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Cover story
Page 3

The Empathy Paradox:

Balancing Compassionate Care and Frontline Burnout in Sri Lanka

CONTENTS

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FROM THE EDITORS

Dr Lahiru Kodithuwakku
Co-Editor

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This month, we focus on healing a nation while fixing the system: the modern Sri Lankan health system challenge. we bring you a diverse collection of articles that reflect the deeply human, intellectual, and technologically advancing facets of contemporary medical practice in Sri Lanka.

Our cover story, "THE EMPATHY PARADOX: Balancing Compassionate Care and Frontline Burnout in Sri Lanka," addresses a critical issue facing our healthcare workforce today. It explores the delicate tension between delivering deeply empathetic patient care and managing the psychological toll and work-related challenges of frontline healthcare workers. We hope this piece sparks vital conversations about the future of our most treasured asset, the healthcare workforce.

In our Opinion section, the featured commentary questions the rationale behind the formal integration of medical humanities into the curriculum, arguing that not everything can be solved by teaching and testing.

Our feature article examines the practical applications and clinical benefits of chyme reinfusion therapy, offering insight into managing complex gastrointestinal cases. In our Novice section, we celebrate the work of emerging researchers with an introductory piece on utilizing artificial intelligence for predictive dengue modeling.

Finally, we present two special articles tackling areas of medicine that are often under-discussed. The first provides an updated approach to chronic pain management, while the second shines a light on the hidden mental health challenges experienced by families and staff within Neonatal Intensive Care Units (NICUs).

We trust this issue will expand your clinical horizons while providing much required food for thought for critical health reforms in the country.

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COVER STORY

Dr Lahiru Kodituwakku
Co-Editor,
The SLMA Monthly Magazine

THE EMPATHY PARADOX: BALANCING COMPASSIONATE CARE AND FRONTLINE BURNOUT IN SRI LANKA

The once-revered public image of doctors is being challenged increasingly. This highly demanding profession still commands much respect and gratitude, particularly during emergencies when physicians are elevated to a near-divine status. However, the steady erosion of public affection remains deeply troubling for both the medical community and the national healthcare ecosystem. Empathy towards patients becomes visible in these debates, frequently serving as a pretext for friction between governments and healthcare trade unions. However, these disputes merely expose the tip of the iceberg, failing to address the crux of the issue for either side. At the heart of the problem sits a fundamental question: Is clinical empathy an innate moral duty, or is it a systemic resource that must be funded, supported, and protected?

The Executive Call for "Compassionate Doctors"

The debate took center stage at the inaugural meeting of the Expert Committee on Sri Lanka's National Policy for Medical Education. Addressing the panel, the Hon. Prime Minister of Sri Lanka stressed the urgent need to integrate what she called "a new dimension" into the national medical curriculum: producing doctors driven by compassion.

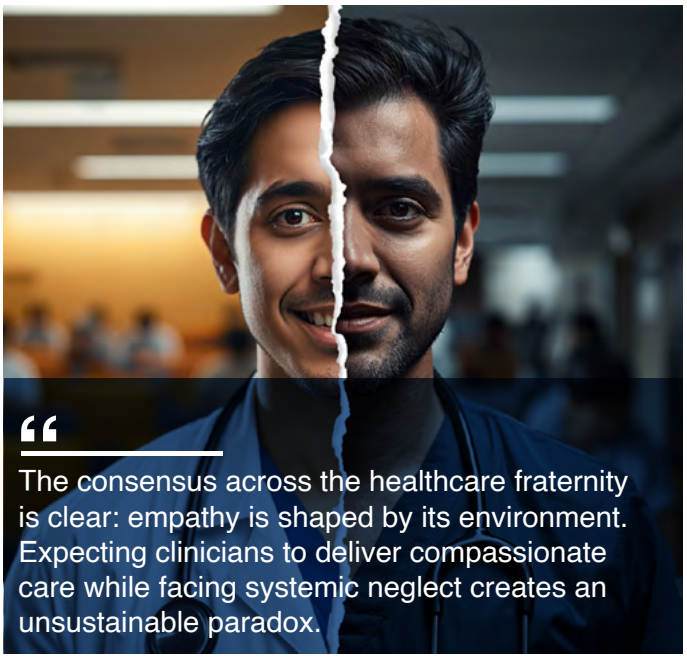
The Prime Minister's vision calls for systemic reforms across medical school curricula, evaluations, and clinical training. The goal is to shape disciplined professionals capable of meeting the psychological and emotional demands of modern healthcare. Public sentiment often mirrors this view, with calls for a more person-centered approach where patients feel seen, heard, and respected.

The Frontline Reality: Systemic Bottlenecks

While the call for empathy is valid, frontline medical professionals argue that teaching empathy in a classroom is meaningless if the workplace realities actively destroy it. The medical community contends that empathy is not a bottomless emotional well. Instead, it requires stable institutional support to survive.

Sri Lankan doctors are currently facing severe systemic challenges:

- **Crippling Work Conditions:** Overcrowded wards, recurring shortages of critical medicines, and exhausting work shifts.



> "The consensus across the healthcare fraternity is clear: empathy is shaped by its environment. Expecting clinicians to deliver compassionate care while facing systemic neglect creates an unsustainable paradox.

- **Eroded Professional Dignity:** limited scope for continued professional development, stagnating salaries while cost of living keeps rising, and an underfunded public sector forces the clinicians to work under extreme stress.
- **The Brain Drain:** The mass exodus of doctors because of the 2022 economic crisis, has left the remaining workforce severely overburdened.

This comparison highlights a complex set of national issues that requires an evidence-based, apolitical, practical, and dignified solution. The debate exposes sharp contradictions between institutional expectations and frontline realities:

- **Standard Practice vs. Burning Out:** Policy makers and the public argue that empathy must be a standard practice, whereas frontline clinical realities show that severe burnout rapidly drains emotional capacity.
- **Soft Skills vs. Structural Constraints:** Policy makers argue that medical curricula should emphasize the value of soft skills as much as clinical competence. However, the doctors counter that ever increasing patient volumes leave hardly any room for extended communications with patients.
- **Compassionate Training vs. Erosion of Dignity:** Policy makers assert that medical training must focus deeply on compassion, while doctors point to the stagnant salaries despite rising cost of living that compromise their professional dignity.
- **Individual vs. System-Based Compassion:** The public demands individualized, compassionate attention from their doctors, whereas clinicians point out that it is solely their compassion and commitment that keep an underfunded, struggling healthcare system afloat.

To move beyond vague political rhetoric, medical education experts argue that compassion must be taught systematically rather than left to chance. This has driven a pioneering shift in Sri Lanka towards including Medical Humanities within undergraduate curricula. Rather than treating medicine as an isolated, objective science, this discipline uses literature, history, ethics, and the performing arts to help students understand patient suffering, implicit bias, and human behavior.

Yet, while Medical Humanities equip students with the psychological tools needed for patient care, frontline professionals argue that classroom theory is meaningless if the workplace actively destroys a clinician's well-being and capacity to function effectively in critical situations. Ultimately, the medical community contends that empathy requires stable institutional support to survive and endure.

The Way Forward: A Shared Responsibility

Global research reveals that while intensive experiential training improves empathy scores among medical students, these scores decline sharply during clinical practice due to high-pressure, under-resourced work environments. The consensus across the healthcare fraternity is clear: **empathy is shaped by its environment**. Expecting clinicians to deliver compassionate care while facing systemic neglect creates an unsustainable paradox. If Sri Lanka wishes to foster a compassionate healthcare system, it must protect its healthcare providers, the very individuals save the system from decay. True reform requires balancing curriculum modifications with tangible improvements to working conditions, opportunities to grow, fair pay, and institutional respect. Without this critical balance, the ultimate casualty of this crisis will be Sri Lanka's treasured public health system.

PRESIDENT'S MESSAGE

Dr Manilka Sumanatillake

132nd President of Sri Lanka Medical Association

EMPATHY, INNOVATION, AND RESILIENCE IN SRI LANKAN HEALTHCARE

Dear Members and Colleagues,

It is my distinct privilege to address you in this month's edition of the SLMA Monthly newsletter. As we navigate the complex landscape of modern healthcare, our collective focus must remain focussed on adopting cutting-edge clinical innovations while safeguarding the humanistic foundation of our profession.

