SLMA NEWS

THE OFFICIAL NEWSLETTER OF THE SRI LANKA MEDICAL ASSOCIATION

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Cover story

World Health Day 2019

Page 10

Inside

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CONTENTS

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

Dear members,

This is my fourth message to you in the monthly Newsletter. After reading the previous Newsletters I am sure that you are adequately updated about the activities of the SLMA. Despite the delay in producing the January Newsletter due to technical problems with our publisher, the Editorial Committee, headed by our Editor-in-Chief, Dr. Amaya Ellawala has worked round the clock to produce the April newsletter remarkably quickly so that the backlog regarding delayed printing has been completely cleared by now. The Editorial Committee deserves a big bouquet for their great efforts.

The monthly seminar organized by the SLMA for the media and the public was held to observe the International World Birth Defect Day on the 5th of April at the Lionel Memorial Auditorium. A packed programme of events was organized by our Secretary Dr. Kapila Jayaratne. Over 150 members of the public, media and special children participated in this event. The Director General of Health Services Dr. Anil Jasinghe and the Director (Maternal and Child Health) of the Family Health Bureau, Dr. Chithramali De Silva, graced this occasion. The dance item performed by Kosala, affected by Down Syndrome, to the tune of "**මවිබිම ලංකා**" was heartwarming and appreciated by all.

Dr. Duminda Samarasinghe, Paediatric Cardiologist, from the Lady Ridgeway Hospital, the pioneer of the Little Heart Hospital project showcased a video about the work already done and the funds that are needed to be collected in the future to complete this worthy and meritorious project. The presentation regarding club foot by Dr. Sunil Wijesinghe, Orthopaedic Surgeon of the Lady Ridgeway Hospital showed the excellent results of non-surgical management of club foot. This was both informative and educational.

The World Health Day, on the 7th of April as declared by the World Health Organization was celebrated at the SLMA on the 5th of April with a joint meeting of the WHO Country Office and the Ministry of Health. Members of the media were invited to this meeting. Dr. Padmal de Silva of the WHO and Dr. Susie Perera, Deputy Director General – PHS II of the Ministry of Health addressed the gathering along with the President and the Secretary of the SLMA. The theme was "Health For All - Everyone, Everywhere".

This year, the WHO celebrated the World Health Day with a change of practice from entertaining VIPs in hotels to a very people friendly programme at the Independence Arcade, Colombo 07. The programme for the day began with yoga and zumba. This was followed by a healthy breakfast comprising of a banana, helapa and king coconut water! Thereafter a video was presented with six patients expressing their views on the health services provided to them. Based on these revelations, a seminar titled "Voices from the field" was held, moderated by our immediate Past President Dr. Ruvaiz Haniffa. Dr. Palitha Abeykoon, former President and I represented the SLMA at this seminar. The other participants were Deputy Ministers Dr. Harsha de Silva and Mr. Faizal Cassim, and the Director General of Health Services. The government launched the "Essential Services Package" (ESP), at this event.

March, the consumer rights month was observed with a public seminar titled "The Milk Issue" held on 27th March. This was organized by the NCD committee of the SLMA. The speakers were Mr. Ariyaseela Wickramanayake, Chairman Pelwatte Dairy Industries and Dr. Damayanthi Perera, Nutrition Specialist.

The monthly SLMA joint clinical meeting was held with the Sri Lanka College of Anaesthesiologists on the 19th of March and was titled "Blood gas analysis". On 25th of March an important meeting was held with the National Cancer Control Programme (NCCP) to identify strategies to declare cancer as a disease of mandatory reporting. Dr. Sudath Samaraweera, Director NCCP chaired the meeting. Representatives from the Sri Lanka Colleges of Histopathologists, Haematologists and Pathologists were invited along with the medical staff of the private sector. The Health Minister will be informed about the outcome of this meeting to declare cancer as a disease of mandatory reporting. An interesting seminar titled "Over diagnosis and over treatment", organized by Prof Kumara Mendis with the participation of six consultants from different specialties, was held on the 28th of March. The next day, the therapeutic lecture update for March on "What is new in Thyroid Disease" was delivered by Prof. Thilak Weeraratne.

The Sinhala and Tamil Aluth Avurudda is just around the corner and brings with it our age-old customs and traditions linking family members from near and far with unity, solidarity and a sense of belonging. However we must be aware of the downside of the celebrations which include indulgence in alcohol and its consequences, injuries from use of fireworks and the high consumption of **අලුත් අවුරුදු කැවිලි** aggravating NCD among the community. However, all in all, the Avurudu Season is a time for strengthening bonds, showing our respect for elders, celebration, enjoyment and spreading happiness all around.

"**සුභ අලුත් අවුරුද්දක් වේවා**".

"இனிய புத்தாண்டு நல்வாழ்த்துக்கள".

Dr. Anula Wijesundere,

President, SLMA

SLMA Press Release

The Sri Lanka Medical Association (SLMA), the apex of all professional medical associations of Sri Lanka, is deeply saddened by the horrific acts of terrorism which have resulted in the barbaric massacre of over 250 fellow citizens of our country and foreign nationals.

At this moment of unprecedented violence, the members of the medical profession have rallied round the clock and done their utmost to treat the injured and alleviate the suffering of the affected patients.

The SLMA extends its heartfelt condolences to the families of the deceased and hope the injured will recover speedily. Along with all peace loving citizens of our country, we condemn this terrible act of violence and hope that the government will introduce effective measures to prevent repetition of further catastrophes of this nature.

Dr. Anula Wijesundere,
President, SLMA

SLMA Regional Meeting at Base Hospital, Homagama

Dr. Thathya de Silva
Assistant Secretary-SLMA

The second SLMA Regional Meeting, organized in collaboration with the Clinical Society of Base Hospital (BH), Homagama and the Anti-Malaria Campaign, was held at BH Homagama on 27th of February 2019 with the attendance of approximately 60 participants. The programme commenced with the welcome address delivered by Dr. Prathapan, President of BH Homagama Clinical Society and Dr. Anula Wijesundere, President of the SLMA.

