SLMA NEWS

THE OFFICIAL NEWSLETTER OF THE SRI LANKA MEDICAL ASSOCIATION

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Cover story

Monthly Media Seminar to Commemorate World No Tobacco Day

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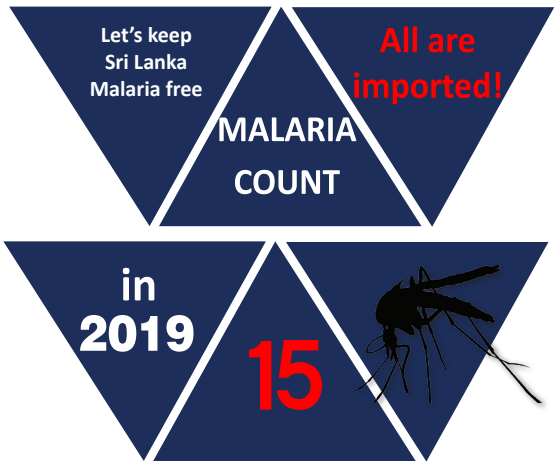

SLMA Theme 2019

Facing the challenges and forging ahead for better health outcomes

OFFICIAL NEWSLETTER OF THE SRI LANKA MEDICAL ASSOCIATION

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President's Message

Horror on the highways

In my message in the March issue I mentioned the downside of the New Year celebration which include indulgence in alcohol and its consequences, injuries from use of fireworks and the high consumption of New Year sweetmeats, aggravating NCDs among the community.

True to form, 1270 persons were arrested for drunk driving and nearly 35000 drivers have been fined for flouting traffic laws during this period. In all, forty one persons were killed in traffic crashes during the New Year period.

Out of this number, fourteen road deaths occurred within a 24 hour period. These statistics highlight the serious nature of this problem of road traffic crashes. This information was obtained from a media statement issued by the DIG - Traffic Mr. Ajith Rohana.

The most horrific among the road deaths during this period was the major crash involving a private bus and a van driven by a 19 year old lad in Mahiyangana which claimed the lives of 11 members of connected families. The young lad of 19 years had apparently fallen asleep at the wheel. Obviously, he has had very little driving experience and had not completed sufficient mileage before handling a large vehicle on a long journey.

As I was formulating this article after the New Year vacation, came the horrific Easter Sunday bomb explosions with all its ghastly consequences. Naturally this disaster took precedence over the road traffic crashes and I decided to postpone my message on road traffic crashes to the following month – so here is my belated message on road traffic crashes.

Magnitude of the problem.

The death toll on Sri Lankan roads is approximately 3000 per year, averaging 1 death every 3 hours, 8 deaths per day and 2920 deaths per year. It is estimated that the number of lives lost from road traffic crashes would even surpass the number of lives lost during the 30 year terrorist war!

Economic cost of road traffic crashes.

Each death costs the government of Sri Lanka approximately Rs. 1 million by way of investigations, treatment, ICU care, legal work and post mortem. Approximately 25% of the annual budget of the National Hospital is spent on treatment of victims of road traffic crashes.

Social consequences of road traffic crashes.

Quite often, the victim of a road traffic crash is the bread winner of the family. This often leaves the children orphaned and in dire straits without adequate financial and family support. Furthermore, death of a bread winner leads to economic disaster for the family as all the wealth is often utilized for management of the victim. Those who do not die are often left with severe disabilities, either totally or partially paralyzed or in a vegetative state or totally dependent and wheel chair or bedbound.

Death of OIC of traffic, Borella Police.

This responsible officer was on his way to work at 4.30 am on Sunday the 31st of March to supervise the ironman competition held at the Galle Face Green. He was mercilessly mowed down whilst on his motorcycle by a vehicle driven by an intoxicated youth with strong political connections. After an extended period of ICU care, he succumbed a while later. So many questions remained unanswered due to various influences. However, this case needs to be taken up again to ensure that justice prevails. No amount of financial compensation can replace the role of a devoted husband and the yearning of his young children for their father.

A national consensus is therefore required to ensure road safety. The concerned socially responsible public, the private sector, media and NGOs should join the main responsible sources, the Ministry of Highways and the Traffic Police, in the prevention of road traffic injuries and deaths in our country.

The way forward.

1. **Increase the minimum age for obtaining a driving license. This would ensure greater suitability and more maturity of those handling vehicles.**
2. **Control the mushrooming of incompetent driving schools which have sprouted in all street corners. These institutes handout certificates of competence in driving with the minimum of training and inadequate driving standards.**
3. **Adequate assessment of driving skills and knowledge of road rules must be ensured before driving licenses are issued by the motor traffic department. The corruption prevailing there should be firmly curbed.**
4. **An age ceiling must be imposed on drivers of heavy vehicles such as tippers driven by old men on long journeys, which are often involved in crashes.**
5. **Testing of road worthiness of vehicles should be ensured at regular intervals.**
6. **Modernization of the road network.**
7. **Introduction of road rules as in European countries to prohibit drivers from driving more than six to eight hours as they are more likely to doze off due to tiredness and monotony.**
8. **Ensure that road users obey traffic rules at all times. Drivers should never drink and drive or drive when tired and sleepy.**
9. **For drunk driving - suspend the driving licenses for 6 months and impose a jail sentence.**
10. **Implement strictly without reservation, the recent heavy traffic fines introduced by the parliament of Sri Lanka.**

It is my intention to activate the SLMA Sub-committee on Road Traffic Crashes. All stakeholders will be invited for discussions and hopefully, meaningful steps can be taken to make our highways safe for its citizens to travel.

