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The SLMA Monthly

Official Newsletter of the
Sri Lanka Medical Association

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FROM THE EDITORS



Dr Lahiru Kodituwakku

Co-Editor



Dr Kumara Mendis

Co-Editor

Welcome to this month's edition of 'The SLMA Monthly', a compilation designed to challenge traditional medical narratives and foster robust, cross-disciplinary alliances across our healthcare system. Guided by our fundamental mission of "Serving the Profession, Serving the Nation," this issue bridges the gap between strict clinical precision and profound social empathy. As the boundaries of modern medicine continue to expand, our editorial selections challenge us to look past traditional boundaries and integrate planetary health, advanced diagnostics, digital ethics, and the healing power of the humanities into daily practice.

Our cover story focuses on the intersection of medicine and social justice.. In "*The Voice as Medicine*," we reflect on how cultural icons like late Visharada Nanda Malini used her voice to galvanize public opinion, proving that art is an essential tool for health equity and societal well being. We expand this systemic lens in "*From Cascading Risk to Planetary Health*," which outlines a vital data-sharing framework to mitigate ecological disruptions and zoonotic spillbacks before they overwhelm clinicians. Furthermore, our institutional review, "*Leading by Example*," charts the progressive steps the SLMA has taken to leave the past behind and pioneer a new public health-centered era.

The remainder of this issue provides actionable, forward-thinking guidance for the modern practitioner navigating clinical and digital spaces. We address the sharp rise in conditions like Central Serous Chorioretinopathy, reminding physicians how mental distress manifests as organic retinal pathology. On the diagnostic front, we examine the evolution of emergency care in a study advocating for modern venom-detection techniques to replace the traditional 20-minute bedside clotting test for snake envenoming. Finally, we tackle the chronic disease epidemic by exploring non-pharmacological strategies for sustainable pain management, and our opinion piece brings a valid argument to the center stage, "*Should Doctors Be Influencers?*", which balances public health education against the strict boundaries of digital medical misinformation and patient privacy.

We invite you to read through these diverse pages, absorb these new perspectives, and empower yourselves with the knowledge necessary to champion a more equitable and resilient future for Sri Lankan healthcare.

The SLMA Monthly
Official Newsletter of the Sri Lanka Medical Association

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COVER STORY

Dr Lahiru Kodituwakku

Co-Editor,

The SLMA Monthly Magazine



VOICE AS MEDICINE: HOW CULTURAL ICONS STOOD FOR HUMANITY

When Visharada Nanda Malini passed away, Sri Lanka did not just lose a musical pioneer; it lost a fierce guardian of the collective public conscience. While history books celebrate her as the “Voice of the Nation” for her courageous stance against oppression and human rights violations during a turbulent era, the medical and humanitarian communities recognize a deeper truth in her legacy: she understood that human rights, physical and mental well-being, and social justice are inextricably linked. A universal truth that modern medicine is beginning to decode and understand.

Her life illustrates a profound truth about social medicine. When systemic oppression, war, natural calamities or stigma paralyzes a society, public health messaging alone cannot heal the divide. The voice of an artist could be the magical remedy that bridges the divide and heals the wounded souls. Around the world, a rare breed of musical giants has wielded this exact cultural power, transforming mass adoration into a powerful shield for humanity, and mental resilience.

The Flag-Bearers Against Oppression and Inequality: Nanda Malini, Victor Jara, and Miriam Makeba

A nation cannot be healthy if its people live in fear. Dr. Nanda Malini’s defiance of violence in Sri Lanka during the youth uprisings and subsequent civil strife, found a profound global parallel across the seas in Chile through the life of folk singer **Victor Jara**. A central figure in the *Nueva Canción* (New Song) movement, Jara used his music to champion the rights of peasants and laborers. His songs focused intensely on what modern medicine terms the *social determinants of health*, singing out against child malnutrition, unsafe work conditions of poor miners, and the grueling poverty of working-class neighborhoods. Jara understood that medicine cannot cure a society broken

by inequality, eventually paying the ultimate price when he was martyred by Chile’s military junta.

South Africa’s **Miriam Makeba** (“Mama Africa”) was forced into decades of exile for using her music to combat the systemic cruelty of Apartheid. When she returned, she recognized that the next great threat to human dignity was the HIV/AIDS epidemic, paralyzing nations, a crisis worsened by government denial and crushing social stigma.



As a UN Goodwill Ambassador, Makeba used her immense global visibility and recognition to humanize patients, advocate for maternal health, and demand access to affordable, life-saving medication for developing nations. For Malini, Jara, and Makeba, socio-political freedom and human health were parts of the exact same struggle.

Peace as Preventive Medicine: John Lennon and Joan Baez

While some artists fought domestic tyranny, others looked at the global theater of war and recognized it for what truly is: a severe impending public health crisis. **John Lennon**, alongside Yoko Ono, famously transitioned from a pop icon into a peace activist, staging global demonstrations like the “Bed-Ins for Peace” and writing the immortal anthem “*Imagine*.”

Lennon’s philosophy, shared deeply by American folk icon **Joan Baez**, argued that the massive resources funneled into military

machine to forge wars in unknown lands were directly stolen from the resources required for well-being and healthcare of the public. By using their unmatched stardom to cry for global peace and support international medical relief, Lennon and Baez were practicing the ultimate form of preventive medicine: fighting to eradicate the physical trauma, displacement, and intergenerational psychological devastation caused by war.

Building sanctuaries of hope: Lata Mangeshkar and Neela Wickramasinghe

For humanity to thrive, cultural reverence must sometimes be translated into physical sanctuaries. In India, a nation spellbound by art and music, **Lata Mangeshkar** commanded a cross-generational devotion that wove her voice into the post-independence identity of the nation. She mobilized her immense star power and national adoration to establish the Master Deenanath Mangeshkar Hospital in Pune, ensuring top-tier, highly subsidized medical care reached underprivileged communities while fronting massive awareness campaigns to educate the public on tuberculosis.

Locally, Visharada **Neela Wickramasinghe** stands as a magnificent example of an artist transforming a personal tragedy into a lifelong campaign for health access. A contemporary of Nanda Malini and a childhood

survivor of polio, Wickramasinghe displayed her disability as a badge of resilience. Partnering with UNICEF and the Ministry of Health, her trusted voice echoed across rural Sri Lankan villages during National Immunization Days, reassuring hesitant parents and driving up vaccination rates. Her cultural capital directly contributed to Sri Lanka being declared polio-free, a monumental victory in Sri Lanka’s public health journey.

The Prescriptive Power of the Artist

For the medical community, these figures represent far more than just cultural entertainment; they are essential partners in global humanitarian health. Whether it was Nanda Malini standing with oppressed youth, Victor Jara fighting for starved workers, or John Lennon demanding an end to bloodshed, these icons possessed an asset that money and policy cannot buy: the hearts of the people. As we honor the enduring legacy of Dr. Nanda Malini, the medical community must continue to look to the art, music and dance not just for solace, but as an indispensable ally in the ongoing defense of human dignity and health equity.

John Lennon once sang, “*You may say I’m a dreamer, but I’m not the only one. I hope someday you’ll join us, and the world will be as one.*” In beautiful harmony, Nanda Malini echoed that very same human yearning: “වගන්තට හැකි නම් ගිගුම් දී වියළි ගම් බිම් වලට ඉහළින්, ඉදෙන්නට හැකි නම් ඔතක් වී ඔතක් නොසිඳෙන පැලක රහසින්” (If only I could pour down over the parched lands... secretly becoming a pot of rice in a starving hut). These cultural giants have already written the score for a more just and compassionate world.

Now, it is time for the healers to follow their notes!

PRESIDENT'S MESSAGE

Dr Manilka Sumanatillake

132nd President of Sri Lanka Medical Association



EXPANDING HORIZONS FOR HOLISTIC AND RESILIENT HEALTHCARE

Dear Colleagues,

As the President of the Sri Lanka Medical Association (SLMA), it is my privilege to address you in this month's bulletin. Our commitment to excellence demands that we look beyond clinical silos. True healing and sustainable healthcare require us to embrace an intersectional approach, one that connects planetary health, cutting-edge diagnostics, holistic patient management, digital ethics, and the profound power of the humanities.

remains an indispensable ally in defending health equity.

- **Planetary Health & Disaster Resilience:** The climate crisis is no longer a distant threat; it is an active medical emergency. *"From Cascading Risk to Planetary Health: Building the Disaster - One Health Nexus in Sri Lanka"* outlines a vital framework for intersecting human, animal, and environmental health data to proactively mitigate ecological disruptions and zoonotic spillbacks before

Should Recognize" serves as an essential reminder of how mental distress directly translates into organic pathology, urging us to maintain a high index of suspicion and offer timely intervention for stress-linked visual impairment.

- **Advancing Acute Diagnostics:** In rural healthcare fronts, precision is lifesaving. *"Beyond the 20-minute Whole-Blood Clotting Test: Improving the Early Diagnosis of Snake*

- **Holistic NCD Management:** Dealing with the epidemic of non-communicable diseases requires us to expand our therapeutic toolkits. *"Beyond Medication: Non-Pharmacological Strategies for Chronic Pain Management"* champions the integration of cognitive behavioral therapies, physical rehabilitation, and lifestyle medicine to offer sustainable relief from debilitating, long-term pain without relying solely on long-term pharmaceutical intervention.

- **The Ethics of Medical Communication:** The digital age presents a new frontline for public health education. In *"Should Doctors Be Influencers?"*, we tackle the delicate balance between professional status and public outreach. As trusted leaders, clinicians must actively combat digital medical misinformation while strictly upholding our timeless ethical



Image created by: Google Gemini AI

This month, our editorial selections highlight the diverse challenges and innovative frontiers defining modern Sri Lankan medicine:

- **Social Medicine & The Humanities:** In our feature article, *"The Voice as Medicine: How Cultural Icons Stood for Humanity,"* we reflect on the profound legacy of figures like **Dr. Nanda Malini** and **Visharada Neela Wickramasinghe**. They proved that socio-political freedom, structural equality, and public well-being are completely inseparable. By leveraging their cultural power to combat stigma and drive historic vaccination drives, they showed us that art

they overwhelm our clinical infrastructure.

- **Leading By Example:** In our institutional review, *"Leading by Example: How the SLMA Closed the Bar and Opened a New Era in Public Health,"* where SLMA took a decisive step to move away from its past and embrace the future, through progressive and public health centered approaches.
- **The Physical Manifestations of Stress:** As clinicians, we are witnessing a steep rise in psychophysiological conditions. *"Central Serous Chorioretinopathy: The Stress-Related Retinal Disease Every Physician*

Our commitment to excellence demands that we look beyond clinical silos. True healing and sustainable healthcare require us to embrace an intersectional approach, one that connects planetary health, cutting-edge diagnostics, holistic patient management, digital ethics, and the profound power of the humanities.