The first session comprised lectures by Dr. Thusith Goonewardene, Consultant Physician, Dr. Wasantha Vithana, Consultant Paediatrician and Dr. Arunajith Pieris, Consultant Surgeon, all from BH Homagama on "An Approach to Resistant Hypertension", "Kawasaki Disease in Children" and "Management of Acute Abdominal Pain" respectively. The first session was chaired by Dr. Anula Wijesundere, President of SLMA and Dr. Dhammika Wickramasekera, Consultant Surgeon, BH Homagama.

The second session was dedicated to lectures from the Anti-Malaria Campaign. This session included lectures by Dr. Anula Wijesundere, Consultant Physician and President of the SLMA on "Malaria in Sri Lanka-The Polonnaruwa Experience" and Dr. Dewanee Ranaweera, Consultant Community Physician from the Anti-Malaria campaign on "Prevention of Re-introduction of Malaria to Sri Lanka". The session was chaired by Dr. Kumari Senaratne, Consultant Physician, BH Homagama and Dr. Indira Kahawita, Consultant Dermatologist, BH Homagama.

The meeting concluded with the vote of thanks delivered by Dr. Piyumi Senanayake, Secretary of the BH Homagama Clinical Society. All participants were awarded a certificate of participation. The meeting was sponsored by GSK Pharmaceuticals Ltd.

Words of inspiration from Nelson Mandela, former South African President

After I became President, one day I asked some members of my close protection unit to stroll with me in the city and have lunch at one of its restaurants. We sat in one of the downtown restaurants and all of us asked for some sort of food. After a while, the waiter brought us our requests.

I noticed that there was someone sitting in front of my table waiting for food. I then told one of the soldiers to go and ask that person to join us with his food and eat with us. The soldier went and asked the man. The man brought up his food and sat by my side as I asked and began to eat. His hands were trembling constantly until everyone had finished their food and the man went away. The soldier said to me "that man was apparently quite sick. His hands trembled as he ate"!!

My reply to the soldier was "No, not at all, that man was the guard of the prison where I was jailed. Often, after the torture I was subjected to, I used to scream and ask for a little water. The very same man used to come every time and urinate on my head instead"

So I found him scared, trembling, expecting me to reciprocate now, at least in the same way, either by torturing him or imprisoning him, as I am now the President of the State of South Africa.

But that is not my character, nor part of my ethics.

The mentality of retaliation destroys states while the mentality of tolerance builds nations.

Originally from an e-mail sent by Mrs. Esther Amarasekera.
Extracted and presented by Dr. B. J. C. Perera

Authenticated by https://www.zambianobserver.com/nelson-mandela-former-south-african-president-wrote-a-personal-awesome-story/

Dietary cadmium and lead alone accounts for epidemic scale CKDu

Dr. Kamal Gammampila
MPhil, PhD, DIC
Independent Biomedical Scientist

The following is a synopsis of the Guest Lecture delivered by Dr. Gammampila on 13th February, 2019 at the Professor NDW Lionel Memorial Auditorium, SLMA.

CKD prevalence and distribution in Madawachchiya Divisional Secretariat by Gramasevaka Niladhari Divisions are presented in Figure 1 (Ministry of Health, 2015). In 25 percent of the rural Divisions, the majority of the people suffer from CKD. This presents a bleak prospect not only for those communities but for the whole of Sri Lanka.

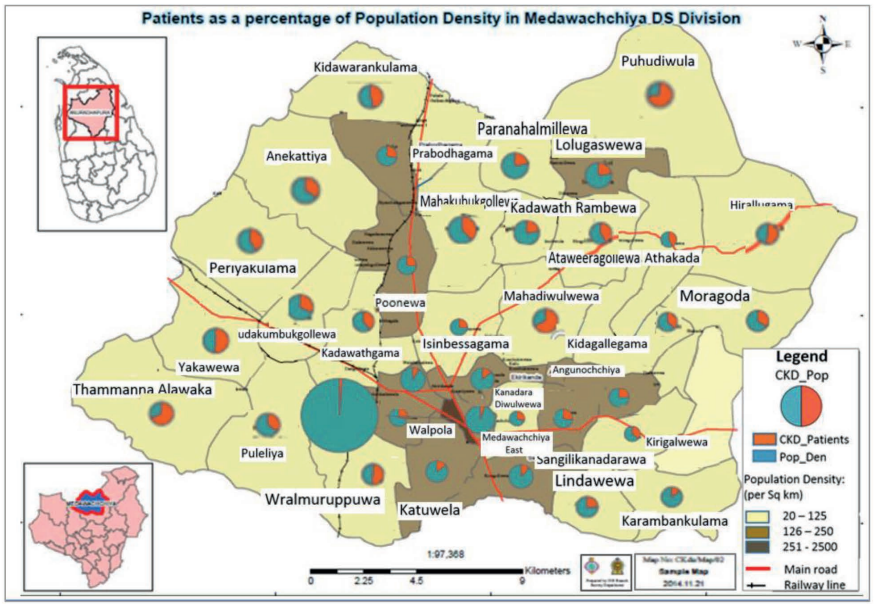

Figure 1. Prevalence of CKD in Madawachchiya Divisional Secretariat by Gramasevaka Niladhari Divisions. Courtesy: MOH 2015 Please note, in this figure the size of the circles has no bearing on the results. Circle sizes have been increased to improve visual clarity and presentation. However, the circles are filled proportionately by orange and blue to represent CKD and CKD-free respectively.