Dr. Anula Wijesundere,
President, SLMA

The Monthly Clinical Meeting of the SLMA for May, 2019

Dr. Sajith Edirisinghe,
Assistant Secretary-SLMA

The monthly clinical meeting of the SLMA for May, 2019, organised in collaboration with the Ceylon College of Physicians, was held on 21st May 2019 at the Professor N. D.W. Lionel Memorial Auditorium of the SLMA. A Lecture Discussion on "A middle aged woman with shortness of breath: A rare cause of dyspnoea" was discussed by Dr. Namal Wijesinghe, Senior Lecturer in Medicine, General Sir John Kotelawala Defence University, Dr. Dumitha Govindapala, Senior Lecturer in Medicine, General Sir John Kotelawala Defence University, Dr. Priyamali Jayasekera, Senior Lecturer in Medicine, General Sir John Kotelawala Defence University and Dr. Nipun de Silva, Lecturer in Medicine, General Sir John Kotelawala Defence University. The meeting was well attended by Medical Officers, Postgraduate Trainees and Medical Undergraduates. The meeting was chaired by Dr. Anula Wijesundere, President, SLMA. A synopsis of the presentations is provided below.




A middle aged woman with shortness of breath: A rare cause of dyspnoea

Dr. DS Govindapala, Dr. Nipun De Silva, Dr. Thisara Samarawickrama, Dr. Priyamali Jayasekera, Dr. Namal Wijesinghe
Faculty of Medicine
General Sir John Kotelawala Defence University

Case report

A 67 year old, previously healthy female presented with intermittent chest pain and shortness of breath on mild to moderate exertion for one year. Chest pain was sub-sternal, dull aching type, with no radiation and improved on the left lateral position. She had no orthopnoea, paroxysmal nocturnal dyspnoea or leg oedema. There were no constitutional symptoms such as fever, loss of appetite or loss of weight. Two years before she had presented to a tertiary care unit with chest pain and was evaluated with coronary angiography, following which she was reassured and discharged.

Her physical examination was unremarkable and basic investigations including full blood count, inflammatory markers, chest X-ray and electrocardiogram did not reveal any abnormality. Trans-thoracic echocardiogram showed a large mass in the left atrium, attached to the interatrial septum, filling the whole chamber with slight protrusion into the anterior mitral valve leaflet and left ventricle during diastole (Fig. 1). A diagnosis of left atrial myxoma was made based on the appearance of the tumour and patient was referred for urgent surgery. She has successfully undergone surgery and histology confirmed the diagnosis of atrial myxoma. Her breathlessness and chest pain have completely resolved following surgery.

This patient is selected for discussion to highlight few important aspects in her presentation and management. Although dyspnoea is a common presentation of atrial myxoma, atypical chest pain is not a commonly reported symptom. According to the literature, patients with large left atrial myxomas present with cardiac murmurs due to obstruction of the mitral valve. Although this patient had a large myxoma protruding into the anterior mitral valve, her physical examination was completely unremarkable. It is uncertain whether this patient was evaluated with an echocardiography two years back when she presented with chest pain. Hence, whether her initial presentation was due to the same cardiac lesion or whether this cardiac myxoma had grown within the last two years is unclear.

Cardiac tumours

Primary cardiac tumours are rare and the prevalence at autopsy ranges from 0.001% to 0.3%. Three quarters of these tumours are benign and nearly half the benign cardiac tumours are myxomas[1-2]. Epidemiologically, myxomas show a female predominance and are generally classified into two main forms; the familial and the sporadic. The sporadic form represents 95% of all cases and affects mainly middle-aged women. This form of tumour is more commonly single and localized to the left atrium. On the other hand, the familial type affects young males more frequently. Multiple tumours and atypical locations are seen in cases of familial myxoma [3].

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A middle aged woman...

Histogenesis

The exact aetiology of myxomas is unknown. The current theory states that these tumours originate from entrapped embryonic foregut and hence they are derived from multi-potent mesenchymal cells. Typical myxomas are polypoid, often pedunculate, round or oval, tumours with a smooth or gently lobulated surface [4]. Myxomas consist of a myxoid matrix composed of an acid-mucopolysaccharide–rich stroma. Polygonal cells with scanty eosinophilic cytoplasm are scattered throughout the matrix [5].

Clinical manifestations

The clinical presentation depends on the location, size and mobility of the tumour. Most patients present with one or more of the triad of intra-cardiac obstruction (67%), embolic manifestations (29%) and constitutional symptoms (19%) [6-7]. Commonly observed symptoms and signs are dyspnoea, orthopnoea, paroxysmal nocturnal dyspnoea, pulmonary oedema, cough, haemoptysis, and fatigue. Symptoms may be worsened in certain body positions due to movement of the tumour within the atrium. Occasionally, patients can be asymptomatic, particularly with small tumors[8].

Laboratory abnormalities such as anaemia and elevations in the erythrocyte sedimentation rate, C-reactive protein or globulin level are present in patients with systemic symptoms [7]. electro-cardiography is usually unremarkable. The trans-thoracic echocardiography is the investigation of choice. Trans-oesophageal echocardiography and further cardiac imaging may be needed in selected patients where diagnosis is uncertain [9].

Treatment and prognosis

Surgery is the treatment of choice for myxomas and it is usually curative. After the diagnosis has been established, surgery should be performed urgently, because of the possibility of embolic complications or sudden death [10-11]. Recurrences of myxomas have been observed, mostly within the first four years after surgery [6,12]. Therefore, annual follow-up is recommended.