Envenoming in Sri Lanka" reviews critical diagnostic evolutions. By upgrading our traditional bed-side tests with modern venom-detection techniques, we can accelerate targeted antivenom administration and significantly improve patient outcomes.

Let us leverage these diverse insights to build stronger, cross-disciplinary alliances across our healthcare ecosystem. By combining clinical precision with true social empathy, we can continue to advance our collective mission of **"Serving the Profession, Serving the Nation."**

boundaries, professional boundaries, and patient privacy.

OPINION

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SHOULD DOCTORS BE INFLUENCERS?

Let me begin this opinion piece by answering my own question.

The answer is: I don't know.

Perhaps that is exactly why I am writing this. I have more questions than answers, and I wonder whether, as a profession, we are asking ourselves enough of these questions.

The mantra of doctors today—globally, and perhaps even more so in Sri Lanka—is that we are understaffed, overworked and underpaid. There is considerable truth in that. It is therefore unsurprising that many seek additional sources of income early in their careers.

Medical students conduct tuition classes. Some become vloggers. Others build audiences on TikTok, Instagram or YouTube. There is nothing inherently wrong with any of these. After all, doctors are people too.

But where does one draw the line?

Many of these ventures are promoted not simply using an individual's name but also their university affiliation. Although codes of conduct for medical students generally discourage such practices, they seem

to occur frequently. Is anyone monitoring this? Should they be?

As audiences grow, the content often shifts from education to documenting the "medical student lifestyle." This is hardly unique to Sri Lanka; it is now a global phenomenon. Yet there does seem to be one important difference. In countries where professional guidance on social

media is more firmly embedded, patients rarely become part of the content. In Sri Lanka, however, newborn babies sometimes become props. So do other patients.

Should they?

Then there are the dancing doctors. Usually in scrubs. Frequently with stethoscopes around their necks. Occasionally within areas where professionalism—or even sterility—is expected.

Does the location matter? Does the attire matter? Or is this simply harmless entertainment viewed through an outdated lens?

When these practices go unchallenged, they gradually become normal. They become

The Sri Lanka Medical Council has recently introduced guidance on the professional use of social media. But how many practising doctors have read it? How many medical students know it exists? And if they do, do they interpret it in the same way?

Commercial endorsements are becoming increasingly common. Cosmetics. Nutritional supplements. Health products. Lifestyle brands. How often are these endorsements based on a careful appraisal of the scientific evidence? How often are they simply business agreements? Should the public be expected to distinguish between the two?

Lifestyle vlogs have become another growing trend. A day in the life of a doctor. Morning

what does consent really mean in this context? Can consent ever be entirely free when it is sought by the very clinician responsible for a patient's care? Even if no pressure is intended, can there still be an imbalance of power?

Recently, one particular event involving a medical professional received widespread attention across both mainstream and social media. How the incident needs to be taken up is not for me to comment on. That is for regulators, ethicists and readers to reflect upon.

What struck me more than the event itself was the reaction to it. The heart emojis. The likes and the shares coming from medical students and junior doctors. That made me pause.

Are our perceptions of professionalism changing?

Have social media norms begun to redefine what we consider acceptable professional behaviour? Are we adequately teaching digital professionalism in medical schools?

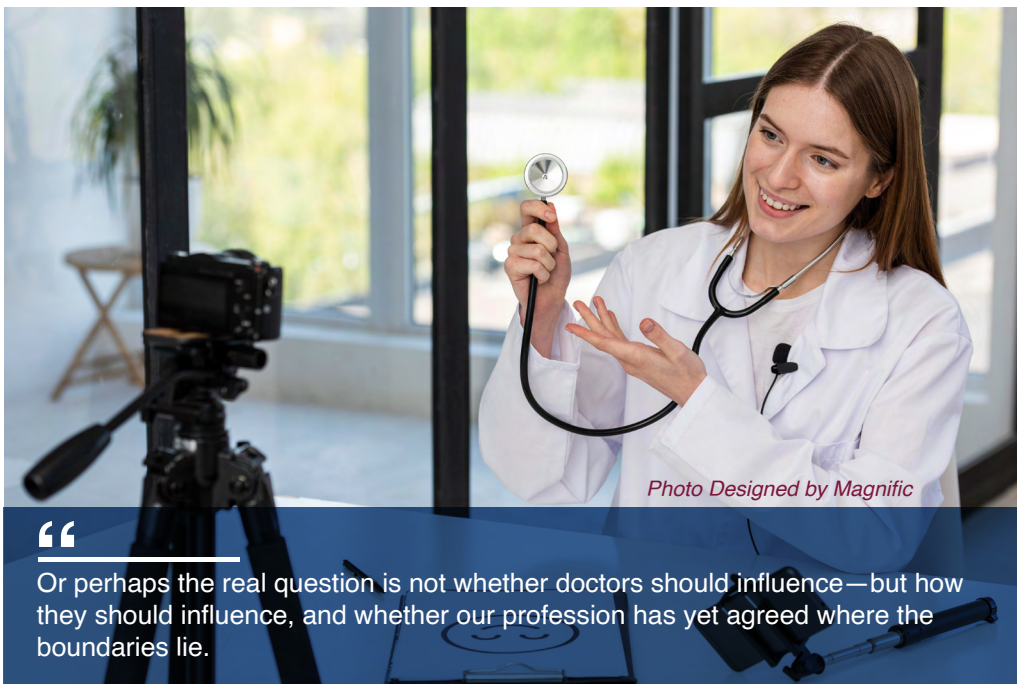
Or are we expecting young doctors to navigate an entirely new ethical landscape using principles that were written before this landscape even existed?

Perhaps doctors should be influencers. Perhaps they should not.

Or perhaps the real question is not whether doctors should influence—but how they should influence, and whether our profession has yet agreed where the boundaries lie.

routines. Ward rounds. Coffee breaks. Night shifts. Do these videos make doctors more approachable? Do they inspire future generations? Or do they unintentionally glamourise a profession that already carries considerable public (dis)trust?

Patient stories have also become part of personal branding. Usually, we are told, with consent. But



“

Or perhaps the real question is not whether doctors should influence—but how they should influence, and whether our profession has yet agreed where the boundaries lie.

mainstream. Perhaps they are helped along by a well-meaning sentiment: “Why stop them? They’re only trying to earn some extra money.”

Is that enough justification?

Graduation rarely changes the trajectory. If anything, the audience grows. The opportunities increase.

FEATURE ARTICLE

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CENTRAL SEROUS CHORIORETINOPATHY: THE STRESS-RELATED RETINAL DISEASE EVERY PHYSICIAN SHOULD RECOGNISE

A 38-year-old bank executive, otherwise fit and well, comes in with a week of painless blurring and distortion of vision in one eye. He had put it down to work fatigue. On examination the anterior segment is unremarkable, but fundoscopy shows a localised serous elevation at the macula. This is a textbook presentation of central serous chorioretinopathy — a condition often dismissed as simple eye strain, but one with clear risk factors and a well-defined diagnostic route.

Introduction

CSCR ranks as the fourth most common retinopathy, behind age-related macular degeneration, diabetic retinopathy, and branch retinal vein occlusion (1). It usually strikes otherwise healthy people between 20 and 50, and men far more often than women — roughly 9.9 per 100,000 men against 1.7 per 100,000 women (2). Many of these patients fit the classic “Type-A” profile: driven, under chronic occupational or psychological stress, a combination well known to trigger the disease (3). Ask directly and a good number will admit to corticosteroid exposure in some form — oral, inhaled, intranasal, topical, or intra-articular — even if they hadn’t thought to mention it themselves (3,7). The presentation itself is usually straightforward: sudden, painless blurring or distortion of central vision in one eye. Put the pieces together — a young or middle-aged man, under stress, with some steroid exposure — and urgent ophthalmic referral is warranted, since a single optical coherence tomography (OCT) scan can settle the diagnosis in minutes.

Epidemiology

Men aged 20–50 bear the majority of this disease, with a male-to-female ratio somewhere between 2:1 and 6:1 (1,2). For a South Asian readership, the regional figures matter: a nationwide study from Taiwan found an annual incidence of about 21 per 100,000, nearly double what the benchmark Minnesota cohort recorded, and bilateral or multifocal disease also turns up more often in Asian populations (2,6). The peak falls between 35 and 44 — right in the middle of people’s working years, which gives it real occupational and economic weight locally.

Pathophysiology

The main factor of it is choroidal vascular hyperpermeability: dilated, congested choroidal vessels, first shown on indocyanine green angiography (6). The choroid thickens into what’s called a “pachychoroid” and develops focal venous outflow congestion, a process likened to a Starling-resistor mechanism (4). Eventually this overwhelms the retinal pigment epithelium’s ability to pump fluid, the barrier breaks down locally, and fluid builds up under the retina. Corticosteroids — whether the body’s own stress-driven cortisol or any exogenous form — seem to act mainly through the mineralocorticoid receptor rather than the glucocorticoid receptor alone: intraocular aldosterone reproduces the same choroidal vasodilation and subretinal fluid in animal models that closely resemble human CSCR (5). This is the pathway behind the use of mineralocorticoid

receptor antagonists in treatment, discussed later along with an important caveat from the trial evidence (6).

Risk Factors

- Corticosteroid exposure, in any form — oral, inhaled, intranasal, topical, or intra-articular (7)
- Psychological stress or a “Type-A” personality: driven, competitive behaviour (3)
- Endogenous hypercortisolism, as in pregnancy or Cushing’s syndrome (5)
- Obstructive sleep apnoea (6,7)
- Helicobacter pylori infection (7)
- Sildenafil and other phosphodiesterase-5 inhibitors (7)
- Psychiatric medications, including antidepressants and anti-anxiety agents (7)
- Systemic hypertension and smoking, both probable contributory factors (7)

A pooled systematic review and meta-analysis found corticosteroid use, hypertension, and Helicobacter pylori infection to be the most consistent independent associations across studies (7). The practical point for non-ophthalmologists is simple: a focused drug and stress history often tells you more than any single examination finding, and it’s worth asking for in every patient who presents with new visual distortion.

Clinical Features

Patients typically present acutely with painless blurring or distortion of central vision in one eye, most often noticed as micropsia (objects looking smaller) or metamorphopsia (straight lines appearing bent or wavy) (6). Many

describe a grey or dark patch in their vision — a relative central scotoma — along with washed-out colours (dyschromatopsia) and reduced contrast sensitivity (6,7). One clue that’s easy to miss is a small hyperopic shift, with vision improving slightly when a small plus lens is added on refraction; visual acuity itself is usually only mildly affected, typically better than 6/12, which can give both patient and clinician a false sense of reassurance (6).

