiepileptics
- Glucocorticoids
- Oral contraceptives

PREVENTION AND CONTROL

Overweight and obesity, for the most part, are preventable and reversible. Since the key issue is an excess of calories, either reducing the intake and/or increasing the expenditure can effectively control established overweight and obesity.

Individual factors, such as a poor diet, physical inactivity, sedentary lifestyle, and poor sleep need to be addressed at a personal level. However, health promotion activities have a major role to play in educating the public to encourage them to adopt a healthy lifestyle.

Additionally, education and occupation too have an impact on the ability of a person to maintain a healthy weight. The nature of such engagements may render it difficult for people to spend time and energy to maintain a healthy lifestyle. Therefore, those sectors have a responsibility in promoting health among their members. Furthermore, the healthcare sector must be at the forefront of preventing and controlling overweight and obesity at a national level, in collaboration with other relevant stakeholders.

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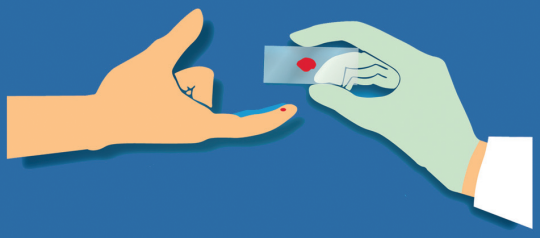

Reduce the Delay in diagnosing imported Malaria

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

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Drug interactions in clinical practice: a friend or foe?

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"Friends are the family we choose for ourselves" says Edna Buchanan. Drugs have been doctors' best friend for years. However, the use of drugs is not without adversities. One such instance is drug–drug interactions. "When a drug is administered, a response occurs. If a second drug is given and the response to the first drug is altered, a drug–drug interaction is said to have occurred".

There are many intended drug interactions in clinical practice. For example, isoniazid, rifampin, pyrazinamide, and ethambutol are used in combination mainly to prevent the development of drug resistance in the treatment of tuberculosis.

The use of antidotes (e.g., naloxone) to reverse the overdose effects of a drug (e.g., opioid) is another intended drug interaction. However, unintended drug interactions could lead to adverse drug reactions and increase morbidity, mortality and health care expenditure. So, drug interactions could be a friend and at times a foe.

Drug-drug interactions are of clinical importance in drugs with a steep dose–response curve, small therapeutic index, enzyme-inducing or inhibiting ability and saturable metabolism. Further, drug interactions become important in polypharmacy, long term treatment, instances where precise plasma concentrations are needed, critically ill patients, hepatic or renal failure and geriatric population. Patient factors like drug clearance, genetics, gender, concurrent diseases, diet and drug factors like dose, route of administration, drug formulation and sequence of drug administration influence drug interactions. Drug interactions could alter the concentration of another drug at its site of action and/or modify the pharmacological effect of another drug without altering its concentration in the tissue fluid. Also, interactions are possible before the drugs enter the body in instances such as intravenous fluids which offer special scope for such interactions.

Drug interactions are common in general practice and identifying clinically relevant interactions is important for patient safety. Few examples are as follows:

1. Warfarin related interactions with amiodarone, antimicrobials, NSAIDs and statins
2. Statin related interactions with amiodarone, azole antifungals, calcium channel blockers, fibrates, macrolides and protease inhibitors
3. Phosphodiesterase-5 inhibitors and nitrates
4. Coadministration of thyroxine and drugs with chelation risk (aluminium, magnesium, calcium and iron)
5. Combination of drugs that prolong the QTc interval (analgesics, antiarrhythmics, antidepressants, antiemetics, antimicrobials, psychotropics and serotonin agonists)
6. Combination of central nervous system depressing agents (antipsychotics, hypnotics, barbiturates, muscle relaxants, benzodiazepines and opioid analgesics)

Paauw DS 2016 states a few dangerous and deadly drug combinations. Selective serotonin reuptake inhibitors co-administered with tramadol could lead to potentially life-threatening serotonin syndrome. Also, a combination of simvastatin with gemfibrozil could lead to rhabdomyolysis. Further, clarithromycin co-administered with nifedipine may lead to hypotension, oedema and acute kidney injury due to reduced renal blood flow. Even paracetamol co-administered regularly with warfarin needs close monitoring as it could increase the international normalized ratio.