Professors Rajitha Wickremasinghe and Kamani Wanigasuriya (Levine et al., 2015) have established the mean, minimum and maximum rice cadmium and lead levels in Poonewa in Madawachchiya Divisional Secretariat, and Medirigiriya at 0.00220, 0.0412 and 0.117 and 0.00796, 0.0286 and 0.146 mg/kg (µg/g) respectively. Considering a national rice consumption at 300g per day, we may estimate that 30 and 15 percent respectively of these populations are adversely exposed to cadmium and lead at or above 0.36 and 0.63 µg/kg bodyweight per day respectively. Therefore, we should conclude that we can explain the CKDu in Poonewa and Medirigiriya populations by the cadmium and lead levels in rice whether any other agent made a contribution or not. Lead or cadmium does not require other agents to cause chronic kidney disease (WHO, 2011). These two agents may act in synergy (Navas-Acien et al., 2009). Based on these findings CKDu crisis must be addressed on the basis of UN accepted agents (cadmium and lead) and the respective adverse levels for CKD (EFSA, 2012; EFSA CONTAM Panel, 2015). Lead is now identified among the ten most environmentally toxic agents (World Health Organization, 2010; WHO, 2018). The MOH/WHO study (Jayatilake et al., 2013) established higher levels of lead than cadmium in the three studied conditions as presented in Table 1.

These findings compound the case for lead playing a greater role in the CKDu crisis, while compounding the hypothesis that cadmium and lead on their own would explain most of CKDu regardless of whether any other agent makes a contribution or not. We should not be held back in these circumstances in addressing the crisis in terms of cadmium and lead.

It is imperative that CKDu crisis is addressed by adhering to the UN accepted dietary exposure reduction strategies to cadmium and lead by reducing the oral intake. Micronutrient supplementation strategies are untested, hence it is an inappropriate approach to address our CKDu crisis particularly in endemic locations when it is known that toxic exposure itself causes micronutrient deficiency.

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Table 1. Urine concentration of arsenic, cadmium and lead for CKDu cases compared with controls from the endemic and non-endemic areas

	Mean, median (range) of concentration in urine (µg/g creatinine)		
	Arsenic	Cadmium	Lead
CKDu cases ($n = 495$)	45.447, 26.3 (0.4 to 616.6)	1.039, 0.695 (0.005 to 8.93)	1.153, 0.95 (0.04 to 8.53)
Controls from endemic area ($n = 132$)	92.443, 6.99 (0.2 to 966.29)	0.646, 0.18, (0.005 to 5.13)[a]	1.254, 0.793 (1.21 to 6.64)
Controls from non-endemic area ($n = 250$)	56.572, 42.025 (5.38 to 350.28)	0.345, 0.265 (0.005 to 2.079)[b]	2.099, 1.434 (0.277 to 20.9)

[a] Urine cadmium concentration of cases compared to controls from endemic area $P < 0.001$.
[b] Urine cadmium concentration of cases compared to controls from non-endemic area $P < 0.05$.

Contd. on page 07

Contd. from page 06

Dietary cadmium...

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The Monthly Clinical Meeting of the SLMA for March, 2019

Dr. Sajith Edirisinghe,
Assistant Secretary-SLMA

The Monthly Clinical Meeting of the SLMA for March, 2019, organised in collaboration with the Sri Lanka College of Haematologists, was held on 19th March 2019 at the Professor NDW Lionel Memorial Auditorium of the SLMA. A Lecture Discussion on 'Blood Gas Analysis' was conducted by Dr Asoka Gunaratne, Consultant Anaesthetist, Colombo South Teaching Hospital, Kalubowila and clinical scenarios related to blood gas analysis were discussed by Dr Nuwan Ranawaka, Consultant Intensivist, National Hospital of Sri Lanka. The meeting was well attended by Medical Officers, postgraduate trainees and medical undergraduates. The meeting was chaired by Dr. Anula Wijesundere, President, SLMA.




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CALL FOR ABSTRACTS

ABOUT THE CONFERENCE

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.

IMPORTANT DATES

CALL FOR ABSTRACTS
01 February 2019

SUBMISSION DEADLINE
30 April 2019

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Sri Lanka's journey towards Universal Health Care

World Health Day 2019

Dr. Ruvaiz Haniffa
Immediate Past President, SLMA

World Health Day 2019 held on 7th April 2019 marked the end of a remarkable year in Sri Lanka's progress towards Universal Health Care (UHC). At an event hosted by the SLMA, senior politicians and policy makers, heard people from all over Sri Lanka describe their experience of the health care system and what they expected from it in the future.

The preceding twelve months had seen Sri Lanka making significant progress in addressing many of the aspirations of it's people.

The year had begun with a rallying call from the Director General of the World Health Organization, Dr Tedros Adhanom Ghebreyesus addressing an international audience in Colombo. Marking World Health Day 2018, Dr Ghebreyesus spoke of Sri Lanka's remarkable progress towards Universal Health Coverage. The country's past achievements were notable but he pointed out that there were challenges ahead. In particular he pointed out the need to reform how we approach the delivery of Universal Health Coverage.

"The best investments will be in promoting health and preventing diseases, rather than treating people when they turn up in your hospitals. And I commend the government for focusing on primary healthcare and the family medicine approach which is in line with health promotion and disease prevention."

Dr Tedros Adhanom Ghebreyesus, WHO Director General

Echoing Dr Ghebreyesus's call to action, the Ministry of Health and Indigenous Medicine and WHO used World Health Day 2018 to launch the Ministry's Universal Health Care Policy, an important policy document which called for a reorganisation of how health care is delivered in the country. A far-reaching review of the delivery model and a paradigm shift is recommended, moving from a curative centred system to one that would place more emphasis on prevention. Primary Health Care was to be a vital component in this reorganisation, bringing services closer to the people who needed them.

All the parties agreed that the key to this refocussing would be the development of an Essential Services Package, a package of services that the people of Sri Lanka should expect from their Primary Healthcare Service Provider. Shortly after World Health Day 2018, a determined consultation process was undertaken through a process of dialogue and consensus with all relevant stakeholders giving their technical inputs for this document. This was followed by national and international experts visiting healthcare facilities in many of the provinces across the country. It is noteworthy that these groups had group consultations with more than 500 officials including Provincial and District Administrators, Health Administrators, Health Planners and Healthcare Professionals. Not only was quality of care and availability considered, but a rigorous costing exercise was also an integral part of the process. Any model developed would have to be affordable and sustainable.