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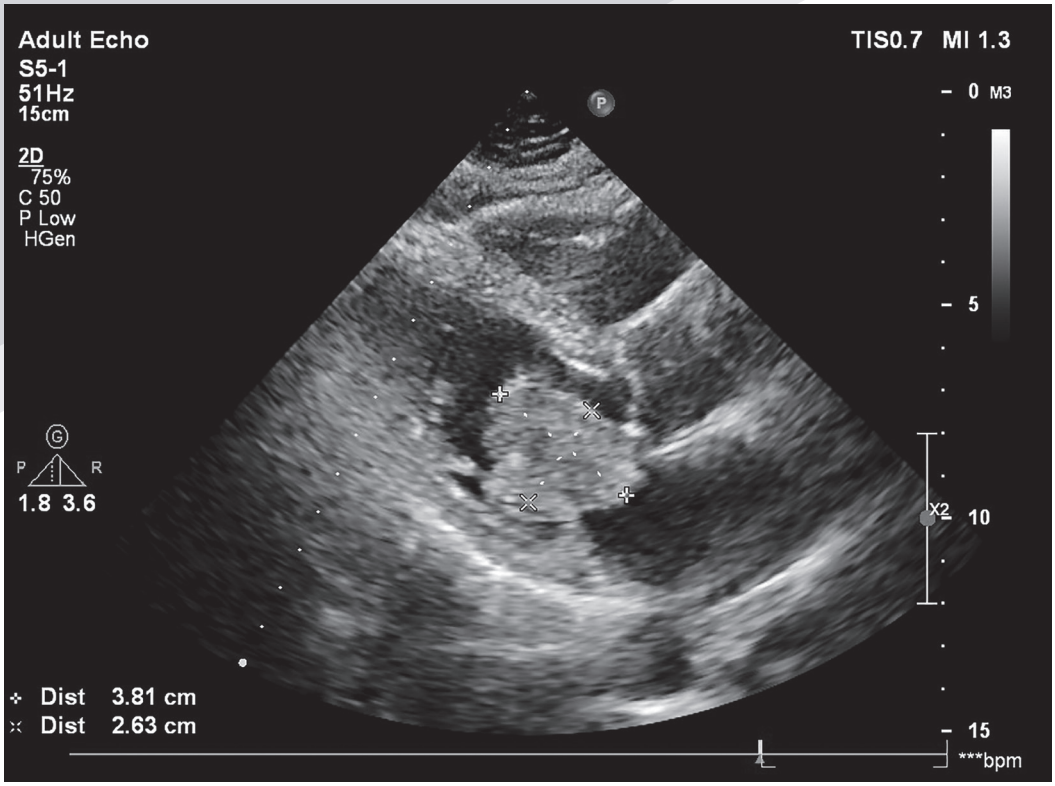

Figure 01

Perspectives on Drug Abuse in Sri Lanka

Dr Jayamal De Silva
Senior Lecturer in Psychiatry,
Faculty of Medical Sciences – USJP
Convenor – SLMA Expert Committee on Tobacco, Alcohol and Illicit Drugs

Even though drugs do not cause much financial damage and loss of lives compared to tobacco and alcohol in our society, they can exert devastating effects on addicted persons, their families and the communities they live in. In the year 2018, there were close to 81,000 arrests for drug related crimes in Sri Lanka. Close to one third of this involved heroin. The total number of users was thought to be about 250,000 from an earlier estimate and it is believed that approximately one fifth of them are heroin users. Police department data suggest that a large proportion of heroin users are imprisoned at a given time and the number of users in the community does not reflect the total number in the country. The rest consist of persons dependent on cannabis, amphetamines, and other drugs. With the recent apparent increase in the use of prescription medication abuse, it is evident that the drug abuse landscape is a variable and a changing one in the country. Hence, it is likely that the traditional treatment and control approaches might not be very effective and the possibility of iatrogenic harm is more unless we take into consideration the changing nature of epidemiology and culture of substance abuse.

The not so useful approaches in substance abuse treatment would include the following: inappropriate health education approaches. public pledges and swearing-in ceremonies and campaigns such as say-no-to-drugs programs in schools. Skills training, likewise, would not yield expected results unless aimed at delivering a set of skills that are useful in empowering people. Most of the generic skills which are taught in these so called life skills programs will not be of much use when it comes to the influence of industrial vectors and already established users. For example, unless children realize that the tendency to use a substance is related to the glamour created around it by the media and it is done for profit, the students who participate in either educational or skills training programs would not gain the full capacity to react to these determinants of substance abuse.

Education of the harm done by the drug is important. However, most current educational programs stop where the participants are provided knowledge on biochemical actions of drugs and their physical and psychological harm. These programmes leave out a few of the most important aspects of drug education which are important in curbing the menace of drugs in the society. For example, there is hardly any discussion on gateway drugs, which are mostly tobacco (smoked and smokeless), alcohol and in some instances, cannabis. And the real harm from addiction, which includes losing ability to experience the pleasures of the world as an individual starts habitually associating all pleasures in life with drug use, is rarely emphasized. Likewise, the restriction of lifestyle and daily routine around a drug seeking behaviour and the constant dwelling in withdrawal states which destroy one's happiness instantaneously, are never mentioned at all.

Apparently scientific approaches such as say-no-to-drugs programmes have not yielded the expected results. For example the D.A.R.E programme which was carried out in the USA spending more than a quarter billion dollars has not given the expected outcomes. Sadly, in some instances, it has been found that the program had increased the use of tobacco and alcohol in some schools where it was successfully completed.

> *clinical approaches are no substitutes for community approaches which call for a mechanism which will change the perception and behaviour of the whole community in preventing new users being recruited to the user group as well as helping existing users to quit on their own or with a little help.*

The presence of industrial vectors could be hard to understand in the instance of hard drug abuse. Whilst the illicit dealers, smugglers and peddlers do not strictly show the organized and established features of an industrial vector such as the alcohol industry, they still behave the same way in most instances. More than that, there is an actual presence of other industrial vectors in the drug scene. For example, the gateway drugs are manufactured and promoted by industries. And these industries benefit from, and actively seek to divulge public attention from their products - which are way more harmful socially and economically- to Ilicit drugs. The pharmaceutical industry actively promotes the use of substitution therapies and the use of addictive substances such as oxycodone. Rise in prescribed and pharmaceutical drug misuse everywhere in the world is becoming a major problem.