Omeprazole and clopidogrel are commonly used in clinical practice and considered good friends of physicians. Free tools indicate a serious interaction between the two drugs and advise using an alternative combination. When omeprazole inhibits the hepatic enzyme CYP2C19 there is a subsequent reduction of clopidogrel metabolism. However, clopidogrel inhibits platelet aggregation via its active metabolite. Therefore, the combination of the two drugs could inhibit the antiplatelet action of clopidogrel.

Drug interactions can be prevented if doctors, nurses, pharmacists and patients are vigilant. There are national formularies and drug interaction software to check drug interactions before prescribing. With the dawn of electronic prescribing, the software could alert the doctors and other healthcare workers on possible drug interactions. Drug interaction software are available as subscription-based (e.g., PEPID, Micromedex, Lexicomp, Facts & Comparisons) or free tools (e.g., Epocrates Free, Medscape, Drugs.com, RxList, WebMD). Among the free tools, Epocrates Free needs a free registration while the rest can be accessed directly from the internet. A study that compared the above tools for screening drug interactions of oral oncolytics found Lexicomp and Drugs.com to be the top-performing subscription and free tools respectively. The above two software did not show a statistically significant difference in performance. Although subscription tools had an overall significantly higher sensitivity and negative predictive value than free tools, no differences were observed between the specificity and positive predictive value. The free tools can be accessed via a mobile phone while at clinical practice and the information on interactions are available for both the consumer and the professionals.

The software alerts on drug interactions are so abundant that these could be overlooked during a prescribing process. Also, a lack of standardization of identification and severity rating systems are observed. Doctors cannot rely only on software to prevent drug interactions. Other approaches like using the minimum possible number of drugs, re-evaluating the therapy regularly, considering nonpharmacological managements, monitoring for effects and adverse effects, adjusting dosages, frequency and administration times should be followed. Drug-drug interaction can be helpful as a friend and at times challenging like a foe. Therefore, doctors, nurses and pharmacists should keep in mind drug interactions while practising. Also, all efforts should be taken to educate and remind the patients of possible serious interactions.

"Treat your friend as if he might become an enemy" Publilius Syrus.

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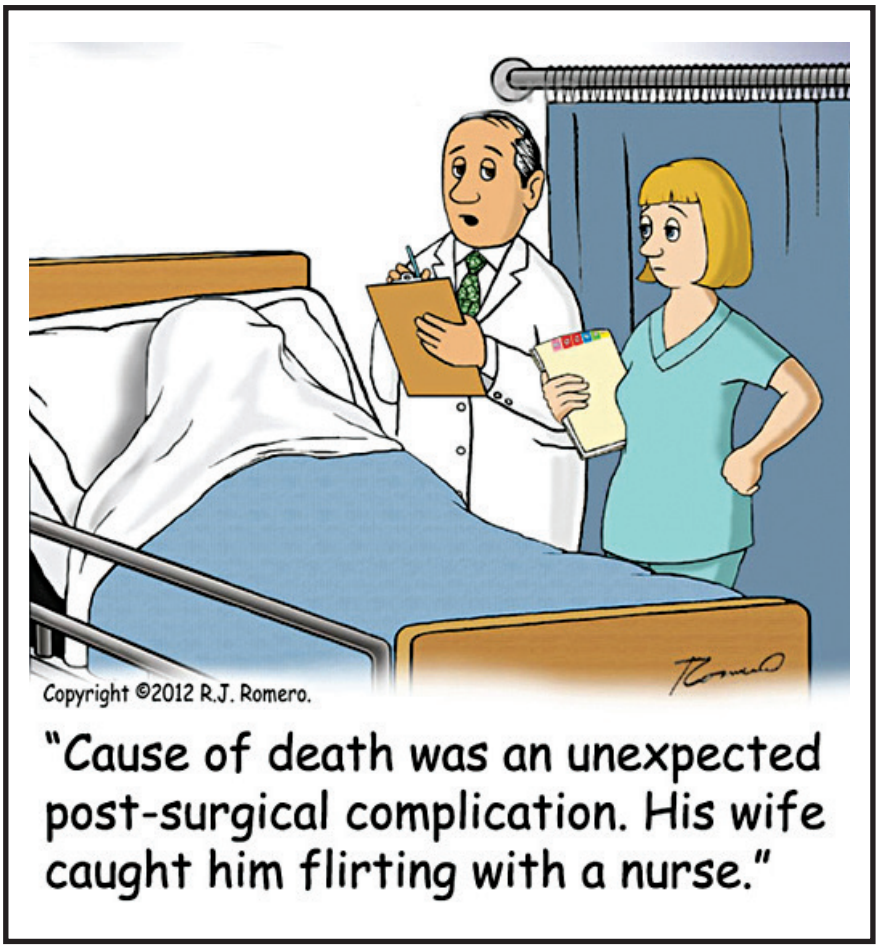