In May at the WHO's World Assembly the Hon. Minister of Health Dr Rajitha Senaratne reiterated the Government's commitment to the reorganisation of healthcare delivery in the country.

"We intend to address UHC through a multifaceted approach, where we believe prevention and health promotion will play a critical role."

Dr. Rajitha Senaratne, Hon. Minister of Health, Nutrition and Indigenous Medicine

As Dr Ghebreyesus had pointed out in his Colombo speech, political will to carry through these reforms was crucial and the SLMA along with WHO Sri Lanka held a discussion in the Parliament in July 2018 to brief politicians on Universal Health coverage, the progress of the project and to provide them information about the nature and extent of the challenges and solutions for the country. They were also invited to make a personal commitment to the achievement of Universal Health Care in Sri Lanka. Fifty-five Members of Parliament committed and signed the Pledge for provision of UHC.

"Health is a human right because people don't seek healthcare when they want it; they seek it because they need it. It's a need and it's our job as healthcare providers to provide them quality care."

Dr. Ruvaiz Haniffa, Immediate Past President, SLMA

By September there were enough pieces in place for the Ministry of Health to appoint a Primary Health Care Steering Committee to coordinate the Public Health Care (PHC) reorganization that was taking place in the country. This committee is headed by the Secretary of Health and also includes DGHS, relevant DDGs, provincial secretaries, PDs, RDs, representatives of the ADB and WB supported PHC projects and WHO. One of the main ideas behind the committee is for better coordination and smooth functioning of the PHC reorganization.

It was also important that the direct benefits of the reorganisation be established especially if efficiencies in the system could be identified. A Cross Programmatic Efficiency Analysis to increase efficiency gains for Ending TB / HIV through the PHC reorganization was undertaken. An Electronic Health Information System mapping exercise was done to better understand the nature of the different information systems.

Contd. on page 11

Contd. from page 10

Sri Lanka's journey...

By October the breadth and scope of the consultation was widened when more than 300 national and international experts came to Colombo for the UHC Talk Conference.

The conference was designed to bring together two communities of researchers and policy makers; those involved in Universal Health Coverage and Primary Health Care reform and colleagues who specialised in the elimination and eradication of TB and AIDS. The conference was co-organized by the Ministry of Health and WHO with support from ADB, GF and WB. The bringing together of these two communities was more than symbolic, something that Dr Razia Pendse, the WHO Representative in Sri Lanka pointed out to the delegates.

"Primary healthcare by design is people-centric and services need to be designed and delivered with focus on people and not individual diseases; we need to design these programmes with a people focus rather than being disease focused."

Dr. Razia Pendse, WHO Representative in Sri Lanka

During the whole process it became clear that "people" didn't mean only patients. Those who were to deliver Primary Health Care were also an important part of the system and would be vital in ensuring its eventual success.

The World Health Day 2019 theme focused on holding advocacy events to fuel the momentum generated in Astana and to focus on our goal of achieving a fairer, healthier world – in which no one is left behind and excluded from health care. The focus will be on equity and solidarity: on raising the bar for health for everyone, everywhere, by addressing gaps in services.

Along with the health workers, policy makers, politicians and International Organisations there was one other group that was brought into the consultation process – the people themselves. Throughout March 2019 consultations were set up in towns and villages throughout Sri Lanka ranging from Jaffna to some of the poorer parts of Colombo. Hundreds of ordinary Sri Lankans were asked what they thought of the healthcare provision and what they wanted in the future. Out of the hundreds interviewed, some forty were videotaped as the basis of a session held at the World Health Day 2019 event where they were presented to politicians and policy makers. This session 'Voices from the field' was a follow up to the UHC discussion in the Sri Lanka Parliament, conducted last year by SLMA, MoH and WHO, attended by a significant number of parlimentarians.

Dr Ruvaiz Haniffa, Immediate Past President, SLMA moderated this session with the panellists including:

- Hon Faizal Cassim – State Minister of Health, Nutrition and Indigenous Medicine
- Hon. (Dr) Harsha de Silva, M.P., Minister of Economic Reforms and Public Distribution
- Dr. Anil Jasinghe – Director General of Health Services
- Mr. P. W. N.P Gunasekera, Director of Health and Nutrition, Ministry of Education
- Dr. Anula Wijesundara – President, Sri Lanka Medical Association

Following the policy dialogue Dr Palitha Abeykoon, President, NATA, summarized the key points of the dialogue.

The centre piece of the World Health Day 2019 celebration was the presentation of the Essential Services Package developed by the Ministry of Health. A special event for the WHD 2019 was the building of a "solidarity chain" for UHC across all layers of society, from high level policy makers to the common people from all over Sri Lanka. Simultaneously, each of the WHO member states celebrated the event by joining this solidarity chain demonstrating their solidarity for UHC, across the planet.

