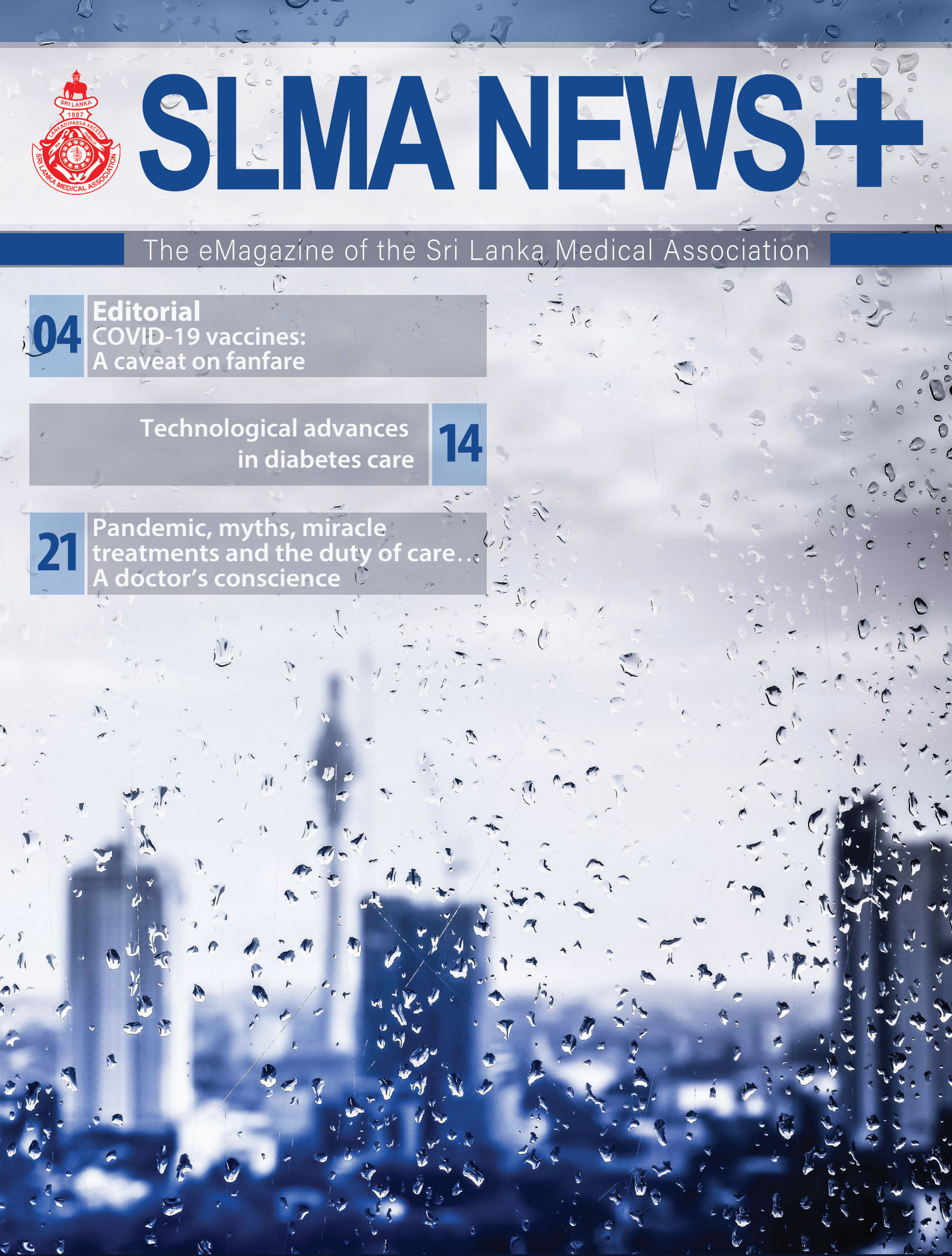
SLMA NEWS+

The eMagazine of the Sri Lanka Medical Association



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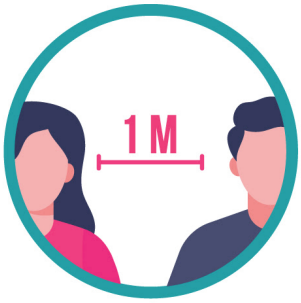
Please Adhere to the Following Simple Steps to Prevent COVID-19 in Your Workplace

Wear a mask.



Maintain distance of one meter with everyone.

Wash hands with soap and water or sanitize with a hand sanitizer.

Cover coughs and sneezes with the elbow

Do not allow any person having fever with or without respiratory symptoms to report for work.

Frequently disinfect commonly contacted surfaces by staff or customers.

Avoid exchange of equipment, utensils or any other items between workers. If exchanged disinfect them before and after exchanging.

Avoid sharing personal items between workers. If shared disinfect them before and after sharing.

Ensure good ventilation and use air-conditioning only if necessary.

If your duty involves close contact or touch customers, (Eg. Barber, Tailor) wear an eye shield or a goggle and sanitize hands immediately afterwards.

If your duty involves using instruments that touches customers (Eg. Measuring tape, Comb) disinfect them after use.

For details please refer to the "Operational guidelines on preparedness and response for covid-19 outbreak for work settings" published by the Ministry of Health. Visit health.gov.lk.

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IN THIS ISSUE

Editorial
COVID-19 vaccines: A caveat on fanfare

In this virus-ravaged world, this month has been nothing short of exciting and full of hope compared to the gloomy rest of the year. Much enthusiasm was generated by the press releases of two companies about their SARS-CoV-2 vaccines which were reported to be 90% to 95% efficacious in preventing symptomatic infections with no major safety concerns. There have been more than 120 candidate SARS-CoV-2 vaccines in development within the first 5 months of 2020, with very few making headlines from time to time. None were as well received as the two messenger RNA (mRNA)-based vaccines of which the preliminary or interim findings of the Phase 3 Trials were released to the media this month. Many called them "game changers" with a celebratory disposition. But.., are they really or would they ever be, the panacea for all ills in COVID-19?

The speed at which these vaccines have been developed is ever so extraordinary. Aided by prior knowledge on the role of the spike protein in coronavirus pathogenesis and the importance of neutralizing antibodies against the spike protein in immunity, Phase 3 Clinical Trials were well underway within months of publication of the first SARS-CoV-2 sequences. In early November, Pfizer and BioNTech announced that their SARS-CoV-2 vaccine candidate has an efficacy above 90%, shortly followed by the biotech firm Moderna, who claimed theirs to be 94.5% effective. In the meantime, Pfizer and BioNTech concluded their study within a couple of weeks of their first press release and reaffirmed their claim, ultimately seeking FDA approval for its candidate by week's end. This astonishing progress was possible due to the upsurge of cases in the USA as these were events-driven studies with symptomatic RT-PCR or other equivalent nucleic acid amplification-based test positive cases being the primary end point. Nevertheless, this is undoubtedly a remarkable feat, compared to the typical timeline of 3 to 9 years taken to develop a new vaccine. It demonstrates the ingenuity and determination of the human race to overcome adversity through innovation, scientific advancement, fostering collaborations and sharing of knowledge.

However, what exactly do these magical numbers mean in the backdrop of a global pandemic which has brought many mighty nations to their knees? When the great majority of COVID-19 infections are asymptomatic or mildly symptomatic, how best should these numbers be interpreted when they indicate only the proportion of symptomatic cases prevented? How about the baseline characteristics in the vaccine and placebo arms in the use of other proven COVID-19 preventive measures such as physical distancing and the use of face masks? And of course, these numbers are from press releases based on the findings of preliminary analysis of data. The complete analysis and the actual data from the studies are yet to be published. Moreover, the safety of both the vaccines cannot be confirmed with the limited duration of follow-up thus far. For the first time in human history, m-RNA vaccines are being considered for mass usage. Are there any long-term consequences? Even if the stipulations on efficacy and safety are set aside, how long would it take to manufacture and distribute these vaccines across the globe, and administer them to billions to effectively prevent spread? There are a myriad of questions which are yet to be answered and these vaccines are not a magic bullet. However, they signify a definite leap in the right direction in combating COVID-19 as these questions would never have been asked if not for the advent of these vaccines.

There is another aspect that could easily be overlooked amidst all this hype about the vaccines; this pandemic is propagated by humans and it can be stopped in its tracks only by humans. No matter how efficacious and safe a vaccine maybe, there would have to be high uptake worldwide for it to be successful in curtailing a global pandemic. In reality, in addition to the enormous logistical challenges of storage transport and distribution, there would be issues of patents, affordability, equity of access, politicising and socio-cultural acceptability that may hinder progress. Most importantly, the trust the general public has in the scientific community, its health sector and the government authorities would play a crucial role in determining the uptake of a vaccine. Without transparency and forthrightness in reporting; scientific or otherwise, policy making and implementation of policies, a fast-tracked vaccine could have far reaching detrimental effects on the health and economy of the populace.

Taking the ground practicalities into considerations, it is reasonable to assume that a safe and efficacious vaccine may not reach the shores of this island nation for many months to come. Even if it does make such a magnificent arrival, it may very well not be the answer to all our prayers. The enthusiasm with which the recent press releases were received indicates the intensity of yearning the whole world has for some respite from this existential threat of the virus. With our lives paused, put on halt, people being compelled to change and adapt in ways that sometimes go against our very nature, under immense pressure from mounting economic burden and perturbed by political unrest and uncertainty, humanity longs for a reprieve.