An Online Drug Index from Independent Medical Practitioners' Association of Sri Lanka - DIMPA

Access IMPA website at https://impasl.com/ to register and use the programme

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Clinical Utility Examples:

What are the available ANTIFUNGALS FOR TOPICAL USE,
What are the available VIRAL VACCINES,
What are the available ANTIFUNGALS FOR TOPICAL USE,
What are the available DRUGS FOR CONSTIPATION
What are the available VACCINES,
What are the available TOPICAL PRODUCTS FOR JOINT AND MUSCULAR PAIN,
What are the available DRUGS FOR CONSTIPATION

How to use the programme

1. Access IMPA website at https://impasl.com/
2. Click any button with DRUG INDEX
3. Sign in or Registration
4. Home Page of the Drug Index
5. At the search box type "Losart"
6. Two outputs will be seen: purple view and the table view
7. Purple view will give the basic pharmaceutical properties of the Generic selected
8. Table view gives all the brands and their details
9. Clicking or tapping at the purple view will give the details of the tapped or clicked entity
10. Same information can also be found by going to Advance Search and typing the entity at the text field

134th Annual International Medical Congress

The Congress was postponed to September due to the prevailing situation in the country!

New dates – 21st to 24th September 2021

Venue – BMICH, Colombo

Online Registration – Now Open

For More Details – Visit – https://conference.slma.lk

"Look into my eyes": identifying and communicating in the times of COVID-19

Dr Nirodha Jayawickrema Randenikumara
Senior Registrar in Orbit Oculoplastic and Reconstructive Surgery

"Look into my eyes", Brian Adams sings in the 1991 movie 'Robin Hood: Prince of Thieves', to show how much the protagonists in the movie mean to each other because eyes can tell what words cannot tell. Hence we call them the windows to one's soul. In the 1942 classic movie Casablanca, the line "Here's looking at you, kid" is uttered by Humphrey Bogart, longingly staring into Ingrid Bergman's eyes glistening with tears, and that line is considered a legend ever since. That's the popular culture.

Being a trainee in Ophthalmology for nearly 5 years there is one wonderful fact I have realized about people's eyes. We can look into someone's eyes and recognize them even when the whole face is covered up. The shape and thickness of their brows, lids, the pupils, unique features on the tiny contours of the iris and the color of it at a glance and of course looking at the microscopic view of the lenses and and their opacities, we know who the person is under the covers even during the surgery; and we can recall the entire story of an eye, the history of all the procedures it went through just by looking at it through the slit lamp, even though the patient's face doesn't ring a bell.

Even though this is the usual scenario for the eye doctors, I had to face a little incident a few months back, which made me realize how things have changed since the eyes became the only source of facial recognition of another human being. I ran into one of my colleagues from the medical faculty while walking along a corridor at the National Eye Hospital, and I struggled for a moment trying to recognize her.

Though the voice and other cues were suggestive, the main feature we used to recognize her was missing from her face. That was the beautiful little birthmark next to her nose which makes her unique, which was very much covered up by the mask. So combining her voice, the stature and of course her smiling eyes, I finally realized who she is!

We humans are a set of social animals and we rely on communication as an integral part in surviving and thriving. Being able to identify and recognize other human beings clearly is a key step in social functioning as humans.

How do we recognize a person to build up interpersonal relationships? There are many other cues to identify someone, such as voice, body habitus, how they smell, the way they dress, the way they move, or the way they groove, yet remembering one's face and recognizing them from their facial features is the shortest bridge between perception, memory and semantic knowledge when it comes to identification. Though this has been the situation for centuries except for a few communities in which the people covered their faces up due to cultural, religious or social reasons, till COVID-19 paid us a visit and decided to linger a little longer than expected, covering up the face with masks has become the new normal. Hence we are forced to identify people looking into their eyes or using other cues.