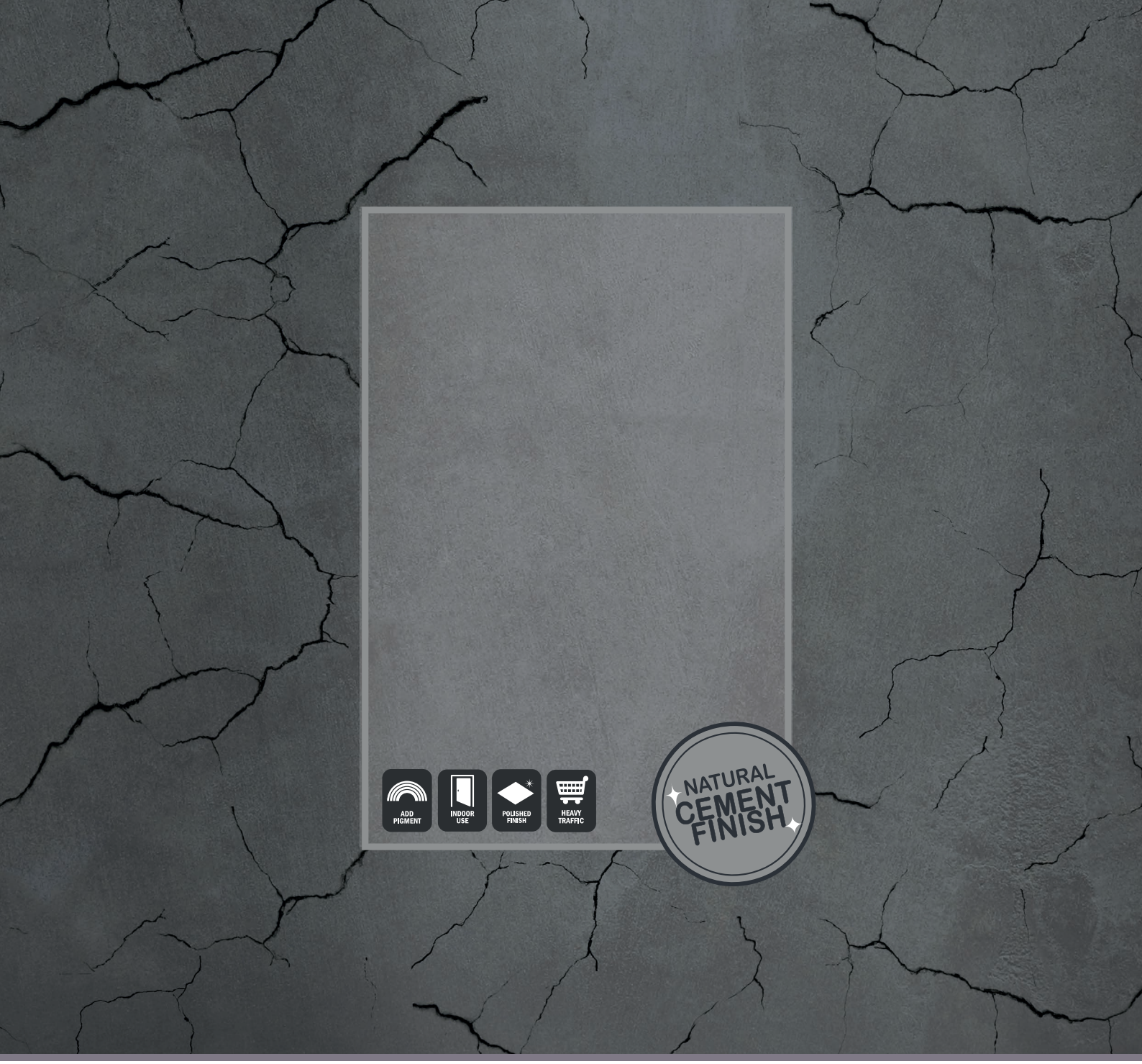
Acknowledgements

The WHO Country Office team and Mr. Bill Boyes, Communications Officer of the WHO Country Office are acknowledged for their contributions to this article.

Contd. on page 12

Contd. from page 11

Sri Lanka's journey...



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Meeting with the Hon. Minister of Health, Nutrition and Indigenous Medicine

Dr. Anula Wijesundere
President, SLMA

A meeting was held between the SLMA and the Hon. Minister of Health, Nutrition and Indigenous Medicine at the Ministry premises on the 14th of March 2019. The Hon. Minister, the Secretary of the Ministry, Mrs. Wasantha Perera and the Director General of Health Services Dr. Anil Jasinghe were present. President SLMA, Dr. Anula Wijesundere, Vice President Dr. Keerthi Gunasekera, Treasurer Dr. Yasas Abeywickrama, Assistant Secretary Dr. Dilhani Samarasekera and SLMA Coordinator Dr. Kaushi Attanayakege represented the SLMA. A very cordial and friendly discussion followed. The Minister was informed about the activities of the SLMA and the programme of the Annual Academic Sessions was presented to him. He commented very favourably on the wide variety of topics scheduled to be covered at the Congress. He accepted the invitation to be the Chief Guest at the SLMA Annual Academic Sessions Inauguration. He also agreed to make a substantial financial allocation from the ministry funds for the SLMA activities.

The Minister was informed about the new venture of the SLMA which commenced this year, namely the monthly awareness programme for the media and the public, based on a health issue as declared by the United Nations or World Health Organisation. The SLMA congratulated him on the firm stance taken by him against tobacco use in Sri Lanka, and also appreciated the great benefit he had provided to the people of Sri Lanka by offering free stents and lenses for cataract surgery.

Establishment of the SLMA Suicide Prevention Task Force

Dr. Ruwan Ferdinando
Convener,
SLMA Suicide Prevention Task Force

Prevention of suicide and self-harm remains a significant challenge in the coming years, with high domestic, health and economic costs to the nation. A multitude of factors leading to high rates have received attention of researchers, healthcare providers and policy makers. The SLMA President Dr. Anula Wijesundere in her Presidential Address highlighted the importance of establishing a Suicide Prevention Task Force (SPTF) under the patronage of SLMA and the SPTF was thus formed. This important Task Force is chaired by Senior Professor Samudra Kathriarachchi and Dr. Lakmi Seneviratne and Dr. Ruwan Ferdinando serve as the Secretary and Convener. The members include Dr Anula Wijesundere, Prof. Thilini Rajapakse, Dr. Champika Wicramasinghe, Dr. Jayamal de Silva, Dr Madhava Gunasekera, Dr Sudath Samaraweera, Mr T. Suveendran, Dr. Sajeewa Ranaweera, Dr. Kapila Jayaratne, Dr. Asanka Ratnayaka and Dr. Prabath Wickrema.

Some of the members of the SLMA Suicide Prevention Task Force (SPTF)

The mandate of the SPTF includes identification of factors that contribute to high suicide and self-harm rates in Sri Lanka, mapping successful programmes and activities that contribute to prevention, developing a policy document on prevention of suicide and self-harm as well as providing a framework to address-long term issues of sufferers. Developing a policy that outlines the above mentioned factors, with a sustainable and coordinated approach, is recognized as the key priority area to work on.