On dilated fundoscopy, the hallmark finding is a well-circumscribed, dome-shaped serous detachment of the neurosensory retina at the macula, without haemorrhage — subtle enough to be missed on routine examination (6). Most acute episodes settle on their own within three to six months, with good visual recovery. Chronic or recurrent CSCR is a different story: long-term follow-up data show that persistent subretinal fluid, recurrence, and secondary choroidal neovascularisation are the strongest predictors of permanent visual loss (10).

Diagnosis

Optical coherence tomography (OCT) is now the first-line investigation and often confirms CSCR before angiography is even needed. It shows localised subretinal fluid, sometimes a shallow serous pigment epithelial detachment (PED), and hyperreflective subretinal dots — a pattern that can show up before any fluorescein leak becomes visible (6). Fundus fluorescein angiography (FFA) still has its place for pinpointing the leak site, classically a “smokestack” (an ascending, mushroom-shaped leak) or, more often, an “inkblot” pattern of gradually spreading hyperfluorescence (6). Indocyanine green angiography (ICGA), though not always available, shows the underlying choroidal vascular hyperpermeability directly and is especially useful when the presentation is chronic, recurrent, or atypical and the diagnosis isn’t obvious (6). Fundus autofluorescence adds to this

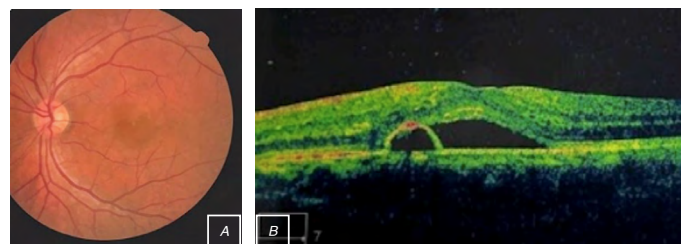


Figure 1. A. Colour fundus photograph showing shallow detachment of the retina at the macula. B. Spectral-domain OCT showing a dome-shaped serous retinal detachment at the macula, with retinal pigment epithelial detachment.

picture by mapping areas of RPE disturbance and the descending tracts of gravitational fluid seen in chronic disease.

A few differentials need to be actively ruled out, since their management is quite different:

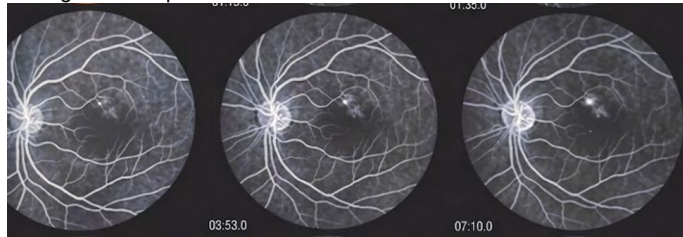


Figure 2. Sequential-phase fluorescein angiogram frames of the same eye as the above patient, showing a focal leak that progressively pools over the angiogram sequence — a pattern consistent with active CSCR.

choroidal neovascularisation, polypoidal choroidal vasculopathy, Vogt-Koyanagi-Harada disease, optic pit maculopathy, and posterior scleritis. Multimodal imaging is what makes this distinction possible (6,8).

Management

The single most important step — and one that's often overlooked outside ophthalmology — is identifying the culprit corticosteroid and, where clinically feasible, stopping or tapering it in consultation with the prescribing specialist. This alone often resolves the condition and should always be tried before considering invasive treatment (6,7).

For acute CSCR, observation remains the mainstay of care. Most episodes resolve on their own within three to four months with good visual recovery, so there's usually no need to intervene early (6). Persistent fluid beyond this window, chronic disease, or recurrent episodes warrant active treatment.

Half-dose (or half-fluence) photodynamic therapy (PDT) has become the best-supported option for chronic CSCR. The PLACE trial, a randomised controlled trial, showed it outperforms high-density subthreshold micropulse laser at achieving complete fluid resolution, and it's now widely regarded as first-line therapy where available (8). Subthreshold micropulse laser is still a reasonable alternative, particularly for extrafoveal leaking points or where PDT is inaccessible, though somewhat less effective (6,8).

Oral mineralocorticoid receptor antagonists (eplerenone, spironolactone) were, until recently, seen as a promising alternative based on the pathophysiological rationale of aldosterone-driven choroidal vasodilation (5). That enthusiasm

now needs an important caveat: the VICI trial — a well-powered, placebo-controlled randomised trial — found eplerenone was not superior to placebo for improving visual acuity in chronic CSCR after 12 months, tempering the

earlier enthusiasm from smaller pilot studies (9). Clinicians should therefore be cautious about routinely prescribing eplerenone based on older literature alone.

Other oral and topical agents have also been explored on similar reasoning. Oral acetazolamide, a carbonic anhydrase inhibitor thought to enhance retinal pigment epithelial fluid transport, has been shown in small comparative studies to speed up subjective and objective resolution of subretinal fluid, though without improving final visual acuity or reducing recurrence. Topical non-steroidal anti-inflammatory drops

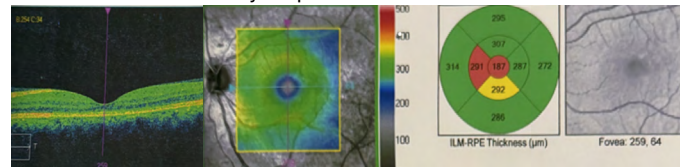


Figure 3. Follow-up OCT in the same patient as Figure 1, taken after resolution of subretinal fluid. Central subfield thickness has fallen from 720 μ m to 187 μ m — below the normal range — illustrating the residual foveal thinning that can persist even after anatomical resolution.

have been trialled on a similar basis, occasionally in combination with acetazolamide, but evidence remains limited to small pilot studies. International consensus guidelines state that, in the absence of large randomised controlled trials, the role of such oral and topical medications in CSCR remains speculative (6).

Anti-VEGF therapy has a limited, secondary role, reserved principally for cases complicated by choroidal neovascularisation rather than for uncomplicated CSCR itself (6). A Cochrane network meta-analysis concluded that PDT currently offers the best balance of efficacy and evidence quality among available interventions (8).

Finally, addressing modifiable lifestyle contributors — chronic stress, poor sleep, and, where relevant, screening for obstructive sleep apnoea — is a sensible

adjunct to any treatment plan, even though robust trial evidence for stress-reduction interventions specifically is still lacking.

Prognosis & Complications

The overall visual prognosis for acute CSCR is good, with 80–90% of patients regaining vision of 6/9 or better within a few months (6). Outcomes are considerably less favourable in chronic or recurrent disease, however: recurrence occurs in roughly 30–50% of eyes following an initial episode, and repeated or persistent subretinal fluid predisposes to progressive RPE atrophy, permanent photoreceptor loss, and irreversible visual impairment (10). Long-term follow-up studies of chronic CSCR identify persistent subretinal fluid, recurrence frequency, and secondary choroidal neovascularisation as the principal drivers of poor final visual acuity (10). Even among patients who recover good acuity, subtle residual metamorphopsia, reduced contrast sensitivity, and colour desaturation may persist indefinitely, and can meaningfully affect quality of life and occupational performance, particularly in visually demanding professions.

Take-Home Message for SLMC Readership

For clinicians outside ophthalmology, three practical points matter most. First, always ask about corticosteroid exposure — in any form — before attributing new visual complaints to “stress” or ageing (6,7). Second, maintain a low threshold for urgent ophthalmic referral in any steroid-exposed patient reporting visual distortion, since early recognition improves outcomes (6). Third, when prescribing corticosteroids for any indication, take a moment to tell patients — particularly middle-aged men — to report any change in vision promptly, rather than dismissing early symptoms as insignificant.

Conclusion

Central serous chorioretinopathy is common, frequently under-recognised outside ophthalmology, and closely tied to two everyday clinical realities: corticosteroid prescribing and psychological stress. A simple, directed history — supported by prompt referral for OCT confirmation — remains the most powerful diagnostic tool available to any clinician. As our knowledge of the underlying disease process improves, so does our ability to recognise this condition earlier and manage it more wisely — an opportunity relevant to every specialty within the SLMC.

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SPECIAL ARTICLE

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FROM CASCADING RISK TO PLANETARY HEALTH: BUILDING THE DISASTER - ONE HEALTH NEXUS IN SRI LANKA

Disasters are no longer isolated events. They are system-wide stress tests, exposing how closely human health, ecosystems, food systems, infrastructure and governance are interconnected. Sri Lanka's recent experience with Cyclone *Ditwah* provides a powerful illustration of this reality.

Late November 2025's Cyclone *Ditwah* affected approximately 2.3 million people, displaced over 200,000, and caused an estimated US\$4.1 billion in direct damage, equivalent to roughly 4% of Sri Lanka's GDP. The disaster placed substantial additional demands on already stretched health and essential service systems.

Yet the significance of *Ditwah* extends beyond the scale of physical damage. The cyclone demonstrated how hazards propagate through interconnected systems: water and sanitation, health services, agriculture, livelihoods, ecosystems, infrastructure and local governance. These are not independent consequences of a disaster; they are components of a cascading risk system.

This is where One Health and Planetary Health offer more than conceptual frameworks. They provide a basis for thinking differently about climate adaptation, disaster preparedness, and resilience.

Sri Lanka's Centre for Planetary Health (CePH) at the Faculty of Medicine, University of Colombo, has positioned itself within this emerging agenda, focusing on the interconnections between human, animal and environmental health and on evidence-based solutions relevant to the Sri Lankan context.

The Health-Environment-Disaster Nexus

Disasters rarely end when the immediate hazard passes. They cascade through systems that may already be under stress and are not designed to absorb them. The compound risks are accumulating faster than governance systems can respond.

Health systems absorb these consequences long after the immediate emergency has subsided; through disrupted safe water and sanitation services, damaged health infrastructure, interruptions to disease surveillances and vector control, food insecurity and nutritional consequences, and psychological distress.

The defining feature of compound and cascading risk is interaction. Hazards combine with exposure, vulnerability and institutional weakness to produce consequences that cannot be adequately understood within a single sector.

Ditwah provides a recent example. Research examining the disaster identified weakness in preparedness, planning and warning communication, alongside broader gaps in the national disaster-management system. Sri Lanka's own subsequent policy response has described *Ditwah* as a "climate stress test" that exposed systemic vulnerabilities in national infrastructure and disaster resilience. This has an important implication for public health: an early-warning system is not simply a meteorological system. It is also a communication, governance and trust system. A technically accurate warning reduces risk only when people receive it, understand it, trust it and know what action to take.

Global policy increasingly recognises this interdependence. The Sendai Framework for Disaster Risk Reduction (2015 - 2030) places health within the broader objective of reducing disaster mortality, losses and vulnerability, while the World Health Organisation's Health Emergency and Disaster Risk Management framework (2019) promotes an all-hazards approach spanning prevention, preparedness, response and recovery. Yet in practice, disaster planning and health planning still tend to happen in separate ministries, separate budgets, and separate professional literatures.