Of course, then there are potential financial implications and possible vested commercial interests behind this hype created by media reports. Yet for all that, compared to their Western counterparts, the local media and authorities seemed rather lethargic to pick-up after this trending development. Although it may have been because we seem far removed from such cutting-edge costly technology for some, the reasons are more complex for the scientifically minded. Many developed countries are burdened with symptomatic cases with their healthcare systems being taxed with severe cases nearing their maximum capacity. The vaccines are primarily aimed at preventing symptomatic disease; and thus, are the solution to their immediate plight. However, Sri Lanka stands on a slightly different footing in terms preventive measures instituted, testing strategy and management of positive cases. Our goal is to prevent the spread of the virus, be it symptomatic or asymptotic while continuing provision of services and economic activities as far as feasible. Even if we bask in the momentary glory of success of the vaccines, we must not lose sight of the tested and proven methods of preventing the spread of COVID-19. We cannot fall back into a slumber nor can we falter in our attempts to implement these measures universally. A vaccine is only one among many in the armamentarium against COVID-19 such as physical distancing, limiting mobility, the proper use of face masks, respiratory etiquette, appropriate and optimal testing, isolation of infectious cases, and treatment. These have been, and will always remain, as absolutely essential manoeuvres.

As Albert Einstein once said "learn from yesterday, live for today, hope for tomorrow. The important thing is not to stop questioning". Across the world, yesterday, today and tomorrow of every human being is being afflicted by a pesky microscopic virus that is causing so much destruction, pain and chaos. Hope and optimism are the impetus that keeps us moving forward. However, being the most intelligent creatures to ever walk on this earth, we must never stop questioning, debating, re-evaluating, learning and re-learning. Let us be cautiously optimistic, sensible and responsible. We must learn to live with COVID-19 if we are to persevere, let our economies recover, let our patients get the optimal care they deserve and let our children play and continue their education. This virus has practically forced us to pause our lives. The goal should be to "unpause" it.

President's Message

Dear Members of the Sri Lanka Medical Association,

Inequities in health have always existed. Over centuries pandemics have disproportionately affected the poor and the disadvantaged. However, the way the COVID-19 pandemic has exposed the spiraling impact of social and structural inequities is unprecedented. The disproportionate impact of COVID-19 on people who are already disadvantaged by virtue of age, health status, residence, occupation, and socioeconomic condition is profound.

Sri Lanka is beginning to experience this reality, with increasing morbidity among the urban poor, factory workers, prisoners, fishermen and daily wage earners. Mortality is higher among the disabled and elderly. Congested, crowded and humid environments, poor ventilation, behaviours conducive to spread such as lack of adherence to infection control measures leads to super spreader events. The complex network and high mobility of daily wage earners can lead to rapid spread as we are experiencing now in Sri Lanka.

Proven epidemiological interventions such as contact tracing, screening, quarantining and implementing preventive practices can be a challenge in these settings. Serious limitations have hampered these measures as there are high number of infections in multiple clusters, some connected with critical economic centres of the country.

Physical distancing measures, which are necessary to prevent the spread of COVID-19, may not be practical in these setting. The urban poor communities are at higher risk of infection during physical lockdowns especially if public spaces are closed, resulting in crowding in confined spaces. Those with chronic conditions facing adverse social circumstances and compound issues, such as reduced access to healthcare, leading to a vicious cycle of poor outcomes.

Therefore, the success of controlling the spread depends on the level of community participation and empowerment. The involvement of community has always proven to be a basic element in outbreaks and epidemics.

A one-way communication process that dictates do's and do not's without having a sound understanding of ground realities is unlikely to succeed in these settings. The needs of affected communities such as maintaining social connectivity, livelihood support, relief services and addressing social issues such as stigma, discrimination and rights of patients and their family members must be addressed.

Participatory approach should empower communities to have greater control over the decisions affecting their lives in order to improve their health and reduce inequalities. However, it is important to note that geographic proximity is not always equivalent to social cohesion and shared interests. Even within the same locality, socio-economic and cultural characteristics may not be uniform.

The effect of social determinants of health and COVID-19 morbidity is perhaps still underestimated. On a positive note, the effects of COVID-19 have shed light on the broad disparities within our society and provided an opportunity to address those disparities.

Professor Indika Karunathilake
President, Sri Lanka Medical Association

SLMA Monthly Clinical Meetings

Dr. Nimani de Lanerolle, Assistant Secretary, SLMA

Clinical meeting in collaboration with College of Obstetrician and Gynaecology in Sri Lanka

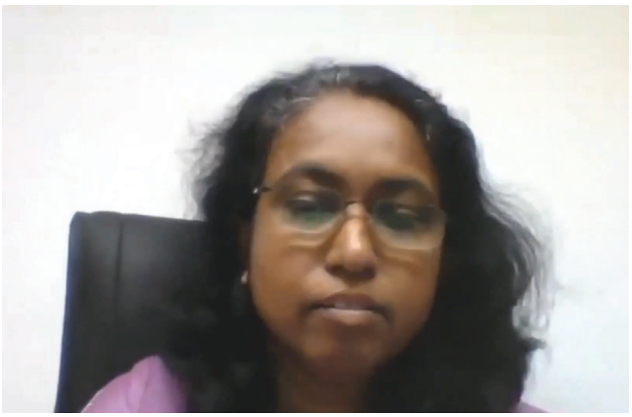
The Sri Lanka Medical Association in collaboration with the College of Obstetrician and Gynaecology in Sri Lanka conducted a clinical meeting on the 20th October 2020 via a web-based platform due to the current COVID-19 epidemic. The programme commenced with case presentations by Dr. Sajith Kodithuwakku, Consultant Obstetrician and Gynaecologist, Base hospital Medirigiriya. Subsequent to that, a lecture discussion was carried out by Dr. Sanjeewa Padumadasa, Senior lecturer, Department Obstetrics and Gynaecology, Faculty of Medicine - University of Kelaniya. Dr. Nilan Rodrigo Senior Lecturer, Department of Obstetrics and Gynaecology Faculty of Medicine, Kothalawela Defense University conducted a lecture on "Peripartum Collapse". The programme concluded with an MCQ discussion by Dr. Rasika Herath, Senior lecturer, Department of Obstetrics and Gynaecology, Faculty of Medicine,University of Kelaniya.

For the full presentations, please visit https://www.youtube.com/watch?v=LJfY5qwSpGM&t=3393s

Clinical meeting in collaboration with Sri Lanka College of Dermatologists

A clinical meeting organised in collaboration with the Sri Lanka College of Dermatologists was held on 29th October 2020 via a web-based platform. This session included a case presentation by Dr TMU Liyanage, Senior Registrar in Dermatology, Teaching Hospital, Karapitiya. and a review lecture by Dr Binari Wijenayake, Consultant Dermatologist, Teaching Hospital, Karapitiya titled "Diagnostic approach to patients with suspected vasculitis." This was followed by a Multiple-Choice Question Discussion by Dr Vanitha Shanmuhathas, Senior Registrar in Dermatology, Teaching Hospital, Karapitiya. The session concluded with the launch of an educational video on psoriasis by Dr. Indira Kahawita, President, Sri Lanka College of Dermatologists.

For the full presentations, please visit https://www.youtube.com/watch?v=GVD1KkGHtxI



Clinical Meeting on "The Eye in Dermatology" in collaboration with Sri Lanka College of Ophthalmologists

A Clinical meeting in collaboration with the Sri Lanka College of Ophthalmologists was held on 3rd November 2020 a webinar titled "The Eye in Dermatology". A Case Presentation was carried out by Dr SWR Somaweera, Senior Registrar, National Eye Hospital, Colombo. This was followed by a review lecture in relation to the cases by Dr Pradeepa K Siriwardena, Consultant Eye Surgeon, National Eye Hospital, Colombo. This program also included a Multiple-Choice Question discussion which was conducted by Dr Kushlani Gooneratne, Consultant Eye Surgeon, National Eye Hospital, Colombo. In addition, a picture Quiz was also carried out by Dr GJN Widanage, Senior Registrar, National Eye Hospital, Colombo.

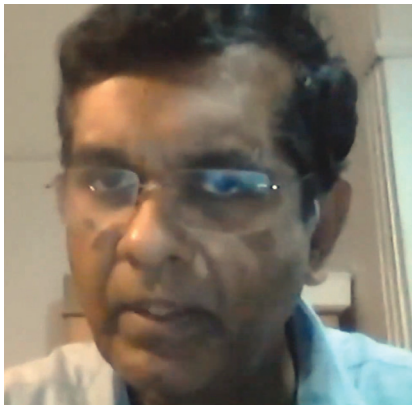
For the full presentations, please visit https://www.youtube.com/watch?v=Vf92H1rFsw4

Webinar on "An update on measures to control COVID-19 infection in Sri Lanka"

Dr. Nimani de Lanerolle and Dr. Sajith Edirisinghe - Assistant Secretaries, SLMA

The Sri Lanka Medical Association together with the Ceylon Chamber of Commerce and Ministry of Health organized a webinar on measures that are being taken to manage COVID-19 epidemic in Sri Lanka. It was held on the 2nd of November and the aim was to educate the cooperate sector regarding the measures and mechanisms to control the current crisis whilst maintaining economic activity.