The SPTF is expected to complete the policy document and to undertake some activities during the year 2019. The membership is invited to send suggestions and information that could contribute to the success of this important Task Force to the following email <sptfslma@gmail.com>.

How to write a prescription – do's and don'ts

Dr Panduka Karunanayake and
Prof Chandanie Wanigatunge

On behalf of Sri Lanka Medical Association Ethics Committee

Introduction

A prescription is written by a prescriber, to provide written instructions to a person who dispenses appropriate medicines and/or devices to a patient. In Sri Lanka the prescriber is a doctor, although in other countries it can also be a healthcare worker of another category, such as a nurse, midwife, pharmacist or healthcare assistant. The dispensing person should ideally be a pharmacist, but it can also be another healthcare worker, such as a dispenser or nurse, who may not have a good understanding of the nature of the disease that the patient is being treated for; in Sri Lanka it is unfortunately, sometimes mere private pharmacy employees with minimal or no formal training who dispense medicines.

A doctor who writes a prescription should keep this in mind. The more trained and more experienced the dispensing healthcare worker is, the more likely that mistakes, discrepancies or unclear instructions would be picked out and sorted out. At the same time, the less trained and less experienced that person is, the more likely that these are missed and something goes wrong, even terribly wrong. We must remember this when we prescribe, no matter how busy we may be.

Although there are no universally accepted standards or guidelines on prescription writing, there are some well-known and widely-accepted principles.

Principle 1: Be as clear as possible

Your handwriting should be as clear as possible because illegible writing is one of the commonest reasons for medication errors. Besides, writing illegibly has been grounds for negligence where it had led to harm: the writing should be clear enough for a busy pharmacist to read with ease.

Give all necessary instructions, such as 'before meals', 'twice daily' and 'at bedtime' and so on. There are standard abbreviations for some of these (see British National Formulary). Because untrained persons giving the medicines, sometimes even trained ones, may be unaware of these, it is good practice to also tell the patient verbally what these instructions are during the consultation.

Principle 2: Establish the patient's identity adequately

In some countries, at least three identifiers are required (e.g., surname with first name + postcode + date of birth). We should include at least two good identifiers (such as name with first name or initials + age). Fortunately, our patients do not usually mind their age being mentioned on the prescription (but it may be necessary to tactfully verify this), because they often have the freedom to choose the pharmacy.

When prescribing controlled substances (e.g., morphine tablets, Fentanyl patches), it is also necessary to write the diagnosis (e.g., 'Bronchial carcinoma'), because the pharmacist is required by law to maintain a record of this. If it is not written by the doctor, the poor pharmacist is compelled to ask the person who has come to take the medicines what the diagnosis is, and that might seem somewhat inquisitive and unprofessional and reflect unfairly on the pharmacist. We must keep in mind that the pharmacist would be quite correct to refuse to dispense such a prescription (and ask the person to bring a properly written prescription, with the diagnosis!), and that would only inconvenience the person and embarrass the doctor.

Principle 3: Date the prescription

This is important because sometimes a patient may unknowingly take an older, used prescription or knowingly take the prescription many months after it has been written.

Sometimes the date-writing can also be ambiguous: for instance, what is 17.03.19? Is it 17th March 2019 or 19th March 2017? Also, in the US the month is written first and the date in the middle: 05.01.17 means 1st May 2017 and not 5th January 2017. Sometimes, Roman and Arabic numerals are mixed so that the Roman numerals are used for the month: e.g., 01.v.17 means 1st May 2017. However, 'ii' (February) can be mistaken for 11 (November) because Roman numerals are not anticipated by the reader.

Because of these reasons, every country has a standard format for writing the date. In Sri Lanka, the Sri Lanka Standards (SLS) has decreed for us that it should be YYYY-MM-DD (e.g., 2019-04-13) – but this is seldom known to the general population and adhered to, even by strict organizations such as banks. Many banks use DD-MM-YYYY for cheques, deposit slips and withdrawal slips. Maybe the medical profession can help popularize this wonderful SLS guideline, which is clearly quite unambiguous and preferable.

Principle 4: The prescriber's information

The prescriber must write or print at least his/her name and SLMC registration number. And of course, it must also be signed by the prescriber. The legal responsibility for the prescription lies with the person who signs it and one should not sign prescriptions written by others. For instance, a consultant should write and sign the prescription oneself, rather than asking a pre-intern to write it and then only inserting the signature there oneself.

Other information such as address and telephone number can be useful to a pharmacist who wishes to clarify something before dispensing the medicines/devices. If a pharmacist or dispenser does call you for clarification, please speak courteously and thank him or her in the end. Such calls should be encouraged because they sometimes prevent a calamity and a lot of trouble for both patient and doctor.

Principle 5: The items prescribed

Number the items from 1 onwards. Use a separate line for each item.

The name of the medication should be written in block capitals, or at least in block letters (i.e., not in flowing letters). The law requires prescribers to use the generic name of the medicine (also known as the international non-proprietary name or INN), but the preferred brand name can be given within brackets. The prescriber may also write 'Do not substitute' if the stated brand name itself must be dispensed. However, there should be rational grounds for this, for instance, issues relating to bioequivalence.

Contd. on page 16

Contd. from page 15

How to write a...

Unfortunately, generic names or INNs keep changing. Sometimes this is on rational grounds (e.g., dropping off unncessary letters, such as CHLORPHENIRAMINE becoming CHLORPHENAMINE, or dropping the letter 'Y' in preference to 'I', such as AMOXYCILLIN becoming AMOXICILLIN or ACYCLOVIR becoming ACICLOVIR). At other times it merely reflects the US market preference (e.g., SALBUTAMOL becoming ALBUTEROL, FRUSEMIDE becoming FUROSEMIDE), which even the BNF follows without any qualm.

