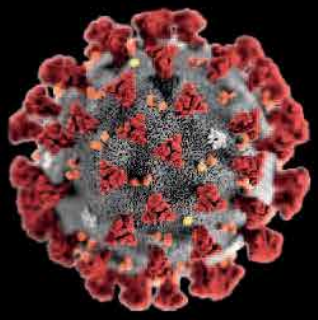
SLMA NEWS+

The eMagazine of the Sri Lanka Medical Association



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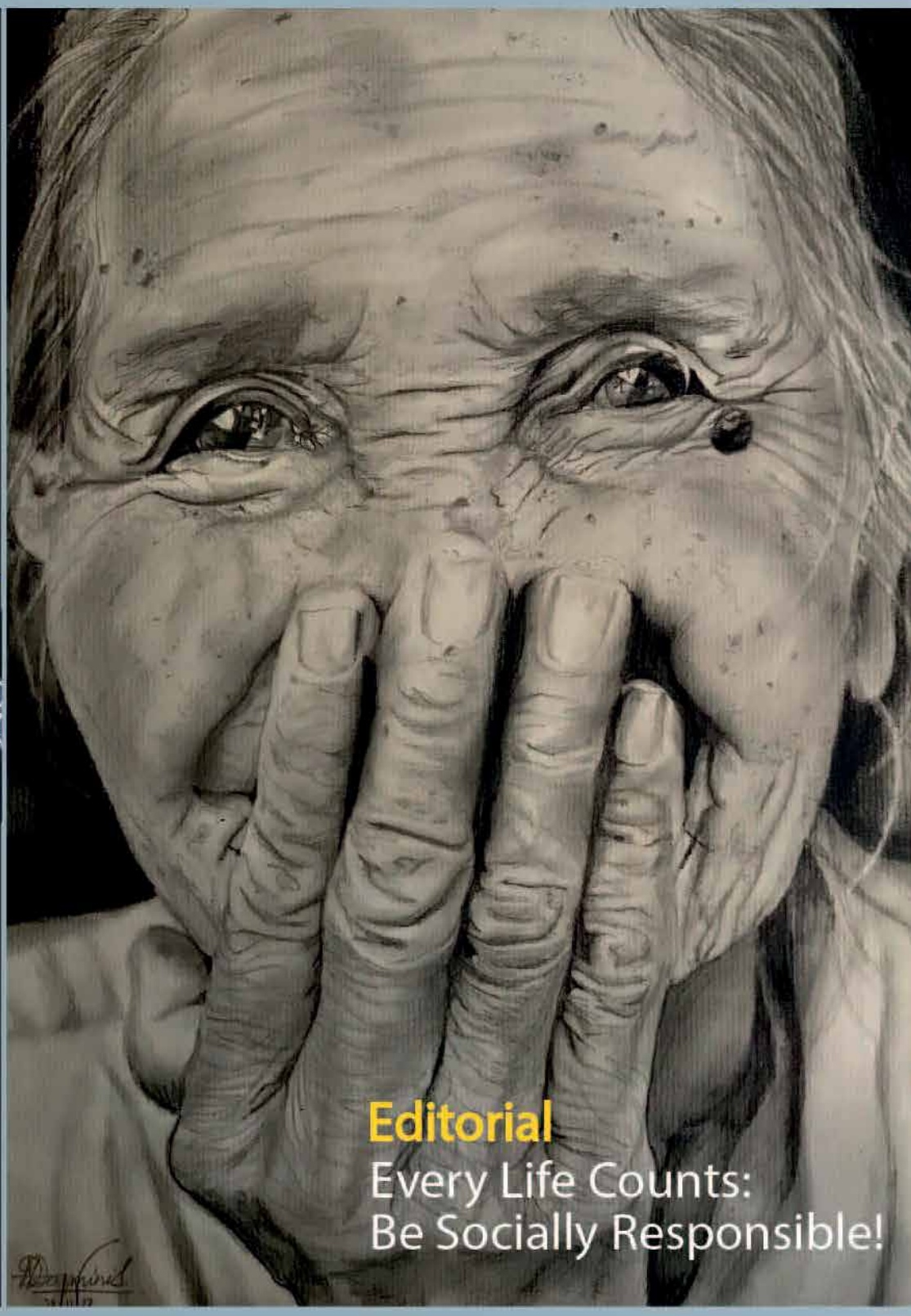


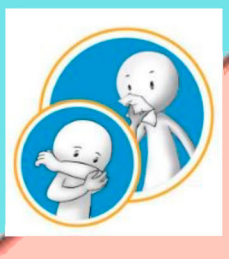
Editorial

Every Life Counts: Be Socially Responsible!

MARCH 2020 | VOLUME 13 | ISSUE 3

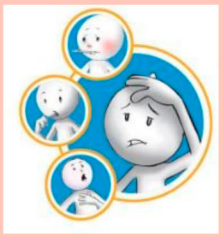
To minimize the possible risk of spreading the Corona virus in the country, public are advised to adhere in to good health practices

- Frequently clean hands by using soap and water or alcohol-based hand rub.



- When coughing and sneezing cover mouth and nose with tissue or handkerchief or with the flexed elbow. Used facial tissues to be discarded properly.
- Avoid frequent touching of face, nose, eyes and mouth.

- Avoid close contact with anyone who has fever and cough.
- If you have fever, cough and difficulty in breathing seek medical care at earliest from a government hospital and share recent travel history.



According to the current situation, it is not necessary to wear surgical face masks by the normal healthy public routinely.

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- දෑත් නිතර පිරිසිදුව තබා ගන්න. මේ සඳහා නිතර සබන් යොදා දෙඅත් හොඳින් සෝදා පිරිසිදු කරගන්න. මේ සඳහා මධ්‍යසාර විෂබීජ නාශකයක් වශයෙන් ඇති දෑත් පිරිසිදුකාරක (Hand Sanitizer) දියර ද භාවිතා කළ හැක.
- කිවිසුම් යාමේදී හෝ කැස්ස ඇතිවූ විටදී මුඛය හා නාසය ලේන්සුවක් භාවිතයෙන්, ටිෂූ කඩදාසියක් භාවිතයෙන් හෝ වැලමිට ඇතුළු පැත්තෙන් හෝ ආවරණය කරන්න. භාවිතා කරන ලද ටිෂූ සෞඛ්‍යාරක්ෂිත ලෙස බැහැර කරන්න.
- අනවශ්‍ය ලෙස නිතර මුඛය, ඇස් සහ නාසය ඇල්ලීමෙන් වළකින්න.
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EPIDEMIOLOGY UNIT
MINISTRY OF HEALTH

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SLMA NEWS+

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IN THIS ISSUE

Editorial

Every Life Counts: Be Socially Responsible

Sri Lanka is currently grappling with the rapidly developing COVID-19 outbreak which has put the country's healthcare system as well as its social and institutional structures to a severe test. At the outset, from the 11th of March when the second case was reported to the 14th of March, there was a rapid increase within 72 hours as the number of laboratory confirmed patients stood at 10. At the time of writing on the 16th, the total was 19, thus doubling in just 2 days.

The Sri Lankan government took the very necessary drastic and stringent measures to curtail the spread by closing all schools and universities and declaring public holidays. They kept the public well informed by issuing situations reports and official statements. Certain religious and professional institutions also joined these laudable efforts by cancelling mass gatherings. Some political entities switched from public meetings to on-line platforms, strongly advocating against holding political meetings and rallies.

However, amidst this seemingly united nation-wide attempt to avert an impending disaster, we witnessed some imprudent acts of callous disregard of the country's need of the hour. "Big Match" enthusiasts gathered in thousands with women and children: March Madness typified! A popular television channel gathered 500 priests to bless the country and invited the public to participate! Over 250,000 pilgrims trekked their way up a sacred mountain along with some 15,000 tourists. Two of the imported cases of COVID-19 had reportedly been symptomatic before they emplaned and departed from Italy and had even attempted to avoid quarantine on arrival in Sri Lanka. All these are actions that possibly put entire populations at risk and could aggravate an already rapidly spreading epidemic.

There are only a very few times in history such as the current COVID-19 pandemic, when every individual has the potential to shape the course of subsequent events significantly. This is a time when the actions of every Sri Lankan would count.

Social distancing and isolation by avoiding large gatherings and by minimising movements within and out of the country considerably reduces the risk of spread. Extensive and diligent contact tracing and quarantine of all contacts of index cases remove potential sources from the community. Individuals who are at high-risk of developing more serious complications of the coronavirus infection such as those with underlying medical conditions, the elderly, and their close contacts, should be extra cautious. Every Sri Lankan must be called to act as socially responsible persons and adhere very strictly to official advisories.

Another ethical issue we seem to overlook amidst this pandemonium is the right to privacy and confidentiality of the identified patients. Posts with photographs and personal details of such patients have been rampant on social media. Some even ridicule patients or portray them as enemies of the public. Furthermore and quite sadly, there were many messages that circulated within groups of healthcare professionals carrying information that should have been very strictly kept confidential.

What would the net effect of this flippancy be? We are already witnessing its consequences. There are growing concerns among the medical community about patients not being forthright about their symptoms or travel history. There have been reports of suspected COVID-19 patients who attempt to avoid quarantine and bypass protocols. Such behaviour may be stemming from the primal human instincts of self-preservation and fear of humiliation. As doctors, we have a duty to safeguard the confidentiality of all patients. As fellow human beings, we have a moral obligation to be more empathetic towards those affected and to never forget that they too are ruled by emotions.

Singapore seems to have been able to slow the spread of the epidemic with extensive government orders, strict actions against rule breakers and above all, with a large majority of its people being willing to put societal and community needs above their own private liberties.

Let us learn from our neighbouring countries. Let us come together to collectively fight this pandemic. Let us be socially responsible.

President's Message

Dear Members of Sri Lanka Medical Association,

In February, SLMA News+ cover page carried the question "COVID-19, Are we ready to face it?" Now the same question has become even more pertinent.

Less than three months have passed since COVID-19 came into international notice. The situation is very volatile at present. The global case fatality rate appears to be 3-4%. The virus has now spread to every continent (except Antarctica) and has caused over 16000 deaths. More and more cases are detected and confirmed in Sri Lanka.

The problem is the unknown. A lot of basic epidemiological and pathophysiological aspects are yet to be understood and we do not have a vaccine or medication like we have for influenza. The COVID-19 pandemic might become as bad as the influenza pandemic in 2009 (influenza A (H1N1)pdm09 virus) which caused more than 250000 deaths worldwide.

Considering what is happening in the US, UK, Australia and many other countries, Sri Lanka's response so far is commendable. Sri Lanka has been able to keep the situation under control mainly due to the strength of our public health system, the efforts of the government, Ministry of Health and the World Health Organization (WHO). The Epidemiology Unit and Health Promotion Bureau have been working tirelessly. Armed forces have played a major role in providing quarantine facilities.

As the apex medical professional body of the country, we are already working in close collaboration with the Ministry of Health and the World Health Organization (WHO) on many fronts, mainly enhancing awareness of healthcare professionals and the general public.

Still we cannot afford to be complacent. It would be a fatal pitfall to believe that Sri Lanka is safe due to its hot weather. The WHO has already dispelled it as a myth. If we are to learn by Korean example where one mass gathering triggered off an epidemic, one mistake is enough. We can only hope Sri Lanka was not too late in implementing strict quarantine regulations.

The strength of the Sri Lankan health system is in disease prevention. However, we have limited resources in the curative sector and highly inadequate intensive care facilities to optimally mange the critically ill during an epidemic. We must capitalise on the unique forte of our health system and focus even strongly on preventive measures such as sanitation, health education, disease monitoring, and quarantine measures, as well as isolation of proven or suspected cases. The situation calls for return to the basics. The Sri Lankan health system has long experience in implementing these basic preventive approaches. Coupled with stringent preventive strategies and strict enforcement of regulations, Sri Lanka can contain the spread of this epidemic.