This duality is perfectly captured in this month's cover story, "THE EMPATHY PARADOX: Balancing Compassionate Care and Frontline Burnout in Sri Lanka." The dedication of our healthcare workforce is the bedrock of our medical system, yet we cannot ignore the rising tide of burnout. True professional excellence requires a sustainable environment. We must actively support the mental and emotional well-being of our doctors on the frontlines.

Our ongoing efforts to expand medical knowledge and address these exact frontline challenges were highly evident at our recently concluded **SLMA Regional Clinical Meeting in Polonnaruwa**. This regional event served as an incredible platform for engaging directly with peripheral healthcare professionals, understanding local clinical burdens, and sharing context-specific medical knowledge.

To build a more resilient workforce nationwide, we must also plan how we train future generations. The compelling write up in the opinion section in this issue regarding the value of medical humanities in medical education reminds us that technical proficiency alone does not make a complete physician.

Innovation also takes center stage this month. From the practical clinical insights of chyme reinfusion therapy to our novice article on using artificial intelligence for predictive dengue modeling, we see how Sri Lankan medicine continues to evolve.

Looking forward, we have a monumental opportunity to showcase these exact advancements and collaborate internationally. I am excited to invite you all to register for the upcoming 139th Anniversary SLMA International Medical Congress, scheduled to be held from 22–25 July 2026 in Colombo. Held in collaboration with the International Diabetes Federation Southeast Asia Region, this year's landmark academic summit is themed "Wellness in the Nation through Local and Global Partnerships".

Finally, we must turn our attention to the silent struggles going on within our hospitals. The special articles in this issue on chronic pain management and the hidden mental health crises in our Neonatal Intensive Care Units (NICUs) challenge us to expand our scope of care.

It is our duty and responsibility to explore best possible avenues for implementing these insights into our daily practices and institutional policies. Let's strive towards a more empathetic, responsive and resilient health system for Sri Lanka.

OPINION

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TEACH IT AND TEST IT: EMPATHY AND COMPASSION

- The inclusion of medical humanities in the curriculum expands an already overloaded curriculum. It is prudent to consider the possibility that medical students' lack of engagement in the arts and humanities may, in the first place, be due to an overloaded curriculum.
- Not everything can be solved by teaching and testing. We should realise that there are things that matter that cannot be measured.

For many years, medical schools in Sri Lanka have been grappling with supposedly declining standards of professionalism, deficiencies in communication skills, and inadequate empathy and compassion among medical students and young doctors. However, these purported deficiencies have not been identified based on scientific data, but mostly on anecdotal evidence. One could argue that this situation is neither new nor unique to Sri Lanka. In the meantime, some of our medical schools have recognised these as deficiencies that need to be corrected and are taking steps to address them.

It appears that we teachers try to solve most problems by teaching, and if that is not enough, by testing. A case in point is the introduction of a new subject, medical humanities, to the curriculum in some medical schools. The argument goes like this: students lack empathy and compassion, which may arise from limited exposure to or a lack of interest in the arts and humanities. Therefore, we should include the arts and the humanities in medical and other health professional curricula. This simplistic depiction of medical humanities may reflect my ignorance of this new academic discipline.

The more I tried to improve my understanding of medical humanities, the more confused I became. There is no consensus on what constitutes the medical humanities. For some, it is the use of the arts and humanities in medical education; for others, medical humanities includes communication skills, ethics, professionalism, and even social determinants of health! I would recommend this excellent paper on medical humanities by two eminent scholars (Jayasinghe & Abeykoon, 2025) for an overview of the subject.

The inclusion of medical humanities in the curriculum expands an already overloaded curriculum. It is prudent to consider the possibility that medical students' lack of engagement in the arts and humanities may, in the first place, be due to an overloaded curriculum. Are we practising what we preach? We teach students the importance of diagnosing and treating the underlying cause when caring for a patient. Relief of distressing symptoms is indeed an important component of treatment, but it cannot be the sole treatment.

I have several other reservations regarding the inclusion of medical humanities in the medical curriculum. Still, before discussing these reservations, I would like to draw your attention to this quote from the paper by Jayasinghe & Abeykoon.

> "It is necessary to anticipate sceptics, who will proffer claims that empathy and similar attributes are not suitable for assessments and therefore of little use in an overcrowded curriculum. This could be countered by providing substantial evidence on the utility and feasibility of cultivating compassion and other attributes. Though conventional assessments such as MCQs or OSCEs are of limited use, other qualitative forms of feedback and reflections from portfolios could become valuable in promoting such personality development." (Jayasinghe & Abeykoon, 2025)

The authors have started the above paragraph quite ingeniously, labelling anyone who disagrees with them as a sceptic! As someone who has been teaching medical students and doctors for over 30 years, it is my responsibility/ social obligation to point out the futility or possible harm that might result from not well-thought-out changes to the medical curriculum. The medical curriculum should evolve, but good intentions alone cannot serve as the basis for change.

There is no argument about the need for empathetic and compassionate doctors. One of the factors to consider in the training of future doctors is the raw material, i.e., the medical students. These are students who have gone through an educational system that rewards rote learning and ranks them based on unidimensional testing. In other words, these are test-savvy individuals. You teach them something, test them on it, and they will perform well in the test, but that doesn't mean we have made an impact on their behaviour. Our educational system has conditioned learners to strive for external rewards, at times to the detriment of personal growth. Rather than trying to develop novel assessments, we should channel our efforts to make students less reliant on external rewards, i.e., test scores and more on internal rewards, i.e., personal growth.

Not everything can be solved by teaching and testing. We should realise that there are things that matter that cannot be measured. We are diverting scarce resources to develop appraisal methods to determine levels of empathy and compassion among medical students. There may be valid tools to assess empathy and compassion in a naive population, but that doesn't mean similar instruments can be developed to test students after teaching them.

In summary, there is insufficient evidence that introducing medical humanities into the curriculum will result in more empathetic and compassionate doctors, and it's unlikely that we will be able to come up with valid and reliable assessment methods for measuring empathy and compassion among test-savvy medical students

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FEATURE ARTICLE



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DEVELOPMENTS IN CHYME REINFUSION THERAPY

"From the Top of the World via Down Under to the Ocean Pearl"

Historical background

In the 1980's Ian Bissett, a colorectal surgeon from 'Down Under' New Zealand was working in Nepal (the roof of the world) but found he had little or no access to nutrition support products or services to aid recovery of his post-operative patients who were malnourished because of intestinal failure (IF). IF is defined as the inability of the small intestine to absorb enough water, electrolytes and macronutrients to sustain life or support growth [1]. He therefore resorted to reinfusing the patient's own chyme, following the pioneering work by Dr Etienne Levy in France [2]. Returning to Auckland City Hospital, Ian successfully employed the same technique to his patients with high output enterostomies and fistulas, thus reducing their need for parenteral nutrition (PN).

An enterostomy is an artificial opening where the small intestine is pulled through the wall of the abdomen, diverting intestinal content to a stoma bag placed on the abdomen. A temporary double enterostomy (DES) diverts intestinal contents (chyme) away from a surgical site as it heals, for example a resection of the small intestine secondary to mesenteric ischemia. Entero-atmospheric fistulas (EAF) are catastrophic complications that can occur from prior abdominal surgery in which the small bowel migrates and becomes exposed through the abdominal wall, often leading to intestinal failure (IF). EAF are typically left open for many months to allow swelling to reduce and healing to commence.

If the Gut works: Use it!

The incidence of IF in patients with enterostomies is underestimated. Many develop Type 2 (T2IF) due to short bowel syndrome, requiring nutrition support (usually PN) until they have recovered enough for surgical re-establishment of intestinal continuity, typically 6-12 months after primary surgery [2]. Patients may need to be nil by mouth and are at high risk of dehydration and disease-related malnutrition (DRM) due to excessive fluid losses and intestinal malabsorption. PN dependence is expensive has risks of increased morbidity and mortality, mainly related to central venous thrombosis, catheter-related infections, and sepsis [3], and is frequently associated with the development of IF-associated liver disease (IFALD) due to the digestive system not being utilised. Almost all these complications could be minimized if there was a way to simply return the nutrition-rich stoma contents back into the downstream gut by reinfusion of the patient's own chyme from the stoma bag.