When it comes to communication, facial expressions play a major role. Specially the lower half of the face is responsible for the majority of expressions, yet the involvement of the eyes brings out the genuinity of these expressions. As an example, a genuine smile also known as a Duchenne smile,should reach one's eyes causing crows feet at the corners of the eyes as it involves the orbicularis oculi muscles.

Yet a fake smile, or a sarcastic grin fails to do so. Even if a person who fakes a smile remembers to squint their eyes a bit, the pupils won't show the dilatation compatible with a genuine interest. Yes, of course, we cannot practically measure the pupil size in day-to-day life, but scientifically, eyes don't lie!

Hence, now we better develop the tenderness shown by Humphrey Bogart on screen and try to look into the eyes of the people you meet and see whether we could take a peek at their souls!

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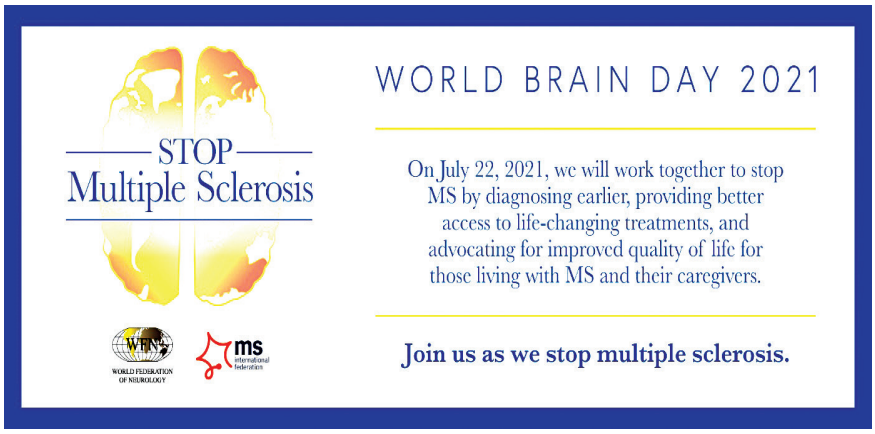
World Brain Day 2021; Aim to Stop Multiple Sclerosis

An Open Invitation to All SLMA members

Professor Tissa Wijeratne
Chair World Brain day
World Federation of Neurology

Professor Wolfgang Grisold
Secretary-General
World Federation of Neurology



The eighth World brain day (WBD) on July 22 2021 moves to stop multiple sclerosis. The World Federation of Neurology and Multiple Sclerosis International Federation teamed up on this ambitious agenda to stop multiple sclerosis as the theme throughout 2021.

Multiple sclerosis affects nearly 3 million people globally. Early diagnosis of multiple sclerosis is critically important.

Early treatment with disease modifying therapies (DMT) culminate in excellent control of the underlying disease.

The aim of DMT is to achieve no evidence of disease activity NEDA. Current therapeutic interventions led to significant reduction in relapses in MS and disability.

The most recent edition of MS atlas reports data from 115 countries with alarming statistics of unmet needs , barriers ad lack of access to therapeutics in many countries.

World brain day is one of the key global advocacy activities of the World Federation of Neurology with immense impact as the campaign reach across over fifty million people annually.

Every year, the World Federation of Neurology (WFN) celebrates World Brain Day on July 22 (It was on July 22 1957, the WFN was established), but each year our focus is on a different theme.

The WFN chooses a topic and promotes the WBD by providing material (press release templates, social media banners and messages, videos, slide deck and more) to their members.

For several topics, the WFN has collaborated with other international organisations.

For the WBD the WFN , with it's 122 members, plan many activities across the world including webinars, seminars,news paper articles, radio and television programs and other media activities.

Member countries are encouraged to celebrate, endorse and promote the WBD in their own country and report on their activities.

There will be global webinar on July 22 2021 with a live question and answer session for the global audience.

SLMA newsletter readers are warmly invited to join the webinar and pre register here.

Our primary focus is for the SLMA members and their families to join us in this ambitious advocacy campaign for the following five key messages as this is critical to change these alarming statistics.

Key Messages

Disability:

Multiple sclerosis is a debilitating neurological disease that impacts every aspect of a person's life, with effects ranging from cognitive impairment to significant physical disability.