The challenge, therefore, is no longer to establish that health matters to disaster risk reduction. It is to build governance arrangements in which health, environmental, animal, food and disaster-risk systems can act on shared risks before they become crises.

One Health and Planetary Health as a Climate Adaptation Strategy

One Health recognises the interdependence of human, animal and environmental health. Planetary Health extends this perspective by considering the health and wellbeing of all living beings within the ecological systems and limits (planetary boundaries) that sustain life on earth. In a climate-disaster context, these perspectives become particularly tangible.

After a cyclone, displaced communities, livestock, contaminated water, damaged agricultural systems, disrupted food systems and degraded ecosystems may become mutually reinforcing sources of risk. The same flood can

simultaneously become a sanitation problem, a disease-risk pathway, an animal-health concern, an agricultural loss and an environmental hazard.

A One Health/Planetary Health approach therefore asks a different question from conventional disaster management.

Rather than asking only, "How do we respond to this hazard?", it asks, "Which interconnected systems are vulnerable, how might those vulnerabilities interact, and where can intervention prevent cascading harm?"

Applied to disaster risk reduction, this means designing early warning systems around community understanding and trust; treating water, sanitation and waste management as components of health resilience; incorporating animal and food-system risks into preparedness; and assessing recovery not only through rebuilt infrastructure but also through nutrition, psychological wellbeing, livelihoods and ecosystem recovery.

The value of the approach lies in making interconnectedness actionable.

Relevance to Sri Lanka

Few settings illustrate the importance of this integration more clearly than Sri Lanka.

Sri Lanka is a densely populated island exposed to floods, landslides, droughts, extreme rainfall and tropical cyclones, with substantial dependence on agriculture, fisheries, natural resources and climate-sensitive livelihoods. Its health system has historically achieved important population-level gains, but

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repeated emergencies and economic pressures have placed additional demands on health and local governance systems.

The experience of *Ditwah* reinforced these vulnerabilities. The post-disaster assessment identified substantial damage across infrastructure, agriculture and ecosystems, while subsequent recovery planning has placed emphasis on debris management, environmental protection, public health and “building back better.”

Sri Lanka already possesses important components of a disaster-governance architecture, including the Disaster Management Act, National Policy on Disaster Management, National Disaster Management Plan and National Emergency Operation Plan. These instruments are publicly maintained by the Disaster Management Centre.

The opportunity is therefore not simply to develop more plans, but to strengthen the connections between the plans, institutions and sectors that already exist. A trusted, multilingual and impact-oriented early-warning system is one example. Its effectiveness should ultimately be judged not only by technical accuracy, but by whether warnings lead to timely protective action and reduce avoidable health and livelihood impacts.

This is precisely where locally grounded evidence, community experience and cross-sector knowledge become important.

Current State of the Art

From Concept to Practice: The Center for Planetary Health

The Center for Planetary Health at the Faculty of Medicine, University of Colombo (CePH) has been developing an interdisciplinary platform to address the connections between human, animal and environmental health. Over the past two years, it has also been building the practical scaffolding for this agenda. Following the 2024 Sri Lanka contribution to the Lancet Countdown on Health and Climate Change, CePH has developed its research portfolio to include health, nutrition and climate change, food policy and regulation, and climate health

digital platforms. Its emerging international collaborations also demonstrate how this agenda can move beyond conceptual discussion towards applied research and governance.

In 2026, CePH partnered with the Centre for Sustainable Development Reform at the University of New South Wales to develop a waste governance framework applied to the Cyclone *Ditwah* response, a Planetary Health approach to a problem usually treated purely as logistics. A comprehensive Disaster Waste Management Framework for relief centres and internal displaced person (IDP) settlements in Sri Lanka was co-developed with the local authorities, drawing on lessons learned from recent flooding events and refined using international best practices. This guideline will serve as a practical resource for local authorities, disaster management officials, and waste management practitioners to effectively plan for, respond to, and manage waste generated in relief centers and internal displaced person (IDP) settlements following climate-related disasters. The guideline addresses management protocols for waste management in relief centres and IDP settlements, including sanitation, hygiene, and public health considerations, as well as resource requirements, equipment checklists, and pre-positioning strategies. The Centre for Planetary Health will conduct stakeholder consultations with the relevant authorities, and relevant experts to ensure the guideline is contextually appropriate and operationally feasible. The final guideline will be integrated into capacity building workshop materials and be available for future training.

This framework was presented at an Expert Roundtable and the first workshop of a three-part Disaster Risk Reduction-One Health research series held at Harper Adams University, UK on 17 July 2026, co-led by Professor Thoradeniya (CePH), Dr Herath (HAU), and Professor Amaratunga (LU).

From Global Frameworks to Local Action

The case for integration is not new. At the United Nations High-Level Meeting on the Midterm Review of the Sendai Framework for Disaster Risk Reduction

held in 2023, One Health was discussed in relation to ecosystem health, pandemic preparedness, disaster risk and biological risks.

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The experience of *Ditwah* reinforced these vulnerabilities. The post-disaster assessment identified substantial damage across infrastructure, agriculture and ecosystems, while subsequent recovery planning has placed emphasis on debris management, environmental protection, public health and “building back better.”

What has changed is the urgency of implementation.

Climate change is increasing the complexity of hazards and their interactions. An environmental disruption may generate health consequences; a disaster may destabilise food systems; food-system disruption may affect nutrition and livelihoods; and all these effects may place additional pressure on health and governance systems.

One Health helps make these pathways visible.

Planetary Health adds a further dimension: human health and wellbeing ultimately depend on the condition of the ecological systems that sustain communities.

This means that health resilience cannot be separated from water security, food systems, biodiversity, waste management, land use, coastal ecosystems and climate adaptation.

The interconnectedness of human, animal and environmental health, and analysis of past disaster and health emergency events through an ‘OH lens’, have also been explored in the context of the UN meeting. This work examined different disaster and health emergency contexts, their similarities, differences

and patterns, and why specific interventions succeed or fail, in settings where climate change is contributing to increased health risks.

An inclusive, integrated One Health approach to preparedness for disaster response and health emergencies has been developed to better addresses the systemic nature of risk. A central tenet of this approach is to provide a comprehensive multi-sector and multi-agency perspective that better integrates the health sector and natural hazard communities. Health resilience is treated as a shared outcome, with attention to how climate change affects health, how health actors intervene during natural crises, and how better understanding of the pathways between climate, environment, and health can help protect and promote human health and wellbeing in the face of climate challenges.

The Harper Adams Initiative and Beyond

The international research programme described above was intended to extend this cross-system analysis through a series of workshops and expert-consensus processes, bringing together perspectives from disaster risk reduction, agriculture, animal health, environmental systems and human health.

The first workshop and Expert Roundtable focused on integrating disaster governance and One Health for resilient food and animal systems. The broader aim is to examine where existing governance arrangements remain fragmented and where One Health and Planetary Health principles can provide a more integrated basis for preparedness and resilience. This brought together academics at Harper Adams University, a leading UK higher education institution specialising in agriculture, food production, animal sciences and veterinary-related education and research, to explore how disasters affect crop sciences and agroforestry, livestock, aquatic and fisheries systems, companion animals and human-wildlife interfaces in the UK. Through a pre-defined group exercise, participants defined their system components, mapped interconnections across food, animal and environmental systems, identified governance

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gaps and areas of vulnerability. Participants were also asked to develop recommendations underpinned by One Health/Planetary Health concepts, to strengthen resilience through more integrated and systems-based approaches.

Across all groups, there was a strong consensus that implementation of One Health and Planetary health within UK disaster governance remains uneven and fragmented. While certain human-animal interfaces, particularly those relating to livestock and to a lesser extent, human-wildlife interfaces, have been incorporated into existing governance arrangements, significantly less attention has been directed towards crops and agroforestry, companion animals and emerging hazard contexts such as heatwaves. The key challenges identified included unclear leadership, fragmented governance, limited data integration, and weak coordination across human, animal, plant, and environmental sectors. Participants called for a more inclusive and coordinated One Health/Planetary Health approach, supported by stronger governance structures, cross-sector collaboration, and enhanced awareness, education and research.

The first workshop and the Expert Roundtable at Harper Adams University, UK was the first of three. Workshops 2 and 3 will extend the cross-system analysis to further agricultural and animal health contexts, culminating in a modified Delphi consensus round and a planned Global South hybrid workshop that will bring Sri Lankan practitioners together with the global practitioners directly into the process. The series is intended to seed a replicable model, a set of tools and a governance framework that other climate-vulnerable countries with strong agricultural and coastal dependencies could adapt to their own institutional contexts.

A parallel UKRI NERC Global Partnerships Seedcorn proposal, anchored on Cyclone *Ditwah*, has extended this Sri Lanka-UK partnership into a formal Actionable Planetary Health framework. This proposed project, "Systemic Planetary Health Equity and Resilience Endeavour for Sri Lanka (SPHERE-SL) will co-develop, with Sri Lanka's Centre for Planetary Health

(CePH), University of Colombo, a proposed Framework for Planetary Health (FramePH): an empirically validated, equity-centred tool that translates evidence from climate disasters and ecosystem degradation into actionable environmental governance for tropical island states.

Together, these represent a working demonstration, not just an argument, that disaster risk reduction and One Health/Planetary Health can be operationalised jointly.

The scope for growth is substantial. Traditional knowledge integration, human and animal wellbeing in climate-exposed communities, and trust in early-warning systems are all identified gaps ripe for dedicated research attention, several already being scoped as follow-on studies by the UK (Loughborough and Harper Adams Universities)-CePH partnership.

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It is an opportunity to rethink how resilience is designed, from fragmented response towards integrated action, and from reacting to disasters towards reducing the systemic vulnerabilities that allow hazards to become disasters.

As Sri Lanka rebuilds from Cyclone *Ditwah* and looks ahead to future extreme events, the case for treating disaster resilience and community health as a single planning problem, rather than two adjacent ones, has rarely been clearer. The implementation priorities that the UK (Loughborough and Harper Adams Universities)-CePH partnership will continue to explore include:

Policy Alignment - Embedding health metrics and One Health/Planetary Health concepts into national and local disaster risk reduction strategies.

Capacity Building - Strengthening local health systems to manage concurrent crises, such as natural

disasters combined with disease outbreaks.

Building Back Better – Developing mechanisms to restore safer environments and robust infrastructure and future systemic biological risks.

Sri Lanka has an opportunity not only to learn from international disaster-risk and planetary-health research, but also to contribute locally grounded evidence to the development of integrated models of resilience for climate-vulnerable countries.

The next phase should focus on implementation.

Three priorities stand out.