Chyme Reinfusion Therapy

Chyme is a semifluid material that transits the small intestine made of partially digested food, saliva, gastric juice, biliopancreatic and intestinal secretions, whereby transforming food into absorbable nutrients by enzymatic digestion and under the influence of bile salts. When all the nutrients have been absorbed from chyme, the remaining indigestible or non-absorbable waste is eliminated as stool.

Chyme Reinfusion Therapy (CRT) establishes an extracorporeal circulation of chyme between the collection stoma bag and the downstream small intestine. CRT is one of several distal feeding or fistuloclysis techniques, all of which restore digestive function in the downstream intestine and potentially reduce the need for PN. Distal enteral feeding, in which the chyme is discarded, and enteral feed is instilled into the distal gut, has been tried with some success [1], but the physiological nature of chyme affords CRT clear nutritional advantages and for minimizing stoma losses. Unfortunately, despite the apparent simplicity of this 'natural' approach, CRT, has not been practically easy to achieve. Nevertheless, in a comprehensive meta-analysis Vaghiri et al [4] confirmed that in patients with high output DES or EAF, CRT has been shown to be an effective method of preventing T2IF, allowing weaning from PN, and improving surgical recovery and is therefore recommended by various nutritional and international guidelines whenever possible [1,3]

Clinical experience in France since the 1970s has demonstrated that CRT can correct IF, restore enterohepatic circulation, and stimulate L-cell enterocytes, which secrete anorectic peptide hormones such as glucagon-like peptide-1 (GLP-1). In a retrospective analysis of CRT in over 300 IF patients from 2000 -2018, Picot et al [2] reported significant increases in weight (+3.5 ± 8.4%), albumin (+5.4 ± 5.8 g/L), and reductions in intestinal losses (-2.1 ± 1 L/day). CRT patients exhibited improved intestinal absorptive function, with the majority showing enhanced nutritional status and reduced IFALD, frequently leading to independence from PN in those with a DES. PN weaning was achieved in 188/211 (89%) of cases.

In China, the role of preoperative CRT in reducing complications after surgery for small intestinal EAF was examined in a retrospective study over 8 years to 2019 [5]. Patients receiving CRT were compared to a control non-CR group. Postoperative complications occurred in 126 cases (79.3%), with 49/72 in the CRT group versus 77/87 in the non-CRT group (OR = 0.289; 95% CI: 0.123–0.733; p = 0.006). CRT reduced fistula recurrence and provided some protection for patients from postoperative ileus. The authors found no relationship between CRT and incision-related complications but concluded that preoperative CRT is effective in reducing postoperative complications after surgery for EAF.

New technology for CRT

In 2019 Bhat et al [6] conducted a systematic review, which revealed 24 articles and 481 cases describing CRT. These publications reported multiple significant benefits, with no serious adverse reactions or mortality events in adults. Nevertheless, all studies reported major practical barriers to CRT, including complicated manual methods that were time-consuming and distasteful to both patients and nurses. Consequently, nutritious chyme has, in the past, often been discarded.

Fig 1: Straining of chyme then manually reinfusing through a catheter to the distal limb of bowel

Following discussions in Auckland, between Prof Bissett, another colorectal surgeon, Prof Greg O'Grady with John and Rob Davidson, two university engineers, an innovative, simple device was developed that overcomes these practical limitations and facilitates CRT in a closed system.

Fig 2. The Insides system for CRT

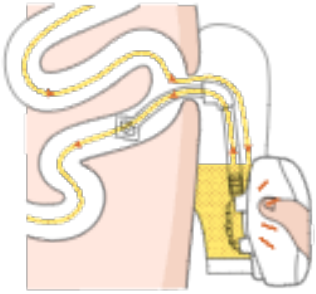

Fig 3a: CRT in pump-assisted closed system

Fig 3b Patient self-managing the CRT system

The Insides® System has been well received by nutrition teams and stomal therapy nurses in over 25 countries, allowing patients to recommence oral feeding earlier and, in most cases, manage the CRT themselves at home.

After obtaining CE marking in Europe, the system has been successfully used in over 1000 patients at IF centers in New Zealand, Australia, South Africa, Europe, the UK. Most recently in SE Asia, clinical experiences from Singapore and Malaysia were presented at the 13th Biennial Congress of the ASEAN Society of Colorectal Surgeons. The motivational presentation by a Malaysian typhoid patient, now published in his autobiography, described how CRT allowed him to re-commence oral feeding earlier at home. For most CRT cases, home self-management is one of the benefits of the pump-assisted system.

In addition, a recently completed multicentre randomised control trial of CRT using The Insides System versus standard of care (PN) at several IFU's across the UK and USA is currently under review. Results indicate that many participants in the CRT group were weaned off PN using the chyme reinfusion device by 60 days. A substantial reduction in intestinal losses was also demonstrated in the pump-assisted group [8].

In a first in Sri Lanka, we conducted a pilot study at the National Hospital of Sri Lanka in Colombo, comparing a machine-based system with the manual chyme reinfusion procedure. This two-case evaluation utilized structured checklists and key informant interviews with patients, caregivers, and hospital staff.

Case Study 01 (Manual CRT Technique)

A 17-year-old severely malnourished girl, presented with ileal perforation. A double-barrel ileostomy was created following the resection of the jejunum and proximal ileum. During management, nasogastric (NG) feeds were associated with high ileostomy output despite medical and dietary management. Therefore, manual CRT was administered via a catheter through the distal loop. Supplementary PN was started to meet the energy gap, but she was unable to achieve the targeted albumin and weight gain, hence ileostomy reversal was not possible.

Case Study 2 (pump assisted CRT Technique)

A 56-year-old male with descending colon tumour, presented with intestinal obstruction and distended small bowel loops with an ileal tear. Surgical resection of the diseased small intestine and creation of double-barrel ileostomy was performed. A special feeding tube was inserted into the downstream limb and connected to a small centrifugal pump within the stoma bag. An external electronic driver was coupled to drive the pump and facilitated CRT. This patient had a significant weight gain with a favourable albumin level and underwent ileostomy reversal in eleven weeks [8]

This comparison of two cases illustrated several key findings. However, these results require verification in a larger multicentre comparative study, planning for which is underway by the same research team:

- Manual CRT has not been a pleasant experience and was unpopular among nurses and caregivers, causing frequent interruptions in the procedure.
- In contrast, pump-based CRT was well-tolerated by the patient and accepted by caregivers.
- The pump assisted system has physiological advantages over PN with relatively few complications.
- CRT could be a cost effective and valuable addition to IF nutritional management.

This accumulating evidence has heightened interest among Sri Lankan medical professionals in integrating CRT into clinical practice. During a recent Sri Lanka Medical Nutrition Association's (SLMNA) webinar Dr Thaksala Uduwavidana described her experience with a 33-yr old underweight and severely malnourished (BMI<18.5 kg/m2) mother of two with Crohn's disease, who had 30cm of ileum resected and a double-barrel loop ileostomy created with a plan for reconnective surgery after 6-12 months.

The MDT commenced CRT with the Insides System at postoperative day (POD) 3 without PN, but increased oral nutrition supplementation (ONS), to provide 1.5g/Kg protein and 20 kcal/kg/d energy plus omeprazole and loperamide, with oral phosphate to address refeeding syndrome. When stoma output had decreased from 1850ml to 750ml at POD 6, CRT was discontinued due to patient-related management issues. However, the combination of CRT and ONS had the benefits of: reduced output, improved absorption, stabilised electrolytes, resulting in weight gain of 3.6 kg over 9 weeks post-surgery. Daily monitoring by the MDT was essential during hospitalisation with regular follow up after discharge, to avoid relapse in medication adherence and nutritional support.