Everyone has a responsibility during this national crisis. It is a time for vigilance, social responsibility, collaboration and firm decision making.

Professor Indika Karunathilake
President, Sri Lanka Medical Association

More on COVID-19

From the first report of the COVID-19 outbreak in December 2019 in China, right up to the present time when it has become a global pandemic, our understanding of the epidemiology, symptomatology and treatment of this new infection has evolved, and it is still evolving.

Given below are some recent findings that would help us understand some finer details.

COVID-19 Infection in Children

A study published in The New England Journal of Medicine reported on 6 children hospitalised between January 7th and January 13th during the early phase of the outbreak in Wuhan, causing moderate-to-severe respiratory illness.

Common clinical characteristics included high fever (all 6 six patients), cough (all 6 patients), and vomiting (in 4 patients). Duration of fever was 3 to 11 days. Four children had pneumonia. **Three patients showed patchy shadows in both lungs, and one showed patchy ground-glass opacities in both lungs.**

Only one child was admitted to the Paediatric Intensive Care Unit and received pooled immune globulin from healthy donors. Duration of hospitalisation was 5 to 13 days. All children recovered after hospitalisation.

Reference: https://www.nejm.org/doi/full/10.1056/NEJMc2003717

Risk factors for COVID-19 deaths in adults and duration of viral shedding

This study published in The Lancet, described 191 patients with confirmed COVID-19 from 2 hospitals in Wuhan. It demonstrated that older age, showing signs of sepsis, and having blood coagulation derangements on admission were key risk factors associated with death in adults hospitalised with the virus.

A **high Sequential Organ Failure Assessment Score and having d-dimer >1 µg/mL are the factors that could help early identification of patients with a poor prognosis.** Those who developed complications such as respiratory failure (98 vs 36%), sepsis (100% vs 42%), and secondary infections (50% vs 1%) had a higher mortality rate than those with uncomplicated disease.

New data on viral shedding was also presented in this study. **It indicates that the median duration of viral shedding was 20 days in survivors (ranging from 8-37 days).** Furthermore, the virus has been detectable until death in non-survivors. The duration of viral shedding may be influenced by disease severity and the results should be interpreted cautiously as approximately two-thirds of whom had severe or critical illness. Moreover, the estimated duration of viral shedding was limited by the low frequency of respiratory specimen collection and the lack of measurable genetic material detection in samples in this study.

Reference: http://www.thelancet-press.com/embargo/coronavirusriskfactors.pdf

Detection of COVID-19 virus in different clinical specimens

A study published in JAMA evaluated whether SARS-CoV-2 can be detected in different types of clinical specimens to determine the potential to transmit in ways other than through respiratory droplets. It included 205 patients with COVID-19 (1,070 specimens) collected from 3 hospitals in the Hubei and Shandong provinces and Beijing, China, from January 1st, 2020 to February 17th, 2020.

Specimens included pharyngeal swabs, blood, sputum, feces, urine, and nasal samples, bronchoalveolar lavage fluid and fibrobronchoscope brush biopsy. Bronchoalveolar lavage fluid specimens showed the highest positive rates (93%), followed by sputum (72%), nasal swabs (63%), fibrobronchoscope brush biopsy (46%), pharyngeal swabs (32%), **faeces (29%)**, and blood (1%). **None of the 72 urine specimens tested positive.**

Detection of the live virus in feces, indicates that COVID-19 may be transmitted by the faecal route. A small percentage of blood samples had positive PCR test results, suggesting that infection sometimes may be systemic. **Transmission of the virus by respiratory and extra-respiratory routes may help explain the rapid spread of disease.** In addition, testing of specimens from multiple sites may improve the sensitivity and reduce false-negative test results.

Reference: https://jamanetwork.com/journals/jama/fullarticle/2762997
Comment: Faecal transmission may have particular significance for Asian countries with their ablution practices after defaecation.

Source: https://dgalerts.docguide.com/clinical-findings-6-children-covid-19-risk-factors-associated-covid-19-death-and-detection-sars-cov?nl_ref=newsletter&pk_campaign=newsletter&nl_eventid=33884&ncov_site=covid-

Guidelines from local authorities and professional colleges on COVID 19

- Provisional Clinical Practice Guidelines on COVID-19 suspected and confirmed patients, Ministry of Health, Sri Lanka http://www.epid.gov.lk/web/images/pdf/Circulars/Corona_virus/covid-19-cpg_march-2020-moh-sl.pdf
- COVID-19 outbreak in Sri Lanka - Guidance for Sri Lanka General Practitioners. https://slma.lk/blog/2020/03/17/ministry-of-health-guidelines-for-management-of-covid-19/

Sri Lanka Medical Association Position Statement on Effectively Combating the Corona Virus (COVID-19)

Sri Lanka Medical Association (SLMA) is the apex body of the medical profession in Sri Lanka. The SLMA has contributed towards achieving our main objective, i.e. the betterment of health in the Sri Lankan population from its inception in 1887.

We are already working in close collaboration with the Ministry of Health and the World Health Organization (WHO) on many fronts in combating the ill effects COVID-19 epidemic, mainly by enhancing awareness of healthcare professionals and the general public.

Although the total number of laboratory confirmed patients may seem low at the moment, we are seeing a steady increase with more patients being detected from the community. However, we are still within a brief window of opportunity to act as these cases are from localities with known contagious contacts and there is no report of community spread, as yet. Unless stringent actions are taken to curtail the spread at this moment, Sri Lanka too will witness a rapid increase with community spread. Our health system will soon get overwhelmed beyond their capacity.

We would like to make the following recommendations to curtail and manage the spread of the infection in the country.

1. Consider localized lock-down of districts from where most of the infected persons have been identified and where the returnees who were not quarantined reside (those who have entered the country since 1st March 2020). The locations of index cases, contacts and returnees from high risk countries should be identified the high-risk areas for lockdown Strict measures should be implemented to prosecute any individual who does not adhere to the regulations and instructions. In case of localized lockdown, there is a need to ensure that essential items are made available for people living in that area.

2. Active and extensive contact tracing and quarantining of suspected, probable or confirmed patients and all contacts of confirmed patients should be done as a routine activity of the preventive sector to eliminate all likely sources of infection from the community. The confidentiality and privacy of the patients must be respected at all times while prosecuting any who do not heed the quarantine measures and instructions.

3. Take immediate measures to set-up or identify dedicated hospitals exclusively for COVID-19 suspected/probable and confirmed patients to minimise spread within health care institutions Admission of suspected, probable or confirmed cases of COVID-19 to busy tertiary care hospitals precariously exposes hundreds of patients and staff who routinely use these health care institutions. This may accelerate the spread even further. Therefore, these patients should be admitted only to dedicated hospitals with all necessary manpower, material, resources and facilities for referral if needed.

4. Ensure a continuous supply of all Personal Protective Equipment (PPE) to be supplied to the hospitals and the general public. The availability of hand sanitizers and masks and other PPEs should be ensured. The whole supply chain to provide protective clothing, supply of extra oxygen and waste disposal have to be considered to avoid overloading of the system and to ensure safety of frontline health workers.

5. Ban all religious, social, political and other mass gatherings and events for a minimum duration of 2 weeks.

6. Encourage private sector and state sector institutions to facilitate working from home as much as possible, wherever this is valid.

7. Compulsory regulations for commercial institutions to implement sanitisation processes targeting areas frequently used by the customers.

8. Develop and utilise technological advances such as GPS tracking and tele-medicine for surveillance and patient management and to utilise online learning and social media for health education.

We strongly believe that Sri Lanka's strength is in its public health system. We further believe that Sri Lanka should capitalise on this unique strength and focus even more on preventive measures such as sanitation, health education, disease monitoring, and quarantine measures, as well as isolation of proven or suspected cases.

While we fervently urge the Government to act on the above proposals, we appeal to the public to be safe, responsible and sensible. Let us come together to further strengthen our country's fight against COVID-19.

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Dr. C G Uragoda History of Medicine Lecture – 2020

"Progression of Paediatrics: From ancient times, to the modern era"

By Dr. B. J. C. Perera

Dr. Nimani de Lanerolle
Assistant Secretary, SLMA

The History of Medicine Lecture was inaugurated in 2012 to commemorate the 26th of February 1887; the day on which a group of doctors gathered at the Colonial Medical Library to discuss the formation of the forebear the Sri Lanka Medical Association (SLMA), the Ceylon branch of the British Medical Association.

The first History of Medicine Lecture was delivered on the 26th February 2012, on the 125th anniversary year of the SLMA by Dr. Dennis J. Aloysius. Since then, this lecture has been held on the 26th of February each year.

In 2017, it was renamed the "Dr. C.G. Uragoda History of Medicine Lecture" in honour of Dr. Uragoda's contributions to documenting the history of medicine in Sri Lanka.

In keeping with this tradition, the 8th History of Medicine lecture titled "Progression of Paediatrics: from ancient times to the Modern era" was delivered by Dr. B.J.C. Perera on the 26th of February 2020 at the Lionel Memorial Auditorium, Colombo.

This year's speaker, Dr. Bonaventure Jayasiri Crispus Perera is an acclaimed paediatrician who commenced his medical career from the Faculty of Medicine, Colombo. His contribution to research and postgraduate training is immense with over 80 oral research presentations both in Sri Lanka and abroad. He has delivered over ten scientific orations and many guest lectures in both national and international arenas. His research interests are childhood asthma, respiratory infections, breast-feeding and paediatric HIV disease. He has been an Editor, Chapter Author or Joint Author of seven books. Whilst being a pioneer in the field of paediatrics, he is also the founder president of the Sri Lanka College of Paediatricians and the founder president of the Respiratory disease study group in Sri Lanka. He held the chairmanship of the Board of Study in Paediatrics of the Postgraduate Institute of Medicine (PGIM), University of Colombo from 2003 to 2006. He was honoured with the prestigious award of "The Outstanding Paediatrician of Asia" by the Asia Pacific Paediatric Association in 2007. Dr. B.J.C. Perera, was also the president of the SLMA in 2013.

This year's lecture was a captivating account of the progression of paediatrics both world-over and in Sri Lanka. The lecture commenced with an introduction to the much-admired respiratory physician and historian, Dr. C.G. Uragoda and an account of their relationship, focusing on the support and advice given by him to Dr. B.J.C. Perera in his academic life. He went on to discuss about the amazing subject of healthcare of children with an account of children's health in the context of the diverse religions of the world. The documentation of paediatrics in ancient scripts such as the "Sushruta Samhita" from India was then discussed.

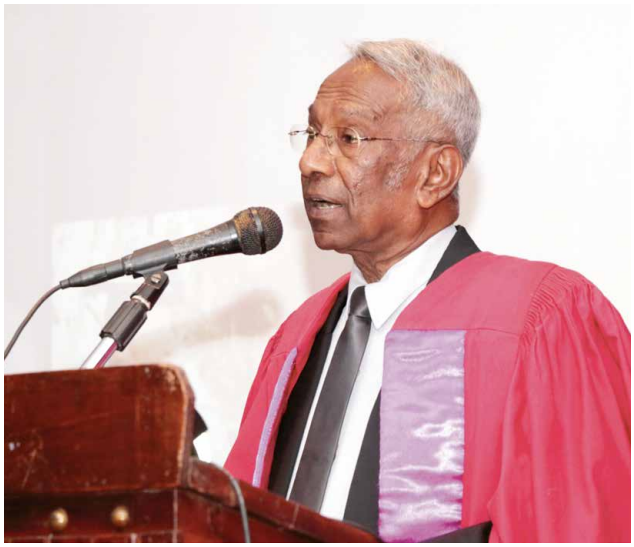
He added that from a worldwide perspective child health care has evolved from home-based care, rooted in the medical practices in ancient Greece, Rome, India and the Middle East into the sophisticated science it is today.