Prevalence:

2.8 million people of all ages globally are affected by MS, and someone receives this life-altering diagnosis every five minutes.

Education:

We must work with health care professionals to recognise the signs and symptoms of MS so people can be diagnosed early and effectively treated.

Access to Treatment:

Disease-modifying treatments slow disease progression, dramatically improving the quality of life for those living with MS, yet access to these medications is unavailable in many parts of the world.

Advocacy:

We can stop MS by diagnosing earlier, providing better access to life-changing treatments, and advocating for improving the quality of life for those living with MS and their caregivers.

You can access the world brain day 2021 toolbox here.

The WFN World Brain Day committee and social media team offer continuous support.

You can contact us for additional support wbd2021@wfneurology.org, or jade@wfneurology.org.

We want you all to be part of this campaign and making difference to our patients lives.

Thank you!

Upgrading infrastructure of an autopsy laboratory to conduct autopsies of bodies infected with SARS CoV-2 virus

Sarathchandra Kodikara[1], Chathula Wickramasinghe[2], Vasana Kudagammana[3], Dinesh Fernando[4], Amal Vadysinghe[5], Deepthi Edussuriya[6], Sadiq Siddique[7], Gayan Kumarasinghe[8], Tharanga Nayakarathna[9], Sameera Gunasekara[10], Saman Chandradasa[11], Niranjala Kulathunga[12]

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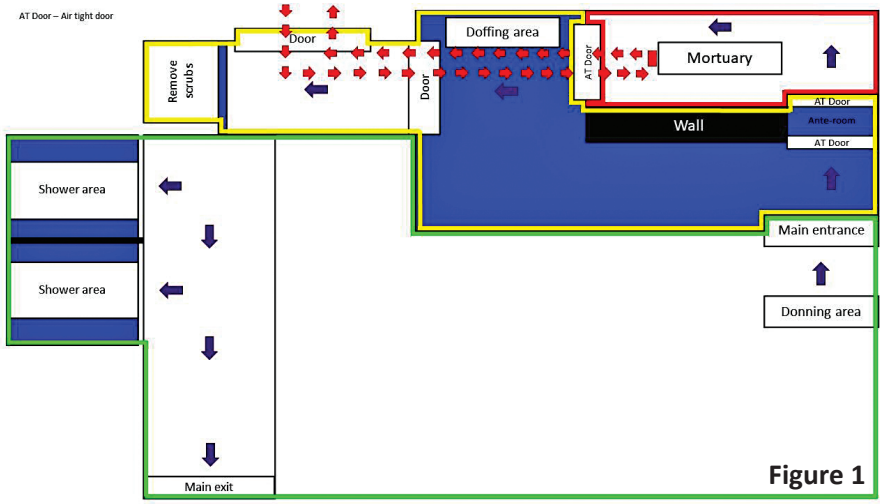

Figure 1

Figure 2

Figure 3

SARS CoV-2 virus responsible for the current COVID- 19 pandemic is a novel corona virus which is categorized as a bio- hazard group 3 virus. Autopsies of persons infected with SARS CoV-2 virus should ideally be performed in an autopsy laboratory with a biosafety level of 3 (BSL-3). BSL-3 autopsy laboratories are established in only a few countries (e.g. Austria, China) 1, 2. A literature survey done using the google search engine revealed that there is no such facility available in any South Asian country. However, the Department of Forensic Medicine of the University of Peradeniya, Sri Lanka upgraded its mortuary infrastructure to achieve BSL-3 standards as much as possible, with minimum facilities, in order to perform high risk autopsies including those of SARS CoV-2 virus infected bodies.

Renovations of the mortuary took place under the guidance of a Clinical Microbiologist.

The facility has been demarcated into three zones; contaminated, semi-contaminated and uncontaminated while the boundaries were marked on the floor in red, yellow and green colors respectively (Figure 1).