In summary,

CRT improves intestinal function in IF patients with an EAF and can now be considered a first-line treatment in IF patients with DES. Nutritional status and intestinal absorptive function are enhanced, intestinal losses are reduced, and oral nutrition can be started earlier. Consequently, PN dependence can be shortened or avoided, with concomitant improvements in IFALD, reducing the chance of line-related complications, and shorter hospital stays lessen the financial burden.

Future researchers can expand knowledge of this technique by investigating the actual metabolic effects of CRT, the influence of chyme on the absorption and metabolism of micronutrients, the metabolism of most drugs, and most importantly, the roles of chyme and bile salts in enterokinase production and their effects on the gut microbiota.

Given the promising evidence from the global studies and with implementation of standardised protocols and local research in settings such as Sri Lanka, CRT offers scope for further evidence-based enhancements. Moreover, cost-effective adaptations will benefit the national health system in the long term by making high-end technology accessible in low resource settings, for patients who need it most, to optimise both clinical management and patient outcomes.

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Prof Ishan De Zoysa and the staff of the Surgical professorial unit (Male) and Dr ANK Abayajeewa and the staff of general surgery (Female) unit, National Hospital of Sri Lanka.

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SPECIAL ARTICLE

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CHRONIC PAIN MANAGEMENT: WHY EXPERT CARE MATTERS

Pain: Understanding the Shift from Symptom to Chronic Disease

Pain is one of the most frequent reasons patients seek medical attention in hospitals, outpatient clinics, and primary care settings. In routine clinical practice, it is often approached as a symptom that points to an underlying disease process. The usual clinical response is to identify the cause and treat it, with the expectation that the pain will resolve as the primary condition improves. This approach is generally effective in the management of acute pain.

However, chronic pain takes a different course. It often continues beyond the expected period of healing. It affects sleep, mood, mobility, work, relationships, and confidence. It often changes a persons' behaviour and drives them to go for repeated consultations. Chronic pain leads to overuse of medications, poly pharmacy, multiple referrals, and frustration for both patients and clinicians. With time, the pain itself becomes the main problem(1).

The International Association for the Study of Pain defines pain as "an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage"(2). Chronic pain is generally defined as pain that persists or recurs for longer than three months. Modern classifications such as ICD-11 now recognize chronic pain as a distinct health condition rather than a mere symptom. This is considering the independent effect it has on a persons' health and functioning(3).

It is important for primary care doctors and postgraduate trainees to recognise this distinction. Chronic pain is common, and it is rarely a simple clinical problem. It cannot always be managed by prescribing another analgesic, arranging another scan, or offering another brief review. For this reason, chronic pain management has evolved as a distinct field of clinical practice, with its own principles of assessment and treatment.

Transition from acute to chronic pain reflects the fact that the pain experience has become more complex. Peripheral sensitisation may occur, and central pain processing may also be altered. Poor sleep, low mood, fear of movement, and ongoing work or family stress can further increase symptom burden. As a result, the pain is no longer explained by tissue injury alone(4,5). Therefore, it is unhelpful for physicians to question whether the pain is "real". The more useful question is what mechanisms are sustaining it and what can be done to reduce its impact.

When a patient continues to have pain, it does not simply mean that treatment has failed. In many cases, the illness has moved into a different stage. At that stage, the patient needs a wider assessment and a more thoughtful, multidisciplinary approach to management.

Figure 1. Nursing involvement in pain management through small-group education and coping support sessions. (Consent obtained from patients for publishing this picture)

The hidden workload in everyday practice

Chronic pain is not a niche issue. It is part of the daily workload of primary care. Patients present with low back pain, neck pain, osteoarthritis, diabetic neuropathy, chronic pelvic pain, post-surgical pain, postherpetic neuralgia, headache disorders, cancer pain, and widespread pain syndromes. Although some come with an established diagnosis, many do not.

Chronic pain affects many individuals across the globe, and it contributes substantially to years lived with disability. Common pain disorders such as low back pain remain among the leading causes of long-term disability across populations(6). The World Health Organization has also emphasized that chronic low back pain has a marked effect on physical function and represents an important public health challenge.

Why chronic pain is hard to treat

One reason chronic pain is difficult to manage is that it is usually multifactorial. Biological factors like inflammation, nerve injury, central sensitisation, muscle deconditioning, altered posture, and sleep disturbance will exaggerate the intensity. At the same time, psychological factors such as anxiety, depression, trauma, fear avoidance, and catastrophic thinking may worsen disability. Social factors such as financial strain, family stress, isolation, and job insecurity can also shape the pain experience(4,5,7).

This doesn't necessarily mean that every patient with chronic pain has underlying psychological problems. However, these patients should be approached using a biopsychosocial model. This framework is useful in understanding why there is a difference of functioning between two patients who have similar scans. It may further explain why biomedical treatment alone often gives only partial relief.

As a primary care doctor, in clinical practice, persistent pain should not be assessed only in terms of anatomical location. A good chronic pain history must include function, sleep, mental health, occupational effect, family impact, prior treatment, and patient expectations.

When these dimensions are missed, management tends to become repetitive and reactive, without much change in the patient's overall condition. With a stronger foundation, the path forward becomes clearer, leading the way to more effective long-term care.

One word, many syndromes

Patients often present with a simple phrase: "Doctor, I have pain." However in reality, chronic pain is not one simple condition. It is a group of different syndromes with different mechanisms and different treatment implications.

A patient with diabetic neuropathy is not the same as a patient with fibromyalgia. Chronic low back pain is not the same as trigeminal neuralgia. Chronic pelvic pain differs from complex regional pain syndrome. Cancer pain differs from post-surgical neuropathic pain. Myofascial pain behaves differently from radicular pain.

This is where specialist input becomes especially valuable. Pain specialists are trained to recognise distinct pain syndromes and to classify pain more precisely. This is important because effective treatment should be guided by the underlying mechanism and clinical pattern, not by pain severity alone. Neuropathic pain may require one strategy, mechanical pain another, and pain driven by central sensitisation may call for a different approach altogether. Some patients may benefit from targeted interventions, while others need rehabilitation, careful adjustment of medicines, psychological support, or a combination of these measures.

This is an important lesson for postgraduate trainees as well. Good pain medicine starts with careful diagnosis. Before treatment can be rational and effective, the clinician must first understand what type of pain is being treated. In many cases, identifying and naming the pain syndrome is the step that brings structure to management and helps move care in a more purposeful direction.

Why expert care matters

Experts are trained to manage complexity. Chronic pain is rarely solved by a single prescription or a single procedure. It requires careful assessment, prioritisation of problems, realistic goal setting, and coordinated follow-up.

Expert care matters because specialists can diagnose pain syndromes more precisely. They can identify neuropathic features, procedural indications,

medication-related harms, functional barriers, and psychological contributors. Another important aspect in specialist care is deciding what not to do. In chronic pain, over-investigation and over-treatment can be just as harmful as under-treatment.

Pain medicine is often misunderstood as being mainly interventional. While nerve blocks, epidural injections, radiofrequency procedures, and other image-guided techniques may help selected patients, expert pain care goes far beyond interventions. It includes medication review, de-prescribing when necessary, patient education, pacing strategies, sleep optimisation, functional rehabilitation, and multidisciplinary coordination.

For front-line doctors, referral to expert care should not be seen as failure. It should be seen as appropriate escalation for a complex long-term condition.

The multidisciplinary basis of effective pain care

Owing to its complex biological, psychological, and social determinants, chronic pain often requires coordinated multidisciplinary care. The consultant pain physician or pain specialist usually provides overall clinical leadership and guides diagnostic clarification, pharmacological management, and selection of appropriate interventions. Interventional pain specialists may contribute when procedural therapies are indicated.

Psychiatrists and psychologists play an important role in identifying and managing comorbid depression, anxiety, trauma-related symptoms, sleep disturbance, maladaptive coping patterns, and unhelpful pain-related behaviours. Physiotherapists support functional recovery through graded activity, movement rehabilitation, strengthening programmes, and restoration of physical confidence. Occupational therapists assist patients in modifying daily activities, improving functional independence, and planning a safe return to work or household responsibilities. Social workers may also be essential, particularly when financial difficulty, caregiver burden, family stress, or barriers to accessing care significantly influence the pain experience.