Brand names are preferred over generic names or INNs on pharmacological grounds in the case of drug combinations (e.g., MODURETIC, while AUGMENTIN is also technically a drug combination), with long-acting drugs (e.g., DIAMICRON MR), when bioavailability variation between brands may be worrisome (e.g., various brands of warfarin), and when issues such as composition, palatability and long-term experience are considered important (e.g., cough syrups and multi-vitamins). Of course, another controversial concern for prescribing by the brand name is drug quality. In Sri Lanka, some medications are much more widely known by their brand name rather than by the generic name or INN (e.g., DIETHYLCARBAMAZINE, CO-CARELDOPA, PIVMECILLINAM), even by trained and experienced pharmacists, which reflects as much on our own past prescribing practices as on their knowledge.

The dosage should be written using full numbers and not decimals: e.g., '500 mg' rather than '0.5 g'. If a decimal point is necessary, then it must be preceded by a zero: e.g., '0.5 g' rather than '.5 g'. Do not use unnecessary zeros at the end (e.g., write '2.5 mg' rather than '2.50 mg'). And do make sure that the decimal point is clearly seen.

There must be a space between the number and unit: e.g., '500 mg' rather than '500mg'.

The units used must be standard: e.g., 'ml' rather than 'teaspoon'. Since milligrams and micrograms can be mixed up, only milligrams should be abbreviated (e.g., 'mg') and micrograms should not be abbreviated (i.e., write 'microgr' or 'micrograms' rather than 'µg' or 'mcg'). Similarly, nanograms should be written in full, because 'ng' can look like 'mg'. Also, 'units' and 'international units' should be written in full (i.e., not 'u'/'U' or 'iu'/'IU') because these letters can be mistaken for the numerals 1 and 0.

The US abbreviations for frequency is quite different: for instance, 'q12H' means 'every 12 hours', which is quite different to 'BD' which means 'twice a day (at any time of the day)'. For instance, q12H may mean giving the medication exactly at 8 am and 8 pm, while BD can even mean giving it at 5 am and 9 pm. Antibiotics and short-acting antihypertensives are best given at correctly spaced intervals (e.g., q12H, q8H) rather than just twice or thrice daily at any time (i.e., not as BD or TDS).

Standard abbreviations include AC (before meals), BD (twice daily), PRN (when required – but remember, you must also indicate the maximum number of doses allowed per day), etc. Abbreviations often misunderstood include SOS instead of PRN, and vesper instead of nocte ('vesper' means 'evening', not night). The BNF gives a list of standard abbreviations.

Don't forget to write the duration of treatment. We do use abbreviations for months (e.g., '3/12' = 3 months) and weeks (e.g., '2/52' = 2 weeks), but remember that it is not generally used for days (e.g., '1/7' is not widely understood for '1 day'). Writing 'days' is better than 'd'.

If the statement 'Please repeat' is used, it is necessary to say how many times. Otherwise, the poor pharmacist is called upon to make a rather serious medical decision.

Conclusion

Prescription writing is important enough to deserve our attention to these details. Although at first sight they may seem demanding, once we get used to each of these practices, they soon become second nature and are easily followed.

Further reading:

The BNF gives excellent guidelines in the preamble pages. See also the WHO website <http://apps.who.int/medicinedocs/en/d/Jwhozip23e/5.4.html>.

Dr M S Seneviratne
MBBS(SL), DCH(SL), DFM(SL)
National Hospital of Sri Lanka
Colombo
(Address of doctor and hospital)

02.11.2018 *(Date)*

Mrs Chandra Perera *(Full name of the patient)*
Rajagiriya *(Patient's address)*

65 years (1953.10.23) *(Patient's age, preferably date of birth)*
60kg *(Patient's weight)*

Rx

ENALAPRIL 2.5 mg BD
AMLODIPINE 5 mg MANE
METFORMIN SUSTAINED RELEASE 500 mg BD
for 1 month

(No. of medicines in sequence IN BLOCK letters)
Be clear about dose, preparation, dosing frequency and duration of treatment in generic names (specify a preferred brand in parenthesis)

(Signed in ink)
Name, Qualifications – accepted by SLMC/PGIM/MOH, SLMC registration number with seal

Roman soldiers and saline

After adequate oxygen, water, the ability to exhale carbon dioxide freely, and nutrition, the most important thing that sustains mammalian life is access to salt. I mean of course, sodium chloride, and not any of the other salts that are important to varying degrees for good health.

Distant memories of physiology lectures may remind you that water forms about 50% - 60% of lean body mass in men but only 45% - 50% in women, and that in a healthy man weighing 70 kg, total body water (TBW) content is about 42 litres. About 14 litres of TBW is extracellular fluid (ECF). ECF that provides a happy medium in which blood cells may safely graze, and enables all cells of all living tissues to derive in ample measure everything they need for their miracles to perform, is mainly a solution of sodium chloride in water. The sum total of millimoles of ions in ECF is about 295, of which 244 (nearly 85%) is contributed by Na^+ and Cl^- ions. So it should elicit no surprise that the most frequently administered life-saving medicinal product in the history of medicine happens to be intravenous isotonic sodium chloride.

Ideally, clinical use of the word 'dehydration' ought to be confined to the clinical entity produced by severe water deficiency that is relatively uncommon compared to clinical ECF ***volume*** deficiency, which fully deserves a more appropriate definition such as 'hypovolaemia' or 'saline deficiency.'

But I digress. The question I should be focusing on is what relationship, if any, Roman soldiers have with the word 'saline'. Well, it has to do with the glory days of the mighty Roman Empire when their soldiers ravaged lands, looted the riches of their peoples, and raped every woman they could get hold of, in an apparently permanent state of war. But the one thing they found hard to acquire then was what we refer to now as common salt. So much so, that soldiers were given a special allowance to purchase salt for which the Latin word was ***sal***. Naturally, the soldiers' special allowance was called a ***salarium*** in Latin. Hence the English derivative word 'salary' for a fixed payment paid by an employer to an employee, the adjective 'saline' meaning 'containing salt', and the noun 'saline' for the medicinal product that has a fixed amount of sodium chloride with or without other salts or substances. Since intravenous saline has an osmolality close to that of ECF, let us all as men of science pledge to call the product 'isotonic saline' or 'physiological saline'. Not 'normal saline' for the word 'normal' in the now outdated chemical sense is almost extinct as even young students of chemistry know. And 0.9% sodium chloride is not 'normal' even in the extinct chemical sense!