First, policy alignment. Health, disaster risk reduction, climate adaptation, agriculture, animal health, food systems and environmental governance need stronger connections through shared risk assessments, indicators and planning mechanisms.

Second, capacity and coordination. Local authorities and frontline services need the skills, resources, data and institutional relationships required to manage concurrent and cascading crises.

Third, building back better. Recovery should not simply restore what existed before the disaster. It should reduce the vulnerabilities that made the disaster so damaging in the first place. This means stronger infrastructure, safer land-use planning, resilient health services, improved water and waste systems, more resilient food and agricultural systems, and early-warning arrangements that communities understand and trust.

A Different Way of Thinking About Resilience

Cyclone *Ditwah* should not be remembered only as a disaster that Sri Lanka survived.

It should also be understood as a stress test of the systems that determine whether communities can remain healthy, safe and resilient in a changing climate. The lesson is not necessarily that Sri Lanka needs more plans. It is that existing institutions, plans, knowledge and investments need to work together more effectively. One Health and Planetary Health provide a way of structuring

that conversation. The future of disaster resilience will depend not only on our capacity to respond to individual hazards, but on our ability to understand and govern the systems through which hazards become crises. For Sri Lanka, this means placing health within the centre of disaster resilience, recognising ecological integrity as a determinant of health, and treating cross-sector collaboration as an operational principle rather than an aspiration.

The opportunity emerging from *Ditwah* is therefore larger than recovery from one cyclone. It is an opportunity to rethink how resilience is designed, from fragmented response towards integrated action, and from reacting to disasters towards reducing the systemic vulnerabilities that allow hazards to become disasters.

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**Let's be grateful
for everything that
allows us to
stay healthy
and well!**

SLMA Kids Art 2026

For ages from Pre-school to Grade 10
(Each grade is recognized as a category)

Colouring Medium: any medium Paper Size: A4 Paper

Submissions should include:

1. Full name
2. Age
3. Grade
4. School
5. Home address
6. Parent name & contact number (WhatsApp number)

- ★ Drawings need to be certified by Principal or Class Teacher of the child.
- ★ The drawing should not be copied from the internet or any other source.
- ★ One child can submit up to a maximum of 2 drawings.
- ★ All drawings need to be sent ONLY by post or hand delivered to

Sri Lanka Medical Association
No. 6, Wijerama Road, Colombo 07.

Deadline: 30th October 2026

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RESEARCH IN FOCUS

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BEYOND THE 20-MINUTE WHOLE-BLOOD CLOTTING TEST: IMPROVING THE EARLY DIAGNOSIS OF SNAKE ENVENOMING IN SRI LANKA

Introduction

Snakebite envenoming remains a major neglected tropical disease and an important environmental and occupational hazard in tropics and subtropics. It disproportionately affects rural communities, particularly agricultural workers, and causes substantial mortality, disability and socioeconomic consequences. Sri Lanka has one of the highest snakebite burdens globally, with marked geographic variation. The epidemiology has also changed: recent surveys and hospital cohorts indicate that hump-nosed viper bites now constitute a large proportion of snakebites, while Russell's viper, Indian cobra and common krait remain important causes of death. [1,2]

Snake envenoming produces diverse syndromes depending on venom composition and the species involved. Important systemic manifestations include neurotoxicity, myotoxicity, acute kidney injury and, most commonly, haemostatic abnormalities. Venom-induced consumption coagulopathy (VICC) is particularly important following viper envenoming because it can cause spontaneous bleeding, including gastrointestinal, urinary and, rarely, intracranial or pulmonary haemorrhage [3]. Early recognition is therefore critical because antivenom is the cornerstone of treatment and is most useful before irreversible venom-mediated injury develops. [4]

The diagnostic problem

VICC is diagnosed by evidence of coagulopathy in a patient presenting following a snakebite. Laboratory-based international normalised ratio (INR) is the most useful standard laboratory test, with fibrinogen and D-dimer providing additional information. However, these tests are not consistently available in rural and resource-limited settings. Clinicians therefore frequently rely on bedside clotting tests, particularly the 20-minute whole-

blood clotting test (WBCT20). [4,5]

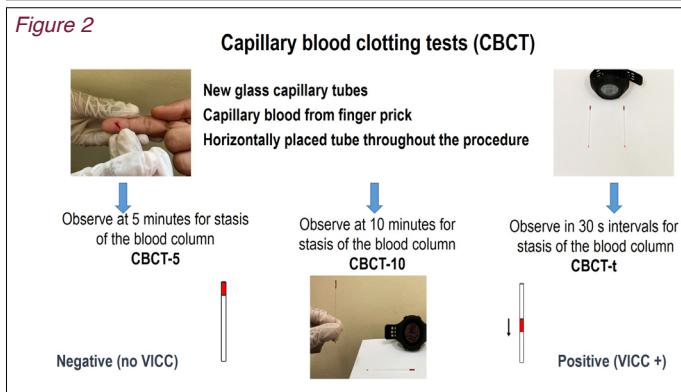
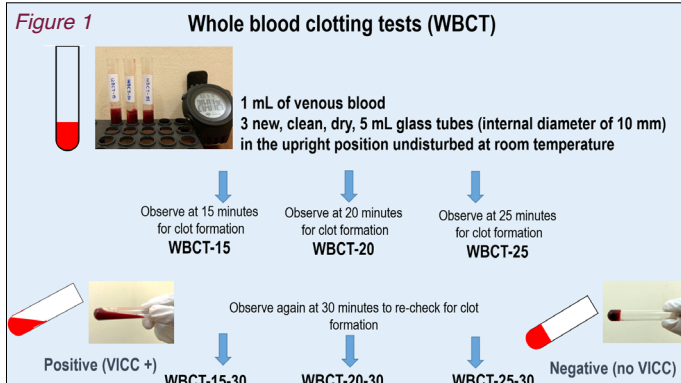
WBCT20 is widely used because it is simple, inexpensive and requires minimal equipment. Fresh venous blood is placed in a clean, dry glass tube and left undisturbed for 20 minutes; failure to clot is considered evidence of VICC. The test has subsequently become embedded in snakebite management practices worldwide. However, widespread use does not necessarily imply adequate validation. Our scoping review of 147 clinical studies found important limitations in the evidence supporting bedside clotting tests. There is no clear scientific basis for the 20-minute threshold, and test performance may be influenced by tube characteristics, blood volume, sampling technique and operator expertise. [5]

The problem is especially relevant as patients reach hospitals earlier than in the past. A patient presenting soon after a bite may have venom exposure but only mild or evolving coagulopathy. If antivenom decisions depend on a positive bedside test, a false-negative result can in fact delay treatment. [6]

Evidence from rural Sri Lanka

These concerns led us to undertake a prospective clinical study at the Emergency Treatment Unit of Teaching Hospital Anuradhapura between July 2020 and June 2021. We recruited 272 adults with confirmed snakebites. On admission, three whole-blood clotting approaches (15, 20 and 25 minutes) and three capillary blood clotting approaches were compared with INR. Venous blood was also collected for fibrinogen, venom-specific assays and biomarker measurements, while clinical manifestations, treatment and outcomes were recorded. [7]

Systemic envenoming was defined by VICC, neurotoxicity or acute kidney injury, while VICC was defined using INR. None of the bedside clotting



tests demonstrated adequate sensitivity for mild VICC. WBCT20 had a sensitivity of only 30.8% for VICC overall, although sensitivity increased to 57.3% for complete VICC. WBCT15 performed somewhat better, with sensitivity of 46.8% for VICC and 68.4% for complete VICC, but remained inadequate as a reliable early diagnostic test. Extending observation beyond 20 minutes did not overcome the problem. [7]

The limitations were particularly evident among patients presenting early, within two hours of the bite and among patients bitten by hump-nosed vipers. Sensitivity was higher for complete VICC, later presentations and Russell's viper envenoming. False-negative bedside tests can delay recognition of systemic envenoming and antivenom administration, potentially increasing the risk of complications such as acute kidney injury. [7]

Our findings also help explain the apparently better performance

reported in previous Sri Lankan studies. A previous study reported WBCT20 sensitivity of approximately 98%, but all 79 patients with VICC had an unrecordable INR of 12, indicating severe coagulopathy. In our Russell's viper subgroup, WBCT20 sensitivity was 51% when performed within two hours of the bite compared with 78% when performed two hours or more after the bite. Thus, WBCT20 appears considerably better at detecting established coagulopathy than early coagulopathy. [7,11]

Can biomarkers detect envenoming earlier?

The limitations of bedside tests prompted evaluation of biomarkers that might identify systemic envenoming before overt coagulopathy or renal injury. In the same cohort, admission serum secretory phospholipase A2 (sPLA2), serum neutrophil gelatinase-associated lipocalin

(sNGAL) and serum clusterin were measured. [8,12]

Among the biomarkers evaluated, sPLA2 showed particular promise as an early predictor of systemic envenoming, especially following Russell's viper bites and in patients presenting early. This is biologically plausible because phospholipase A2 enzymes are important components of many viper venoms. [8]

Renal biomarkers may provide complementary information. Previous Sri Lankan research has evaluated urinary NGAL and urinary clusterin for early identification of venom-associated acute kidney injury, potentially before serum creatinine rises. However, biomarker assays currently require specialised laboratory facilities, trained personnel and financial resources. Their greatest future value may therefore be in the development of inexpensive, rapid point-of-care assays suitable for rural hospitals. [12]

Using clinical sense when laboratory tests fail

Another strategy is to make better use of information already available at the bedside. Non-specific systemic symptoms may precede definitive laboratory abnormalities. In Sri Lanka, abdominal pain, nausea, vomiting and dizziness have been recognised as early manifestations of viper envenoming. We therefore

sensitivity to 88.2%. Therefore, a negative WBCT20 should not be interpreted in isolation, particularly when clinical features suggest envenoming. Where INR is unavailable, combining simple clinical assessment with bedside clotting testing offers a pragmatic approach to identifying patients who might otherwise be missed. [9]

Clinical and policy implications

The key message is not that WBCT20 has no value, but that its limitations must be recognised. A positive WBCT20 is highly specific in the appropriate clinical context, but a negative result—particularly soon after the bite—cannot reliably exclude early or mild VICC. Diagnostic assessment should incorporate the timing of presentation, likely snake species, clinical manifestations and, whenever available, laboratory coagulation testing. [5,7]

Where INR is available, it should be obtained early rather than waiting for WBCT20 to become positive. This is particularly relevant at secondary and tertiary hospitals, where laboratory testing is usually accessible. The findings from this work led to a policy brief advocating admission INR rather than complete reliance on WBCT20; this was submitted to the Snakebite Expert Committee of the Sri Lanka Medical Association for consideration in future guideline revision and

bedside clotting tests have particularly poor performance. Future research should prioritise methods that are sensitive to early and relatively mild haemostatic abnormalities. [7]