Figure 4

An area in the main mortuary complex which was secluded was selected. A separate entrance and exit were created for staff. This enabled unidirectional movement of staff through the autopsy laboratory (indicated in violet colored arrows in figure 1). A separate entry and exit was identified for corpses to be brought in and out (indicated in red colored arrows in figure 1). The "high risk autopsy area" is accessed via two air tight doors, that precinct an anteroom (Figures 2 & 3). The exit of this room is also secured with an air tight door. On exiting the "high risk autopsy room" a doffing area was identified equipped with color coded garbage bins. Disinfection, waste segregation and doffing of personal protective equipment occur in this area. This area leads through swivel doors to the "yellow" scrub removal area with an automated washing machine. Personnel then proceed to the shower areas separated for males and females. All doors have been made "air tight" using velvet, rubber and aluminum beading. Standard sign boards with step-wise instructions on donning and doffing, disinfection, waste collection are displayed in relevant areas.


Figure 5


Figure 6

The shower and donning areas were marked as green zones while areas just prior to entry to the anteroom and areas just after the exiting door (including scrub removal area) were marked as yellow zones (Figure 1). The high risk autopsy room was marked as a red zone (Figure 4).

A camera system which requires minimum handling was installed in order to take high quality photographs (Figure 5). A remotely controlled closed circuit television system was installed enabling viewing of the proceedings of a high risk autopsies from a safe distant location via a distant light emitting diode screen (Figure 6).

This upgrade was done with minimal expenditure and hence appropriate for developing countries in order to perform autopsies of dead bodies infected with SARS CoV-2 virus.

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"Dining in the dark"

Dr B.J.C.Perera
Specialist Consultant Paediatrician and Honorary Senior Fellow Postgraduate Institute of Medicine, University of Colombo, Sri Lanka.

Please read this true story before you close your eyes for today and open it for tomorrow...

I am sharing someone's wonderful experience.

That person attended a fund-raising event for the visually handicapped people in a centre. As usual, since it was a Friday evening, she first thought of skipping the event, considering it could be a bit boring.

She would rather spend the evening relaxing by some other means. But being alone and sometimes finding it difficult to kill time, she thought of accepting the invitation and registered on-line for a booking.

When she went there, there were approximately 40 people present. Initially they were shown a video about the visually handicapped centre. It was a short 15-minute video and quite inspiring. It was about how people from different walks of life spent their time in helping these visually handicapped people, without expecting anything in return.

After the video, all were gathered in a dining hall and were briefed about the next event.

The theme of the next event was **"Dining in the Dark"**. This is the event that turned out to be inspiring and well worth sharing.

What it meant, was that all 40+ people, were going to have Dinner in a Pitch-Dark Room!

The next two hours were completely planned, organized, directed and executed by three blind youth.

One was a girl (leader) and other two boys were assistants to her, forming a team of three visually-handicapped volunteers.

The visually handicapped leader first gave them tips for dining (THESE WERE ACTUAL STANDARDS THE VISUALLY HANDICAPPED PEOPLE FOLLOW IN ORDER TO MAKE THEIR LIFE EASIER).

She said that when you sit at your table the things will be placed as follows:

1. There will be a plate in front of you.
2. At 3 o'clock of your plate, you will find a spoon;
3. At 9 o'clock : a fork;
4. At 12 o'clock : a spoon;
5. At 2 o'clock : an empty glass tumbler;
6. At the centre, a paper napkin.
7. There will be two large Jugs circulated to you. The jug with plain walls will have water and the jug with curved engraved wall will have orange juice.
8. When you get your jug, based on your choice, you have to pour it in to your glass. You have to dip your forefinger in the glass so that when you fill it and the liquid touches your finger, you have to stop pouring.

Then she asked whether everyone had understood. All said yes, but everyone was confused and trying to remember what she had said and confirming with each other.

Then the girl switched the lights off. The entire Dining Room was PITCH DARK.

Each one was directed by a visually handicapped person till he/she sat on a chair. They, the attendees, were finding it awkward because actually they are supposed to guide visually handicapped people to their destination and help them.

Then they were served a full five course dinner by this team of three visually handicapped people... welcome drinks, appetizers, starters, main course and desserts.

The amazing thing was that the team of three visually handicapped people were serving vegetarian dishes to the vegetarian people who were sitting randomly in the room! When registering on line, they were asked the question to choose from "Vegetarian" or "Non vegetarian". The narrator of this story had chosen vegetarian. All of them were so nicely hosted that they did not have to wait in-between serves. As they were finishing one dish, they were served with the next without any delay.

The one and half hours they spent were full of fun and were a real learning experience. In a completely pitch-dark room where they COULD NOT SEE ANYTHING, they were enjoying various types of delicious food without seeing them.

