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SLMA Launches the 9<sup>th</sup> Edition of the Guidelines and Information on Vaccine

# The SLMA Monthly

Official Newsletter of the  
Sri Lanka Medical Association

SEPTEMBER 2026

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## STRENGTHENING CURATIVE PRIMARY CARE IN SRI LANKA: A National Priority

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## FROM THE EDITORS



**Dr Lahiru Kodithuwakku**

Co-Editor



**Dr Kumara Mendis**

Co-Editor

This issue of the Sri Lanka Medical Association newsletter focuses on the vital foundation of our health system: Primary Health Care. As Sri Lanka reshapes its primary healthcare framework to meet the evolving demands of our population, a series of articles in this edition emphasizes the need for a holistic approach, one where all relevant stakeholders are actively consulted, and past restructuring efforts are thoroughly studied and understood.

In this edition, we highlight the crucial role of the primary care physician within the curative sector, specifically focusing on the early recognition and management of mental health disorders, Non Communicable Diseases (NCD) and infectious diseases right at the primary care level. Complementing this, our opinion piece addresses a vital aspect of our public health infrastructure by proposing the key paradigm shifts required in Sri Lanka's National Immunization Programme to cater to the healthcare needs of an aging population. Additionally, a seasoned clinician shares insights from decades on the front lines, exploring the delicate yet essential balance between

evidence-based medicine and humanism in daily patient care.

This edition also captures key highlights from the launch of the 9th Edition of the SLMA Guidelines and Information on Vaccines, marking a significant milestone in updating clinical guidelines and vaccine recommendations for practitioners across the island.

It has been an exceptionally busy and productive month for the SLMA. We recently successfully concluded our joint Regional Sessions with the Kurunegala Medical Association. Alongside these sessions, several of our Expert Committees have been actively carrying out key project activities, notably the "Helmet Hero" project led by the Expert Committee on the Prevention of Road Traffic Accidents. Comprehensive coverage and highlights of all these events are featured throughout this issue.

As we navigate these vital shifts in primary healthcare and reflect on our collective work, your insights and engagement remain invaluable. We invite you to read through this issue, and send us your thoughts and feedback.

**The SLMA Monthly**  
Official Newsletter of the Sri Lanka Medical Association

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## COVER STORY

### Dr Kumara Mendis

Co-Editor,  
The SLMA Monthly Magazine



# STRENGTHENING CURATIVE PRIMARY CARE IN SRI LANKA: A NATIONAL PRIORITY

Sri Lanka has long been recognised for its impressive healthcare indicators, including life expectancy and low maternal and infant mortality rates. A major contributor has been the country's well-organised preventive primary healthcare system, developed over several decades. However, **curative primary care (CPC) has not received comparable attention**, resulting in a fragmented system requiring urgent reform.

President Anura Kumara Disasanayake's proposal to establish 1,000 new Arogya primary healthcare centres is therefore welcome. However, their success will depend on understanding how Sri Lankans utilise healthcare services and addressing existing structural weaknesses.

## Understanding Healthcare Utilisation

A study by Withana et al., published in 2025, provides valuable insights into healthcare utilisation in Gampaha District. In a random sample of 1,000 individuals observed over one month, 938 experienced symptoms, 452 sought healthcare, and only 23 required hospital admission. These findings highlight the substantial demand for outpatient care.

Medical officers working in government outpatient departments (OPDs) provide a remarkable service, often managing large numbers of patients within severely constrained consultation times. Appropriate public education on self-care, recognition of warning symptoms, and when to seek medical attention could help reduce unnecessary consultations without compromising patient safety.

According to the 2024 Annual Health Bulletin, government hospitals recorded approximately 55 million OPD visits. Of these, 38% occurred at secondary and tertiary hospitals, while 59% were at primary care institutions, including Divisional Hospitals

and Primary Medical Care Units (PMcUs).

Many patients perceive larger hospitals as providing better care, with easier access to specialists. This perception is understandable and must be addressed by improving the quality, accessibility, and credibility of local CPC services.

## Reorganising Curative Primary Care

Approximately 19% of government OPD visits, representing around 11 million consultations annually, occur at tertiary hospitals. A carefully planned, phased reduction of

Importantly, qualified CPC medical officers should be empowered to refer patients directly to specialists at secondary and tertiary hospitals when clinically indicated, without unnecessary intermediate OPD consultations. Such arrangements would improve continuity of care and strengthen public confidence in primary care practitioners.

## Investing in the Primary Care Workforce

Sri Lanka has approximately 14,000 Grama Niladhari divisions, 544 PMcUs, and 484 Divisional Hospitals. Developing a comprehensive CPC network serving population units of

of General Practitioners of Sri Lanka.

## Recognising the Private Sector

Approximately half of outpatient care is provided by the private sector, much of it outside regular government OPD hours. A considerable proportion is delivered by government medical officers engaged in private practice. Any national CPC strategy must recognise this contribution and explore ways of coordinating public and private services while maintaining quality, affordability, and continuity of care.