Iatrogenic harm in the treatment of substance abuse could be based on baseless treatment programs such as substitute therapies and treatment approaches such as counselling and various forms of newer psychotherapies. One fundamental issue with some of these approaches is the damage to the self-efficacy of the users who are capable of giving up substance abuse on their own. What this simply means is that as doctors, we inculcate the fear of giving up of substance use unassisted, preventing the majority of users giving up on their own. This happens as we emphasize on detoxification programs and the need for various forms of substitute therapies. At this point, it would be worth reminding ourselves that heroin withdrawal is not at all fatal and any user, irrespective of the degree of dependence, will come out of heroin within one week completely even if we do not administer any drug or psychological treatment. This recovery naturally happens with most users when they decide to come out of it.

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Perspectives on Drug...

Any other "hard drug" would have the same pattern of recovery and in most instances, there is no specific detoxifying agent available. What the dealers and the industry carry out as an "education" of the current users and the general public is inculcation of the idea that one cannot come out of the drug due to the "sickness" and one must either continue to use or seek treatment at a rehab centre. This myth is one important phenomenon that the medical community must handle in helping users of all categories to stop their habit.

Counselling and newer forms of psychotherapies as CBT or mindfulness training, have a serious limitation when it comes to prevention of drug abuse, whilst being useful in treating individual users in a clinical and community setting. These clinical approaches are no substitutes for community approaches which call for a mechanism which will change the perception and behaviour of the whole community in preventing new users being recruited to the user group as well as helping existing users to quit on their own or with a little help. Moreover, the limited resources which we have, when spent solely on individual approaches, would leave the health system deprived of the same being invested in prevention activities.

What must be done in order to make the illicit substances disappear from Sri Lanka would include some of the following: decrease the initiation by reducing attraction attached to drugs, help people quit on their own and help them to understand and change the determinants of substance abuse. Addressing gateways becomes an important issue in doing so. As a medical community, we must always keep in mind that the inadvertent iatrogenic harm is a reality and we must take action to prevent that by using science and taking into account the whole of the evidence available rather than focusing on clinical samples.

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APPRECIATION
Dr. Dennis Jesuthasan Aloysius: A man loved by all

Dr. B. J. C. Perera
Specialist Consultant Paediatrician
Past President, Sri Lanka Medical Association

On the 24th of May 2019, Dr. Dennis Aloysius, the man supreme for many an occasion, bid his final adieu to this world and left us all forever. The call from the Lord above finally came to him and he gently passed away plunging his family and friends into indescribable desolation and unbearable sorrow.

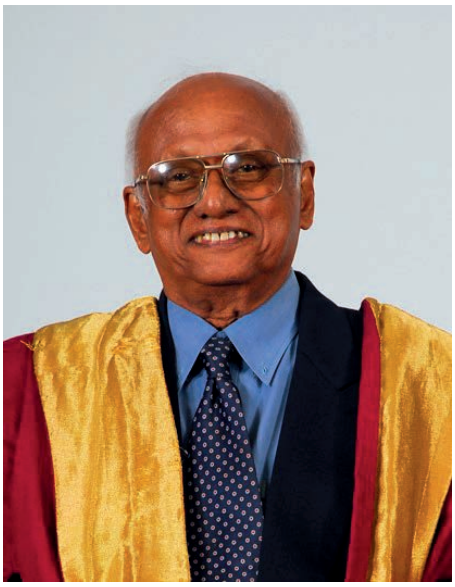
Dr. Dennis Aloysius is indeed a man of many and much admired facets. Here was a man who chose Family Practice as his vocation very early on in his professional life. He adorned that calling with absolute distinction and later became a much valued mentor to junior doctors who aspired to follow in his masterly footsteps. He was indeed a much loved Family Doctor to his patients. It is no exaggeration at all to say that his patients, of all ages and from all types of strata in society, simply adored and even worshipped him. More than anything, he always had plenty of time for them. For many of those patients, just talking to the man was good enough even to secure physical and mental liberation from many a malady. The healing mental touch of the man was quite legendary.

Dennis was an invaluable and trusted friend to his associates, an administrator par excellence to those who worked with him and generally a gem of a human being to all and sundry who had the superlative good fortune to come into contact with him. To all of us who were so very fortunate enough to be his friends, the man was the epitome of unbridled kindness, an astute agent of advocacy, a friend exhibiting unfailing loyalty and a fantastic exponent of all-encompassing camaraderie. Being such a socialising, warm and genial person, to be with him was to be in the best company imaginable, and even ever possible. In Medical Administration, he played a vital and crucial role in formulating, nurturing and maintaining the North Colombo Medical College (NCMC). Those whom he had managed and taught over there would definitely vouch for the fact that he was indeed somebody ever so exceptional. Their unparalleled affection for him was portrayed most vividly by the large numbers of NCMC graduates, who followed him in mourning, during his last journey on Mother Earth.

Dr. Dennis Aloysius has held many exalted positions in several medical organisations of acclaimed repute. Just to pick out only a few of the galaxy of positions he held, he was the President of the College of General Practitioners of Sri Lanka, the President of the Sri Lanka Medical Association, the President of the Sri Lanka Paediatric Association and the President of the Organisation of Professional Associations of Sri Lanka. He adorned these positions with well-sustained competence and incomparable gentleness and saw to it that those institutions worked like well-oiled machines during his tenures of office. He was, most definitely, their guiding inspiration of unmatched wisdom.

> *He was indeed a much loved Family Doctor to his patients. It is no exaggeration at all to say that his patients, of all ages and from all types of strata in society, simply adored and even worshipped him. More than anything, he always had plenty of time for them.*

The love of his life, Chrissie, predeceased him by a couple of years. That was a real blow to the man as his life-long companion was such a captivating strength to him.