He also stated that the first hospital dedicated for children's health was established in 1802 in Paris and was closely followed by many dedicated childcare institutions in other parts of the world. Although the evolution of healthcare systems in Sri Lanka are well documented in the annals of Ceylon history there is little mention of children's healthcare in ancient scripts. The first children's hospital in Sri Lanka, the Lady Havelock Hospital, later renamed the Lady Ridgeway hospital was opened in Sri Lanka in 1895. It is indeed important to note that this is the largest childcare institute in the world. Dr. B.J.C. also described the great accomplishments in the field of paediatrics in Sri Lanka. While eliminating or controlling certain diseases which results in high child fatality rates such as smallpox, plague, whooping cough and malaria, Sri Lanka has achieved excellent health indices suggestive of the high standard of children's healthcare in the island.

The inception of the Ceylon Paediatric Association which was later named the Sri Lanka College of Paediatrics was aptly explained by Dr. Perera. He explained how the College continues to contribute to improve child healthcare through professional development of doctors of all grades and allied health care professionals.

Whilst re-counting the achievements in the field of paediatrics in Sri Lanka, he spoke about the advancements which may soon follow in fields such as robotics, artificial intelligence and genetics.

He summed up, with a fitting tribute to his wife, the wind beneath his wings, the late Dr. Mrs. Sarojini Perera. This insightful lecture was followed by the launch of Dr. B.J.C. Perera's autobiography titled "A Trek known only to a few". The evening concluded with cocktails and fellowship.



Awareness Programme on Injury Prevention for School Children

Dr. Nimani de Lanerolle, Assistant Secretary, SLMA

Injuries are a leading cause of morbidity and mortality in children across the world. However, majority of these injuries are preventable. The Sri Lanka Medical Association (SLMA) together with the Sri Lanka Academy of Young Scientists (SLAYS) conducted a programme on injury prevention for school children on the 28th of February 2020 at the Lionel Memorial Auditorium, Colombo. The programme was chaired by Professor Indika Karunathilake, President, SLMA and Dr. Chamindri Witharana, President, SLAYS.

Over 120 students from several leading schools in the country participated in this programme. There were many distinguished resource persons including the internationally acclaimed racing champion Mr. Dilantha Malagamuwa who spoke on "How to be a responsible road user." Dr. Miyuru Chandradasa, Consultant psychiatrist and Senior lecturer at University of Kelaniya spoke on "Risky behaviours during adolescence." "First aid following injuries" was covered by Dr. Yasas Abeywickrama, Consultant plastic surgeon at the Colombo South Teaching Hospital. The programme concluded with an interactive session moderated by Dr. Thilina Egodage of the SLMA, discussing the concepts of injury, its prevention and management. This was a very successful programme which enabled children gain knew knowledge and share experiences with different experts in the field.

Beauty is not only skin deep: How safe are your cosmetics?

Dr. Charuni Kohombange
Medical officer, National Blood Transfusion Service.

Today, cosmetics play a major role in building self confidence in many of us. Some studies show that an average woman uses 12 personal care products a day containing 168 different chemicals. To educate the public on the safe use of cosmetics, the media committee of the Sri Lanka Medical Association (SLMA) conducted a symposium and a live webinar on 20th February 2020 at the Lionel Memorial auditorium. Colombo 07.

Dr. Sriyani Samaraweera, Consultant Dermatologist, Lady Ridgeway Hospital and Dr. Indira Kahawita, Consultant Dermatologist, Base Hospital Homagama shared their expertise on this topic. This article is based on the presentations made at this symposium.

Defining cosmetics

Cosmetics are defined as any substance or preparation that is intended to be placed in contact with various external parts of the human body, exclusively or mainly for cleaning, perfuming, changing appearance, correcting body odours, protecting and keeping the external appearance of the part in good condition.

Thus, substances or mixtures which are intended to be ingested, inhaled, injected or implanted into the human body are not considered as cosmetics.

Devil behind the makeup: How bad are your cosmetics?

Hair dyes:

Hair dye allergy usually occurs after repeated use of a dye and usually not with the first exposure. Allergy to hair dye can occur with any type of hair colour/dye, including black henna and dye shampoo. The symptoms usually manifest as itching, redness, eczematous rash of scalp or facial oedema immediately after or within 2 to 3 days of the application.

''Hair dye allergy usually occurs after repeated use of a dye and usually not with the first exposure. Allergy to hair dye can occur with any type of hair colour/dye, including black henna and dye shampoo.''

Whitening creams:

Whitening creams contain hydroquinone, topical corticosteroids and heavy metals such as mercury and lead. Although the accepted upper limit of hydroquinone content in skin preparations is 4%, it is exceeded in whitening creams.

Glutathione is another chemical compound found in fairness creams. It can cause skin lightening by converting melanin to a lighter colour by deactivating the enzyme tyrosinase, which helps produce the pigment. This switch from brown to red melanin may increase the risk of sun induced skin cancers.

They also contain highly potent steroids like clobetasol and mometasone which are not recommended to be applied on facial skin as they can cause irreversible skin damage.

''This switch from brown to red melanin may increase the risk of sun induced skin cancers.''

Complications associated with whitening creams:

- Deposition of pigment on the face (ochronosis)
- Steroid dependent facies
- Severe acne
- Unevenly distributed white patches on the face
- Stretch marks (striae) especially when used in flexural areas like armpits
- Poor wound healing
- Nephropathy
- Infections
- Suppression of hypothalamic, pituitary, adrenalaxis.

Lipsticks:

There are significant differences in the lead, cadmium and chromium concentrations among various brands of lipsticks. International studies show that there is a potential risk to consumers' health due to the presence of unacceptably high concentrations of these elements in more than 50% of the lipstick brands. This is similar with the concentrations of titanium, aluminium, cadmium, chromium and manganese. Due to the simultaneous use of lipsticks with other types of cosmetics, the risk of exposure to toxic elements may rise to hazardous levels.

''There are significant differences in the lead, cadmium and chromium concentrations among various brands of lipsticks.''

Cosmetics and cancer

Whitening creams and cancer

There are not enough studies in this area to come to a conclusion. However, the skin cancer incidence in Sri Lanka is on the rise, possibly due to the increasing use of these agents.

Antiperspirants and breast cancer

There is some evidence to suggest that Parabens, which are used as a preservative in antiperspirants, cosmetics and sunscreens, are a risk factor for developing breast cancer.

Hair dye and breast cancer

There are several studies that show a possible association of breast cancer with the use of hair dye. The risk appears to be proportionate to the length and frequency of use. Even though none of the researchers have made solid recommendations, it may be advisable to limit the use of hair dye especially in females already at high risk of developing breast cancer.

''There are several studies that show a possible association of breast cancer with the use of hair dye.''

Talc and ovarian cancer

An association between the use of talc on the perineal region and ovarian cancer has been shown. Therefore, it has been recommended not to use talc powder on female babies.

Regulations

The global situation

The two most important laws pertaining to cosmetics marketed in the United States are the Federal Food, Drug and Cosmetic Act (FD&C Act) and the Fair Packaging and Labelling Act (FPLA). FDA regulates cosmetics under the authority of these laws. India, Australia and countries in the European Union (EU) have adopted their own set of regulations on the cosmetics market.

Sri Lankan context

The Cosmetics, Devices & Drugs (CDD) Act, which came into effect in 1986, was the legislative framework to control cosmetics, medical devices and drugs including vaccines for nearly three decades in Sri Lanka. According to the CDD Act, manufacturing, importation, storage, selling and offering for selling of cosmetics is prohibited without a valid license.

With the introduction of National Medicines Regulatory (NMR) Act in July 2015, regulation of cosmetics was removed from the previous CDD Act. Hence, cosmetics were not regulated by the NMRA for nearly two years, opening the doors for unsafe and sub-standard cosmetics to encroach into the Sri Lankan market.

Due to the many complaints that were reported to the Ministry of Health on sub-standard products, a special cabinet paper was passed in 2017, authorising the NMRA to regulate cosmetics in accordance to the legal requirements of the previous CDD Act. The Cosmetics Evaluation Subcommittee (CESC) was reformed after this cabinet paper. With the appointment of representatives of the Sri Lanka College of Dermatologists as members for the CESC, dermatologists became involved in the regulation of cosmetics in Sri Lanka for the first time.

The NMRA Act is presently being revised to confer wider powers to regulate cosmetics industry in Sri Lanka. The revised Act will also stipulate the penalties for those who violate the Act.

''Due to the many complaints that were reported to the Ministry of Health on sub-standard products, a special cabinet paper was passed in 2017, authorising the NMRA to regulate cosmetics in accordance to the legal requirements of the previous CDD Act. The Cosmetics Evaluation Subcommittee (CESC) was reformed after this cabinet paper.''

KEY POINTS

- **All cosmetics should be used with caution.**
- **The use of whitening creams is discouraged.**
- **Hair dyes may play a role in the development of breast cancer.**
- **The use of talc in perineal areas may increase the risk for ovarian ma lignancy.**

Tackling emerging health challenges through research and innovation: a Sri Lankan perspective

Dr. Priyanga Ranasinghe (MBBS, MD, PhD)
Senior Lecturer, Department of Pharmacology, Faculty of Medicine, University of Colombo

Today, despite achieving steady economic progress and higher standards of living, Sri Lanka and other countries in the South-Asian region are facing several emerging health challenges resulting in the decline of their vital healthcare indicators. This paper aims to look at the most likely and significant healthcare challenges in Sri Lanka in the coming decades and how policies should be geared towards addressing these concerns through targeted home-grown research and innovations.

Emerging healthcare challenges

The Sri Lankan healthcare system is internationally recognised for achieving health indicators almost comparable to Western developed countries, at a quite low-level of GDP per capita (approximately US$ 4,065), surpassing countries with similar economic development in the South Asian region. Maternal and infant mortality has rapidly declined and life expectancy has steadily increased. However, the country is presently facing a double burden of both communicable and non-communicable diseases. Communicable diseases such as dengue, leptospirosis, tuberculosis, acute respiratory infections and sexually transmitted infections such as HIV are still important causes of morbidity and mortality [1]. Non-communicable diseases (NCDs) such as diabetes, cardio- and cerebro-vascular diseases and malignancies have also increased, while injuries caused by road traffic accidents have become a major cause of mortality. Remarkable achievements in the preventive healthcare services of the country have resulted in the recent elimination of several communicable diseases including lymphatic filariasis, measles and malaria. This has been reflected in recent data which indicates that the burden is shifting from communicable to non-communicable diseases in Sri Lanka with NCDs accounting for over 70% of non-accidental mortality in the country [2]. Demographic transition and urbanisation are some of the likely influential factors behind this transformation. However, it is important to note that several infectious diseases such as dengue and leptospirosis still cause seasonal outbreaks, although case fatality rates remain low due to improved diagnostic and management strategies. In addition, the current outbreak of the novel corona virus (COVID-19) is likely to test the ability of the Sri Lankan healthcare system to rapidly respond to a global pandemic.

Sri Lanka in the global medical research landscape

Medical research has been the driving force guiding improvements in health systems and practices around the world. Published scientific literature indicates that the Sri Lankan medical research output is relatively small in the global landscape. Studies have shown that the number of medical publications from Sri Lanka in indexed journals during the decade starting from year 2000 is only 0.086% of the global medical research output, of which a large proportion (>35%) has been descriptive cross-sectional epidemiological studies [3]. It is impressive to see that 44 medical journals (28 currently in print) are published in Sri Lanka. However, to the best of the author's knowledge, only a handful of journals including the Ceylon Medical Journal are indexed in international medical databases such as PubMed, Web of Science and Scopus [4]. The Scimago journal and country ranking (by Scopus), shows that Sri Lanka occupies the 77th position (out of 233) when ranked according to the number of publications in 2018 with other countries in the region like India, Pakistan and Bangladesh occupying higher positions [5]. However, it is important to understand that for accurate comparisons, these figures need to be standardised as per the size of the respective populations and the total health care expenditure of that country. Sri Lanka may surpass its regional counterparts when adjusted in this manner. In addition, it is noteworthy that recent trends in Sri Lanka has seen a steady increase in scientific research and publications (Figure 1), with an increasing focus on locally relevant research in areas such as diabetes, ischaemic heart disease, chronic kidney disease, dengue and road traffic injuries [3].