This team-based model is particularly valuable in patients with high-impact chronic pain, in whom persistent pain is accompanied by substantial impairment in daily functioning. Meaningful clinical improvement is reflected in better sleep, improved mobility, enhanced coping, reduced reliance on unnecessary medication, return to work, and restoration of family and social roles. These are clinically important outcomes, even when pain is not fully abolished (8).

What this means for primary care

Primary care is where patients present first. It's where they will go for follow up even after specialist review. This makes the role of the primary care doctor both important and demanding.

A good primary care approach begins with identifying red flags and excluding urgent structural pathology where appropriate. After that, the focus should broaden. What is the likely pain mechanism? How long has the pain been present? What is its functional impact? How is sleep? What medications have already been tried? Is there anxiety, depression, substance use, or social breakdown? What does the patient believe is happening? What are they hoping treatment will achieve?

Primary care doctors play an important role in preventing unhelpful patterns of care. These may include repeated imaging that adds little clinical value, continued escalation of analgesics without clear benefit, conflicting advice from multiple providers, and delayed referral when pain becomes disabling or the diagnosis remains uncertain. Such patterns can prolong distress and make management more difficult over time.

Figure 2: Interventional pain procedures performed by pain specialists at the National Hospital of Sri Lanka (NHSL) as part of comprehensive multidisciplinary pain management.

The Sri Lankan picture: progress, but limited reach

Sri Lanka has made meaningful progress in pain medicine, but the service footprint remains small relative to the burden. The National Hospital of Sri Lanka remains the best-known specialist centre and has played an important role in the development of pain services and training in the country. Historical summaries from Sri Lankan pain medicine groups also note the earlier development of dedicated pain services, including cancer pain care and the later formal establishment of pain management units.

Outside Colombo, a few outstation services have emerged. These centres provide a wide range of pain management activities, including outpatient chronic pain care, inpatient consultations, cancer pain support, medication-based management, and selected interventional procedures. Teaching Hospital Peradeniya, for example, describes a structured Pain Medicine Unit with multidisciplinary links.

This is encouraging, but it also highlights the gap. Many parts of the country still do not have easy access to established chronic pain clinics. Patients may travel long distances or may never reach specialist review at all. In routine practice, many chronic pain cases are still managed in fragmented ways, often without clear referral pathways or team support.

For Sri Lanka, the challenge is not whether pain medicine is needed. It is how to expand access in a realistic and sustainable way.

Education will shape the future

Chronic pain care improves only when knowledge improves across the system. Nurses, medical officers, postgraduate trainees, consultants, physiotherapists, and other allied staff all need a better working understanding of chronic pain.

There are positive signs in Sri Lanka. The Faculty of Pain Medicine, working with national stakeholders, has reported educational activity including Essential Pain Management programmes and certificate level training for nursing officers, with further training initiatives continuing in recent years. Local policy documents have also recognized the service gap in pain care across many hospitals.

Pain is a common and often complex feature of clinical practice across all these fields. For that reason, a stronger grounding in pain medicine can help trainees become more thoughtful, more effective, and more complete clinicians, regardless of their eventual specialty.

A practical message to take back to clinic

Chronic pain should not be approached as a vague complaint that simply refuses to improve. When managed well, patients may not always become pain-free, but many do become more functional, more independent, and more hopeful.

This is why specialist care matters. Chronic pain is important not because it is uncommon or unusual, but because it is so frequently encountered in everyday practice.

In the Sri Lankan context, we need stronger referral pathways moving forward. The education of the healthcare professionals involved also needs to be expanded along with multidisciplinary services. It's about time that we recognized that chronic pain is a major health issue in its own right. That shift in thinking could change the lives of many patients who currently live, work, and suffer in silence.

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CERVICAL CANCER: DO SRI LANKAN WOMEN KNOW ENOUGH?

Evidence from a cohort of women attending outpatient services at a Teaching Hospital

Cervical cancer is the 4th most common cancer in women globally. It disproportionately affects low-resource regions in the world, giving rise to a high mortality rate among young women in these countries. It is one of the commonest gynecological cancers among Sri Lankan women too. National Cervical Cancer Control Programme in Sri Lanka target to eliminate cervical cancer by 2030 by adopting three main evidence-based approaches for the prevention of cervical cancer; HPV vaccination, widespread cervical screening and public education. Vaccination of school aged girls with HPV vaccine is the main primary prevention method. HPV vaccination was introduced into the National Immunization Programme (NIP) of Sri Lanka only in 2017 and took time to scale up properly, especially with the impact of COVID-19 pandemic. Hence, the main secondary prevention approach, screening for cervical cancer with pap smear/ HPV DNA screening holds an important role among the women of reproductive age. Cervical cancer screening is highly effective and crucial for saving lives, as it can prevent disease by detecting precancerous cell changes before they become cancerous. Identifying abnormalities early, allows for early treatment significantly reducing mortality. Regular screening can detect up to 90% of cervical cancers early. The National Screening Program offers free screening through Well Woman Clinics network which is wide-spread and easily accessible. However, current screening coverage seems to remain well below WHO's 2030 target of 70%.

Why this study?

As the current National programme aims at screening of 35-year-old and 45-year-old cohorts specifically, the coverage data are monitored for these age cohorts only. In this recent cross-sectional study conducted at the Outpatient Department (OPD) of the National Hospital of Sri Lanka (NHSL), we aimed to have a more wholistic picture of the coverage of cervical screening of all women aged 35-to 49-year-old. This was deemed important with the disruptions to service delivery systems due to pandemic as well as economic crisis. Therefore, 151 women who attended OPD for other minor ailments were interviewed to find out their understanding on the cervical cancer, awareness on the screening services and screening coverage. Looking at this data is even more important as this cohort comprises of women receiving screening services through two main models of health care delivery, i.e. municipal council and regional health services.

What did we observe?

The findings gave us some important insights to shape and improve our service delivery systems. Out of the women enrolled in the study only 72.8% were aware of well women clinic services and 26.5% thought that the screening services are not free of charge. Only 68.5% of women were aware of the availability of a test to detect cervical cancer at early stage, and only 45.7% could name the 'pap smear test' correctly. Only 9.9% were aware of HPV/ DNA test probably because if was a very recent introduction to the programme and only 9.3% women knew that Human Papillomavirus (HPV) is the cause. Considering all the areas tested, only about half had 'satisfactory' level of awareness on the risk factors modes of transmission, symptoms and prevention methods. Medical officers of Health, Public Health midwives and mass media emerged as the main sources of information currently. Interestingly, the model of service delivery (Municipal Vs MOH) or district of residence did not have a significant impact on awareness level, indicating that current public education efforts have similar strengths and gaps in both these models. However, the educational level (less than O/L) and religion (non-Buddhists) showed lower levels of awareness.

The Wake-Up Call- Coverage of screening

Among the women interviewed only 41.1% (n=62) has ever undergone cervical cancer screening. Only 5% were unmarried and probably not actively encouraged for screening, the rest either were not aware of it or not convinced enough to get themselves screened.

Cervical cancer is preventable. Free screening services are available at Well Woman Clinics across the country. Yet, this study reveals the gaps needing improvement at a highly urban information dense central hub.

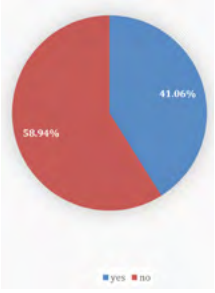

Figure: Proportion underwent screening

The Hidden Opportunity

Among those who had never been screened, the causes were analyzed and we found that the single most common barrier was simply lack of awareness (39.4%). This was further evident with the fact that higher screening coverage being significantly associated with better awareness. This is an indication that the public education could still be a cost-effective method to scale up screening uptake.

Some other barriers were absence of symptoms, negligence, fear of examination and never being requested by a doctor all of which could be overcome with proper counselling.

Among unscreened women, 62.9% expressed willingness to undergo screening in the future, indicating a favorable attitude that can be enhanced through better education and awareness.