This session was organized by Dr.Padma Guneratne, President Elect SLMA and Mr. Manjula de Silva Secretary General and CEO of the Ceylon Chamber of Commerce. The programme commenced with an overview of the current situation and the conceptual framework presented by Professor Indika Karunathilake, President SLMA. This was followed by a presentation by Dr. Lakshman Gamlath, Deputy Director General-Environmental and Occupational Health and Food Safety Unit of the Ministry of Health, and a panel discussion. The panelists included Dr. Ananda Wijewickrama, Dr. Shirani Chandrasiri, Professor MC Weerasinghe, Professor Saroj Jayasinghe and Dr. Lakshman Gamlath. The webinar concluded with a lively question and answer session where members of the corporate sector asked pertinent questions related to their businesses.



The key points discussed during the webinar are summarised below.

- In the second wave, the virus transmissibility has increased, and the number of cases is rising. The possible reasons identified by the health authorities for the rapid spread of the virus in free trade zone and fish market were highlighted during the discussion.
- As people would have to adapt to living in the "New Normal" with the current global situation being expected to last for another 2-3 years in order to sustain the economy in the country. The 3Cs, namely Cleaning hands, Crowded places - avoid, Cover nose and mouth with a mask were presented as the main points that the general public should adhere to prevent the spread of COVID-19.
- In the meantime, the government and the higher authorities of institutions should follow the 3Ls; Legislations, Leadership, Legal enforcement. The measures to be taken in workplaces to prevent the spread of COVID-19 were discussed in detail. The guidelines on prevention of COVID-19 in workplaces can be found on eohfs.health.gov.lk.
- Trace, Test, Treat - the 3Ts were emphasised as the main tasks of the front-line health care workers. Even though these three sectors have well defined roles, the need for coordination, collaboration, communication, and commitment to win the battle against COVID 19 was emphasised during the discussion. Guidelines, regulations and legislations regarding management and control of COVID-19 need to be updated from time to time, and all the parties should adhere to these to yield the optimal outcome.
- As contacts are primarily home-quarantined now, there are practical difficulties in stringent monitoring of a large number of individuals in the community by MOHs and PHIs. Therefore, the support of the general public and adhering to recommendations by individuals is essential in this crucial situation.
- The currently treatment protocols for management of COVID-19 cases were also discussed during the webinar by Dr. Ananda Wijewickrama. He stated that there are no specific antiviral drugs or therapies to boost immunity with proven benefit so far. Furthermore, it was emphasised that inhalation of steam at temperatures required to kill the virus (above 600C) could damage the cells in the respiratory system and be harmful. Although, normal steam inhiations may relieve symptoms such as nasal congestion, there is no proven benefit in prevention COVID-19 or killing the virus. Testing for COVID-19 was also discussed and it was stated that antigen testing is not an alternative for PCR as PCR is the diagnostic test while the antigen test is primarily used for screening.

- The alcohol percentage in disinfectants and hand sanitizers should of 75% or more to be effective and quality of these products should be assured.
- There was consensus among the panelist that the country's industries should function to ensure economic stability whilst strictly adhering to health guidelines. Also, it is advisable to promote and adapt more remote and digital methods of working whenever the possible.

For the full webinar, please visit For the full webinar, please visit https://youtu.be/dcafJ0yPGUk

Conceptual Framework Presented by Prof. Indika Karunathilake, President SLMA

Continuing Health Promotion activities via telephonic and social media networks - Lessons learnt from the NIROGI Lanka Project

Dr. Chathuranga Ranasinghe
Chairperson, NIROGI Lanka project, Sri Lanka Medical Association, Sri Lanka

Background

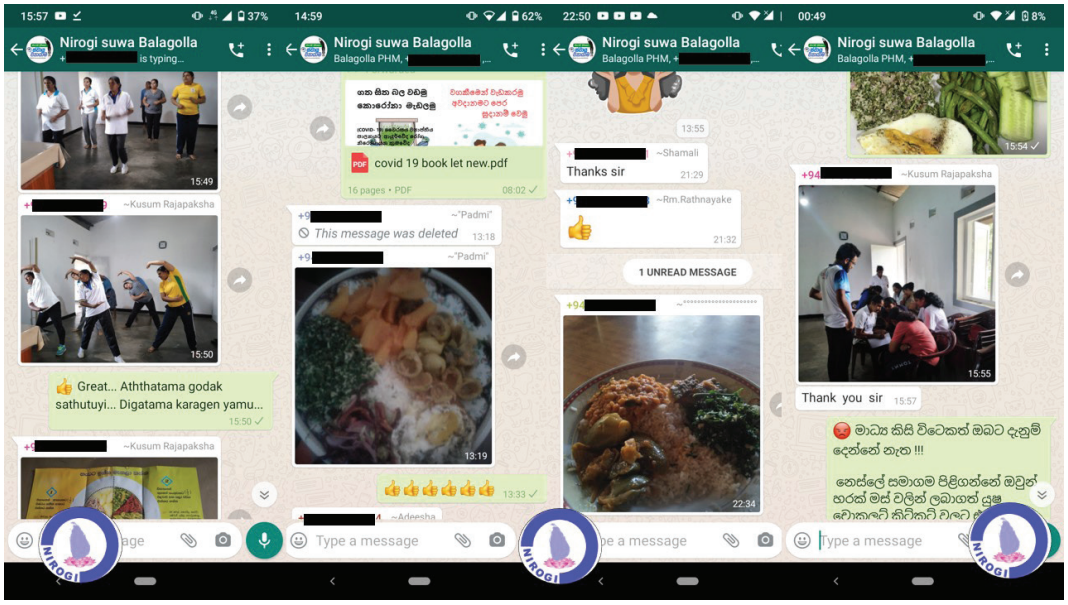
The NIROGI Lanka Project, a flagship venture initiated under the Non-Communicable Diseases (NCD) Expert Sub-committee of the Sri Lanka Medical Association in 2009, aims to prevent and manage the growing burden of NCDs in Sri Lanka. The project which is carried out in collaboration with the Ministry of Health Sri Lanka, World Diabetes Federation, Sri Lanka Diabetes & Cardiovascular Initiative, Rotary International, academia and relevant technical experts successfully completed 11 years in 2020. Phase III (2016-2019) of the NIROGI project identified 'health promotion' with capacity building of the workforce and public on lifestyle modification to achieve a healthy life as a priority and launched the "NIROGI Diviya" (Healthy Lifestyle) theme. A health promotion model was developed, and activities were conducted through Health Promotion Officers (HPOs) allocated to Medical Officer of Health (MOH) areas in Sri Lanka. The project was initially carried out in urban communities in the Colombo district and later expanded to rural and suburban communities in 6 districts (Galle, Ratnapura, Kurunegala, Kandy, Anuradhapura and Colombo). Currently over 10,000 families are enrolled from 6 districts, 18 MOH areas in more than 200 different settings covering communities, schools and workplaces. This model is now accepted to be institutionalized to the state health sector in Sri Lanka.

However, with the COVID-19 pandemic which is causing devastating global morbidity and mortality,the initial lockdown and curfew enforced in Sri Lanka compelled the health promotion activities of the project to be halted. As social distancing and isolation profoundly affect the lifestyles and health of the public, they are afflicted by physical, social and psychological stress and anxiety.Now we are experincing another wave of increased cases and restrictions are being gradually imposed.

Challenges and interventions

During the first phase of lockdown (March to June 2020), the NIROGI team faced many challenges to continue the health promotion activities (which were conducted face-to-face) and initiated an intervention to maintain the already ongoing activities via telephone and social media platforms to overcome these constraints. The objective was to help communities to maintain their healthy behaviour without falling back, facilitating mental wellbeing in uncertain situations, motivating to practice and initiate new healthy behaviours and practicing COVID-19 prevention measures.

During the intervention, members of the community were contacted individually via telephone. They were facilitated to re-start the group communication via telephone and social media platforms, encouraged to re-initiate the health promotion-setting groups, and provided continuous technical and psychological support. An on-going dialogue developed among them, and the health promotion activities on lifestyle modification and living in the 'New Normal' during the COVID- 19 pandemic were re-initiated.



Outcome

By this simple intervention we were able to facilitate 256 individuals in different communities including grass root level healthcare workers in 6 districts to engage in health promotion activities. Through those active community leaders, 2782 families were reached. The individuals were followed up by health promotion officers where new social media groups were developed within the communities to share their knowledge and reinforce practiced behaviours. These group-initiated actions were used to motivate other members in the community by virtually reaching a larger number of individuals. Weekly online meetings were held to review the progress and to address challenges.

Conclusions and the way forward

With the use of telephone and social media platforms, we were able to continue some of the health promotion activities which were previously done as face-to-face interventions. With this new intervention, the project developed a novel mode of communication through which continuous community engagement and mobilization became possible, even during challenging times. This process is currently on-going and facing the second wave of COVID-19 with new additions and improvements.

NIROGI Team

Senior advisor Prof. Chandrika Wijeyarathne, Dr. Chathuranga Ranasinghe, Dr. Jayanthimala Jayawardena, Prof. Carukashi Arebepola, Dr. Manoj Fernando, Dr. Ajith Alagiyawanna, Dr. M Ramasubbhu.

Health promotion officers: Mr Pradeep Tharanga, Mr. Ushan Dandudeniya , Mr. Ravindra Athurupana, Mr. Sanjeewa Kumara, Mr Deshapriya Thennakoon , Mr Mahesh Madurasiri ,Mr Dilanka Sandaruwan.