We have all known the two of them to be the most devoted of all couples and when Chrissie left this mortal world, we saw that a guiding beacon of existence had gone out of Dennis's own life. However, he fought on bravely, until the inevitable passage of years took its toll on him.

From a very special personal viewpoint, Dennis has been my much valued and dear friend for the last four decades or so. He has been responsible for nurturing me through my professional life and has been a friend with whom I could be on the very same wavelength, time and time again. He stood by me most resolutely whenever I was in need of assistance. Even when I had my own doubts about my ability to head the Sri Lanka Medical Association in 2013, he was the one who persistently advised, sweet-talked, coaxed and even cajoled me to take up that exalted position. At the end of my term, he was the first one to congratulate me on a most productive tenancy of office.

Finally, we offer our heartfelt condolences to his family members and hasten to reiterate that their unimaginable loss is our loss too.

Good bye, dear friend Dennis, our fervent prayer and sanguine wish is that you would be blessed with the ultimate and just reward of being with your creator in heaven.

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Monthly Media Seminar to Commemorate World No Tobacco Day

Dr Anula Wijesundere
President, SLMA

The monthly media and public awareness program on health related issues was held on the 28th May 2019 at the Lionel Memorial Auditorium of the SLMA. This was conducted to commemorate the 'World No Tobacco Day' on 31st May 2019 based on the WHO theme 'Tobacco and Lung Health'.

The President, Dr Anula Wijesundere welcomed Dr Palitha Abeykoon, Chairman National Authority on Tobacco & Alcohol (NATA), Dr Pubudhu Sumanasekara, Executive Director of Alcohol and Drug Information Centre (ADIC), Dr Palitha Karunaprema, Director Family Health Bureau, Dr Kapilawansa, President and other members of the Sri Lanka College of Pulmonologists, and members of the SLMA subcommittee on Tobacco, Alcohol and Illicit drugs and members of the public.

She mentioned the hazards of smoking and recalled that smoking kills around 20,000 Sri Lankans annually, about 7 million globally and that smoking was the no. 1 killer of preventable deaths worldwide. She emphasized that tobacco smoke contains more than 4000 harmful chemicals of which 250 are known to cause disease and more than 50 directly carcinogenic.

Dr Palitha Abeykoon, Chairman NATA said that tobacco consumption among males in Sri Lanka has now reduced to 14.5% and among women, less than 0.5%. True to the adage that "The last mile is always difficult" achieving 10% was going to be a formidable, yet an achievable task, he maintained. He further claimed that smoking will cease to be a public health problem only if the country reaches less than the 10% consumption milestone. NATA's goal, he said was to achieve this target in another 5 years.

Dr Pubudhu Sumanasekara of ADIC said that over the last 5 years, the incorrect and irrational taxing of tobacco by the Ministry of Finance has led to a loss of Rs 100 billion to the government of Sri Lanka by way of uncollected tax money.

Dr Sumanasekara further pointed out that in Sri Lanka tobacco consumption is sensitive to prices and global phenomenon of 10% increase of tobacco prices leading to 5% decrease in consumption is applicable locally as well. Hence, he said that it was rational to impose the highest possible tax on tobacco products.

With 12% increase of tobacco tax in the 2019 budget, the price of Gold leaf cigarettes increased by Rs 5.33. The tobacco company added an additional Rs 4.65 to the stick. Hence the price of a Gold leaf cigarette increased by Rs 10, thus, the industry made a huge profit of about 12 billion or more per year based on this pricing. This money should have been government revenue if the Ministry of Finance has adopted a rational tax policy.

Dr Kapilawansa reiterated the harmful effects of tobacco smoke and emphasized that nicotine was a powerful drug which affected the brain and quickly caused addiction. He further stated that tobacco smoke can exacerbate diseases such as asthma and emphysema and finally lead to chronic obstructive lung disease which is one of the leading causes of death globally. He mentioned that smokers have a 22 times higher risk of developing lung cancer in their lifetime when compared to non-smokers. Ten years after quitting smoking, the risk will be halved. However, only 5-10% of quitting attempts are successful due to powerful addiction of nicotine. He further stated that quitting smoking needs a multidisciplinary approach which needs support from friends and family apart from medical supervision.

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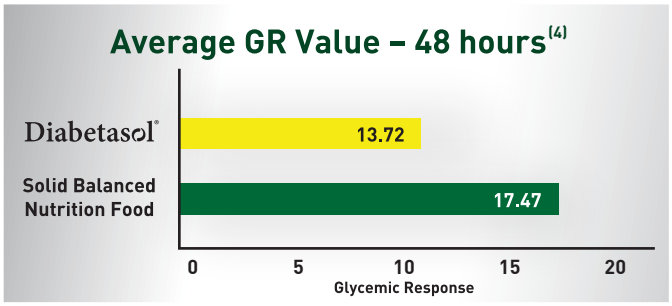

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*Glycemic response is the change in blood glucose concentration that occurs after food consumption.

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*ADA - American Diabetes Association **EASD - European Association for the Study of Diabetes

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1. Holub I, Gostner A, Theis S, Nozek L, Kudlich T, Melcher R, et al. Novel findings on the metabolic effects of the low glycaemic carbohydrate isomaltulose (Palatinosee). 2010. British Journal of Nutrition; 103;1730–1737 2. Slavin J. Fiber and Prebiotics: Mechanism and Health Benefits. 2013. Nutrients; 5:1417-1435 3. C L Bodinhamet al, Efficacy of increased resistant starch consumption in human type 2 Diabetes, 2014 , vol. 3.2:75-84. 4. Eliana F, Handoko SH, Ambarwati FD, Setiawati A. Response profile of blood glucose and satiety level after the administration of Diabetasol compared to solid food with controlled calorie on type 2 diabetes mellitus patients. CDK. 2018; 45(5): 332-8.

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Contd. from page 12

Monthly Media Seminar...