Implications for practice

- Integrate cervical cancer awareness into routine primary health care contacts, a 2-minute conversation or waiting area video which can change a life.
- Targeted programmes for vulnerable pockets: lower income, less educated, and young women of religious minorities with community health worker led sessions.
- Emphasize the role of Human Papilloma Virus and sexual transmission clearly but without stigma.
- Link willing unscreened women directly to Well Woman Clinic appointments on the same day through integrated health services.
- Training the public health midwives and nurses on patient centered communication to alleviate fear and other barriers which discourage them from screening.
- Expand research in rural and underserved populations and identify specific factors influencing their level of awareness and screening practices.

NAWALOKA LABORATORY

EXTENDED LIPID PROFILE

(COMPREHENSIVE HEART HEALTH CHECK)

What is Extended Lipid Profile

The Extended Lipid Profile provides a detailed assessment of cardiovascular risk beyond the routine lipid panel. In addition to total cholesterol, LDL,HDL,triglycerides,it includes advanced markers such as,

- Apolipoprotein B (Apo B),
- Apolipoprotein A1 (Apo A1),
- Lipoprotein(a).

These parameters reflect the number and quality of lipoprotein particles, helping to identify hidden atherosclerotic risk even when standard lipid values appear normal.

Who benefits the most & why?

- **Individuals with a family history of heart disease**
  detects inherited lipid abnormalities such as elevated Lipoprotein(a).
- **Patients with diabetes/hypertension/metabolic syndrome**
  identifies residual cardiovascular risk not seen in routine lipids.
- **Individuals with normal lipid profile but high clinical risk**
  reveals particle-related risk missed by standard tests.
- **Patients on statin or lipid-lowering therapy**
  helps monitor treatment effectiveness more accurately.
- **Individuals with premature cardiovascular events**
  supports advanced risk stratification and long-term management

More Info.

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NOVICE

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DENGUE TODAY, WHAT TOMORROW?

Building AI-Powered Early Warning Systems for Public Health

While developing a machine learning model to predict dengue transmission patterns in Sri Lanka, I kept encountering the same question from public health officers. They did not ask whether the model was accurate. They asked whether it could tell them something useful before the outbreak had already begun.

That question captures something important about the limits of current public health practice. We are very good at measuring what has happened. We are far less equipped to act on what is about to happen. Artificial intelligence and machine learning are beginning to change that, and this article explains how.

Why We Are Always One Step Behind

Traditional disease surveillance is, by design, reactive. A case must occur. A clinician must identify it. A report must be filed. Data must be aggregated at regional level. Only then can a coherent picture begin to form. For fast-moving outbreaks, this lag can be measured in weeks, by which point transmission is already well established.

Climate change is compressing the window still further. Changing rainfall patterns are altering the habitats of disease vectors such as the Aedes mosquito. Flooding is creating conditions for water-borne illness. Extreme heat is increasing health system demand at precisely the moments when supply is most strained [1]. The seasonal predictability that district health officers have long relied upon for planning is eroding.

Disaster risk reduction research has long recognised this dynamic. Risk accumulates before it becomes visible. Effective management therefore requires anticipatory capacity, not simply response capacity [2]. This is precisely the gap that AI and machine learning are now well positioned to close.

Traditional Surveillance	AI-Augmented Early Warning
Outbreak begins	Environmental signals detected
↓	↓
Cases accumulate undetected	ML model identifies anomaly
↓	↓
Clinicians report to authorities	Early warning issued
↓	↓
Data aggregated at regional level	Pre-emptive response mobilised
↓	↓
Alert issued — response mobilised	
Typical lag: weeks to months	**Typical lag: days to weeks**

Figure 1: Traditional disease surveillance compared with an AI-augmented early warning system. The reduction in lag time between outbreak onset and public health response is the central benefit of machine learning-based prediction.

What AI and Machine Learning Actually Do

Artificial intelligence is not infallible, and it is not a replacement for clinical judgement. It is a set of computational methods that identify patterns in large and complex datasets. Machine learning, a subset of AI, refers to systems that learn those patterns from historical data rather than following rules written in advance by a programmer.

In public health, this matters because the data relevant to disease risk is vast and comes from many sources at once: climate and rainfall records, satellite land-use imagery, hospital admission trends, population mobility estimates derived from mobile phone networks, and vector surveillance counts. No conventional statistical model can integrate all of these in real time. Machine learning models can.

In developing the dengue prediction model for Sri Lanka, climate variables including rainfall, temperature, and humidity were combined with historical case data and satellite-derived vegetation indices across multiple districts. The aim was not to replace the judgement of a public health officer. It was to provide an earlier, more spatially specific signal to act upon. Research in comparable tropical settings has shown that well-constructed ML models can forecast dengue incidence four to eight weeks ahead at district level [3, 4]. That lead time can be the difference between a controlled response and an overwhelmed health system.

> “Traditional disease surveillance is, by design, reactive. A case must occur. A clinician must identify it. A report must be filed. Data must be aggregated at regional level. Only then can a coherent picture begin to form. For fast-moving outbreaks, this lag can be measured in weeks, by which point transmission is already well established.

The key distinction is this: these tools generate information. The decision remains entirely with the clinician, the epidemiologist, and the public health officer.

Applications Beyond Dengue

Pandemic and respiratory disease surveillance

During the COVID-19 pandemic, machine learning models drawing on emergency department records, internet search trends, and wastewater surveillance detected early signals of SARS-CoV-2 spread before official case counts reflected the true situation [5]. Wastewater-based epidemiology, in particular, has moved rapidly from research to operational practice in several countries. It provides a population-level signal independent of health-seeking behaviour or reporting rates, making it especially valuable in settings where formal surveillance is uneven.

Non-communicable disease risk stratification

AI is not limited to infectious disease. Predictive models applied to electronic health record data have demonstrated the ability to identify individuals at elevated risk of type 2 diabetes, cardiovascular events, and chronic kidney disease before clinical presentation [6]. For Sri Lanka, where the burden of non-communicable disease is rising and primary care resources are constrained, tools that enable more precise targeting of screening and early intervention could have a meaningful impact on both health outcomes and system efficiency.

Disaster-related morbidity and climate-health linkages

Floods, cyclones, heat extremes, and landslides generate predictable patterns of injury, disease, and health system

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demand. AI systems linking climate forecasts to historical health impact data can help authorities anticipate those patterns in advance [1]. The 2016 and 2017 floods in Sri Lanka illustrated what inadequate anticipatory capacity costs in practice. Even 48 to 72 hours of additional warning would have allowed for medicine pre-positioning, health worker redeployment, and early transfer of vulnerable patients.

Why Governance Matters as Much as the Technology

The potential of AI in public health is real. So are the risks, and the medical community deserves an honest account of both.

Data quality is the most fundamental constraint. A model trained predominantly on urban hospital records will reflect the gaps in rural reporting and may perform poorly in exactly the districts where early warning is most needed. This is not a reason to abandon the approach. It is a reason to invest in data quality and to validate models rigorously across all populations they are intended to serve.

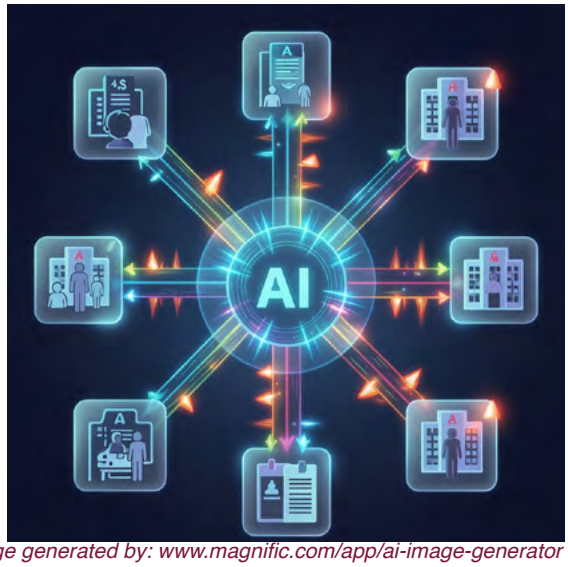
Transparency is the second concern. A district health officer receiving an AI-generated alert must be able to understand why the alert has been issued, not simply that a model has produced one. Many high-performing ML systems are difficult to interpret, and this tension between predictive power and explainability has not yet been fully resolved.