"Studies have shown that the number of medical publications from Sri Lanka in indexed journals during the decade starting from year 2000 is only 0.086% of the global medical research output"

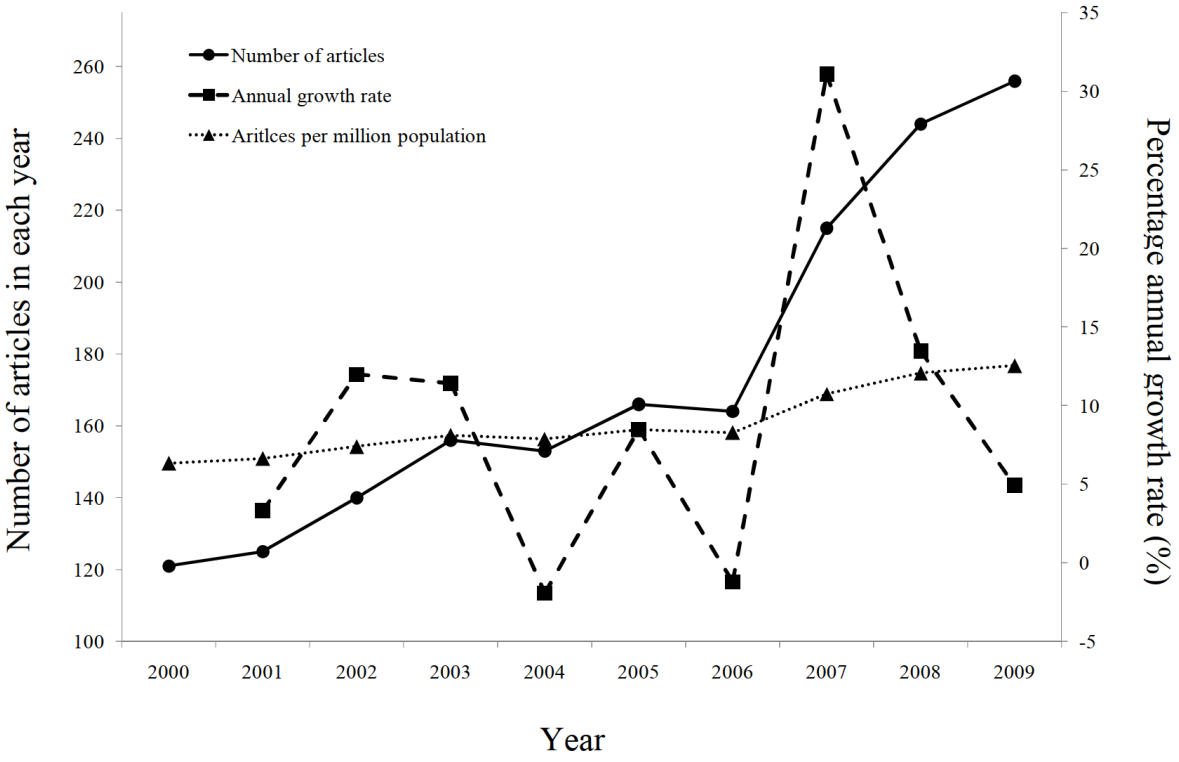


Figure 1: Annual research publications output 2000-2009

Source: Ranasinghe P, Jayawardena R, Katulanda P: Sri Lanka in global medical research: a scientific analysis of the Sri Lankan research output during 2000-2009. BMC Res Notes 2012, 5:121-121.

Importance of home-grown research and innovation

The 10/90 gap is a term adopted by the Global Forum for Health Research, which indicates that less than 10% of worldwide resources are allocated for health research in developing countries where more than 90% of all preventable deaths occur [6]. This is substantiated by the plethora of research evidence available to support the management of global health problems commonly affecting developed countries such as diabetes, ischaemic heart disease and malignancies, whilst there is scarcity of evidence for regionally and locally prevalent diseases such as dengue and chronic kidney disease of unknown aetiology. This necessitates home-grown, locally driven research and innovations, while regional collaboration should be fostered to tackle Sri Lankan health issues of regional importance. Local research also plays a vital role in quality improvement of healthcare provision in the country. It is important to understand that social and cultural differences play a vital role in the management of the common non-communicable diseases. For example, diet is a main factor in the pathogenesis, progression and management of diabetes, hypertension and cardiovascular disease. The Sri Lankan diet is considerably different from that of other countries, with studies showing less dietary diversity, higher consumption of starch and a lower intake of fruits and vegetables [7]. Hence, preventive strategies need to be home-grown and based on local interventional studies, taking in to account these social and cultural differences. Furthermore, genetic differences also play a key role in the aetio-pathogenesis and progression, with studies indicating that South Asians are at a higher risk of diabetes and non-communicable diseases even at lower levels of obesity. New evidence from pharmacogenomic studies show that genetic differences are also likely to alter the response to treatment and possibly the adverse effects of medicines [8]. This is important especially in the context that most medicines are developed from clinical trials originating from countries with predominately Caucasian populations. This highlights the need for local home-grown research to study the aetio-pathogenesis, progression, prevention and even for diseases like diabetes on which there is already a high degree of global research on management originating from developed countries. Evidence-Based Practice is defined as the judicious use of current "best evidence" in making decisions about the care of the individual patient, using the "best available" external clinical evidence arising from research. The above examples highlight the need to derive the "best available evidence" for application in the local context from home-grown research.

Current policies and practices

At present medical research in Sri Lanka is primarily driven by academic institutions such as universities with several dedicated government or semi-government research institutions and a very few private organisations also contributing towards health research and development (R&D). It is noteworthy to mention that government healthcare institutions also contribute about 15% of the total medical research in Sri Lanka [3].

In any country, government policies and funding play an important role in research and development. In the Sri Lankan context, the total investment for R&D (for all scientific disciplines) expressed as a percentage of the GDP was only 0.11% in 2015 [9]. In the same year, most of the research conducted in the country came under the discipline of agriculture (31.5%), with medical sciences accounting for only 8.6% [9]. This indicates that the funding allocations for medical research is likely to be a much lower percentage of the GDP. In comparison, regional counterparts like India (0.86%) and Pakistan (0.26%) allocate a higher percentage for R&D, and the figure is greater than 2.0% in most Western developed countries. Figure 2 clearly demonstrates the position Sri Lanka occupies in relation to R&D expenditure in comparison to other countries around the world.

"In the Sri Lankan context, the total investment for R&D (for all scientific disciplines) expressed as a percentage of the GDP was only 0.11% in 2015"

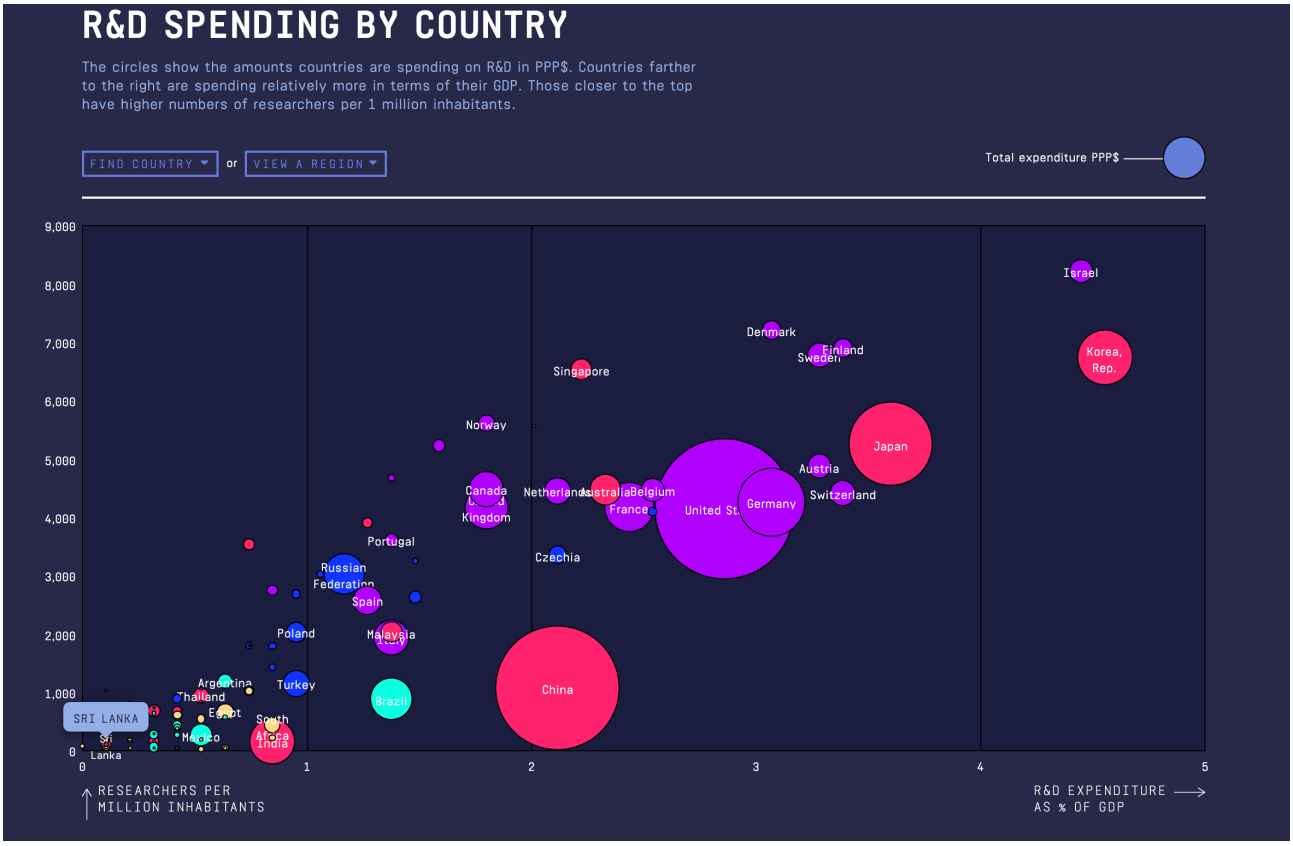


Figure 2: R&D expenditure in different countries
Source: UNESCO institute for statistics (http://uis.unesco.org/apps/visualisations/research-and-development-spending/)

However, realising the importance of local research, successive governments have initiated and maintained several strategies to popularise health research in the country, with mixed results. The introduction of the "Research Allowance" for universities and doctors in health care institutions and implementing awards schemes at institutional and national level are a few such examples. Furthermore, funding agencies such as the National Research Council (NRC) and the National Science Foundation (NSF) have also identified national priority areas for medical research. The success or failure of these recently implemented policy changes remains to be seen in the years to come.

Challenges and the way forward

Sri Lanka has a very well established, robust healthcare system able to achieve so much with minimal resources and funding allocations. However, in light of the ongoing epidemiological, demographic and economic transitions in the country, Sri Lanka is likely to experience a rise in the incidence of non-communicable diseases and varying periodic outbreaks of communicable diseases in the future. To effectively combat these challenges, the country needs an efficient national R&D strategy, targeting medical research under strategically important scientific themes. In a resource poor setting, identifying and prioritising funding remain one of the key strategies. Even when priority areas are well-defined, it is important to identify the deficiencies in the local evidence within such areas. Targeted research focusing on prevention and improving management aiming to reduce morbidity and mortality are essential. In the case of diabetes, shifting the focus from cross-sectional epidemiological studies towards interventional studies is one such example.