Point-of-care INR devices, portable viscoelastic coagulation platforms and validated clinical prediction models are promising approaches. Machine-learning methods may also have a role if they can integrate readily available clinical variables, timing of presentation and simple laboratory parameters into reliable risk scores. At the same time, sPLA2 warrants multicentre validation and translational research aimed at developing an affordable point-of-care assay. [7,8]

No single test is likely to solve the problem. Future diagnosis is therefore likely to integrate clinical phenotyping, bedside coagulation testing, laboratory INR where available and targeted biomarkers, moving beyond rigid dependence on a single historical bedside test. [5,7,8]

Conclusion

The 20-minute whole-blood clotting test has served clinicians for decades because it is simple, inexpensive and accessible. However, evidence from rural Sri Lanka demonstrates that its sensitivity is inadequate for early and mild VICC, particularly among patients presenting soon after a bite. The challenge is not simply to replace WBCT20, but to recognise what it can and cannot tell us. [5,7,11]

A combination of timely INR testing where available, careful assessment of early clinical features, and development of affordable biomarkers and point-of-care technologies offers a more rational path forward. In a setting where patients increasingly reach hospitals early, improving recognition of systemic envenoming before severe coagulopathy or acute kidney injury develops could reduce preventable morbidity and improve the safe and effective use of antivenom. [6,8,9,10]

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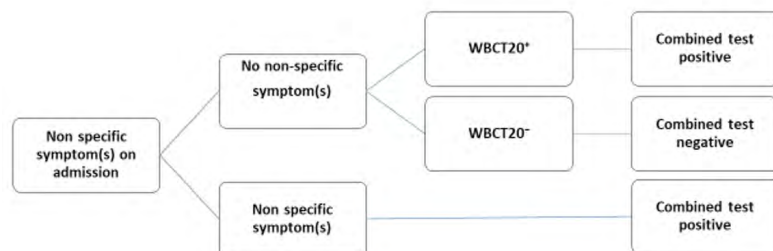


Figure 3

assessed whether clinical features could complement WBCT20. [3,9]

In our Russell's viper study, approximately one-third of patients had abdominal pain, headache or vomiting on admission. Abdominal pain was the most useful individual feature, with a sensitivity of 63.2% and specificity of 87.5% for systemic envenoming. Any non-specific symptom increased sensitivity to 72.1%, although specificity was lower. [9]

More importantly, combining clinical information with WBCT20 improved diagnostic performance. Abdominal pain or a positive WBCT20 increased sensitivity to 82.4%, while considering any non-specific symptom or a positive WBCT20 increased

subsequently published as a lead article in the Ceylon Medical Journal. [10]

Improving diagnosis also has implications for rational antivenom use. Antivenom can be lifesaving, but unnecessary administration exposes patients to potentially serious acute adverse reactions. Conversely, delayed administration in genuine systemic envenoming may allow irreversible venom-mediated injury. Better diagnostics can therefore improve both the safety and effectiveness of antivenom therapy. [4,13,14]

The road ahead

The diagnostic challenge is greatest for hump-nosed viper envenoming, for which existing

VOICES FROM THE PERIPHERY

Dr Ashani Ratnayake

MBBS, MD, FRCA

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BEYOND MEDICATION: NON-PHARMACOLOGICAL STRATEGIES FOR CHRONIC PAIN MANAGEMENT

Chronic pain is best treated through an accurate diagnosis, a shared biopsychosocial understanding and a coordinated plan that restores function - not by medication alone.

Introduction

Pain is one of the commonest reasons for hospital visits, even though chronic pain rarely fits neatly within one clinic or one specialty. In Sri Lanka, a person with persistent back, neck, joint, pelvic or neuropathic pain may first consult a general practitioner or outpatient department, then see an orthopaedic surgeon, neurologist, rheumatologist, rehabilitation physician or rarely a pain physician. The same patient may also receive physiotherapy, seek Ayurvedic or other traditional care, purchase over-the-counter remedies, or follow advice from family and social media. Each provider may address one part of the problem, but the patient may still be left without a single diagnosis, a shared plan or realistic goals.

Physiotherapists, psychologists, nurses, occupational therapists, counsellors and appropriately trained traditional practitioners can make major contributions. The problem is uncoordinated care. Chronic pain is best managed when everyone shares an understanding of the pain mechanism, goals and plan.

Sri Lanka has skilled clinicians and developing pain services, but dedicated multidisciplinary centres remain limited and concentrated in larger hospitals and cities. Many patients travel repeatedly and collect multiple prescriptions without structured rehabilitation. Strategies beyond medication are therefore essential components of care in hospitals, GP practices, physiotherapy units and patients' homes.

From acute pain to chronic pain

Acute pain usually indicates a tissue damage. Tissue injury or inflammation stimulate pain pathways, encouraging the person to limit movements, protect

the affected area and seek help. As healing occurs, the pain disappears. Chronic pain is defined as pain that persists or recurs for more than three months and has different characteristics than acute pain. In some patients, the original disease continues to generate pain, as in osteoarthritis, cancer or inflammatory arthritis. In others, the tissue injury has healed but the nervous system has become more responsive.

Transition from acute to chronic pain involves sensitization of nerves involving pain pathways. Repetitive pain signals will increase the firing of the nerves leading to persistent pain as well as abnormal pain sensations like allodynia and hyperalgesia. This is often accompanied by poor sleep, anxiety, low mood, fear of movement, and isolation. Avoidance then causes weakness and loss of confidence, reinforcing disability. This is not imaginary pain; it is a real change in how the nervous system processes threat and sensation.

Chronic pain may be mainly nociceptive, arising from tissue damage or inflammation; neuropathic, caused by disease or injury of the somatosensory nervous system; or nociplastic, reflecting altered pain processing without sufficient tissue or nerve damage to explain its severity. Many patients have mixed pain. Classification guides a rational combination of physical, psychological and medical therapies.

The first treatment is a proper assessment

Going "Beyond medications" should always follow a proper diagnosis. A clinician must first identify the likely cause, look for red flags and determine whether urgent investigation or specialist referral is needed. New neurological weakness, bladder or bowel dysfunction, fever, unexplained weight loss, cancer history, significant trauma, night pain with systemic illness, or a hot swollen joint should not be managed as routine chronic pain. These need urgent attention.

There should be extensive assessment of chronic pain involving all aspects. Pain score at rest and movements should be documented followed by quality of life and sleep assessments. Aggravating and relieving factors and belief of patient related to pain must be properly addressed. Pain often affects relationships, therefore one should go into depth of the social history exploring social relationships and psychological aspect of chronic pain. It is not uncommon for these patients to be emotional during assessments and therefore one should be ready to spend considerable time with the patient on initial assessment.

In Sri Lanka, patients may move between practitioners with little transfer of information. Psychological distress may be overlooked because of stigma. Long-term use of NSAIDs, sedatives, gabapentinoids, opioids or combined products can cause gastrointestinal, renal, cognitive and dependency-related harm. Travel costs and limited access to physiotherapy or psychology reduce follow-up, while promises of a quick cure compete with gradual rehabilitation.

Non-pharmacological strategies that can make a difference

1. Pain education and supported self-management

Education is an active treatment. Patients should understand that pain and tissue damage are related but not identical, and that gradual movement can be safe even when some discomfort remains. The aim is not to tell a patient to "live with it," but to give them skills to reduce flare-ups, restore function and regain control.

A written plan can include two or three meaningful goals, such as walking to a nearby shop, attending a religious service or returning to gardening. Progress should include function, sleep and participation, not pain intensity alone. Explaining the plan in the patient's preferred language and

involving family can improve adherence.

2. Physiotherapy, movement and graded exercise

Exercise is among the most consistently recommended treatments for many chronic musculoskeletal pain conditions. It improves strength, mobility, cardiovascular fitness, mood, sleep and confidence in movement. The best programme is not necessarily the most sophisticated one; it is the one that is safe, acceptable and continued.

A physiotherapist can identify movement limitations, prescribe strengthening and flexibility work, and teach pacing. Graded activity starts below the level that produces a major flare and increases according to a schedule rather than moment-to-moment pain. Walking, cycling, water-based exercise, yoga or home exercises may be useful. Patients should avoid doing too much on a good day and remaining inactive for several days afterwards.

3. Transcutaneous electrical nerve stimulation

TENS delivers low-voltage electrical impulses through electrodes placed on the skin. It may reduce pain temporarily by modifying transmission of pain signals at spinal level and activating the body's inhibitory systems. Its effects are often greatest during or shortly after use, and responses vary between individuals and conditions. Guidelines do not recommend routine TENS for all chronic primary pain, so it should be offered as a time-limited individual trial rather than an automatic long-term treatment. Practical way is to use it as a trial to see the response and of responding, to use in a regular basis.

A clinician should demonstrate electrode placement, intensity and duration, then assess whether TENS improves activity or sleep. It should not be placed over broken or numb skin or the front of the neck. Patients with implanted electronic devices require specialist advice. Its

purpose is to create a window for movement, not replace rehabilitation.

4. Heat and cold therapy

Heat can reduce muscle spasm, stiffness and guarding and may make stretching or morning activity easier. A warm shower, hot-water bottle wrapped in cloth or reusable heat pack can be applied for about 15 to 20 minutes. Cold may help short-lived inflammatory flare-ups, swelling or pain after activity by reducing local nerve conduction and discomfort. A cold pack should also be wrapped and used for short periods.

Neither method treats the underlying cause. Patients with reduced sensation, neuropathy, poor circulation or fragile skin require caution because injury may occur without warning. They should inspect the skin and stop if there is excessive redness, blistering, numbness or worsening pain.

5. Cognitive behavioural therapy

CBT does not claim that pain is “all in the mind.” It examines how thoughts, emotions and behaviours interact with pain. Catastrophic thoughts such as “movement will permanently damage me” increase fear, muscle tension and avoidance. A therapist helps the patient test these beliefs, develop coping responses, improve problem-solving, plan activity and manage flare-ups.

CBT can be delivered individually, in groups or through guided digital programmes. Where clinical psychologists are unavailable, trained counsellors and other health professionals can incorporate selected components, with specialist referral for severe depression, anxiety, trauma, substance-use problems or suicide risk. Psychological care should be integrated early, not offered only after physical treatments fail.

6. Mindfulness, breathing and relaxation

Mindfulness teaches a person to notice pain, thoughts and emotions without immediately reacting to them. Slow breathing, body scanning and brief meditation can reduce physiological arousal and improve attention, sleep and emotional regulation. These practices may not remove pain, but they can reduce the distress and struggle surrounding it.

Patients can begin with five minutes of slow diaphragmatic breathing twice daily, making the

out-breath slightly longer than the in-breath. A guided recording in the patient’s language may help. Mindfulness is developed through repetition, not a single session during a severe flare.