Active Lanka *Entry Point to Wellbeing..*

NIROGI Facebook page: https://www.facebook.com/nirogidiviya
You tube channel: https://www.youtube.com/channel/UCwuq8Ook7NoY7aJpdBwuwPA
Website: http://nirogilanka.org/

Activities of the SLMA expert committee for control of tobacco, alcohol and dangerous drugs

Dr. Anula Wijesundere, Immediate Past President - SLMA

The SLMA expert committee for control of tobacco, alcohol and dangerous drugs participated in a press conference arranged by the Sri Lanka Temperance Association to protest against attempts to legalize the growth of cannabis in Sri Lanka for medicinal use. It was held on 22nd of September at the All Ceylon Buddhist Congress and was attended by more than 30 journalists from the print and electronic media. The meeting was presided over by Ven. Itthapane Dharmalankara Thero, President of the Sri Lanka Temperance Association with Cardinal Malcom Ranjith in attendance. Ven. Trincomalee Ananda Thero also participated. The SLMA expert committee was represented by Dr Mahesh Rajasuriya, Dr Manuj Fernando and Dr Anula Wijesundere. This conference received much publicity both in the print and electronic media.

The SLMA expert committee also participated in a seminar organized by the Organization of Professional Associations (OPA) to protest against the promotion of the growth of cannabis. This was held at the OPA headquarters on 29th of September. The SLMA was represented by President Elect Dr Padma Goonaratne, Dr Sajeewa Ranaweera, Dr Manoj Fernando, Dr Jayamal de Silva and Dr Anula Wijesundere. All the members made very useful presentations.

Source: Lankadeepa Newspaper, 23rd September 2020, page 08

SLMA Foundation Sessions 2020
Continuing traditions in the new normal

Dr. Sankha Randenikumara, Council Member - SLMA

The SLMA Foundation Sessions is an annual event which holds an important place in our calendar. Due to recent developments in the country related to the COVID-19 epidemic, there was much uncertainty in conducting the sessions as before. With the fruitful experiences gained from the SLMA Annual International Virtual Congress conducted earlier this year , the SLMA council headed by the President Professor Indika Karunathilake decided to go ahead with the tradition of conducting the Foundation Sessions in the "New Normal" even in these unprecedented times. Thus, the sessions became a virtual one for the first time in history and it was webcasted live from the historic Wijerama House for all who were interested to participate online free of charge!

The EM Wijerama Endowment Lecture which was held on the 6th of November evening gave an energetic start to the Foundation Sessions. This lecture was delivered by Professor Narada Warnasuriya, the Past President of the SLMA in 2010. Professor Warnasuriya's talk on 'Personal Reflections of a Professional career" had gained live attraction from hundreds of participants to the webcast. Dr Anula Wijesundere, the immediate past president of the SLMA graced the occasion as the Chief Guest and she delivered a speech on "Stop ragging in Universities", a topic on which she passionately worked on during her tenure.

The academic programme of the Foundation Sessions which were held on the following day, the 7th of November consisted of four symposia which continued till the late afternoon. The first session "Stay strong: Live long" included some thought-provoking ideas on healthy lifestyle. Dr Renuka Jayatissa, Medical Nutritionist at MRI spoke about 'Food to Live Longer', Dr Chaturanga Ranasinghe, Specialist in Sports and Exercise Medicine on "Exercise is Medicine: A vital sign not to miss" and Dr Mahesh Rajasuriya, Consultant Psychiatrist on "Stress and NCDs".

The second symposium on Neurology was a stimulating discussion, based on common patient scenarios related to acute headache in adults, symptoms in peripheral nervous system and dementia syndromes. Resource persons were Consultant Neurologists, Dr Gamini Pathirana from the National Hospital of Sri Lank (NHSL), Dr Champika Gunawardana from Teaching Hospital Ratnapura and Dr Manjula Caldera from Teaching Hospital Anuradhapura.

The third symposium "Safety is No Accident" commenced as the post-lunch session and was about three important topics. Dr Chameera Bandara, Consultant Oculoplastic Surgeon of National Eye Hospital gave a holistic view on 'Eye Injuries and Management'. In his talk on 'Safe Living - Is it a Dream?' Dr Jagath Rathugamage, Consultant Neurosurgeon at NHSL elaborated on unnoticed aspects of safety in day-to-day life. Dr Yasas Abeywickrama, Consultant Plastic and Reconstructive Surgeon at Colombo South Teaching Hospital then presented important aspects on 'Management of Burns'.

The final symposium "Know your Heartbeat" was an interesting scenario-based discussion conducted by a panel of eminent cardiologists. The session was mainly focusing on acute coronary syndrome,its practical approaches and interesting presentations of sudden cardiac death. The resource persons include Consultant Cardiologists, Dr Sampath Withanawasam at NHSL, Dr Aruna Wijesinghe at BH Panadura, Dr Stanley Amarasekera at NHSL and Dr Susitha Amarasinghe, Consultant Cardiac Electrophysiologist of Teaching Hospital Karapitiya.

The sessions concluded as an immense success with over 2000 viewers online. We are especially grateful to all the resource persons from professional colleges and associations, our own Dr. Pamod Amarakoon (Asst. Treasurer - SLMA) and the IME audio-visual production team led by Dr. Dinil Abeygunawardane for their valuable contribution in this challenging time.

A situation analysis of the Peliyagoda Fish Market cluster

Professor Indika Karunathilake, President SLMA

A situation analysis of the Peliyagoda Fish Market cluster was conducted by Sri Lanka Medical Association in collaboration with the Ministry of Fisheries.

According to data of PCR testing performed on 19th October 2020, those who were in wholesale and retail stalls were more affected than the fishermen and labourers who handle fish directly and customers who came there. Over-the-phone interviews with who were tested positive indicated poor adherence to infection control measures.

The high number of infected persons, highly conducive environment and long exposure at the Peilyagoda Fish Market made people highly vulnerable to contracting the infection. Based on available information, it can be concluded that congested, crowded and highly humid environment, behviours conducive to spread such as lack of adherence to infection control measures have led to rapid spread within the fish market. Several wholesale buyers travelling in same vehicle, poor infection control measures, dense network of fish vendors have contributed to spread within congested urban areas. There is no evidence of transmission due to consumption of fish.

Out of 866 who were tested positive at Peliyagoda Fish Market on 23rd October, many were from densely populated and congested urban slum areas. This too may have played a role in rapid spread to first and second level contacts or close contacts.

The SLMA has suggested a systematic approach in order to re-establish and sustain a COVID free supply-distribution mechanism. This approach consists of both structural and behavioural changes in the entire fisheries industry. Breaking the chain of transmission at all steps from catching to consumer can only be achieved by strict adherence to basic preventive measures. Minimising of gathering of crowds during all steps is essential.

Technological Advances in Diabetes Care

Dr. Sachith Abhayaratna MD (Col) MRCP (Lon) MRCP (Diabetes & Endocrinology) FACE (USA)
Specialist in Endocrinology & Senior Lecturer in Pharmacology, Faculty of Medicine, University of Colombo

Despite the availability of several new classes of medicines with improved glycaemic and cardiovascular outcomes, a person with diabetes still may experience significant physiological, cognitive and psychological burdens. To achieve and maintain optimal glycaemic control, those who require insulin generally must engage in time consuming behaviours such as frequent finger prick glucose monitoring, adjusting insulin doses according to carbohydrate intake and exercise while also attempting to avoid hypo and hyperglycaemic episodes.

"Optimal glycaemic control" is now understood to be more than simply achieving a target haemoglobin A1c (HbA1c) level. Other factors such as glycaemic variability and "time-in-range" may have important clinical implications in cardiovascular and other outcomes.[1] Diabetes technologies have gained a considerable importance in diabetes care in recent times and the American Diabetes Association describes Diabetes technology as "the hardware, devices, and software that people with diabetes use to manage blood glucose levels, stave off diabetes complications, reduce the burden of living with diabetes, and improve quality of life".[2] In recent times we have seen an influx of plethora of new diabetes technologies aiming to improve the accuracy of glucose monitoring and to reduce the burden placed on frequent insulin injections. Given the labour intensive and data driven nature of technologies involved in diabetes management, having access to the right tools can be critical to improving glycaemic control. This article will highlight the emerging new technologies in the fields of glucose monitoring and insulin delivery. Although currently most of these technologies are not available in Sri Lanka, as the production costs are expected to decline with time, some of these new technologies may be available to us in near future.

""Optimal glycaemic control" is now understood to be more than simply achieving a target haemoglobin A1c (HbA1c) level. Other factors such as glycaemic variability and "time-in-range" may have important clinical implications in cardiovascular and other outcomes."

Continuous Glucose Monitoring

Self-Monitoring of Blood Glucose using a glucometer has become an integral component of effective therapy in patients taking insulin. In recent years, continuous glucose monitoring (CGM) has emerged as a convenient and more accurate method for assessing glycaemic control. CGM helps to obtain a more complete understanding of glycaemic variability by examining glucose levels every 5-15 minutes throughout the day (**Figure 1**). As such, CGM allow patients and providers to assess trends, patterns and percentages of time spent in or out of glycaemia targets. Many studies have shown that use of CGM improved glycaemic control, decreased time spent in hyper or hypoglycaemia, and decreased the risk of complications secondary to diabetes.[3,4] Each of these CGM systems require a sensor that is inserted subcutaneously, measures interstitial fluid glucose values and data is then relayed to a transmitter.

CGM accuracy is often evaluated using the mean absolute relative difference (MARD), the difference between the CGM reading and the blood glucose level measured by a reference system. Current CGM systems are able to achieve a MARD under 10% (**see Table 1**). The data from CGM can be downloaded or directly viewed through a data receiver or from a smartphone and these data can also be sent directly to the treatment provider. Most of the currently available CGM systems have a warning alarm above or below a set blood glucose level.