Enhancing collaborations within and between institutions is also an effective strategy in preventing duplications and ensuring the efficient utilisation of scare resources. Furthermore, regional collaboration with other South Asian countries which presently stands at less than 10% of the total national medical research output also needs to be strengthened in order to face common challenges efficiently [3]. Fostering a research culture among medical undergraduates and enhancing their research competencies would help to improve the contribution by future doctors to research originating from health care institutions. Introducing research based promotional schemes would further strengthen their contribution. In addition, promoting "intellectual honesty" where researchers propose, perform and report research findings with honesty and integrity is an essential requirement. Balanced assessment of quality of research, during awarding of grants and promotions should be strongly considered over the current system based on the quantity of research. Resources available to the academic institutions needs improvement. For example, most institutions currently lack facilities to access medical databases such as Web of Science and Scopus, whilst availability of support staff for language editing and statistical analysis are virtually non-existent. In addition, these institutions need to be empowered to recruit and retain top-level medical researchers in the country by providing competitive salaries and a guaranteed future in research. Furthermore, at the national level frequent appraisal of the medical research output is also necessary to identify deficiencies and plan improvements.

''Fostering a research culture among medical undergraduates and enhancing their research competencies would help to improve the contribution by future doctors to research originating from health care institutions.''

In conclusion, scientific research plays a key role in the practice of evidence-based medicine. It is important to identify locally derived solutions to the challenges faced by the Sri Lankan healthcare system in order to refine and tailor local healthcare practices to suit the national requirements [10].

''It is important to identify locally derived solutions to the challenges faced by the Sri Lankan healthcare system in order to refine and tailor local healthcare practices to suit the national requirements''

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Overdiagnosis: Too Much Medicine

Professor Kumara Mendis,
Cadre Chair, Department of Family Medicine, Faculty of Medicine, University of Kelaniya

What is overdiagnosis?

Overdiagnosis occurs when individuals are diagnosed with conditions that will never cause symptoms or death. In a broader sense, it refers to problems arising from it; over medicalisation and subsequent overtreatment. Diagnosis creep, shifting diagnostic thresholds, and disease mongering, are all processes that lead to healthy people with minor problems or those who are at at low risk, being reclassified as suffering from some significant illness.

Overdiagnosis is not:

a. a false-positive diagnostic test
b. the same as overtreatment; unnecessary or over-aggressive treatment
c. synonymous with over-testing
d. misdiagnosis

Too much medicine emanates from combined overdiagnosis and overtreatment.

Why is Overdiagnosis important?

Expenditure on healthcare in the USA is the highest in the world, approaching 18% of the GDP. The estimated cost of healthcare waste identified in six domains, ranges from $760 billion to $935 billion; about 25% of the total healthcare spending. Overtreatment and low-value care are some of the six domains which account for $12.8 billion to $28 billion. Between 2011-2013, the average expenditure for each false-positive mammogram, invasive breast cancer, and ductal carcinoma in situ, within the year following diagnosis were $852, $51,837 and $12,369 respectively in the USA. This translates to a national cost of $4 billion each year.

Too much medicine is not just a problem of rich countries. South Asia needs even better recognition of the manifestations and drivers of overdiagnosis. There may be some unique features in this region because of cultural and contextual differences from the West.

Other than the massive expenditure, the psychological trauma and anxiety, sometimes imposed for life, caused by overdiagnosis, have not been estimated. Furthermore, "too much testing of healthy people and not enough care provided for the sick, worsens health inequalities and deters professionalism, harming both those who need treatment and those who do not."

What are the drivers of overdiagnosis?

In a nutshell, Dr. Iona Heath, the former President of the Royal College of General Practitioners says that it is because of a "A toxic combination of vested interests and good intentions"

The following infographic summarises the drivers and the solutions for overdiagnosis.

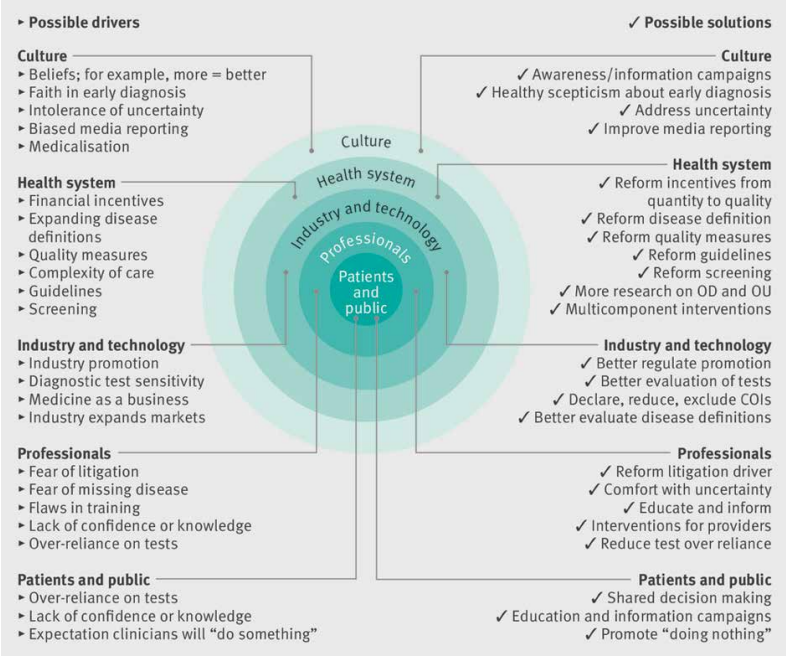


Fig 1 Overdiagnosis and related overuse. Mapping possible drivers to potential solutions.
COI=conflict of interest; OD=overdiagnosis; OU=overuse.
Mapping the drivers of overdiagnosis to potential solutions. Thanya Pathirana, Justin Clark, Ray Moynihan. Center for Research in Evidence-Based Practice, Bond University, Australia

Examples of Overdiagnosis

The classical but controversial example is the use of mammography for breast cancer screening. The ultimate aim is to lower the number of women who die of breast cancer. When we explain the findings to patients, we use decision aids that would make it easier to understand the epidemiological facts.

Over-detection over 20 years of screening in Australia

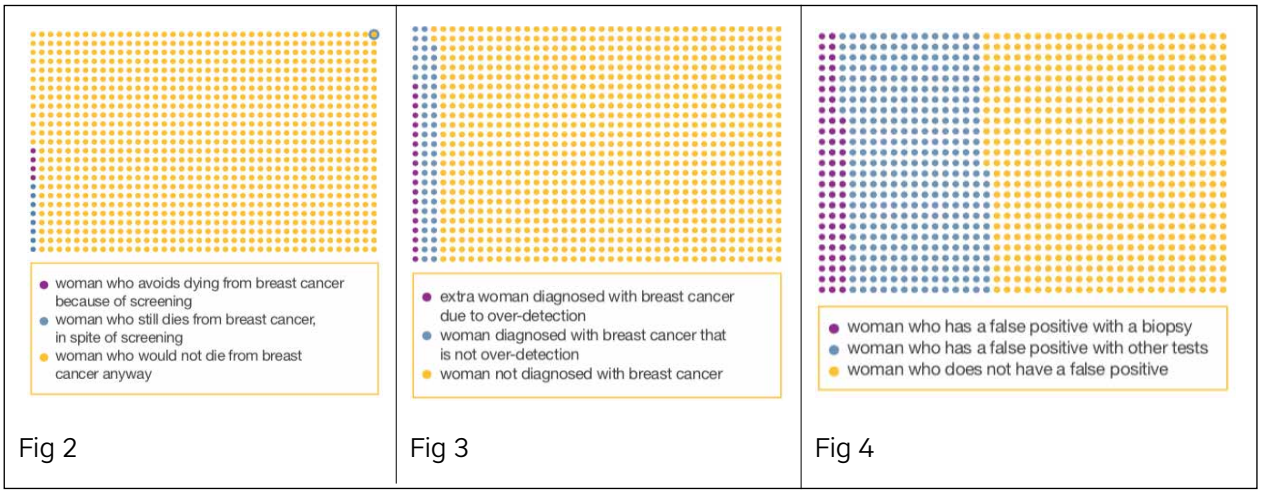


Fig 2 Fig 3 Fig 4

Supplement to: Hersch J, Barratt A, Jansen J, et al. Use of a decision aid including information on overdetection to support informed choice before breast cancer screening: a randomised controlled trial. Lancet 2015; published online Feb 18. http://dx.doi.org/10.1016/S0140-6736(15)60123-4.

Out of 1000 women who had been screened for breast cancer for 20 years, 4 women avoided dying from breast cancer because of screening and 8 women still die from breast cancer despite screening (Fig 2).

Screening leads to finding some breast cancers that are not harmful (over-detection). The cancers found by screening are treated to try and prevent problems later. But some cancers found by screening would not cause problems anyway. Cancers like this may grow very slowly or just stay the same. Without screening, they would never have been noticed nor would they have caused any trouble. Finding these cancers through screening is over-detection (or over-diagnosis).

Out of 1000 women who had breast cancer screening for 20 years, 73 women were diagnosed with breast cancer. Of these, 19 women experienced over-detection; they were treated for cancer that would not have caused any trouble. (Fig 3).

Some women remain anxious about breast cancer for a while even after being told that there is no cancer. Out of 1000 women who had been screened for breast cancer for 20 years, 412 women experienced a false-positive result. They had an abnormal mammogram initially followed by extra tests, but they did not have cancer.

Of these, 67 women had a biopsy and 345 women had other extra tests but no biopsy (Fig 4).

In Sri Lanka, the Ministry of Health guidelines on early detection and management of breast symptoms was updated in 2019 and it is available at https://www.nccp.health.gov.lk/pdf/publications/guidelines/GuideLine.pdf. However, if you search the web for 'breast cancer screening guidelines in Sri Lanka' you can see for yourself how some private hospitals superfluously advertise and advocate breast screening.

The lack of evidence on how best certain diseases could be managed also leads to overtreatment. Oseltamivir ('Tamiflu') was initially said to reduce mortality in patient with influenza and the United Kingdom spent £424m (€550m; $613m) on stockpiling oseltamivir. However, a reanalysis of data by a Cochrane team in 2016 found that it does not save lives, but that "it reduced the length of the infection in adults by 16.8 hours and in otherwise healthy children by 29 hours and that, used prophylactically, it significantly reduced the risk of flu symptoms". . This year, the BMJ reported that one of the Cochrane Collaboration researchers who conducted the reanalysis of data is now suing the drug company Roche in the US, claiming that

it defrauded federal and state governments by falsely claiming that oseltamivir ('Tamiflu') could be a powerful tool in mitigating a flu pandemic. We sincerely hope that all governments will learn from this lesson in this moment of impending doom where another antiviral drug may be magically introduced by pharma for COVID-19.

What can be done to prevent overdiagnosis?

Medical students, doctors and the public should be made aware of the topic. One of the key concepts, which may be difficult to comprehend, is that 'more is not always better' even in healthcare and 'less is perhaps more'. The use of supplemental oxygen in an acute uncomplicated myocardial infarction is a good example. It was difficult to convince doctors that 100% oxygen saturation might do more harm during an ongoing myocardial infarction. It is now recommended that supplemental oxygen be given only when the saturation is below 90%.

Health systems problems and solutions

Reforming incentives for healthcare professionals and organisations to reward the quality of care rather than the quantity is commonly cited as a key approach to tackle the problem of too much medicine.

Everyone is aware of the kickbacks offered by pharmaceutical companies. They are kickbacks from overdiagnosis at times. In the USA, the Open Payments Programme catalogues and records payments made to physicians by pharmaceutical and device companies. Payments include consulting fees, honoraria, gifts, food and beverage, and travel. Research payments include funds received for basic and applied research as well as for product development. Associated research payments include research funding for which the doctor was a principal investigator and ownership includes investment interests in companies. According to the open payment programme, for six months in 2013, there were 2.7 million identified payments totalling $527 million. In Sri Lanka, there is no such mandatory registration of payments made to doctors by pharmaceutical companies.