7. Sleep, pacing and restoration of daily roles

Pain disrupts sleep, and poor sleep increases pain sensitivity. A consistent waking time, reduced caffeine late in the day, less screen exposure before bed, daytime activity and a calm bedtime routine can interrupt this cycle. Long daytime naps and spending prolonged periods in bed may worsen both sleep and physical deconditioning.

Pacing divides difficult activities into manageable periods with planned breaks, followed by gradual increases. It is not permanent avoidance. Returning to household work, employment, study, social life and spiritual activities is itself rehabilitation.

8. Plant and nature based activities

Horticultural or plant-based therapy uses gardening and contact with nature as structured therapeutic activity. Watering plants, preparing soil, growing herbs or vegetables and spending time in green spaces can provide gentle movement, sensory engagement, purpose, attention away from symptoms and social connection. Sri Lanka’s home-garden culture makes this a particularly accessible option. Tasks can be adapted: raised pots for a person who cannot bend, lightweight tools for hand arthritis, shaded morning sessions for heat intolerance, or seated planting for limited mobility.

Evidence for direct analgesia is still developing, so horticultural therapy is an adjunct, not a cure. Its value may lie in mood, coping, participation and meaningful graded activity. Safe lifting, sun protection and prevention of falls, cuts and infection remain important.

9. Pet and animal-assisted activity

Interaction with a suitable animal can reduce loneliness and anxiety, provide comforting touch, create a routine and encourage walking or social engagement. Formal animal-assisted therapy uses a trained animal and handler toward defined clinical goals; simply owning a pet is not the same intervention. Small studies suggest short-term benefits for pain and emotional well-being, but the evidence remains limited.

This approach must match the patient. Allergy, fear, infection risk,

falls, bites, cost and the ability to provide humane care must be considered. Supervised visits or interaction with a familiar family animal may offer benefit without the burden of ownership.

Teaching patients to build their own toolkit

Instead of handing a patient a long list, choose a small starter plan: ten minutes of graded walking five days a week; prescribed exercises; heat before activity if appropriate; five minutes of breathing twice daily; a consistent waking time; and one enjoyable activity. Record sleep, pain interference and one functional goal, then review after two to four weeks.

A flare-up plan may include temporary activity reduction without bed rest, heat or cold, relaxation, gentle movement, safe use of agreed medicines and warning signs for seeking review. This can prevent panic-driven visits and unsafe self-medication.

A practical future for Sri Lanka

Sri Lanka does not need to wait for a large pain institute in every district before improving care. GP-led pain clinics, including private GP practices, could become accessible hubs for early assessment and coordination. The GP can exclude red flags, identify the dominant pain mechanism, review medication, screen sleep and mood, set functional goals and coordinate referral. A linked physiotherapist can lead graded rehabilitation; a psychologist or trained counsellor can provide CBT-based care; nurses can deliver education and follow-up; pharmacists can reduce polypharmacy; and pain specialists, rehabilitation physicians, surgeons or other specialists can review complex cases.

This model can use shared forms, brief team meetings, group education, teleconsultation and functional outcome measures. Public hospitals and professional colleges can support regional training and referral pathways. Dedicated centres remain necessary for complex cases, interventions, education and research, while primary-care networks bring treatment closer to home.

All providers including medical, allied health and traditional healers should know their limits and communicate with each other. Traditional approaches involving movement, massage or relaxation may be incorporated when safety

is not a concern. Patients should disclose herbal products because they may interact with medicines or affect the liver, kidneys or bleeding. Integration means one shared plan, not parallel unrecorded treatments.

Conclusion

Medication remains valuable when it is correctly selected, monitored and combined with treatment of the underlying disease. However, a prescription alone rarely restores sleep, confidence, strength, work or connection. Chronic pain management must begin with an accurate diagnosis and a biopsychosocial understanding, then equip the patient with practical skills.

The most meaningful question is not only, “How severe is your pain today?” but also, “What would you like to return to doing?” When education, movement, psychological support, simple physical measures and purposeful daily activity are brought together, patients can move from repeatedly seeking relief to actively rebuilding their lives. That is the real promise of going beyond medication.

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THROUGH THE LENS OF THE PAST

Dr Murali Vallipurathan

Consultant Community Physician, Ministry of Health
Council Member, SLMA



LEADING BY EXAMPLE: HOW SLMA MOVED AWAY FROM A COLONIAL LEGACY TO A NEW ERA IN PUBLIC HEALTH

There was a time, not too long ago, when a doctor stepping out of a gruelling clinical shift or an intense academic seminar, could walk straight into the Sri Lanka Medical Association (SLMA) very own bar that served alcoholic beverages. Much like other traditional professional associations of the era, operating an in-house bar and serving alcohol was seamlessly woven into the social fabric of collegial networking. It was an accepted organizational norm, punctuated by the long-held cultural belief that “moderate drinking” might even carry certain cardiovascular health benefits.

But medical science evolves, and with it, so must the choices made by the custodians of public health too should move with the times. The SLMA Bar was closed a couple of decades ago but it did not enforce a complete embargo on serving alcohol, even at official functions.

The SLMA has now formally shattered the old *status quo*. A milestone resolution presented at the Annual General Meeting has collated a policy transitioning the association into a completely “dry”, health-first organization. Proposed by Dr Padma S. Gunaratne (Past President) and seconded by Emeritus Professor Saroj Jayasinghe, the resolution mandates that the President and the Council of the SLMA shall completely refrain from serving any form of alcohol at all official functions.⁽¹⁾

While quite a few consecutive SLMA Presidents have quietly practiced this over recent years, this official resolution permanently institutionalizes the policy, firmly positioning the SLMA as a national and regional pioneer.

The Paradigm Shift: From “Moderate Benefit” to Zero Safe Limit

For decades, historical observational data allowed a persistent myth to linger. That was the contention that a casual glass of wine or a moderate daily alcoholic drink could prolong

life or protect the heart. Modern epidemiology and rigorous, large-scale systematic reviews have thoroughly debunked this narrative.

The scientific reality is unambiguous. As explicitly outlined in the resolution, the World Health Organization (WHO) has declared that there is no “safe limit” and that “no level of alcohol consumption is safe” for human health.⁽¹⁾ Alcohol consumption is definitively linked to an array of severe systemic risks, including immediate injuries,

alcohol use disorders (AUDs), liver cirrhosis, and profound cardiovascular disease.⁽¹⁾

Perhaps the most compelling shift in modern consensus lies within oncology. There is a direct, linear, and causal link between alcohol intake and increased cancer risk; specifically along the gastrointestinal tract (GIT), including malignancies of the oral cavity, pharynx, larynx, oesophagus, liver, colon, and rectum. Underscoring this emergency, the US Surgeon General issued an advisory firmly naming alcohol consumption as the third leading preventable cause of cancer.⁽²⁾

As medical professionals, continuing to serve a known

Group 1 Carcinogen at official events while simultaneously treating its devastating public health and clinical fallout in hospitals, creates an undeniable ethical paradox.

Are We Alone? The Global Context

The SLMA’s decisive move mirrors a growing, highly respected, global movement among elite health networks aimed at dismantling entrenched “wet cultures”. While many

commercial entities still struggle to disentangle themselves from alcohol

sponsorships, global medical leaders are drawing a hard line as given below:-

- **The World Heart Federation (WHF):** In a historic policy brief, the WHF aggressively challenged the “moderate drinking is healthy” narrative, actively urging national cardiology societies and medical foundations to advocate for strict domestic controls and push back against normalized alcohol availability.⁽³⁾
- **The World Medical Association (WMA):** Guided by its global health declarations, the WMA actively pressurises national member associations to champion institutional harm-reduction policies, noting that

alcohol cannot be treated as an ordinary consumer commodity.⁽⁴⁾

- **Global Youth Health Organizations (YHO):** Globally, leading health student networks and youth advocacy groups have enacted strict, comprehensive alcohol-free mandates for all official meetings, removing peer pressure and highlighting corporate social responsibility.⁽⁵⁾

Setting the Example for Sri Lanka

By shutting down its historical bar culture and formalizing an absolute ban on alcohol at official functions, the SLMA is executing its true purpose: standing at the absolute forefront to curtail alcohol-related health hazards in Sri Lanka.⁽¹⁾

This resolution is a loud, clear message to all other professional organizations, corporate bodies, and sister medical professional colleges across the island. If the premier medical organization in the country can toast to the future with non-alcoholic beverages, so can everyone else.

The SLMA has set the standard. It is now time for the rest of professional Sri Lanka to follow our lead.

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SLMA IN AUGUST

Highlights

SLMA conducted following 'Saturday Talks' during the month of August with active participation of junior doctors and medical students

- Transient Loss of Consciousness - Speaker: Dr Lanka Wijekoon Senior Lecturer and Honorary Consultant Physician, Department of Medicine, Faculty of Medicine and Allied Sciences, Rajarata University

- Fetal Growth Restriction - Speaker: Dr Achintha Dissanayake Senior Lecturer, University of Sri Jaywardenepura & Consultant Obstetrician & Gynaecologist, Colombo South Teaching Hospital
- Optimising Growth in Infants - Speaker: Prof. Heshan Jayaweera, Professor in Paediatrics, Department of Paediatrics, Faculty of Medicine, University of Peradeniya
- Mood Disorders - Speaker: Dr Rasangi Adicaram, Consultant Psychiatrist & Lecturer, Department of Psychiatry, Faculty of Medicine, University of Peradeniya



Sri Lanka Medical Association
Presents

Saturday Talk Series

Transient Loss of Consciousness

Date : 1st August 2026 | Time : 6.00 pm to 6.45 pm



Speaker
Dr Lanka Wijekoon
Senior Lecturer and Honorary Consultant Physician
Department of Medicine
Faculty of Medicine and Allied Sciences
Rajarata University



Moderator
Dr Nilanka Wickramasinghe
Lecturer, Department of Physiology,
Faculty of Medicine,
University of Colombo



Meeting ID : 889 4301 9379
Passcode : 234913



Meeting ID : 848 8763 2039
Passcode : 553138

Export talk followed by
MCQ Discussion

For more Details : Call 011 269 3324 or Visit www.slma.lk



Sri Lanka Medical Association
Presents

Saturday Talk Series

Fetal Growth Restriction

Date : 8th August 2026 | Time : 6.00 pm to 6.45 pm



Speaker
Dr Achintha Dissanayake
Senior Lecturer,
University of Sri Jaywardenepura
Consultant Obstetrician & Gynaecologist,
Colombo South Teaching Hospital



Moderator
Dr Marius Suranjan
Senior Registrar in Radiology,
National Hospital of Sri Lanka