Dr Jayamal De Silva said that all studies on tobacco cessation pharmacotherapy have been carried out as combination interventions which include a psychological counseling component without which pharmacotherapy appears to be ineffective.

He mentioned that an upcoming major problem was the use of e-cigarettes for smoking cessation. The theoretical possibility of smokers giving up conventional cigarettes by using the e-version exists, but its role as a gateway to tobacco and drug use among adolescents should be a serious deterrent for us not to recommend e-cigarettes at all.

Considering the overall evidence, Dr Jayamal de Silva recommended the following measures to reduce the incidence of smoking in Sri Lanka:

1. Awareness of forces that maintain the tobacco epidemic and promote the smoking habit
2. Improve the current tobacco control activities of NATA and ADIC
3. Combine pharmacotherapy with counseling and family support
4. Create an environment where smoking is difficult, unacceptable and unattractive.

"The Milk Issue"

A Public Seminar in the Consumer Rights Month

Dr Sankha Randenikumara
Member – SLMA NCD Subcommittee

The SLMA Expert Committee on Non-communicable Diseases (NCD) conducted a public seminar on "The Milk Issue" in the last week of March 2019. This topic had become the talk of the town due to allegations made by several parties on the adulteration of powdered milk in Sri Lanka. It was well attended by the general public and journalists in addition to healthcare professionals.

Dr Jayanthimala Jayewardene, Consultant Cardiologist chaired the session. Dr Damayanthi Perera, Nutrition Specialist spoke on "The untold story of milk and milk products -What the consumer should know?". Dr Perera presented a holistic view on the milk issue covering a wide range of connected issues, ranging from historical data on unethical marketing of infant formulae from the 20th century to 21st century, 'White-collar milk fraud' such as fat-filled milk powder and age specific imitation milk powder marketed to children. As a key message she explained that milk consumption is an acquired habit and there is no physiological need for cow's milk. Dr Perera argued that the benefits of cow's milk have been hyped up by the milk industry and highlighted that milk consumption is associated with a number of serious NCDs. In relation to the alleged imported milk powder adulteration, the speaker explained that the issue may be connected to fat-filled milk and other imitation milk powder.

Mr Ariyaseela Wickramanayaka, the Chairman of Pelwatte Dairy Industries, then delivered his speech on "Making Sri Lanka self-sufficient in milk". He revealed an eyebrow-raising fact, that Sri Lanka is the fourth largest milk powder importer from the world's largest milk powder exporter. Mr Wickramanyaka elaborated further on data gathered from the Department of Census and Statistics, which showed that our milk production was about 472 million litres in 2018 whilst the requirement was around 765 million litres (Mnl). He pointed out that self-sufficiency in milk is a well-achievable target, as there is a rapid continuous up growth in milk production within the last ten years which is about a 126% increase (208 Mnl in 2008 and 472 Mnl in 2018). Mr Wickramanayaka highlighted the importance of government support that should be extended to the local milk industry both at policy levels and in infrastructure development.

Mr Wicramanayaka's presentation brought the session's first part to an end as the next scheduled lectures had to be cancelled at the last moment. Both Deputy Director General - Environmental Health and Food Safety of the Ministry of Health and Senior Deputy Director of the Sri Lanka Standards Institute had excused themselves due to stands taken by the Ministry of Health and the Sri Lanka Standards Institute on this issue. They were to talk on 'National surveillance of imported milk' and 'Quality assurance of milk products in Sri Lanka' respectively.

The audience actively participated in the Q & A session expressing their concerns and posing various questions to the panellists which initiated a lively discussion.

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Two Birdies? It's Just Not Cricket

Prof. Colvin Goonaratna
Consultant Physician, and Chancellor,
Open University of Sri Lanka.

The Times, a revered English institution, published this brief report about a World Cup cricket match in its edition on 5 June 1999.

TWO BIRDIES? IT'S JUST NOT CRICKET

The cricket World Cup has witnessed some weird things in its 21-year history, but yesterday hit all previous oddities for six. Not one, but two birdies were killed by the ball.

A quintessentially British play on the word ***birdie***, which means a score of one stroke (= hit) under par for a hole in golf. The report was printed in the newspaper just above another report asserting that the British public had voted golf as the second most excruciatingly boring game shown on television after baseball, which had secured first place.

I read these two reports soon after returning to my rooms in Sussex Gardens in Paddington, after having watched an enthralling day's cricket at Lords (the mecca of cricket), braving the biting cold and three brief interruptions for rain. England had laboured to a score of 125 runs for the loss of three wickets during some 200 minutes of play against two wily Indian spinners who bowled maiden overs at fairly regular intervals to the English batsmen. The nice British guy seated next to me clapped demurely after each maiden over and glanced smilingly at me while doing so, obviously mistaking me for an Indian. My failure to return his smile or clapping may have puzzled him.

When umpires called time after the fourth shower, dislodged the bails and took possession of the ball, spectators were starting to leave. My British neighbour smiled again with me and said, "Oh! What a wonderful day's cricket!". I smiled with him and nodded in agreement.

The game of cricket has a long history but its actual origins and early forms are controversial. One aspect that may be reliably dated is the earliest written reference to it in a document. One John Denwick, during the last few years of Henry VIII's reign, has written the memories of his schooldays at the free school of Guildford in a document dated 1598. He has described how he would run to a small ground with his friends as soon as classes were over, "and play there at Crekett and other plaies." The word cricket came into common use in the early seventeenth century.

County cricket became popular in the seventeenth century in southern England, and the genesis of vigorous inter-county competitiveness is attributed to a match between Surrey and Kent in 1709. Some county matches attracted unwieldy crowds with much drinking and heavy betting so rules of cricket became necessary to ensure orderly play. The earliest rules of cricket were laid down in 1774 by "a committee of noblemen and gentlemen" according to available records.