"studies have shown that use of CGM improved glycaemic control, decreased time spent in hyper or hypoglycaemia, and decreased the risk of complications secondary to diabetes"

Limitations in Continuous Glucose Monitoring

Most CGM systems require calibration with finger prick blood glucose readings before any treatment decisions are made based on CGM readings. However, some newer CGM systems have eliminated the need for user calibrations with more accurate factory calibrations. Sensors of most CGM systems have to be replaced every 7-10 days which may be seen as a hassle by some patients. Efforts for developing more long-lasting sensors are under way. Until recently most CGM systems required a separate component ("receiver") to display glucose data. The FDA's increased regulatory flexibility now allows smartphones to be used as display devices and many CGM manufactures have provided smartphone compatibility eliminating the need of a separate CGM receiver. Apart from above mentioned technological limitations, cost remains to be the main barrier in using these devices in a majority of patients. Wide choice of CGM systems are now available in the market and **Table 1** summarise the features of currently available CGMs.

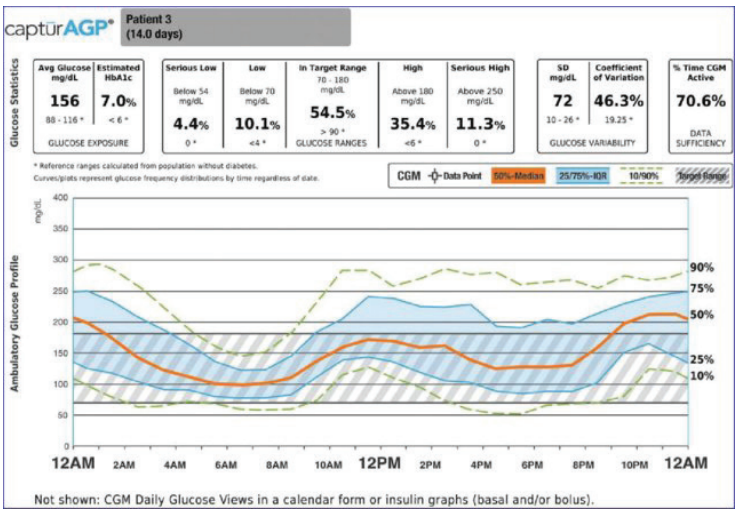


Figure 1 : *Continuous Glucose Monitoring report* [5]

Table 1 : Currently available CGMs [6]

CGM	Receiver	Size and weight	Warm-up/ calibration	Dosing decisions	Duration	Alerts	Share feature	Age	MARD	Software
Abbot Freestyle Libre 	Reader; Sensor stores 8 hours of data if not read	1.38 in. diameter x 0.2 in; 0.18 oz.	1-hour warm up; no calibration required	Yes	14 days	No	No	≥18 years and older	10%	LibreView
Dexcom G5® 	Receiver or Dexcom phone app	1.5 x 0.9 x 0.5 in; 0.4 oz. with sensor	2-hour warm up; calibration required every 12 hours	Yes	7 days	Yes	Yes	≥2 years and older	9%	Clarity®
Dexcom G6® 	Receiver or Dexcom phone app (Apple and Android devices) or integrated with t:slim X2™ pump	4.02 x 2.44 x 0.46 in; 3.3 oz.	2-hour warm up; no calibration required	Yes	10 days	Yes	Yes	≥2 years and older	9%	Clarity®
Medtronic Guardian™ Sensor 3 	Integrated with Medtronic MiniMed 670G insulin pumps	1.4 x 1.12 x 0.37 in; 0.19 oz. without sensor	2-hour warm up; calibration required every 12 hours	No	7 days	Yes	No	≥7 years and older	9.1% (8.7% with 3–4 calibrations a day	Carelink™
Medtronic Guardian™ Connect 	Guardian™ Connect smart phone app (Apple devices only)	1.41 x 1.13 x 0.38 in; 0.04 oz.	2-hour warm up; calibration required every 12 hours	No	7 days	Yes	Yes	≥14 years and older	9.1% (8.7% with 3–4 calibrations a day	Sugar.IQ™
Senseonics Eversense® 	Smart phone app (Apple and Android devices)	1.48 x 1.89 x 0.35 in; 0.39 oz.	24-hour warm up; calibration required every 12 hours	No	90 days in USA; 180 days in Europe	Yes, and transmitter vibrates alerts when away from phone	Yes	≥18 years and older	8.8%	Eversense® DMS

CGM = continuous glucose monitor; in = inch; MARD = Mean absolute relative difference; oz = ounces.

Smart insulin pens

The Timesulin® insulin pen cap was released in 2011 and it fits all insulin pens and shows users when the last insulin injection was administered. The 'InPen' is another smart pen device that uses insulin cartridges in a reusable pen and links to a smartphone app that provides a bolus advisor and insulin on-board calculations (**figure 2**). some of the CGM systems can be linked to the 'InPen' app to provide trends and blood glucose averages as well. These enhanced smart insulin pens may help to overcome the barriers to adherence with insulin administration including inappropriate dosing and the need for remembering to administer insulin injections on time.

Figure 2 *- InPen and its smartphone app (Source-https://www.companionmedical.com/why-inpen/)*

Insulin pumps

The first insulin pump was invented in 1974 but it was so large that it could only be used during diabetic ketoacidosis (DKA) and hospitalisations. The first commercial insulin pump was released in the 1980s. The basic advantage of an insulin pump is its ability to supply a continuous infusion of low dose rapid or short acting insulin subcutaneously to satisfy the patient's basal insulin needs. In addition, the patients can manually deliver a larger bolus insulin doses to manage the body's mealtime insulin needs using an insulin pump. The pump contains a reservoir that can store a range of 200 to 300 units of insulin. The pump is connected to the user's body via an infusion set that must be changed approximately every 3 days. In sensor-augmented insulin pump, it combines the technology of an insulin pump with a CGM system to deliver a more improved performance. Newer insulin pumps loaded with features like low glucose threshold suspend and predictive low glucose suspend have shown to reduce the hypoglycaemic episodes without an increase in hyperglycaemia. During the last four decades there has been a remarkable advancement in insulin pump technology and efforts are underway to build a device that delivers insulin without any user involvement (**figure 3**).

Figure 3: *Different types of insulin pumps (Source - Insulin pump awareness group ,https://www.ipag.co.uk/)*

Limitations in insulin pumps

All patients on insulin pumps are recommended to keep a spare insulin pen as a safety measure as pump malfunction remains a distant yet a possible complication with any technological device. At present the patient is still required to count carbohydrates and enter these data into the pump, know when and how to override the system if warranted, regularly change and rotate sites, and troubleshoot issues that may arise (e.g., line occlusions, extreme hyperglycaemia, discrepancies between sensor and calibration value).Dislodging the tubing of insulin pump while playing has always been a concern when insulin pumps are used in children. Small tubeless patch pumps have been designed to overcome this issue and has been an extremely popular option specially in children with type 1 diabetes.

Artificial pancreas

Getting a step closer to fully independent insulin system delivery without any user inputs, closed loop systems have been recently introduced to the market. Currently two partially automated (hybrid) closed-loop systems of insulin delivery (artificial pancreas) are commercially available for people with type 1 diabetes. These insulin pumps are paired with a CGM Sensor and in the 'auto mode' a built-in algorithm adjusts the basal delivery of insulin every 5 minutes based on the CGM data received and according to the predetermined target glucose level. Artificial pancreas is able to suspend or decrease insulin delivery to prevent an expected hypoglycaemic episode on its own. Each of the available devices can transmit insulin dosing data, CGM data and pump and CGM settings to cloud-based systems. These data can be retrieved and reviewed on demand. Compared with the sensor-augmented pump, use of the hybrid closed-loop system in type 1 diabetes patients has shown to result in a greater proportion of time spent in the target range, lower mean glucose level and the mean HbA1C level with less hypoglycaemic events.[7]

"Research is ongoing to introduce a bionic pancreas that can autonomously administer either insulin or glucagon depending on the patient's specific needs and that does not require carbohydrate counting"

New technologies expected in future

Some of the newer CGM systems come with more long-lasting implanted sensors which can be kept in for 6 months. Trials have been completed for implanted sensor which could be kept for 12 months and these new long-lasting sensors could give additional options for those who view frequent changing of the sensor as a hassle. Research is ongoing to introduce a bionic pancreas that can autonomously administer either insulin or glucagon depending on the patient's specific needs and that does not require carbohydrate counting. As mobile devices and apps become even more prevalent, they will undoubtedly play an increasingly significant role in helping patients live successfully with diabetes in future. More advanced patch pumps with close loop system are also expected in the near future.

New blood glucose monitoring and insulin delivery devices have revolutionised the diabetes care and represent an historic opportunity to improve the lives of people with diabetes. To achieve optimal results even with the most sophisticated devices available today, it is essential to have patient motivation, education of the healthcare team and continuous technical support from the device manufacturer. While many issues are still needed to be resolved before these new technologies could make a sizable impact on diabetic care in patients in our region, it is prudent to keep an eye on some of these exciting new developments lined up for the future.