Industry and technology

The advent of increasingly sensitive tests which detect "abnormalities" of uncertain clinical significance mandates thorough evaluation of the effects of diagnostic testing on health outcomes. Detecting otherwise harmless pulmonary emboli in a CT scan done for a different reason is one such example.

Genetic testing is currently undertaken to diagnose diseases or to predict serious diseases with the opportunity to offer a specific intervention. In some diseases, genetic tests can help - e.g. BRCA1 and BRCA 2 breast cancer genes. Even these genes predict a risk, not a certainty of developing breast cancer. The penetrance ranges from 30% to 70%. The new wave of genome scanning tests may be a looming disaster of overdiagnosis as they become available freely, even in Sri Lanka. For example, a 25-year old woman who receives the first genome scan report: "a 4-fold increased risk of ovarian cancer, and a debatable increase in the risk of breast cancer. There may be an increased risk of heart disease and the presence of genetic variants that both increased and decreased her risk of macular degeneration." What are you going to do about this information? Should her ovaries be removed prophylactically? But then what about her heart disease because the protective oestrogens will stop? Will this increase her breast cancer risk?

Professional

Overdiagnosis and overtreatment due to fear of litigation for missing or delaying a diagnosis is a major concern in developed countries. The need to address these medico-legal concerns is discussed as a key solution in the literature in the USA. However, in Sri Lanka, as litigation is not that rampant and still doctors are trusted to do the best, an open discussion about the tests would solve the problem in most situations.

Patients and the public

Awareness campaigns to educate patients and the public on harms as well as benefits of screening and treatment options are essential for tackling overdiagnosis.

Furthermore, shared decision making should be promoted. However, the majority of our consultations takes a paternalistic model still. This is because the patients expect the doctors to take the initiative and recommend the tests or medicines.

(The complete article, with references and graphics, is available at https://kmendis.org/)

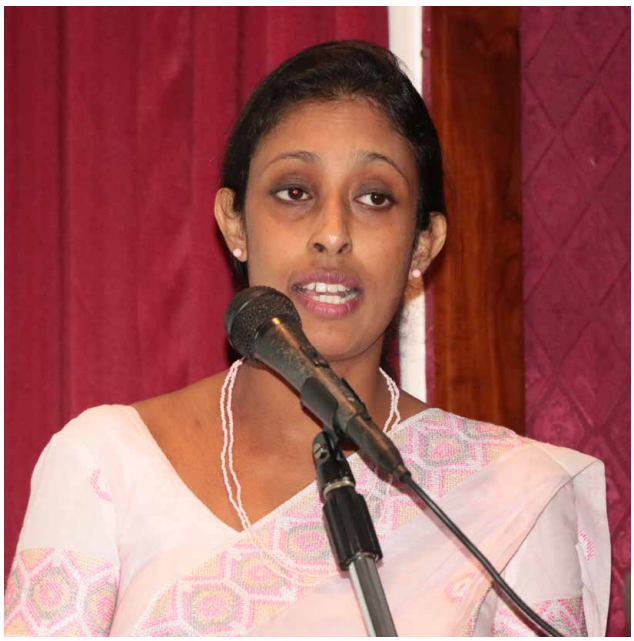
Monthly Clinical Meeting

"The darker side of tacrolimus in renal transplant; Thrombotic microangiopathy revisited"

Dr. Sashika Sandaruwanie, Council Member, SLMA

The Monthly Clinical Meeting of the Sri Lanka Medical Association (SLMA) for February 2020 was organised in collaboration with the Sri Lanka College of Haematologists and it was held on Tuesday, 18th February 2020 at the Lionel Memorial Auditorium of the SLMA. The topic of the meeting was "The darker side of tacrolimus in renal transplant; Thrombotic microangiopathy revisited". Dr. Nadishani Ediriwickrama, Consultant in Clinical Haematology chaired the meeting. The case presenter was Dr. M.S. Buddadasa, Registrar in Clinical Haematology and the case discussion was done by Dr D.P. Ranasinghe, Senior registrar in Clinical Haematology.

The meeting was well attended by medical officers, postgraduate trainees and medical undergraduates.



CLINICAL PEARLS

- The key features of Thrombotic macroangiopathy (TMA) are thrombocytopenia, microangiopathic haemolytic anaemia (MAHA), fluctuating neurological signs, renal impairment and fever. However, all 5 of these signs are present in only less than 10% of patients.
- Both hereditary and acquired disorders are known to mediated TMA. These include ADAMTS13 deficiency, complement disorders, metabolic disorders, coagulation defects, auto-antibody mediated diseases and drugs.
- Three of the commonest drugs known to cause TMA include quinine, cyclosporine and tacrolimus.
- Thrombotic thrombocytopenic purpura is a life-threatening form of TMA characterised by MAHA, severe thrombocytopenia and organ ischemia linked to disseminated microvascular platelet-rich thrombi formation
- Treatment of TTP is by daily plasma exchange and immunosuppression with the use of corticosteroids and or rituximab.

Regional Clinical meeting

Dr. Sajith Edirisinghe,
Assistant Secretary, SLMA

The second regional clinical meeting of the Sri Lankan Medical Association (SLMA) organised in collaboration with Asiri Group of Hospitals, was held on 27th February 2020 at the Auditorium of the Asiri Surgical Hospital, Colombo. The proceedings commenced with the welcome address delivered by Dr. Anil Perera, Clinical Director, Asiri Surgical Hospital and Asiri Hospitals Holdings. The programme comprised of two sessions with lectures on "A practical approach on stroke follow-up" by Dr. Padma Gunaratne, Consultant Neurologist, "ABC of blood cancer care" by Dr. Saman Hewamana, Consultant Haemato-oncologist, "Diabetes in Childhood" by Dr. Navoda Atapattu, Consultant Paedeatric Endocrinologist, "Invasive and non-invasive diagnosis of cardiac diseases" by Dr. Chamara Rathnayake, Consultant Cardiologist and "Diagnosis and management of osteoporosis" by Dr. Chiranthi Liyanage, Senior Registrar in Rheumatology and Rehabilitation and Lecturer, Department of Pharmacology, Faculty of Medicine, University of Colombo. Professor Indika Karunathilake, President, SLMA, Dr. Manujula Karunaratne, Chief Executive Officer, Asiri Hospital Holdings PLC, Dr. B.J.C. Perera, Consultant Paediatrician and Dr. Anil Perera, Clinical Director, Asiri Hospital Holdings PLC chaired the sessions. The meeting concluded with the vote of thanks delivered by Dr. Champika Bogahawatta, Medical Director, Asiri Surgical Hospital. It was well attended with more than 100 medical officers, postgraduate trainees, specialists, allied health professionals and nurses. All participants were awarded a certificate of participation.

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Sri lanka medical association call for orations

Applications are called for the following orations to be delivered in 2020

SLMA Oration - July 2020, Hotel Galadari, Colombo

The SLMA Oration is the most prestigious oration of the Association. Instituted in 1979 it recognises outstanding achievement in research. It is delivered at the Inaugural Ceremony of the Annual Scientific Congress of the SLMA.

Dr. S.C. Paul Oration - July 2020, Hotel Galadari Colombo

The S.C. Paul Oration is the oldest oration of the Association. Instituted in 1966, it is delivered in the memory of Dr. S.C. Paul, an outstanding surgeon. It is delivered on the second day of the Annual Scientific Congress of the SLMA.

Dr. S. Ramachandran Oration - July 2020, Hotel Galadari Colombo

It is delivered during the Annual Scientific Congress of the SLMA.

Dr. N.W.D. Lionel Oration - July 2020, Hotel Galadari Colombo

It is delivered during the Annual Scientific Congress of the SLMA.

Dr. Murugesar Sinnetamby Oration

Instituted in 1968, this oration is delivered in the memory of Dr. Murugesar Sinnetamby, an outstanding obstetrician and gynaecologist.

Sir Nicholas Attygalle Oration

Instituted in 1975, this oration is delivered in the memory of Sir Nicholas Attygalle, an outstanding obstetrician and gynaecologists, the first Ceylonese Vice-Chancellor of the University of Ceylon and President of the Senate. It is delivered on the second day of the Foundation Sessions of the Association.

Sir Marcus Fernando Oration

Institute in 1969, this oration is delivered in the memory of Sri Marcus Fernando, an outstanding physician and the first Sinhalese member of the Legislative Council.

Applicants should submit the full script of the oration. The covering letter, addressed to the Honorary Secretary, SLMA should explain why the applicant believes that the work is of sufficient merit to deserve an oration, and list the original papers and conference presentations (both oral and poster) of the applicant cited in the oration. Applications should reach the Honorary Secretary, SLMA, No. 6 Wijerama Mawatha, Colombo 7 **on or before 15th April 2020.**

All orations:

- Substantial part of the oration should be based on original research.
- Orations based on work published in peer reviewed journals will be given priority.
- in case of multi-author research and publications, the applicant should inform the other authors of his/her presentation and provide details of the contribution to design, data collection, analysis and writing of the manuscript by the applicant.
- A separate sheet stating the publications on which the oration is based should be attached to the submission (see below for details).
- The Dr. Murugesar Sinnetamby Oration should be preferably on a topic pertaining to obstetrics and gynaecology.

Guidelines for submission

- A covering letter should indicate the oration/orations for which the manuscript should be considered.
- The oration should be written in full. The IMRAD format is suggested unless the content requires otherwise.
- For all research involving human or animal subjects, state 'Ethics Clearance' in the methods section. Randomized Control Trials should have been registered in a WHO recognized Clinical Trial Registry.
- The oration should be typed using Times New Roman, size 12, double line spacing. Harvard or Vancouver system of referencing can be used.
- **Seven (07) copies of the scripts should be submitted to the SLMA office (Honorary Secretary, 'Wijerama House', No.6, Wijerama Mawatha, Colombo-07). Of these, one (01) copy should be with the name of the author and six (6) copies should be without the name of the author.**
- Each copy should be accompanied with a brief resume of the salient points in one sheet of paper (A4 size) indicating the contribution made to advances in knowledge on the subject. Further particulars may be obtained from the SLMA office.

The manuscript should be accompanied by a separate document which indicates the following;

1. The impact of the research in terms of advancing scientific knowledge, quality of clinical care and improvement of service delivery.
2. In case of multi-author research/publications, the contribution of the applicant to design, data collection, analysis and writing of publications/manuscript.
3. A declaration by the applicant that the other authors of the presented research have no objections to the submission of the oration.

4. The applicant should declare if all or part of the work included in the manuscript has already been presented as an oration.
5. Declaration of financial and other conflicts of interests.

All authors of orations should be members of the SLMA, if they are eligible for membership. (If you are not a member at present, please become a member before forwarding your application)

Closing date for all orations:
15th April 2020

Thank you!

Dr. Sumithra Tissera,
Honorary Secretary, Sri Lanka Medical Association.

For further details please contact: The Sri Lanka Medical Association, 'Wijerama House', No.6, Wijerama Mawatha, Colombo-07. Tel: +94-112-693324, Email: office@slma.lk

Awards and research grants - SLMA 2020

It is hereby called for applications for the following awards and grants for the year 2020.

CNAPT Award: Applications are invited from doctors and others for the best research publication (article, book chapter or book) in medicine or in an allied field, published in the year 2019, for the Richard and Sheila Peiris Memorial Award. Five copies of the research proposal should be submitted.

Closing date: 31st May 2020

GR Handy Memorial Award: Applications are invited from Sri Lankans, for the best publications in cardiovascular diseases published in the year 2019 for the GR Handy Memorial award. Five copies of the research proposal should be submitted.

Closing date: 31st May 2020

Glaxo Wellcome Research Award: Applications are invited from members for research proposals on topics related to medicine. Five copies of the research proposal should be submitted.

Closing date: 31st May 2020

Professor Wilfred SE Perera Fund: Applications are called from life members of the SLMA, requiring financial support to attend an academic conference, provided an abstract has been selected for presentation at the event. Five copies of the application should be submitted.