Meeting ID : 848 8763 2039
Passcode : 553138



Meeting ID : 814 6911 2593
Passcode : 007399

Export talk followed by
MCQ Discussion

For more Details : Call 011 269 3324 or Visit www.slma.lk



Sri Lanka Medical Association
Presents

Saturday Talk Series

Optimising Growth in Infants

Date : 15th August 2026 | Time : 6.00 pm to 6.45 pm



Speaker
Prof. Heshan Jayaweera
Professor in Paediatrics,
Department of Paediatrics,
Faculty of Medicine, University of Peradeniya



Moderator
Dr Arjuna Athapathu
Lecturer,
Consultant Paediatric Nephrologist (Acting),
Faculty of Medicine, University of Kelaniya
Colombo North Teaching Hospital - Ragama



Meeting ID : 814 6911 2593
Passcode : 007399



Meeting ID : 845 4308 8284
Passcode : 925016

Export talk followed by
MCQ Discussion

For more Details : Call 011 269 3324 or Visit www.slma.lk



Sri Lanka Medical Association
Presents

Saturday Talk Series

Mood Disorders

Date : 22nd August 2026 | Time : 6.00 pm to 6.45 pm



Speaker
Dr Rasangi Adicaram
Consultant Psychiatrist,
Lecturer, Department of Psychiatry,
Faculty of Medicine, University of Peradeniya



Moderator
Dr Maheshi Wijayabandara
Specialist in Geriatric Medicine
National Hospital - Kandy



Meeting ID : 845 4308 8284
Passcode : 925016



Meeting ID : 814 6911 2593
Passcode : 007399

Export talk followed by
MCQ Discussion

For more Details : Call 011 269 3324 or Visit www.slma.lk

SLMA IN AUGUST

Highlights

Two Post Congress Sessions of the 139th Anniversary International Medical Congress were successfully concluded in the month of August.

- Airway Management and Oxygen Therapy- Post Congress Workshop
- Update on Sepsis Management; From Early Recognition to ICU Care

Both sessions were highly well-received by a large audience of doctors and postgraduate trainees. The SLMA extends its sincere appreciation to all the expert speakers for their valuable time and contributions to the success of these sessions.



Post Congress Workshop 3

UPDATE ON SEPSIS MANAGEMENT: From Early Recognition to Intensive Care



Date
August 13th 2026



Time
9.30 am – 1.00 pm



Venue
SLMA Auditorium

PROGRAMME SCHEDULE		
09.30 am – 09.40 am	Welcome and Introduction	Dr Manilka Sumanatilleke President, SLMA
09.40 am – 10.20 am	Recognising Sepsis Early – What Every GP Should Know	Dr Indika De Lanerolle Consultant Emergency Physician
10.20 am – 10.50 am	Sepsis Diagnostics Revisited: Integrating Blood Culture & Rapid Multiplex PCR	Dr Nandini Sethuraman Senior Consultant Clinical Microbiologist Apollo Hospitals, Chennai, India
10.50 am – 11.00 am	Tea Break	
11.00 am – 11.30 am	Precision Medicine in Sepsis- Are We Ready for the Next Era?	Dr Pavan Kumar Vecham Senior Consultant in Critical Care Medicine Vijaya Hospitals, Chennai, India
11.30 am – 1.00 pm	Interactive Clinical Case Discussions Multidisciplinary Panel	Dr Nandini Sethuraman Senior Consultant Clinical Microbiologist Apollo Hospitals, Chennai, India Dr Anushka Mudalige Consultant Intensivist Colombo North Teaching Hospital Dr Mahen Kothalawala Consultant Clinical Microbiologist Dr Pavan Kumar Vecham Senior Consultant in Critical Care Medicine Vijaya Hospitals, Chennai, India Dr Dinusha Gayathri Senior Registrar in Critical Care Dr Priyankara Jayawardana Senior Consultant Physician
1.00 pm	Closing Remarks and Lunch	



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SLMA-UNDP: Building a Healthier, Resilient Sri Lanka

SLMA together with the UNDP Sri Lanka, published a Post Session Technical Brief on Strengthening Sri Lanka's Health System Preparedness, Response and Recovery for Complex Disasters and Climate Impacts based on the plenary session at the 139th Anniversary International Medical Conference, 2026. You can access the full report via slma.lk





Sri Lanka Medical Association

Post Congress Workshop 2

Airway Management and Oxygen Therapy



Programme



8.30 AM – 9.15 AM

• **Airway Management**
Dr Vihara Dassanayake
Senior Lecturer in Anaesthesiology,
Department of Anaesthesiology and Critical Care,
Faculty of Medicine, University of Colombo

9.15 AM – 10.00 AM

• **Oxygen Therapy**
Dr Dakshi Jayawickrema
Consultant Anaesthetist
Lady Ridgeway Hospital for Children

10.00 AM – 10.15 AM

• **TEA BREAK**

10.15 AM – 11.45 AM

• **Skills Stations**

- Dr Chaturika Sagara
Senior Registrar in Anaesthesiology, NHSL
- Dr Manuri De Silva
Senior Registrar in Anaesthesiology, NHSL
- Dr Lalith Chandrasiri
Senior Registrar in Anaesthesiology, NHSL
- Dr Nadeeka Thushari
Senior Registrar in Anaesthesiology, NHSL




REGISTER NOW



Scan to Register



Date:
6th August 2026



Time:
8.30 am to 12 noon



Venue:
SLMA Auditorium



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STRENGTHENING SRI LANKA'S HEALTH SYSTEM PREPAREDNESS, RESPONSE AND RECOVERY FOR COMPLEX DISASTERS AND CLIMATE IMPACTS

Health is not merely a recipient of climate and disaster impacts; it must be an active pillar of national resilience

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Published: August 2026
139th Anniversary International Medical Congress
Plenary Framework



POST SESSION TECHNICAL BRIEF

ACHIEVEMENTS OF SLMA MEMBERS

SLMA President and the Council would like to Congratulate Dr Ananda Wijewickrama, Past President of the SLMA (2024) for his appointment as Professor in Medicine, Faculty of Medicine and Mental Health, University of Moratuwa. ▶

SLMA
in AUGUST

SLMA congratulates Prof. Vajira H W Dissanayake, Former President of the SLMA for spearheading efforts which led to the signing of landmark Project Collaboration Agreement (PCA) between University of Colombo, Sri Lanka, and WHO South-East Asia Regional Office to strengthen regional leadership and capacity for AI-enabled precision medicine across the WHO South-East Asia Region.

The PCA was signed by Professor Vajira H.W. Dissanayake, Director, Centre for Health Systems Policy and Innovation, Faculty of Medicine, University of Colombo, and Dr Nilesh Buddha, Officer-in-Charge, WHO South-East Asia Region. ▼





CONGRATULATIONS



Prof. Ananda Wijewickrama

Professor in Medicine

Department of Medicine and Mental Health
Faculty of Medicine,
University of Moratuwa

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The Sri Lanka Medical Association (SLMA) extends its warmest congratulations to **Prof. Ananda Wijewickrama** on his well-deserved appointment as **Professor in Medicine**.
We commend his distinguished contributions to medicine, academic excellence, and clinical practice, and wish him continued success in his academic and professional journey.
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WHO AND UNIVERSITY OF COLOMBO JOIN FORCES TO ADVANCE AI-ENABLED PRECISION MEDICINE

Regional collaboration aims to build leadership, workforce capacity and governance for the responsible use of artificial intelligence, genomics and precision medicine in strengthening Primary Healthcare and Universal Health Coverage

Vidya Jyothi Professor Vajira H. W. Dissanayake

Director, Centre for Health Systems Policy and Innovation

Chair and Senior Professor of Anatomy, Genetics and Biomedical Informatics,

Faculty of Medicine, University of Colombo

Past President, Sri Lanka Medical Association



Prof. Vajira H. W. Dissanayake, Director Centre for Health Systems Policy and Innovation and the Chair and Senior Professor of Anatomy, Genetics and Biomedical Informatics, Faculty of Medicine, University of Colombo exchanging the agreement with Dr. Nilesh Buddha, Officer in Charge, WHO SEARO while Dr. Anil Jasinghe, Secretary, Ministry of Health, Mr. Manoj Jalani – Director Health Systems Development, WHO SEARO and Dr. Karthik Adapa, Regional Advisor for Digital Health and AI, WHO SEARO looks on at the 79th session of the WHO Regional Committee for South-East Asia in Dili, East Timor on 9 September 2026

Recognising the rapidly growing importance of artificial intelligence (AI), genomics and precision medicine in transforming health systems, the World Health Organization (WHO) and the University of Colombo have entered into a Project Collaboration Agreement to strengthen regional leadership and capacity for AI-enabled precision medicine across the WHO South-East Asia Region.

As countries increasingly adopt digital technologies, AI and genomic medicine, the challenge is no longer simply one of acquiring new technologies. Health systems also need trained professionals, capable institutions, appropriate governance arrangements and practical models for translating innovation into better and more equitable healthcare.

The WHO–University of Colombo collaboration seeks to address

these needs by supporting Member States to build workforce readiness, strengthen governance and policy frameworks, develop practical implementation knowledge relevant to low- and middle-income countries, and integrate AI-enabled precision medicine into primary healthcare in ways that contribute to Universal Health Coverage (UHC).

The University of Colombo brings more than two decades of experience in biomedical and health informatics, genomics and precision medicine. It has pioneered postgraduate education in Biomedical and Health Informatics and Clinical Genetics in Sri Lanka, contributed to national and regional digital health development, and undertaken work in AI governance, genomics, health systems innovation and capacity development through partnerships with WHO and other international organisations. The

Centre for Health Systems Policy and Innovation in collaboration with the the Centre for Genetics and Genomics and the Centre for Digital Health and Health AI of the Faculty of Medicine under the leadership of Prof. Vajira H. W. Dissanayake, Chair and Senior Professor of Anatomy, Genetics and Biomedical Informatics would spearhead this collaboration.

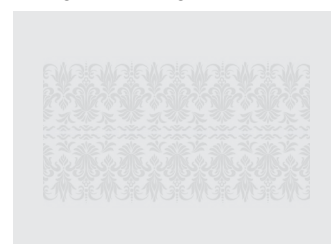
Under the collaboration, WHO and the University will work across **four major areas**.

Building competencies and leadership will be a central priority; **AI governance and health-system readiness; AI-enabled precision medicine within primary healthcare and UHC, and knowledge translation and policy support.**

By strengthening these foundations, WHO and the University of Colombo hope to enable countries in the South-

East Asia Region to move from experimentation with AI and precision medicine towards responsible, evidence-informed and sustainable implementation.

Ultimately, the initiative seeks to ensure that advances in AI, genomics and precision medicine do not remain confined to specialised centres or technologically advanced health systems. Instead, they should contribute to stronger primary healthcare, more personalised prevention and treatment, and equitable progress towards Universal Health Coverage throughout the region.





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