These principles are the substance of what IEEE P7021 is developing as a global standard for ethical AI in climate and environmental projections. The standard addresses transparency, equity, accountability, and the principle that human oversight must remain central to any AI-informed decision. That principle applies directly to public health AI, and the Sri Lankan medical community should engage with this work as it advances [7].

Conclusion

The question is no longer whether AI and machine learning will shape disease surveillance and outbreak response in Sri Lanka. They already are, in research settings and increasingly in practice. The question is whether the medical community will be an active participant in shaping how these tools are designed, validated, and governed.

Earlier warnings produce earlier responses. Earlier responses mean fewer cases, less pressure on health systems, and fewer lives lost. That outcome depends on better data, more transparent algorithms, and medical professionals who understand both the promise and the limits of these tools. It is a path worth taking together.



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SPECIAL ARTICLE

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THE HIDDEN MENTAL HEALTH CRISIS IN NICU: WHY FAMILY-CENTRED CARE CAN NO LONGER WAIT

Introduction

The admission of a newborn to a Neonatal Intensive Care Unit (NICU) is a profoundly distressing experience for families, particularly mothers. While advances in neonatal care have significantly improved survival and long-term outcomes of high-risk infants, the psychological wellbeing of mothers during and after a NICU stay often remains under-recognised and under-addressed.

The NICU is an unfamiliar, highly medicalised environment characterised by equipment, invasive procedures, restricted parental contact, and uncertainty regarding prognosis. Mothers are frequently confronted with feelings of fear, helplessness, guilt, and loss of normal parental role. Maternal psychological morbidity in the NICU setting is often multifactorial, influenced by the infant's gestational age, illness severity, length of hospital stay, and perceived threat to the infant's survival.

A cross sectional analysis of mothers in NICUs of Colombo South Teaching Hospital and De Soysa Maternity Hospital revealed an alarmingly high incidence of maternal psychological morbidity. The incidence of stress, depression and anxiety was 73%, 87% and 77.7%, respectively. At least one psychological condition was noted in 94.3% of mothers, while 59% experienced all three conditions concurrently.

Impact of maternal psychological morbidity on the neonate and the family

Adverse maternal mental health negatively affects infant outcomes. Maternal stress, anxiety, and depression are associated with impaired mother–infant bonding, reduced breastfeeding duration, and altered caregiving behaviours. In the long term, these factors adversely influence infant neurodevelopment, emotional regulation, and attachment patterns.

> "The NICU is an unfamiliar, highly medicalised environment characterised by equipment, invasive procedures, restricted parental contact, and uncertainty regarding prognosis.

Furthermore, untreated maternal mental health problems can persist well beyond discharge. When not identified and managed early, theses can evolve into chronic mental health disorders, which can increase the burden on families and healthcare systems.

Therefore, maternal psychological distress must be recognised as a significant public health concern and structured support systems such as family centered care must be adopted into neonatal practice to mitigate these adverse effects.

The role of family centered care in supporting mothers and families

Family-centred care (FCC) practices, where parents are considered as the part of the team caring for the neonate in the NICU is known to reduce maternal psychological burden. Inside the model of FCC, parents feel respected, empowered, and supported. The key elements of FCC are illustrated in figure 1.

Separation in the immediate postnatal period can disrupt attachment. FCC facilitates early and sustained bonding through physical contact, shared caregiving responsibilities, and active engagement in decision-making. Therefore, NICUs should encourage maternal participation in routine care of the neonate such as diapering, oral care, feeding, kangaroo mother care and bathing to restore the lost parental role. Time for bonding and breastfeeding support should be actively protected. When parents are included in caregiving activities under the guidance of the staff, they develop practical skills and confidence in managing their baby's needs.

Figure 1: Components of family centred care

Good communication with parents, where they are regularly updated regarding the progress of the baby, and involving parents in the decision-making process are key components of FCC. Communication that reduces uncertainty and helplessness is a key protective factor. Daily structured updates using consistent language, such as explaining the current situation, what is expected, and how is baby monitored help parents feel informed and included.

> "...FCC facilitates early and sustained bonding through physical contact, shared caregiving responsibilities, and active engagement in decision-making...

Providing educational materials to parents is vital and this must start very early from the admission and done at regular intervals. The family must be prepared for post discharge care, where they should be trained on routine care, basic infant life support and first aid. This preparedness enhances the transition from hospital to home and may reduce readmission rates.

SPECIAL ARTICLE

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Additionally, having flexible visiting policies, and allowing siblings to visit the NICU allows families to re-connect and have a major impact on maternal wellbeing. Allowing siblings to visit the sick neonate in the NICU, improves the wellbeing of the sibling and enhances bonding and there is no risk for infection outbreaks in NICU, when adhered to infection prevention protocols. FCC models foster peer support and parent-to-parent connection, as it significantly reduces isolation. However, confidentiality and cultural sensitivity are essential in all peer-support initiatives.

> “
> In Sri Lanka, NICUs adopt the traditional approach, neglecting the parental roles and their emotional burden. The concept of FCC is new, and the maternal psychological morbidity is often overlooked.

Identifying and supporting mothers at risk of psychological morbidity is important. Considering the significant stigma associated with mental health concerns, routine screening for maternal stress, anxiety, and depression using validated tools should be considered as part of routine NICU workflow. Screening should be coupled with proper referral pathways. Therefore, collaboration with mental health professionals for further assessment and follow-up is a necessity. (Figure 2)

Beyond individual outcomes, FCC contributes to improved interdisciplinary collaboration, enhanced communication, and potentially through reduced complications and length of stay. Moreover, it promotes a culture of empathy and partnership within neonatal services. Advantages of FCC are summarized in table 1.

Staff training

In Sri Lanka, NICUs adopt the traditional approach, neglecting the parental roles and their emotional burden. The concept of FCC is new, and the maternal psychological morbidity is often overlooked. In this context, capacity building and staff training is important. In Sri Lankan NICUs, shortages in staff and burnout are common. Short regularly recurring training sessions for staff on FCC, provision of psychological support, and mental health screening must be a priority. Furthermore, staff require comprehensive training on communication strategies, particularly focusing on communicating with vulnerable groups of parents. Staff training and education is the key to success and sustainability.

Call for action

Supporting mothers in NICU with an aim to enhance their psychological wellbeing involves implementation of structured support systems like family-centred care coupled with clear and consistent communication, environmental modifications, and access to psychosocial support. These approaches work together to empower parents, to reduce parental distress, and improve both family and infant outcomes.

In Sri Lanka, resource constraints and limited access to perinatal mental health services pose additional challenges. However, integrating basic psychological support into neonatal care does not necessarily require extensive resources. Training healthcare workers to recognise warning signs, providing peer support opportunities, advocating routine screening and strengthening referral pathways can make a meaningful difference.

Conclusions

Addressing maternal stress, anxiety, and depression in the NICU is an essential component of holistic neonatal care. By prioritising maternal mental health, we not only support mothers during one of the most vulnerable periods of their lives but also contribute to better outcomes for infants and families as a whole.

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Table 1: Benefits of Family Centred Care

Benefits for the neonate
Improved physiological stability
Enhanced neurodevelopmental outcomes
Reduced length of hospital stay
Decreased risk of complications
Benefits for parents
Reduced anxiety and psychological distress
Strengthened parent–infant bonding
Increased parental confidence and competence
Improved satisfaction with care
Benefits for the healthcare system
Foster trust between families and staff
Reduce healthcare costs

> “
> Addressing maternal stress, anxiety, and depression in the NICU is an essential component of holistic neonatal care. By prioritising maternal mental health, we not only support mothers during one of the most vulnerable periods of their lives but also contribute to better outcomes for infants and families as a whole.

Figure 2: Screening for psychological morbidity in the NICU

SLMA IN MAY

Highlights

SLMA Regional Clinical Meeting in Polonnaruwa Strengthens Clinical Engagement in the North Central Province

The SLMA Regional Clinical Meeting – Polonnaruwa 2026 was successfully held on 13 May 2026 at the DGH Polonnaruwa Auditorium. The event brought together healthcare professionals from across the North Central Province for academic sessions and technical discussions on Cardiology, Emergency Medicine, Endocrinology, Neurology, Snakebite Management, Medical Ethics, and Neonatology. The SLMA sincerely thanks the DGH Polonnaruwa Clinical Society, organizers, sponsors, and participants for making this event a major success.