Conflicts of interest - none

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Dementia

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"Those with dementia are still people and they still have stories and they still have character and they are all individuals and they are all unique. They Just need to be interacted with on a human level"
-Carey Mulligan-

Dementia is a clinical syndrome, characterized by global cognitive impairment and should represent a decline from the previous level of functioning. Dementia is usually associated with impairment in functional abilities and in many cases they may have behavioural and psychiatric disturbances. ICD 10 defines dementia as a "syndrome due to disease of the brain, usually of chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capability, language and judgement. Consciousness is not impaired. Impairment of cognitive function is commonly accompanied, occasionally preceded by deterioration in emotional control, social behaviour or motivation. This syndrome occurs in Alzheimer's disease, in cerebrovascular disease and in other conditions primarily or secondarily affecting the brain." The prevalence of dementia increases with age with 1 to 2% of the population less than 65 years, 10 to 15% at 80 years and 40% at 90 years having dementia.

"ICD 10 defines dementia as a "syndrome due to disease of the brain, usually of chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capability, language and judgement."

Dementias are broadly classified as cortical dementias and subcortical dementias. Cortical dementias affect the cerebral cortex and memory and language are impaired. Alzheimer's dementia is the commonest. Subcortical dementias such as those seen in Parkinson's disease, Huntington's disease and AIDS dementia complex affect the subcortical areas where main impairment occurs in executive functioning such as speed in thinking, ability to initiate activities while memory and language are not affected until the late stages. In some dementias like multi-infarct dementia both cortical and subcortical areas are affected. Some of the major dementia syndromes are Alzheimer's dementia, vascular dementia and dementia with Lewy bodies.

"Alzheimer's dementia is the commonest."

"Establishing aetiology is essential as there are many correctable causes"

Being a clinical diagnosis, the evaluation of a patient with dementia is of immense importance. The goals of clinical evaluation include establishing that the patient has dementia, characterizing the impaired areas of cognition and assessing the severity of the impairment. Further the functional consequences to the patient and family and the aetiology have to be established. Establishing aetiology is essential as there are many correctable causes. History should focus on the onset and progression, characterizing cognitive impairment, functional ability (activities of daily living) and behavioural changes. The patient should undergo a comprehensive neurocognitive assessment but the basic minimal includes a brief structured screening test such as the mini mental state examination (MMSE) or the Montreal cognitive assessment (MoCA) and a complete neurological examination. Neuropsychological testing is recommended whenever available. Based on an evidence-based review published by Knopman DS et al in 2001, the American Association of Neurology (AAN) recommends the following laboratory investigations - Vitamin B12 levels, Thyroid stimulating hormone levels, a complete blood count to detect anaemia, and serum creatinine levels. If indicated one could proceed with a rapid plasma regain test, HIV test and screening for unusual neurological disorders. A lumbar puncture is not recommended as a routine investigation except in patients with specific indications. EEG has no place in routine evaluation. Brain imaging is recommended to find the aetiology and exclude any sinister causes. MRI is the preferred modality; however CT brain is used in resource limited settings.

"Risk factors for AD include age (every 5 years beyond 65 years the percentage of people with AD doubles), family history, female gender and life exposure factors such as head trauma, high cholesterol, diabetes mellitus, hypertension, obesity and lack of intellectual stimulation"

Alzheimer's disease (AD) is the commonest type of dementia encountered and the rest of this article will focus on it. DSM IV defines it as memory deficit that can be demonstrated objectively on cognitive testing and at least one other cognitive impairment (aphasia, executive functioning, agnosia, apraxia). The onset should be

gradual with a continuing cognitive decline and the decline should be from a previous higher functioning level. There should be impairment in performance of daily activities of living and no other neurological disease to account for the above. Alzheimer's dementia has a Mendelian inheritance of approximately 1% and several new genes are consistently associated with the risk of developing AD. The overall magnitude of acquiring AD due to a genetic cause is small and the clinical relevance is undefined. However familial AD is autosomal dominant with full penetrance and early onset of disease and the 3 genes mainly associated with AD are amyloid precursor protein (APP), presenilin 1 (PSEN 1) and presenilin 2 (PEN 2) genes.

Risk factors for AD include age (every 5 years beyond 65 years the percentage of people with AD doubles), family history, female gender and life exposure factors such as head trauma, high cholesterol, diabetes mellitus, hypertension, obesity and lack of intellectual stimulation. AD can be clinically classified as mild, moderate and severe. Table 1 shows the clinical features of AD.

"The main pharmacological therapeutic agents used are cholinesterase inhibitors donepezil, rivastigmine and galantamine"

Mild AD	Moderate AD	Severe AD
Forgetfulness	Disorientation	Agnosia
Word finding difficulty	Worsening memory loss	Apraxia
Apathy	Confusion	Aggression
Poor attention	Insomnia	Agitation
Difficulty with complex tasks	Wandering	Incontinence
Depression	Speech difficulty	Poor basic activity of daily living
Work trouble	Restlessness	Gait disturbances
	Difficulties with activities of daily living	

Table 1: Clinical features of AD

The main pharmacological therapeutic agents used are cholinesterase inhibitors donepezil, rivastigmine and galantamine. The other drug is memantine which has different mode of action. Table 2 describes the drugs, formulations available and the doses.

Drug	Maintenance dose
Donepezil (long acting reversible acetylcholinesterase inhibitor)	5-10mg/day
Donepezil (sustained release)	23 mg/d
Rivastigmine (pseudo irreversible cholinesterase inhibitor selective for acetylcholinesterase and butyrylcholinesterase)	3mg / 4.5 mg/6mg twice daily
Galantamine (reversible competitive acetylcholinesterase inhibitor)	8mg or 12 mg twice daily

Table 2: *Cholinesterase inhibitors*

Drug	Adverse effects
Donepezil	Nausea, diarrhoea, insomnia, vomiting, muscle cramps, fatigue, anorexia, dizziness, abdominal pain, myasthenia, weight loss, anxiety, rhinitis, anxiety, syncope.
Rivastigmine	Nausea, vomiting, anorexia, dizziness, abdominal pain, diarrhoea, malaise, fatigue, asthenia, headache, sweating, weight loss, somnolence, syncope. Rarely severe vomiting with oesophageal rupture.
Galantamine	Nausea, vomiting, diarrhoea, anorexia, weight loss, abdominal pain, dizziness, tremor, syncope.

Table 3: *Side effects of cholinesterase inhibitors*

Long term safety of cholinesterase inhibitors has not been systematically studied. According to an article published in Clinical Therapeutics in 2010 by Farlow MR et al the risk of syncope was twice compared to those not on drugs and there was a 69% increase in bradycardia, 49% increase in having a pacemaker implantation and an 18% increase in hip fractures. As per Cochrane reviews donepezil is the only cholinesterase inhibitor specifically labeled for patients with severe Alzheimer's dementia.

Memantine came into place in 2003 and was approved for moderate to severe AD. It has moderate affinity and is a uncompetitive N-methyl-D-aspartate (NMDA) receptor agonist. It is usually commenced at 5g/day for 1 week and increased to a maintenance dose of 10mg twice daily. It can be prescribed alone or added on to a cholinesterase inhibitor. The adverse effects include headache, dizziness, confusion, somnolence, hallucinations and gastrointestinal symptoms. However Cochrane reviews show that it has a small beneficial effect in moderate to severe AD but is well tolerated.

The next important clinical decision is deciding the duration of treatment. Due to the difficulty in identifying individual patients who benefit from pharmacological management therapy, the physician should set a goal (eg. a trial for 6 to 12 months) and if there is no significant benefit the drugs should be tapered and discontinued. Trial evidence is inadequate or equivocal to make a specific recommendation.

"The second most common type of dementia is vascular dementia accounting for 20 to 30% of all cases."

The second most common type of dementia is vascular dementia accounting for 20 to 30% of all cases. The common feature is the presence of cardiovascular risk factors including hypertension, diabetes mellitus, dyslipidaemia and coexisting atherosclerosis. Commonly seen in those aged above 60 years, the dominant presenting symptom is sudden onset cognitive deficit and the progession is step wise. Executive dysfunction is the earliest cognitive symptom and the other symptoms depend on the location of the stroke. There is no approved treatment for vascular dementia. All cardiovascular risk factors should be optimized and symptomatic management of behavioural problems is advocated.

Dementia with Lewy bodies is common in the elderly and the prominent clinical features are parkinsonism and prominent visual hallucinations. The visual hallucinations are typically well formed detailed hallucinations which are initially pleasant (those of children, little people, pixies) which later evolve to persecutory delusions.

"Due to the difficulty in identifying individual patients who benefit from pharmacological management therapy, the physician should set a goal (eg. a trial for 6 to 12 months) and if there is no significant benefit the drugs should be tapered and discontinued."

There are secondary forms of dementia associated with diseases like Parkinson's disease, multisystem atrophy, progressive supranuclear palsy and normal pressure hydrocephalus. Addressing them is beyond the scope of this article.

However, I would further like to reinforce that in addition to the pharmacological treatment which we have addressed above, we should also focus on non-pharmacological management. These have been published in detail in a book Dementia - A practical guide for the patient and carers published along with the SLMA in 2017 to mark world dementia day. This book is available in all three languages (Tamil, Sinhala and English)

Details of the book:
Dementia. A practical guide for the patient and carer.
English: ISBN 978 -955-43722 - 4-5 (Self-published)
Tamil: ISBN 978 -955 -43722 - 3-8 (Self-published)
Sinhala: ISBN 978 -955 - 31-2081 -6 (Sarasavi Publishers) (in print)

A Message from the Editor-in-Chief

SLMA NEWS+ is the official e-magazine of the Sri Lanka Medical Association. We invite all SLMA members to contribute to SLMA NEWS+ with articles, letters, poems, cartoons, quizzes, medically relevant photographs, drawings or any material you wish to share with the other members. We also welcome your views on the content published in SLMA NEWS+.