SLMA Research Grant: This grant is offered for research proposals on topics related to any branch of medicine. The maximum financial value of the grant is LKR 100,000.00. The grant is targeted at young researchers in their early career, for proposals on applied research that could be initiated (e.g. pilot study) or completed (e.g. audit) with the grant. Five copies of the research proposal should be submitted. The project should have a supervisor.

Closing date: 31st May 2020

Dr. Thistle Jayawardena SLMA Research Grant for Intensive and Critical Care: This grant is offered for a research project with relevance to the advancement of Intensive and Critical Care in Sri Lanka. The maximum financial value of the grant is LKR 100,000.00. Five copies of the research proposal should be submitted.

Closing date: 31st May 2020

FAIRMED: This grant is offered for a research project with relevance to the advancement of Neglected Tropical Diseases in Sri Lanka. The maximum financial value of the grant is LKR 350,000.00. Five copies of the research proposal should be submitted.

Closing date: 31st May 2020

For further details please contact:
The Honorary Secretary, Sri Lanka Medical Association
"Wijerama House", No. 6, Wijerama Mawatha,
Colombo 7
Telephone: 2693324

Sri lanka medical association Call for abstracts

The Sri Lanka Medical Association invites you to submit abstracts for the 133rd Anniversary International Medical Congress - 2020.

- All abstract submissions should be made electronically through our online abstract submission system (http://conference.slma.lk/). More details can be found on the SLMA conference website (http://conference.slma.lk/).
- Hard copy submissions to the SLMA office will not be accepted.
- One author will be permitted to submit a **MAXIMUM of three (03) abstracts ONLY.**
- All authors of abstracts should be members of the SLMA, if they are eligible for membership.
- All research studies should have obtained ethics approval. All clinical trials should be registered with a Clinical Trials Registry. Authors should provide the letter of approval from an accepted Ethics Review Committee (ERC) for research studies and registration number for clinical trials upon request.
- All the authors should declare any conflict of interests during their presentation at the congress.
- The SLMA considers plagiarism as serious professional misconduct. All abstracts are screened for plagiarism and when identified, the abstract and any other abstracts submitted by the same author will be rejected.
- The SLMA reserves the right to make alterations and to edit the contents of the abstract to improve the quality of presentation.

Instructions for online abstract submission

1. Creating an author profile

Before submitting an abstract, authors must register in the abstract submission system by creating an author profile online.

2. Submitting an abstract

(i) Log in to your author account.
(ii) Enter the information requested in the system (title, names and affiliations, presenting author, abstract text).

Guidelines

- The title of the paper should be concise and the SLMA reserves right to modify the title if necessary.
- The author(s) name(s) should be in the format of last name followed by initial(s). Please DO NOT use prefixes such as Mr/Dr/Prof. (E.g. Perera AB)
- Please DO NOT include the title, names of the authors, institutions, sub-headings or any tables/graphs/figures or references within the body of the abstract. Only the text of the abstract should be included.
- The abstract must be structured as follows:
  - Introduction and objectives
  - Methods
  - Results
  - Conclusions
- The body of the abstract MUST NOT exceed 250 words.

(iii) Please select the relevant submission category (Eg: Dermatology, Family Medicine etc.) from the drop-down list in the abstract submission form.

(iv) When uploading the abstract as a MS Word document, please format as below.

- Title: BOLD CAPITAL LETTERS
- Authors: Last name followed by initials, with the presenting author underlined. A superscript number should be placed after each name to refer to the respective affiliations. (eg.:- Perera AB1, Silva CD2)
- Affiliations: must be listed below the authors
- Body of the abstract: Structured with subheadings: Introduction and Objectives, Method, Results and Conclusions.
- Font: Times New Roman
- Font size: 12, single line spacing

3. Important notices:

- Modifications to the abstract can be made until submission. Please note that NO amendments to the submitted abstracts (including the authors list) would be entertained after closing of submission.
- Abstracts not conforming to the above instructions will be rejected.
- Accepted abstracts will be published in the Ceylon Medical Journal Supplement containing the abstracts.

- A panel of reviewers will review abstracts anonymously and the decision of the Scientific Committee will be final. Successful applicants will be notified via email by 31st May 2020.
- The presenting author is required to register for the sessions upon acceptance of the abstract.
- Please provide a name of a second presenting author (in case of a situation where the original presenting author is unable to attend).
- Failure to make a presentation (oral or poster) once participation is confirmed will be considered an episode of academic/scientific misconduct and the authors will be liable for punitive action.
- The deadline to submit abstracts is 15th April 2020 23:59 Sri Lankan Time.
- Please make note that the deadline for submitting abstracts will not be extended.

The deadline to submit abstracts is 15th April 2020, 23:59 Sri Lankan Time.

Please make note that the deadline for Submitting abstracts will not be extended.

Awards for free papers and posters

The following prizes will be awarded for free papers and posters accepted for presentation at the 133rd Anniversary International Medical Congress 2020.

1. E. M. Wijerama
2. S. E. Seneviratna
3. H. K. T. Fernando
4. Sir Nicholas Attygalle
5. Wilson Peiris
6. Daphne Attygalle (Cancer)
7. Sir Frank Gunasekera (Community Medicine and Tuberculosis)
8. Kumaradasa Rajasuriya (Research Tropical Medicine)
9. Special prize in cardiology
10. The SLMA prize for the best poster
11. S. Ramachandran (Nephrology)

Please note that all submissions should be made electronically through the online abstract submission system. More details can be found on the SLMA conference website http://conference.slma.lk/).

IMPORTANT DATES

Abstract submission deadline: 15th April 2020 23.59 Sri Lankan Time
Abstract acceptance notification: 31st May 2020
Registration for presenting authors: 12th June 2020

Thank you

Dr. Sumithra Tissera
Honorary Secretary
Sri Lanka Medical Association

For further details please contact:
The Sri Lanka Medical Association,'Wijerama House',
No .6, Wijerama Mawatha, Colombo-07.
Tel: +94-112-693324
Email: office@slma.lk

Calling for Applications - SLMA Doctors Concert 2020

The SLMA Doctors Concert at the 133rd Anniversary Medical Congress is scheduled for Friday 24th July at 7.00 PM at the Hotel Galadari, Colombo.

The number of performances this year is limited to 20. This will include an array of performances by previous and new performers.

This is your opportunity to showcase your talents as a musician/singer/dancer or actor.

Each person will be allowed only one item in the entire programme and no one will be allowed to present an item and then join a duet or group (except the council members).

Please send in your application on or before the 31st March 2020 to office@slma.lk.

If you have any clarification, please do not hesitate to call me on 077 25 32 184.

Information Required;

- Name & contact details
- The type of performance (singing/playing a musical instrument/ dancing etc.)
- Number taking part (solo/ duet/ group)
- Have you performed at any previous Doctors Concerts & when?

Looking forward to your early response.

Thank you

Dr. Sumithra Tissera
Honorary Secretary, SLMA (on behalf of the Doctors Concert Organising Committee)

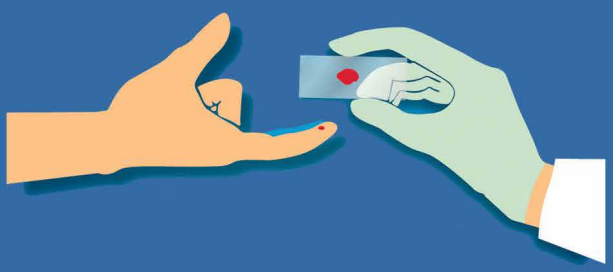
PS. The committee's decision on selection of the performers would be considered as final.

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 or any material you wish to share with the other members. If you have medical relevant, timely photographs or drawings which could be used in the cover page, please do share with us. 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



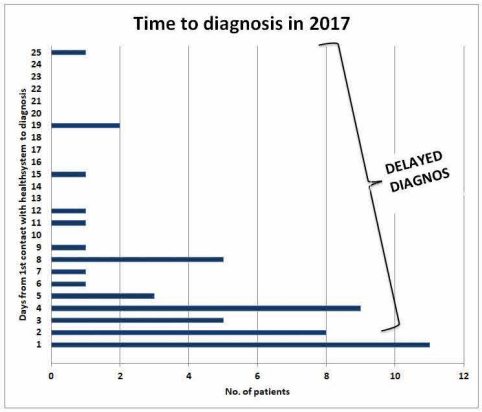
Reduce the Delay in diagnosing imported Malaria

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

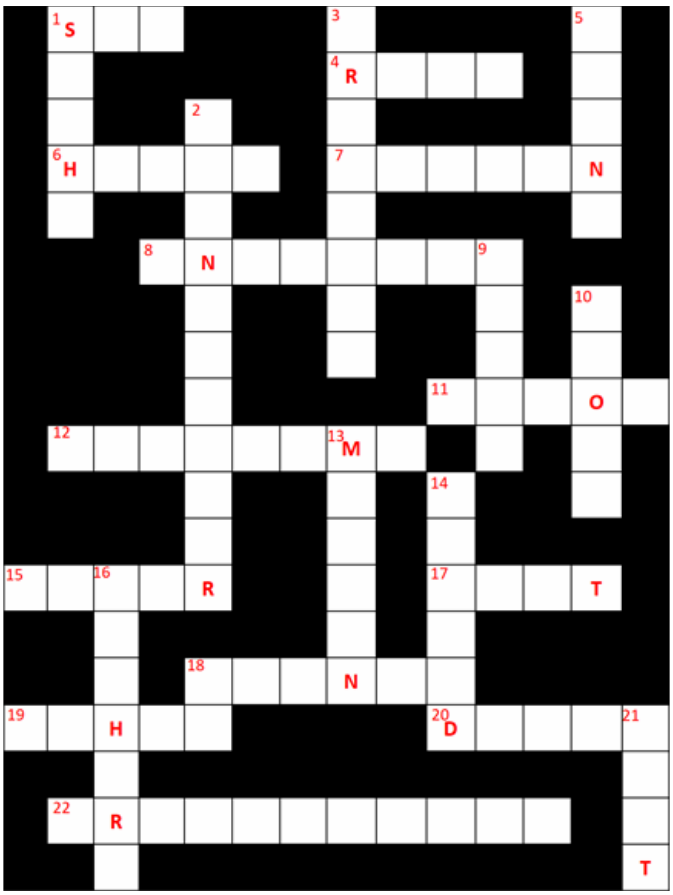
Call now for free advice, treatment and drugs

011 7 626 626

www.malariacampaign.gov.lk

MEDICAL CROSSWORD

Find the Syndrome!



ACROSS

1.Another name for mucopolysaccharidosis type VII
4.It is caused by a mutation on gene MECP 2 on X chromosome and almost always affect girls
6.A complication of pregnancy
7.Characterized by cleft palate and congenital contractures of the hands and feet, it is also known as distal arthrogryposis type 3
8.Most affected children have recurrent seizures and microcephaly with happy and excitable personalities.
11.An autosomal recessive syndrome with increase in conjugated bilirubin
12.A deletion in the elastin gene on chromosome 7 with elfin appearance, hypercalcemia and cardiovascular abnormalities
15.A syndromic form of retinitis pigmentosa with hearing loss
17.Characterised by infantile spasms, hypsarrhythmia on EEG and mental retardation
18.Has only one X chromosome
19.Idiopathic basal ganglia calcifications
20.A form of congenital strabismus caused by faiure of normal development of sixth cranial nerve.
22.The most common form of syndromic obesity

DOWN

1.Also called chronic recurrent multifocal osteomyelitis (CRMO)
2.Men who have an extra X chromosome and commonly present with infertility
3.The most common cause of inherited mental retardation caused by a mutation of FMR1 gene
5.Patients with 47 chromosomes and an extra copy of chromosome 21
9.Arrhythmogenic right ventricular cardiomyopathy (ARVC) and palmoplantar keratoderma and woolly hair.
10.An autosomal dominant disorder with nail hypoplasia or absence of fingernails (anonychia)
13.The most common inherited disorder of connective tissue.
14.Trisomy 18
16.A congenital disorder with hypoglossia, hypodactyly and micrognathia
21.Renal salt wasting with epilepsy, sensorineural deafness and ataxia

An extract from a talk by Preethaji of 'pkconsciousness' on the Coronavirus outbreak

Assembled and compiled by Dr B. J. C. Perera, Specialist Consultant Paediatrician

Paediatrician Nature is a great experimenter. How do you think it conducts its experiments?