Doctors and Lawyers Meet on the Football Field in Inaugural Law-Medical Match

The inaugural Law-Medical Football Match took place at Police Park in Colombo, marking the latest addition to the professional sports calendar jointly organized by the Bar Association of Sri Lanka (BASL) and the Sri Lanka Medical Association (SLMA). This event further strengthens the long-standing partnership between these two prestigious organizations. The thrilling match between doctors and lawyers was attended by SLMA leadership, including Vice President Dr Hiran Amarasekera, Honorary Secretary Dr Isshani Fernando, Head of the SLMA Sports Forum Prof. Chathuranga Ranasinghe, and Past Presidents Dr Vinya Ariyarathne and Dr Padma Gooneratna. Representing the BASL were President Rajeev Amarasuriya (AAL), Honorary Secretary Nalin Chandika De Silva, and their executive team.




SLMA IN MAY
Highlights

SLMA Suicide Prevention Campaign Promotes Professional Support and Responsible Social Media Use

To address the growing concern on suicide, the SLMA Expert Committee on Suicide Prevention conducted a public awareness campaign through social media platforms, reiterating the importance of accessing professional care and support. The campaign also included awareness on responsible sharing in social media , which has been identified as an increasing concern by mental health professionals.

SLMA IN MAY
Highlights

SLMA and Special Olympics Explore Collaboration to Support Persons with Intellectual Disabilities

Ms Shruti Mehta, Senior Manager of Organizational Development for Special Olympics Asia Pacific, along with board members of Special Olympics Sri Lanka, paid a courtesy call on the President and Honorary Secretary of the SLMA. Both organizations explored collaborative synergies to provide health and sports-related services to individuals with intellectual disabilities. Special Olympics is a global movement encompassing over 5.3 million athletes, unified partners, coaches, and volunteers across 256 national and state programmes.

SLMA
in MAY

SLMA Marks World Hypertension Day with Community Screening and Health Awareness Programme

The SLMA collaborated with the Rotaract Club of the Faculty of Medicine, University of Colombo, and other partners to commemorate World Hypertension Day 2026. Held at Independence Square, the event featured a blood pressure screening clinic and a community health festival, bringing together numerous organizations and the public to promote the vital importance of regular health screenings.

SLMA Monthly Clinical Meeting Highlights Advances in Sports and Exercise Medicine

The May Monthly Clinical Meeting was held in collaboration with the Sri Lanka Sports Medicine Association. The technical session was conducted by Dr Upul Madahapola and Dr Rangana Hettige (Consultant Sports and Exercise Physicians at TH Kurunegala and TH Ragama, respectively) alongside Dr Asanka Weligamage (Acting Consultant Sports and Exercise Physician at TH Kurunegala).

SLMA IN MAY
Highlights

Pre-Congress Session Explores Practical Approaches to Sleep Disorders Across the Life Span

A Pre Congress Session on "Sleep Across the Life Span, A Multidisciplinary, Practical Approach for General Practice was held recently, in collaboration with Sri Lanka College of Pulmonologists. Important and practical clinical aspects on sleep disorders, sleep related complex clinical cases and ENT related aspects of sleep disorder evaluation were extensively discussed during the session.

SLMA Saturday Talks

Following 'Saturday Talk' sessions were held during the month of May.

- "Approach to Delirium" delivered by Dr Maheshi Wijayabandara Consultant Geriatrician, National Hospital – Kandy and moderated by Dr Sangeetha Wickramaratne (Lecturer, Department of Paediatrics, University of Kelaniya.
- "Upper GI Bleeding" presented by Dr Hiruni Jayasena, Honorary Consultant Gastroenterologist and Senior Lecturer, General Sir John Kotelawala Defense University, moderated by Dr Arjuna Salinda Athapathu Lecturer and Acting Consultant Paediatric Nephrologist, University of Kelaniya / Colombo North Teaching Hospital – Ragama
- "Newborn Screening" and was led by Professor Imalke Kankanarachchi Professor in Paediatrics and Head of the Newborn Screening Unit, University of Ruhuna , moderated by Dr Arjuna Salinda Athapathu Lecturer and Acting Consultant Paediatric Nephrologist, University of Kelaniya / Colombo North Teaching Hospital – Ragama.

GLOBAL HEALTH NEWS

Measles cases surge in Bangladesh

Bangladesh is experiencing its most severe measles outbreak in a decade, with widespread nationwide transmission. According to the Bangladesh Directorate General of Health Services (DGHS), the cumulative burden has surged to 79,012 suspected cases and 9,686 laboratory-confirmed cases, resulting in 620 deaths. The outbreak has extended to 58 out of 64 districts of the country. Dhaka Division is the epicenter, heavily impacting densely populated urban areas like Korail and Mirpur. High case volumes are also reported in Rajshahi, Chittagong, and the Rohingya refugee camps in Cox's Bazar.

Protracted socio-political instability starting in 2024 disrupted routine immunization services, causing the country to defer its mandatory four-year supplementary mass vaccination campaign. Consequently, an estimated 83% of confirmed cases have occurred in completely unvaccinated or under-immunized individuals.

Ref: Haider N, Hassan M, Khan R Measles resurgence in Bangladesh, 2026: a warning of fragile immunization gains International Journal of Infectious Diseases, 2026; 0

https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON598

Ref: https://www.who.int/emergencies/situations/ebola-outbreak---drc-2026

https://www.cdc.gov/ebola/situation-summary/index.html

Ebola threatens global health security again; WHO declares a Public Health Emergency of International Concern (PHEIC)

The Bundibugyo virus strain of Ebola, an aggressive variant with no currently approved vaccines or targeted therapies has started spreading in several regions in the Democratic Republic of Congo (DRC) and bordering Uganda. The vast majority of transmission is concentrated in Ituri Province, with smaller clusters spreading into North Kivu and South Kivu in the DRC.

As of late May, the crisis has surged to 129 confirmed cases, 1,077 suspected cases, and 246 deaths. Active transmission is occurring along highly vulnerable areas and conflict zones, in DRC further complicating the response operations by the WHO, MSF, Red Cross and other International NGOs and the national government.

World's Largest ME/CFS Genetic Mapping starts in the UK

The UK government launched SequenceME, a £4.75 million genomics project where scientists have begun sequencing the genomes of up to 6,000 Myalgic Encephalomyelitis / Chronic Fatigue Syndrome (ME/CFS) patients to construct the world's first high-resolution genetic map of the illness, aiming to uncover biological pathways for long-overdue diagnostics.

This breakthrough could unlock the biological causes of the condition for the first time ever, paving the way for better diagnostics and new treatments for those who live with the disease.

ME/CFS causes debilitating fatigue, sleep difficulties and cognitive impairment. Around a quarter of those diagnosed are severely affected, leaving them housebound or unable to work.

Ref: https://www.gov.uk/government/news/thousands-of-mecfs-patients-to-benefit-from-genomics-study

Ref: https://www.bbc.co.uk/news/articles/c2325j0xk1vo

A new DNA test for Cancer Therapy

Millions of people with breast cancer could safely avoid chemotherapy as scientists have developed a DNA test that can distinguish between patients who are likely to benefit from the treatment and those who are not, according to recently released trial results.

The international study found that more than two-thirds of its participants could be spared the side of effects of chemotherapy and treated with hormone therapy alone. Chemotherapy can cause fatigue, nausea, hair loss, a weakened immune system and fertility issues.

The study, led by University College London (UCL), involved more than 4,000 newly diagnosed patients over the age of 40 in the UK, Norway, Sweden, Australia, New Zealand and Thailand. Scientists used a gene test called Prosigna to measure the activity of 50 genes involved in breast cancer growth and calculate a patient's risk of the disease returning. The university said more than 5,000 NHS patients a year could avoid chemotherapy because of the trial findings.

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