Please send them by e-mail to office@slma.lk or by post to Editor-in-chief SLMA NEWS+, Sri Lanka Medical Association, No. 6, Wijerama Mawatha, Colombo 7.

Dr. Chiranthi K. Liyanage

Pandemic, myths, miracle treatments and the duty of care... A doctor's conscience

Dr. Kapila Ranasinghe
Chairperson Board of Study in Psychiatry, PGIM, Sri Lanka
Senior Consultant Psychiatrist, National Institute of Mental Health

Hopefully, this article of mine, written in these troubled times, would serve each and every one who has uneasy feelings after noticing '*miracle treatments*' and '*mythical healing powers*' being catapulted into the limelight in Sri Lanka.

The Covid-19 pandemic has entered the 12th month since its origin last December. The inability to contain the virus, as much as the uncertainty of a cure, have instilled fear amongst the general public, rendering them insecure and susceptible. Confounding this, financial difficulties and missed social opportunities have entangled individuals in stress, frustration and despair. As a natural response to the overwhelming anxiety, individuals probe various coping methods that can be harmful in the long run. Some may start avoiding all social contacts and take fastidious precautions in cleanliness whereas others may give up altogether and await fate.

Humans tend to seek out certain practices, cultural or medical, to alleviate anxiety. Inadvertently, this tags undue prominence and value to some practices without a proven benefit to society or the pandemic itself. As a result, Covid-19 has led to an observable rise in mythical healing practices even in high income countries which proclaim to be progressive. Concurrently, lockdowns and isolations have made the internet a convenient escape route to overcome boredom. It is only logical therefore, that the internet would be the most popular venue to capture vulnerable persons into following baseless practices. Such promises of healing or exorcism falsely allege that malignant spirits can be prevented from possessing individuals, which worsens the outcomes of the illness. However, since such countries possess organized systems that monitor fraudulent activity and consumer exploitation, most malpractices fall short of potential excessive damage.

In Sri Lanka, it is well known that certain practices employed during a contagious illness were thought to keep away demons and germs. Engaging in them gives the individual a sense of being in control of an unknown enemy and helps to boost confidence and mitigate the fear of death. The downside of this is that they give a false sense of protection to the individual, at the expense of measures that are known to be effective in preventing the illness, increasing the risk of further spread of the disease. In addition, in situations such as the current pandemic, the emotionally vulnerable groups will be tempted to seek solace by engaging in bogus or ineffective procedures due to mounting hopelessness. It is unfortunate to see that, while being fully aware of pitfalls of mythical healing practices, educated professionals such as doctors engaging in promoting such products to the general public for inexplicable reasons. These acts violate the ethical principles that bind medical practice as well as our general responsibility to the society as a member of it.

Hopelessness and helplessness regarding a situation may act as the worst enemies of rational decision-making, as it impairs the cortical decision-making ability, leaving the sub-cortical primitive instincts to take prominence. Such decisions may alleviate the excessive anxiety of the immediate present but will fail to be beneficial in the future. However, as the prospects of healing or cure by a simple measure is highly appealing, increasing numbers of followers of such practices is unpreventable. The dangers of following such practices in the current pandemic are manifold. For one thing, the lack of a positive response or an immediate benefit from the illness may create further worsening of anxiety and hopelessness. This may lead to the development of a depressive episode with drastic consequences such as suicide. Financially, these individuals will be further constrained due to the monetary costs of such procedures and it will add to their already escalating distress.

Medical professionals have good skills to be excellent advocates. We, the medical professionals, are trained to seek causes of illness and demand evidence to evaluate treatments, care and health policies. This leads us to understand that the solutions advocated for socio-economic crises seen in an epidemic should be evaluated and proven effective as well. Most of us can translate scientific complexities such as diagnoses, treatments, community healthcare or epidemiological principles into layman's terms and communicate complex issues to the public. In addition, we medical professionals, are respected and have access to policymakers and the opportunity to influence public thought and public will. It is high time that we remind ourselves that we are obligated by the ethical principles of beneficence and non-maleficence to ensure all our actions and behaviour do not have any negative consequence to the society. As a responsible citizen, it is each and every person's duty to ensure that any false information which is being circulated is questioned and evaluated for its relevance and truthfulness and to be contradicted, or discredited, if necessary.

Professional medical organizations around the world have statements regarding the social role of doctors and duty of care towards the community. The American Medical Association urges that physicians "advocate for the social, economic, educational, and political changes

that ameliorate suffering and contribute to human well-being". Likewise, the General Medical Council of the United Kingdom requests doctors to "act decisively to protect the public when risks to patient care or wellbeing emerge". Hence it is apparent that we, the doctors in Sri Lanka, have a similar duty of care in promoting evidence-based and scientifically evaluated treatment methods to the community. Some parties may argue that western medical professionals hinder the propagation of alternative medical practice. In truth, even in alternative medical practices, the scientific basis is proven at least by long term experience of positive results and being successfully used in other similar conditions. A treatment method without any proven efficacy and probably only containing the placebo effect, should not be promoted at the expense of national economy at a time such as this. In fact, as medical professionals, we are under obligatory oath of not promoting any commercial item, whether it be a medicine or any other.

On the other hand, it is a worse crime to stay ignorant in the face of corruption. Failure to act on our part to prevent myths and misconceptions spreading will hold us responsible for contributing to the flow of false information which could lead to massive harm to society. The responsibility towards ensuring a knowledgeable and safe society should be one aspect to focus our energy on, in these troubled times. Non- maleficence or preventing unnecessary harm should be given precedence over uncertain beneficence and appropriate knowledge should be disseminated to society in order to empower the public in making informed decisions. Therefore, it is high time that we re-evaluated our morality and conscience and our role as medical professionals in the current pandemic, in order to act responsibly

5th December 2020	9.00 am -12.00 noon	**Scientific Writing Workshop**
6th December 2020	9.00 am -12.00 noon	**ECN Workshop** Global Health opportunities in the new normal
	2.00 pm - 5.00 pm	**Executive Council Meeting** (By invitation only)
	8.00 pm -10.00 pm	**Global Public Health Network Meeting** Role of Public Health Organizations in the New Normal
7th December 2020	9.00 am -12.00 noon	**General Assembly**
	2.00 pm - 4.00 pm	**APACPH Deans' Meeting** Public health education during in the New Normal

MAIN CONFERENCE

Day 1	8th December 2020
7.30 am - 9.00 am	Registration/ Video Presentations/Photo Competition
9.00 am -10.00 am	Ceremonial Inauguration
10.00 am -10.30am	Keynote Address
10.30 am-11.00 am	Tea Break/Video and Poster Presentations/Photo Competition
11.00 am -12.30 pm	Symposium 01: COVID-19 –Regional Perspective-Lessons learnt and way forward
12.30 pm -1.30 pm	Oral Presentations
1.30 pm - 2.30 pm	Lunch Break/ Video and Poster Presentations/Photo Competition
2.30 pm -3.30 pm	Oral Presentations
3.30 pm -5.00 pm	Panel Discussion 1: New frontiers in Diagnosis and Management of COVID-19

Day 2	9th December 2020
7.30 am - 9.00 am	Symposium 02: NCD surveillance during COVID-19 pandemic
9.00 am -9.30 am	Professor Walter Patrick Memorial Lecture
9.30 am -10.00 am	Theme Presentation
10.00 am -10.30 am	Tea Break/Video and Poster Presentations/Photo Competition
10.30 am -11.30 am	Oral Presentations
11.30 am -1.00 pm	Panel Discussion 2: Public Health Research in the New Normal
1.00 pm -2.00 pm	Lunch Break/ Video and Poster Presentations/Photo Competition
2.00 pm -3.30 pm	Symposium 03: Social Determinants of Health and Global Governance
3.30 pm -4.30 pm	Oral Presentations
4.30 pm -5.30 pm	Tea Break/Video and Poster Presentations/Photo Competition
6.00 pm -7.00 pm	Closing Ceremony

Registration:

For details please visit https://slma.lk/apacph-abstracts/register

Sri Lanka Medical Association Research Awards

Glaxo Wellcome Award

Evaluation of prehospitalization and primary care related factors associated with selected disease outcomes of dengue patients in two tertiary care hospitals in Sri Lanka

Dr. M. Salpitikorala, Family Physician, Health Smart, the Family Medical Clinic, Rajagiriya

Fairmed Foundation Award

Psychological distress and stigma among patients attending Central Leprosy Clinics, Sri Lanka

Dr. P. L. A. N. Liyanage, Specialist Dermatological and Senior Lecturer, Department of Community Medicine, Faculty of Medicine, University of Ruhuna

SLMA Research Grant

Clinical audit on Statin prescription of patients with type 2 diabetes in clinic attendees at a tertiary care hospital: Clinical practice vs guidelines

Dr. Thushara Matthias, Consultant Physician, Professorial Medical Unit, Colombo South Teaching Hospital

Dr. Thistle Jayewardene Research Grant

Lung function and associated functional limitation in survivors of pulmonary haemorrhage secondary to severe Leptospirosis

Dr. W. D. Dilshan Priyankara, Consultant Intensivist, Medical Intensive Care Unit, National Hospital of Sri Lanka

ANNUAL GENERAL MEETING: 21ST DECEMBER 2020

The Annual General Meeting of the Sri Lanka Medical Association will be held at 7.00 p.m. on Monday, 21st December 2020, at the NDW Lionel Memorial Auditorium, Wijerama Mawatha, Colombo 7. All members are cordially invited attend the meeting.