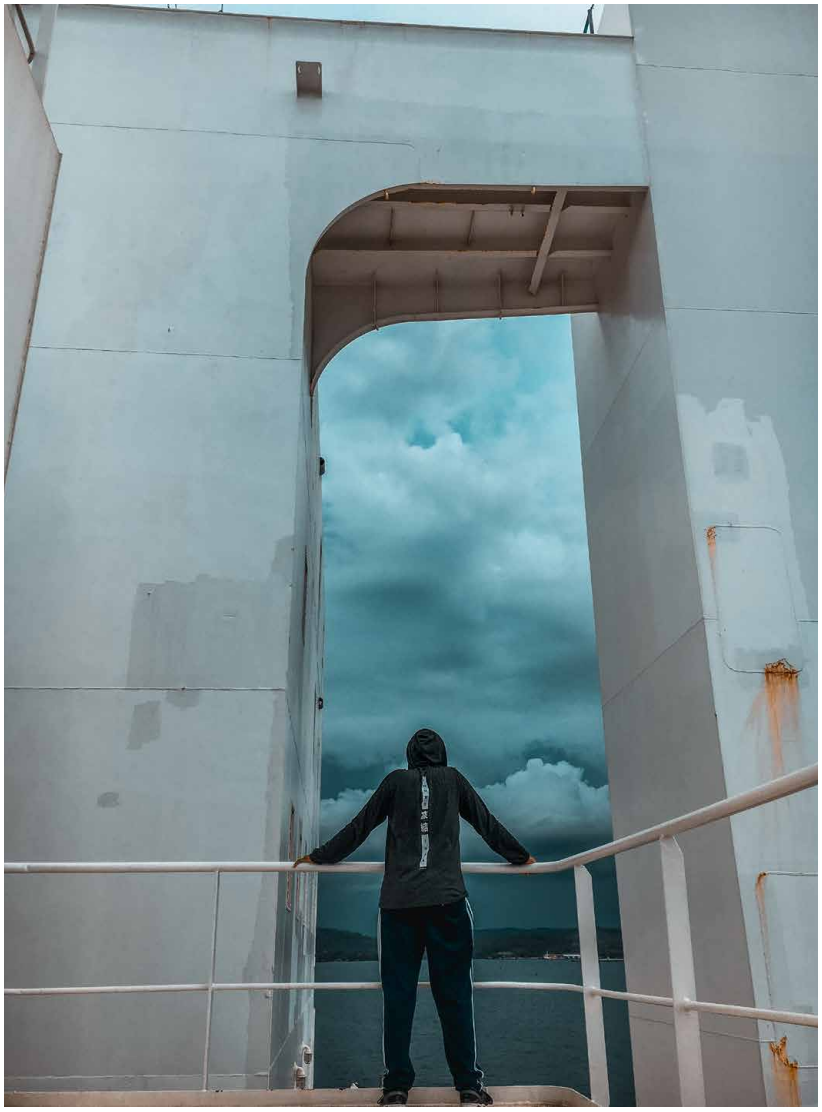
The answer is that it discards the species that is not supporting the whole. It has constantly experimented over millions of years. It has discarded the dinosaurs, it has discarded the sabre-toothed tigers, it has discarded Ramapithecus and it has discarded the Neanderthals. Some of these species have survived for 200,000 years. A few of them have survived for ten to twenty million years. However, all of them have been eliminated. This is perhaps just information for you. But there may be some serious implications.

The question is., how sure are we about the success of our species; the success of this human species? Are you sure that we are going to survive forever?

If we have to survive forever, it means that we need to be beneficial to the whole. If we are not going to be beneficial to the whole, what would nature do? **IT WOULD DISCARD US.**

Are we being beneficial to the whole? If we were to have a conversation with the planet Earth, what do you think the planet would tell us?

It would tell us that it is very unhappy.



The reasons are obvious. We are probably more damaging than the smallpox virus; a virus that is extinct now. YES, we are more damaging, causing greater calamities, and we are being cruel, to this planet of ours. Just as an example, if you look at any other species, they kill somebody else or kill another species, only for its survival, only when it is threatened or when it is very hungry. But we as the human species, we have not evolved. We as a species, kill another species, not merely for our survival, but to prove our superiority over others, to prove our dominance over this entire planet, or sometimes, even for pleasure.

There is a huge noise outside in the world now, about the virus; the coronavirus. What if this coronavirus is nature's way of eliminating the human species that has become a virus? It is a huge possibility. We are not being beneficial to the whole. If we are not being beneficial to the whole, as we have seen again and again, nature discards us. In the current situation, China is not the problem, the Chinese people are not the problem. Then, what is the problem? The problem is our own consciousness. We are living and experiencing life in separation. We are living and experiencing life as though we are separate from everybody else

around us. This separation driven consciousness has its inherent repercussions, and we see it in the world around us. We see it as cancer, we see it in the world as disasters, we see it as natural calamities or may well be, **EVEN AS THE CORONAVIRUS**.

It is time to wake up now. We cannot continue living our life from a disconnected state of consciousness. The more disconnection that we experience, more chaotic would be the world around us. If we are looking for a more peaceful world, if we are truly looking for a more joyful world, if we intend to create a beautiful world for our children and our grandchildren, then the transformation has to happen now and here. It may already be too late, but we could try and act, better late than never.

Available from
www.pkconsciousness.com and https://www.youtube.com/watch?v=zAZ8GVDxWnY

A comment by the compiler

There is a regular order of things in nature. There are built in checks and balances in Mother Nature. Drought will be followed by rain and floods, wars will be followed by peace, destructive natural calamities will be followed by development and cyclones will be followed by tranquil calm etc. However, if we wage war against nature, it will not turn the other cheek. It will retaliate.

This has a compelling message to all politicians, stakeholders, policymakers, and so-called 'statesmen' of the world, as well as to everybody belonging to the species of Homo sapiens.

The message is as follows: **DO NOT, UNDER ANY CIRCUMSTANCE, PLAY AROUND WITH NATURE. IF YOU WAGE WAR AGAINST NATURE, YOU WILL NOT WIN. YOU WILL ALWAYS LOSE.**

Assembled and compiled by
Dr B. J. C. Perera Specialist Consultant Paediatrician

Photo by Ashan Bopitiya

WHY WORRY!

In life there are really only two things to worry about.
Either you are well or you are sick.
If you are well, there is nothing to worry about.
If you are sick, there are two things to worry about.
Either you get better or you die.
If you get better, there is nothing to worry about.
If you die, there are two things to worry about.
Going to heaven or going to hell.
If you go to heaven, there is nothing to worry about.
If you go to hell, you'll be so busy shaking hands with all your friends that you'll not have
time to worry.
So.., why worry at all?

Extracted from https://www.ba-bamail.com/jokes/heaven-and-hell-jokes/
Sent by Dr. B. J. C. Perera

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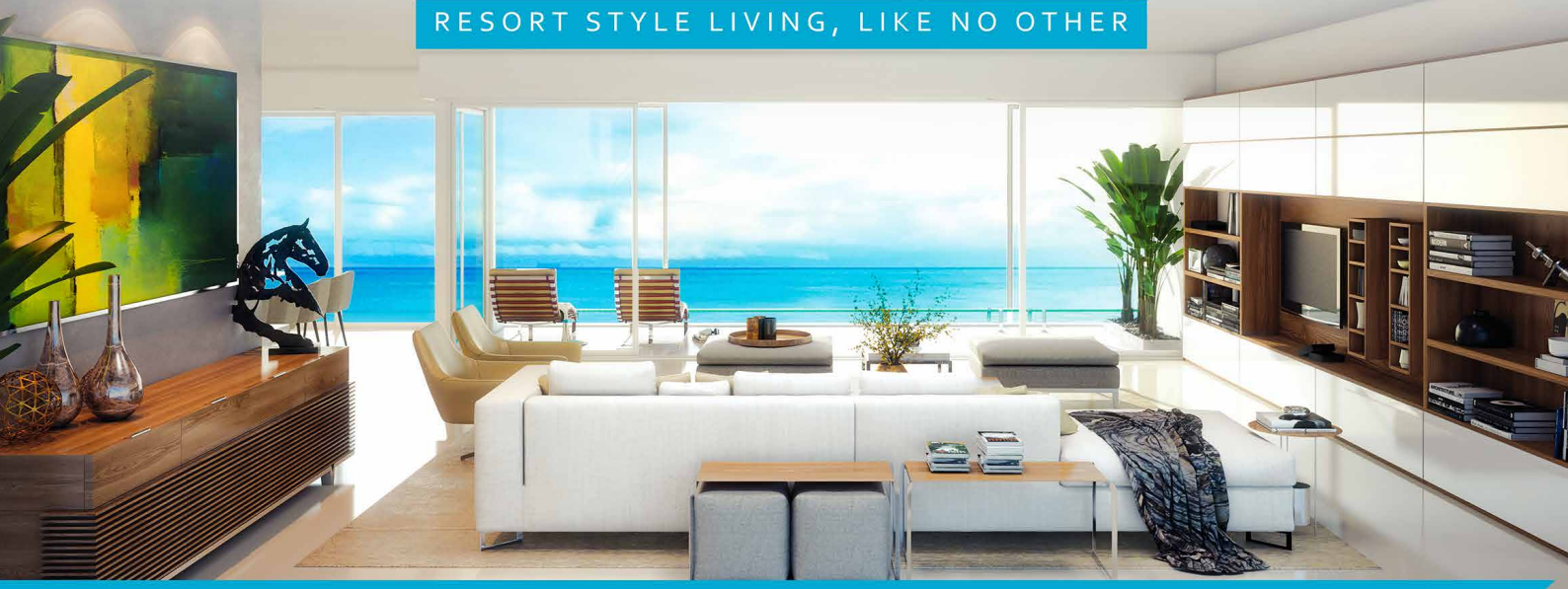
RESORT STYLE LIVING, LIKE NO OTHER



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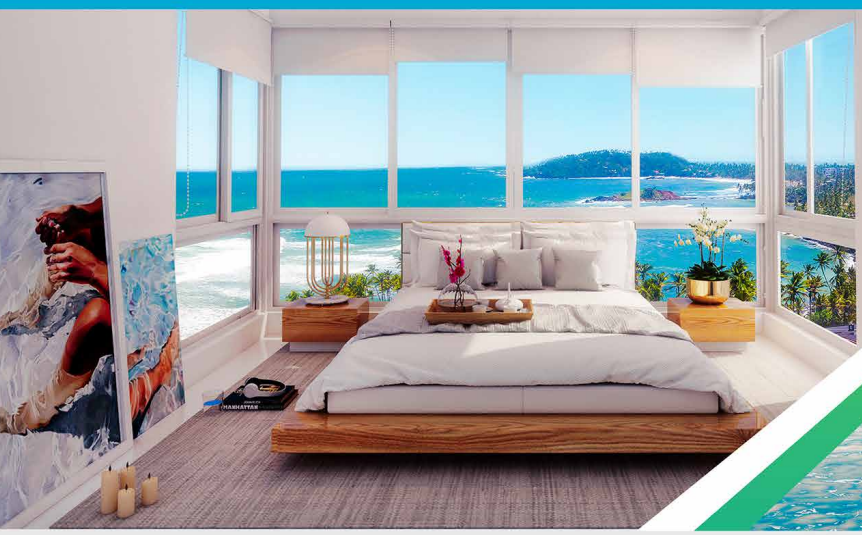

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