Are we not heirs to the immortal words Jesus Christ spoke, for all time, in His sermon in the mount, about *Homo sapiens?*

"Ye are the salt of the Earth: but if the salt have lost his savour, wherewith shall it be salted? It is thenceforth good for nothing, but to be cast out, and to be trodden under foot of men."

Matthew 5:13

Colvin Goonaratna; si7np5e@gmail.com

(Consultant Physician)

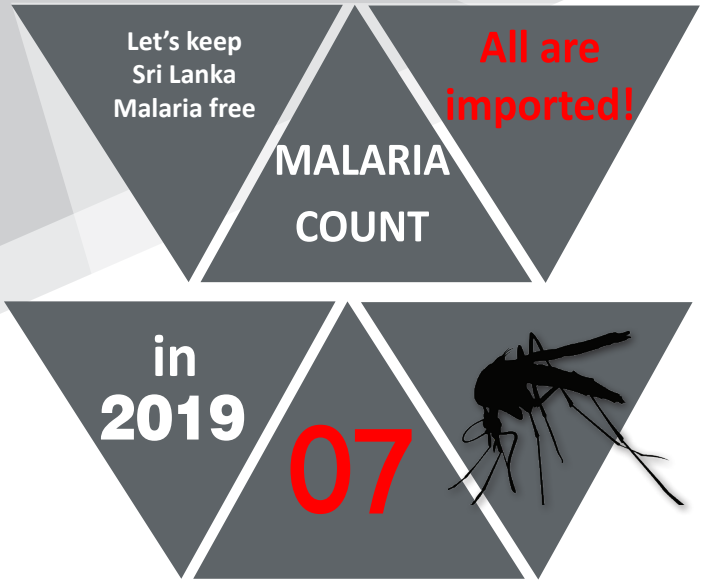
Hippocrates in the 21st Century

An old figure in an ancient garb,
Waited in the queue, unable to grasp.
So confusing is the medical world;
"X rays, ECGs Blood tests and Scans:".

"What happened to the good old tradition
Of inspection, palpation, percussion and auscultations?
It is difficult to make out the jargon,
Too many gadgets, medicines, and surgical operations.

Hippocrates took time to ask an ailing man
"How do you feel, different or still the same?"
"First do no harm", Doctors still do swear in.
So many things have changed ever since.

Dr A. Dayapala
Consultant JMO
Teaching Hospital
Ratnapura



IMPORTANT NOTICE

Cancellation of the SLMA Run and Walk

Due to the recent devastating events on Easter Sunday and the resultant security concerns in the country, the SLMA has decided to cancel the Health Run and Walk 2019 that was due to be held on 9th June, 2019. The Children's Art Competition that was to be held in parallel, has been postponed. The date and venue will be notified in due course.

The President and Council of the SLMA would like to take this opportunity to thank all organisations and individuals who volunteered their time, resources and funding towards organising this event. The SLMA regrets any inconvenience caused by this cancellation.

Vacancies in the Editorial Board, Ceylon Medical Journal

Applications are called from members of the SLMA for vacancies in the editorial board of the Ceylon Medical Journal.
Please apply with a letter outlining your research and editorial experience and a brief CV.
Applications close on 07/06/2019.

Editors
Ceylon Medical Journal

Dear SLMA member,

A printed copy of the SLMA monthly newsletter is currently posted to your personal address. This creates a significant cost for the SLMA and some of the copies are returned. Considering the rising printing costs and the need to minimise paper consumption, the Council of the SLMA has decided to explore the possibility of sending an electronic version of the newsletter to the membership.

SLMA wishes to obtain your preference with regard to receiving the newsletter by email or post.

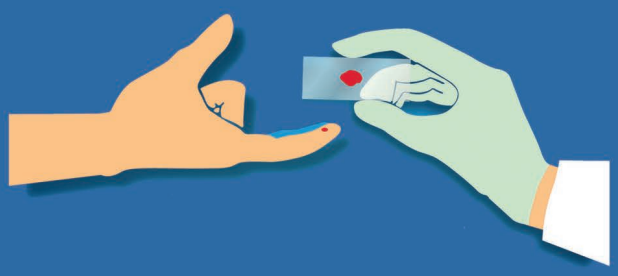
Please indicate your preference of receiving either the printed or electronic newsletter, by email to office@slma.lk. Alternatively, you may phone the SLMA Office (0112-693324), between 9 am and 4 pm on weekdays and inform your choice to the Administrative Officer, Mr. DS Perera.

The deadline for responses (via email or telephone) will be 31st May, 2019.

If no response is received from you, the SLMA will assume that you prefer the electronic version of the newsletter.

Thank you for your understanding and cooperation.

Dr. Kapila Jayaratne
Hony. Secretary
SLMA



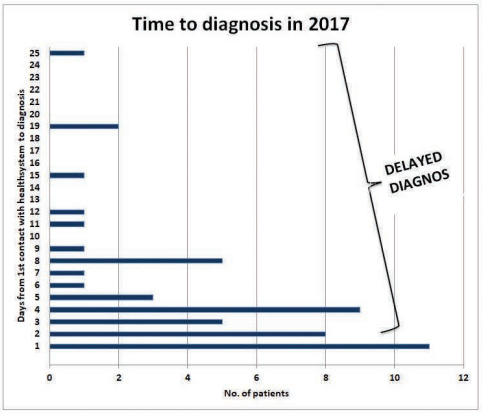
Reduce the Delay in diagnosing imported Malaria

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

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SLMA NEWS

THE OFFICIAL NEWSLETTER OF THE SRI LANKA MEDICAL ASSOCIATION

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