Due to the prevailing COVID-19 pandemic, this will be conducted as a hybrid meeting with limited in-person participation. **Those who wish to attend are kindly requested to email the SLMA office (office@slma.lk) on or before 15th December 2020 to make prior arrangements.**

Any proposals/resolutions to be taken up at the AGM should reach the Honorary Secretary, SLMA on or before 10th December 2020.

The agenda of the meeting is given below.

Dr. Sumithra Tissera
Honorary Secretary, SLMA

Agenda for the Annual General Meeting: 21-12-2020

1. National Anthem
2. Reading of the notice calling for the Annual General Meeting
3. Observation of 1 minutes silence for departed members of SLMA
4. Adoption of the minutes of the last Annual General Meeting held on 21st December 2020
5. Confirmation of new members of the SLMA who joined in 2020
6. Resolutions
7. President's address
8. Secretary's Report for 2020
9. Treasurer's Report for 2020
10. Election of Office Bearers and Council members for the year 2021
11. Appointment of Auditors
12. Address by the Incoming President
13. Any other business

133rd Anniversary International Virtual Medical Congress
Awards made for papers presented (Oral and poster presentation)

Daphne Attygalle Award - for the best paper in Cancer

(OP 44) The Incidence and Patterns of Lung Cancers in Sri Lanka from2001-2010: Analysis of National Cancer Registry Data

Jayarajah U[1], Arulprashanth A[2], Fernando A[1], Ilangamge S[2], Seneviratne SA[1]

[1]Department of Surgery, Faculty of Medicine, University of Colombo, Sri Lanka
[2]Department of Thoracic Surgery, National Hospital for Respiratory Diseases, Sri Lanka

Sir Frank Gunasekera Award - for the best paper in Community Medicine / Tuberculosis

(OP 25) Prevalence and Correlates of Smoking, Alcohol Consumption and Illicit Substance Abuse in School Adolescents in Sri Lanka

Kumbukage MP[1], Senanayake SJ[2], Gunawardena SRHP[1], Wickramasinghe SC[1], Lokubalasooriya A[1], Gunawardena NS[3], Peries R[4], Wickramasinghe SA[5], Maddumahewa CV[1]

[1]Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka
[2]Queensland University of Technology, Australia
[3]World Health Organization Country office, Sri Lanka
[4]Ministry of Education, Sri Lanka
[5]Warwick Medical School, University of Warwick

Kumaradasa Rajasuriya Award - for the best paper in Tropical Medicine

(OP 03) Clinico-Epidemiology of Hypnale zara (Hump-Nosed Viper) Envenoming in Sri Lanka

Rathnayaka RMMKN[1,2,3], Ranathunga PEAN[4], Kularatne SAM[5]

[1]Intensive care unit, Teaching Hospital, Ratnapura
[2]Department of Veterinary Pathobiology, Faculty of Veterinary Medicine & Animal Science, University of Peradeniya
[3]Postgraduate Institute of Medicine (Clinical Pharmacology and Therapeutics), University of Colombo
[4]Medical Unit, Teaching Hospital, Ratnapura
[5]Department of Medicine, Faculty of Medicine, University of Peradeniya

SPECIAL Prize in Cardiology - for the best paper in Cardiology

Not Awarded

S Ramachandran Award - for the best Scientific Communication in Nephrology

(OP 02) A Retrospective Comparative Study on the Outcomes of a Low Dose and High Dose Cyclophosphamide Regimen in the Management of Class III and IV Lupus Nephritis in Sri Lanka

Wijayaratne DR[1,2], Atukorala I[1,2], Gunawardena NS[3], Wijesundara DA[1], Gunarathna K[1], Lanerolle RD[1,2]

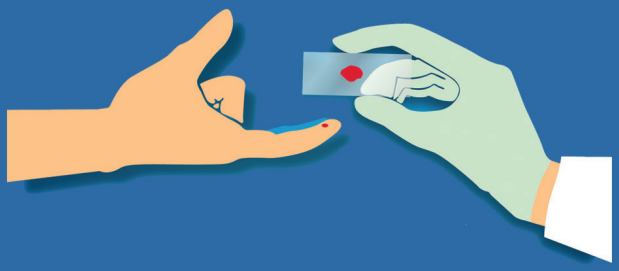
[1]University Medical Unit, National Hospital of Sri Lanka
[2]Department of Clinical Medicine, University of Colombo
[3]World Health Organization Country Office for Sri Lanka

Award for the best presentation in Pharmacology

(OP 53) Echocardiographic Evaluation of Anthracycline-Induced Cardiotoxicity in Breast Cancer Patients from Southern Sri Lanka

Sandamali JAN[1], Hewawasam RP[2], Fernando MACSS[3], Jayatilaka KAPW[2], Madurawe RD[4], Sadanandan PP[4], Ekanayaka U[4], Horadugoda J[4]

[1]Department of Medical Laboratory Science, Faculty of Allied Health Sciences, University of Ruhuna, Galle
[2]Department of Biochemistry, Faculty of Medicine, University of Ruhuna, Galle
[3]Department of Economics & Statistics, Faculty of Social Sciences & Languages, Sabaragamuwa University of Sri Lanka, Belihuloya
[4]Teaching Hospital, Karapitiya



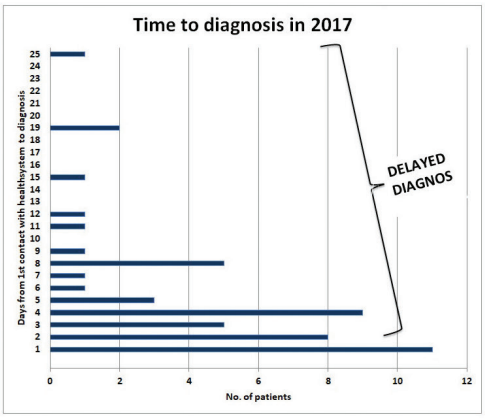
Reduce the Delay in diagnosing imported Malaria

Every single day that a malaria patient is left untreated,

* **His/her chances of survival decreases, &**

* **He/she can transmit the disease to others & re-introduce malaria to Sri Lanka**

Therefore malaria should be diagnosed within 24 hours of onset of fever



Your role:

For all fever patients, always check **travel history** at first interview. If patient has travelled to a malaria endemic country recently, **test for malaria.**

Anti Malaria Campaign Headquarters
Public Health Complex, 3rd floor, 555/5,
Elvitigala Mawatha, Colombo 05
Tell: 011 2 588 408/ 011 2 368 173/ 011 2 368 174
Email : antimalariacampaignsl@gmail.com

Call now for free advice, treatment and drugs

011 7 626 626

www.malariacampaign.gov.lk

The Cranky Old Man

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

When an old man died in a nursing home in an Australian country town, it was believed that he had nothing left of any value.

Later, when the nurses were going through his meagre possessions, they found this poem. Its quality so impressed the staff that copies were distributed to every nurse in the hospital.

One nurse took her copy to Melbourne. The old man's sole bequest to posterity has since appeared in the Christmas editions of magazines around the country and appearing in magazines for Mental Health. A slide presentation has also been made based on his simple, but eloquent, poem.

And this old man, with nothing left to give to the world, is now the author of this 'anonymous' poem winging across the Internet.

Here is the poem:-

What do you see nurses? ..... What do you see?
What are you thinking ..... when you're looking at me?
A cranky old man ..... not very wise,
Uncertain of habit ..... with faraway eyes?
Who dribbles his food ..... and makes no reply.
When you say in a loud voice ..... "I do wish you'd try" !!!!!
Who seems not to notice ..... the things that you do.
And forever is losing ..... A sock or a shoe?
Who, resisting or not ..... lets you do as you will,
With bathing and feeding ..... the long day to fill?
Is that what you're thinking? ..... Is that what you see?
Then open your eyes, nurse ..... you're not looking at me.
I'll tell you who I am ..... as I sit here so still,
As I do at your bidding ..... as I eat at your will.
I'm a small child of Ten ..... with a father and mother,
Brothers and sisters ..... who love one another
A young boy of Sixteen ..... with wings on his feet
Dreaming that soon now ..... a lover he'll meet.
A groom soon at Twenty ..... my heart gives a leap.
Remembering, the vows ..... that I promised to keep.
At Twenty-Five, now ..... I have young of my own.
Who need me to guide ..... and a secure happy home.
A man of Thirty ..... my young now grown fast,
Bound to each other ..... with ties that should last.
At Forty, my young sons ..... have grown and are gone,
But my woman is beside me ..... to see I don't mourn.
At Fifty, once more ..... babies play around my knee,
Again, we know children ..... dark days are upon me...
my wife is now dead.
I look at the future ..... I shudder with dread.
For my young are all rearing ..... young of their own.
And I think of the years ..... and the love that I've known.
I'm now an old man ..... and nature is cruel.
It's jest to make old age ..... look like a fool.
The body, it crumbles ..... grace and vigour, depart.
There is now a stone ..... where I once had a heart.
But inside this old carcass, ... a young man still dwells,
And now and again ..... my battered heart swells
I remember the joys ..... I remember the pain.
And I'm loving and living ..... life over again.
I think of the years, all too few ..... gone too fast.
And accept the stark fact ..... that nothing can last.
So open your eyes, people ..... open and see...
Not a cranky old man,
Look closer ..... see ..... ME!!

Remember this poem when you next meet an older person who you might brush aside without looking at the young soul within. We will all, one day, be there, too!

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