Cricket has been an integral part of English history over several centuries, and along its way the game has accumulated a bewildering variety of descriptive and figurative words, quaint phrases and idiomatic expressions that have become common parts of speech. Examples are too many to recount here, but four familiar ones should suffice.

- The Finance Minister was *clean bowled* by the Opposition Leader's questions.
- *She performed a hat trick* by annexing all three prizes for science subjects.
- Making personal remarks in academic debate is just not cricket.
- He is well known for his *underhand* tactics.

The words ***underhand*** and ***bowled*** take me to another bit of cricket history. In the early seventeenth century the ball was rolled underhand (aka underarm) all along the ground in cricket as it is in the game of bowls. By the eighteenth century bowling underhand above the ground was allowed. By 1825 a round-arm delivery made with the arm fully laterally rotated and abducted (you recall the versatile shoulder joint movements and the main muscles involved, don't you?), and then used in a sweeping movement roughly parallel to the ground, came into popular use in spite of protests from cricket grandees that the ball was actually being thrown. Lasith Malinga more recently reinvented it (but without any fuss from cricket experts this time), adding fiery pace and variable trajectory to the long forgotten round-arm delivery to bamboozle many of the world's best batsmen.

Overarm bowling came in by 1860, once again arousing much dispute and debate before receiving final approval. By 1900 all three bowling styles were permitted and regularly used. Underarm bowling is no longer allowed in international cricket. However, to someone with only a smattering of the history of English words, a niggle persists regarding the question whether any of these styles strictly conform to the original sense of the word ***bowl***. Consider briefly its etymology. The French had apparently taken the Latin word ***bulla*** and changed it to ***boule,*** initially meaning 'sphere, ball' in French, but eventually used for a French game involving a ball rolled along the ground. The English took ***boule*** from French in the fifteenth century, but by the eighteenth, it had evolved into the verb bowl to mean ***rolling*** a ball along the ground as in the splendid English game called bowls. From historical and etymological perspectives, the verb ***bowl*** ought to be restricted to rolling a ball underhand along the turf as in the earliest form of cricket and in bowls. The other two styles of delivery in cricket have opportunistically usurped the verb ***bowl*** and nouns such as ***bowler*** and ***bowling*** perhaps because of their brevity and euphony.

Contd. on page 17

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Two Birdies?...

An underarm bowling incident took place on February 1 1981, when Australia played New Zealand in a One Day International cricket match, in the final of the Benson & Hedges World Series Cup, at the Melbourne Cricket Ground. With one ball of the final over remaining, New Zealand required a six to tie the match. To ensure that New Zealand did not get the six they needed, the Australian captain, Greg Chappell, instructed his bowler (and younger brother), Trevor Chappell, to deliver the last ball to Brian McKechnie underarm, along the ground. This action was legal at the time, but this tactic was nevertheless regarded as being against the spirit of cricketing fair play. The picture shows Trevor Chappell doing exactly as directed by brother Greg. I think this crafty manoeuvre may be described both as an ***underhand tactic*** and also as ***just not cricket*** in the fullness of their idiomatic and metaphorical senses.

Cricket is utterly British, historically and culturally. When the British decided to export this fascinating game to their colonies during the Empire's heyday they probably had little or no reason to suppose that the natives would embrace the game so avidly or that their cricketers would eventually muster teams that would regularly thrash English teams on their own soil.

Introduction of limited over games of 20 overs or 50 overs for each side have become extensively and wildly popular within a very short period of time but happily test cricket continues to entertain fans and fill stadiums, at least for the more popular encounters. Television replays of catches, leg before wicket appeals, and so on have vastly increased the accuracy of umpires' decisions, and enhanced the interest of discerning cricket lovers. And watching games from an armchair at home has become much better than getting elbowed and crushed by screaming, jumping, and flag waving fanatics at stadiums.

Commentators' diction styles for limited over cricket matches are quite different from the styles of their counterparts in test cricket. They speak much faster and louder than the latter, and very often shout and scream, but little is said about important technical matters. For instance, there is an Indian guy who starts every sentence with a long growl, as shown below.

"Oooooorrrr (as in "or" but very loud) he has hit that really hard for six, yes a huuuge six – oh no no, he is going to be caught out by Pant – yes , a good catch, brilliant catch. Hardick has been bowling maidens with leg breaks on a leg stump line to a leg trap field, with a leg slip, short leg, square leg and deep fine leg"

Deborrah Ross, a journalist for the English newspaper ***The Independent*** interviewed the engaging celebrity Dr. Vernon Coleman and asked him about the things in life that pleased him. Dr. Coleman said he enjoys a good book, the beautiful English countryside and ***cricket, because it confuses the Americans.***

Acknowledgement

I acknowledge with respects and thanks Sri Lanka's Wisden, Mahinda Wijesinghe for his advice on the underarm bowling incident and the photograph.

Development of National Guidelines for clinical management of dengue infection in pregnancy

Dr. Hasitha Tissera
Consultant Epidemiologist
Coordinator, Guideline Development and Editorial Committee

Dengue illness continues to be a major health problem in the South and South-East Asian regions and Sri Lanka is no exception. Concern regarding women who are pregnant getting infected with dengue virus has been heightened in the recent years due to an increase in adolescent and adult infections. At the induction of the new President of SLMA held in January 2019 one of the main challenges identified in the Presidential Address was reducing the morbidity and mortality of pregnant women from dengue in Sri Lanka.