After approximately one and half hours of dining in the dark, the leader asked whether everyone had finished eating. After confirmation, she switched on the lights of the dining room.

All the attendees left the Dining Room with tears in their eyes.

They realized how lucky they are and how they have been gifted with beautiful eyes to see the beautiful world. They realized how difficult the lives of visually handicapped people are, without being able to see. They realized how uncomfortable they were for just two hours without being able to see anything and how the visually handicapped people must feel, living their entire lives in PITCH DARKNESS.

They realized how fortunate

they really were, that they do not value such simple things in life that they have, and cry, sometime loudly, sometime within themselves, and run after what they do not have..., for the whole of their lives, without having time to adore all the things that they do have.

The moral of this narrative is to be cheerful and appreciate what you have got. Open your eyes today before it closes down permanently when we die.

Adore the people who love you, speak from your heart with them today. Clear your misunderstandings soon, with the people who love you.

Make your life worthwhile, to live on this earth.

Look at your life, that has come in as a gift. Providence has gifted us eyes to look at all the good people around us.

Complete the MISSION of your life with the VISION of your eyes.

Extracted from an e-mail sent by Mrs Esther Amarasekera.

The UN is switching to Euro-English

Just for a laugh

The European Commission has just announced an agreement whereby English will be the official language of the European Union rather than German, which was the other possibility. As part of the negotiations, The British Government conceded that English spelling had some room for improvement and has accepted a 5-year phase-in plan that would become known as "Euro-English".

- In the first year, "s" will replace the soft "c". Sertainly, this will make the sivil servants jump with joy. The hard "c" will be dropped in favour of "k". This should klear up konfusion, and keyboards kan have one less letter.
- There will be growing publik enthusiasm in the sekond year when the troublesome "ph" will be replaced with "f". This will make words like fotograf 20% shorter.
- In the 3rd year, publik akseptanse of the new spelling kan be expekted to reach the stage where more komplikated changes are possible. Governments will enkourage the removal of double letters which have always ben a deterent to akurate speling. Also, al wil agre that the horibl mes of the silent "e" in the languag is disgrasful and it should go away.
- By the 4th yer peopl wil be reseptiv to steps such as replasing "th" with "z" and "w" with "v".
- During ze fifz yer, ze unesesary "o" kan be dropd from vords kontaining "ou" and after ziz fifz yer, ve vil hav a reil sensibl riten styl. Zer vil be no mor trubl or difikultis and evrivun vil find it ezi tu understand ech oza. Ze drem of a united Europ vil finali kum tru. Und efter ze fifz yer, ve vil al be speking German like zey vunted in ze forst plas.

https://www.ba-bamail.com/jokes/political-jokes/?jokeid=810

Farmer Jack and his Chicks

Farmer Jack lived adjacent to a quiet rural highway. As time went by, the traffic slowly built up and eventually got so heavy and so fast that his free range chickens were being run over, at a rate of three to six a week.

So, Farmer Jack called the local police station to complain. "You've got to do something about all these people driving so fast and killing all my chickens," he said to the local police officer. "What do you want me to do?" asked the policeman. "I don't care, just do something about those crazy drivers!"

So, the next day the policeman had the council erect a sign that said: **SCHOOL CROSSING**

Three days later Farmer Jack called the policeman and said, "You've still got to do something about these drivers. The school crossing' sign seems to make them go even faster!"

So again, they put up a new sign: **SLOW: CHILDREN AT PLAY**

That really sped them up. So, Farmer Jack called and said, "Your signs are no good. Can I put up my own sign?" In order to get Farmer Jack off his back the policeman said, "Sure. Put up your own sign."

The phone calls to the Police Station stopped, but curiosity got the better of the officer, so he called Farmer Jack, "How is the problem with the speeding drivers, did you put up your sign?" "Oh, I sure did and not one chicken has been killed."

The policeman was really curious and thought he'd better go out and take a look at the sign. He also thought the sign may be something the police could use elsewhere to slow drivers down.

So, he drove out to Farmer Jack's house. His jaw dropped the moment he saw the sign .....

NUDIST COLONY
Slow down and watch out for chicks

From an e-mail sent by Mrs Esther Amarasekera
Extracted and forwarded by Dr B. J. C. Perera

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