Against this backdrop, the Central Epidemiology Unit of the Ministry of Health which is responsible for coordinating and further strengthening of Clinical Management of Dengue in Sri Lanka has made a request to SLMA to convene an expert group. A committee was formed comprising of members from Sri Lanka College of Obstetricians and Gynaecologists, Ceylon College of Physicians, Sri Lanka College of Paediatricians and several other technical members to develop a comprehensive Guideline for Clinical Management of Dengue Infection in Pregnancy. This committee has been working diligently over the past several months and meeting fortnightly to discuss clinical experiences, review expert reports, publications and to express their clinical opinion to develop a manual for all levels of clinical practitioners dealing with pregnant women presenting with fever suspected of dengue illness. There is growing evidence that the more severe form of dengue infection – dengue haemorrhagic fever (DHF) occurs more among pregnant women compared to non-pregnant women. In fact, delayed or misdiagnosed DHF leading to life-threatening dengue shock syndrome (DSS) is a common cause of dengue death during pregnancy. Therefore, here we address why dengue infection during pregnancy is a problem, how pregnant women get complicated disease and die and what can be done to prevent severe maternal morbidity and mortality.

This document will be available soon to be used at all levels of health care provision, particularly in the Obstetric settings in both public and private sectors, for the management of dengue/dengue haemorrhagic fever patients who are pregnant.

TU7788

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30.04.2019

Dr Anula Wijesundara
President
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With the establishment of the specialist registry all the consultants are requested to register in the specialist registry within one year.

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Compiled for the
SLMA Ethics Committee by
Dr. Malik Fernando
Member, SLMA Ethics Committee

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WMA INTERNATIONAL CODE OF MEDICAL ETHICS

Adopted by the 3rd General Assembly of the World Medical Association, London, England, October 1949

and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968

and the 35th World Medical Assembly, Venice, Italy, October 1983

and the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006

DUTIES OF PHYSICIANS IN GENERAL

A PHYSICIAN SHALL
always exercise his/her independent professional judgment and maintain the highest standards of professional conduct.

A PHYSICIAN SHALL
respect a competent patient's right to accept or refuse treatment.

A PHYSICIAN SHALL
not allow his/her judgment to be influenced by personal profit or unfair discrimination.

A PHYSICIAN SHALL
be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity.

A PHYSICIAN SHALL
deal honestly with patients and colleagues, and report to the appropriate authorities those physicians who practice unethically or incompetently or who engage in fraud or deception.

A PHYSICIAN SHALL
not receive any financial benefits or other incentives solely for referring patients or prescribing specific products. [1]

A PHYSICIAN SHALL
respect the rights and preferences of patients, colleagues, and other health professionals.

A PHYSICIAN SHALL
recognize his/her important role in educating the public but should use due caution in divulging discoveries or new techniques or treatment through non-professional channels.

A PHYSICIAN SHALL
certify only that which he/she has personally verified.

A PHYSICIAN SHALL
strive to use health care resources in the best way to benefit patients and their community.

A PHYSICIAN SHALL
seek appropriate care and attention if he/she suffers from mental or physical illness.

A PHYSICIAN SHALL
respect the local and national codes of ethics.

DUTIES OF PHYSICIANS TO PATIENTS

A PHYSICIAN SHALL
always bear in mind the obligation to respect human life.

A PHYSICIAN SHALL
act in the patient's best interest when providing medical care.

A PHYSICIAN SHALL
owe his/her patients complete loyalty and all the scientific resources available to him/her. Whenever an examination or treatment is beyond the physician's capacity, he/she should consult with or refer to another physician who has the necessary ability.

A PHYSICIAN SHALL
respect a patient's right to confidentiality. It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can be only removed by a breach of confidentiality.

A PHYSICIAN SHALL
give emergency care as a humanitarian duty unless he/she is assured that others are willing and able to give such care.

A PHYSICIAN SHALL
in situations when he/she is acting for a third party, ensure that the patient has full knowledge of that situation.

A PHYSICIAN SHALL
not enter into a sexual relationship with his/her current patient or into any other abusive or exploitative relationship.

DUTIES OF PHYSICIANS TO COLLEAGUES

A PHYSICIAN SHALL
behave towards colleagues as he/she would have them behave towards him/her.

A PHYSICIAN SHALL
NOT undermine the patient-physician relationship of colleagues in order to attract patients.

A PHYSICIAN SHALL
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[1] includes referring for investigations.

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CALL FOR ABSTRACTS

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Recognizing the need to build capacity in lower-income countries for the prevention of birth defects and preterm birth and care of those affected, the goal of these biennial conferences has been to provide specific practical tools and approaches that developing country participants can use to implement and strengthen surveillance and health care delivery and influence policy and funding in support when they return to their respective countries.

ABSTRACT SUBMISSION

We are now accepting abstracts for the 9th International Conference on Birth Defects and Disabilities in the Developing World to be held from 23 - 26 October 2019 in Colombo, Sri Lanka.

Professionals, policy makers, researchers and students working in the areas related to the theme and topics of this conference are invited to submit abstracts for consideration.

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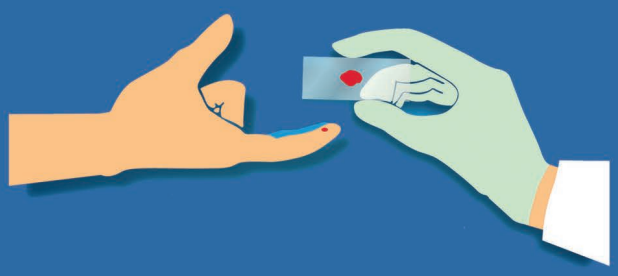

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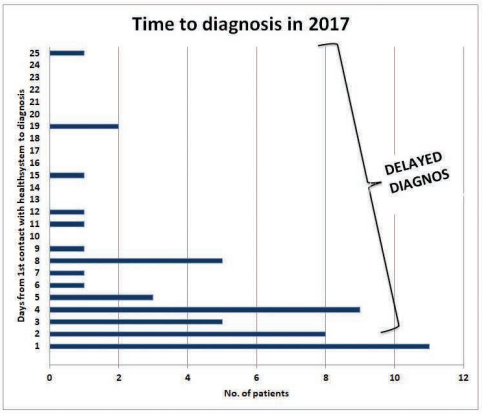

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