## The Way Forward

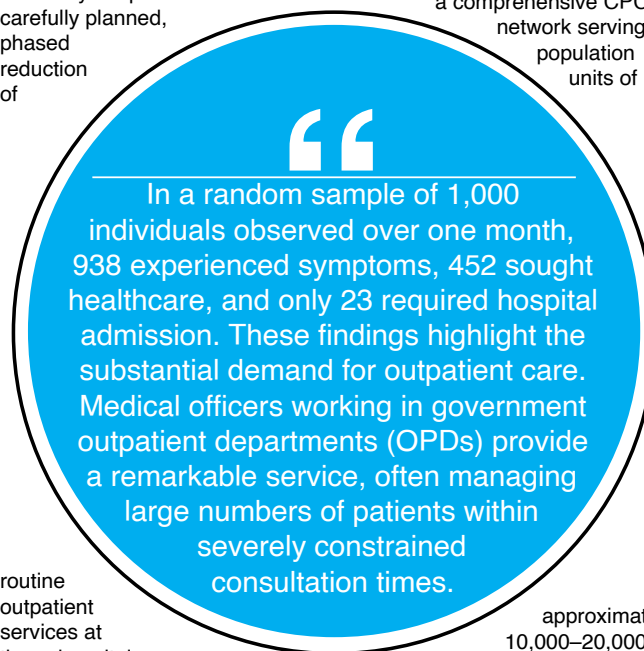
Strengthening CPC requires more than establishing additional healthcare centres. Sri Lanka needs a coordinated national strategy encompassing infrastructure, workforce training, public education, effective referral systems, and a phased reorganisation of tertiary hospital outpatient care.

**The objective should be a trusted, accessible, and professionally competent primary care service that becomes the preferred first point of contact for patients.**

In this edition of the SLMA Newsletter, we present expert perspectives on three conditions commonly encountered in primary care: dengue by Professor Ananda Wijewickrama, depressive disorders by Professor Shehan Williams, and type 2 diabetes mellitus by Dr Chandrika Subasinghe.

## References

1. Withana SS, et al. Ecology of healthcare in an urban and rural area of Gampaha district of Sri Lanka. *BMC Health Serv Res.* 2025;25:1123. <https://doi.org/10.1186/s12913-025-13337-w>
2. World Health Organization. *Sri Lanka Health System Review.* <https://apo.who.int/publications/sri-lanka-health-system-review>



routine outpatient services at these hospitals, with patients redirected to newly established and adequately equipped PMcUs, could substantially reduce congestion and allow specialist institutions to concentrate on patients requiring higher levels of care.

However, establishing new buildings alone will not achieve this objective. CPC centres must have appropriately trained medical officers, nurses and other healthcare staff, essential medicines, basic laboratory facilities, and reliable referral pathways.

approximately 10,000–20,000 people will require substantial investment in workforce development.

More than 2,000 doctors have obtained the Diploma in Family Medicine (DFM). Expanding structured postgraduate training for MBBS-qualified medical officers, particularly through programmes such as the DFM, should be a national priority.

With appropriate government funding, this could be undertaken collaboratively by the Postgraduate Institute of Medicine, Ministry of Health, Sri Lanka College of Specialist Family Physicians, and College

## PRESIDENT'S MESSAGE

**Dr Manilka Sumanatillake**

132<sup>nd</sup> President of Sri Lanka Medical Association



### TRANSFORMING PRIMARY CARE: DRIVING EVIDENCE-BASED AND COMPASSIONATE HEALTH SYSTEM REFORM IN SRI LANKA

Dear Esteemed Members and Colleagues,

It gives me great pleasure to welcome you to this month's edition of the Sri Lanka Medical Association (SLMA) newsletter.

This issue is dedicated to a subject of paramount importance to us all: envisioning and driving the system-wide changes necessary for the future of Sri Lanka's health system. As our nation actively reshapes its primary healthcare structure, we find ourselves at a critical juncture. To build a system that is resilient, accessible, and responsive, our efforts must be rooted in an evidence-based and data-informed approach. Equally crucial is the implementation of a clear, strategic Behaviour Change Communication Plan, one that empowers the health-seeking behavior of our population and fosters trust and acceptance as these transformative changes take root.

In this month's issue, we delve into how primary care can and

must be reoriented to address modern-day public health challenges. Our features highlight practical, ground-level examples, including:

- **Strengthening Primary Care Recognition:**

To address modern-day public health challenges, Sri Lanka must actively reorient its primary healthcare infrastructure. This requires creating advanced, ground-level strategies specifically designed to identify, screen, and manage Non Communicable Diseases (NCD), mental health disorders and emerging infectious diseases at the initial point of care. By prioritizing this, primary healthcare physicians are positioned as the definitive backbone of the curative sector. This first-line defense ensures early clinical intervention, improves patient outcomes, reduces the heavy burden on specialized tertiary hospitals, and establishes a highly responsive medical system.

- **Paradigm Shifts in Immunization:**

The National Immunization Programme has long been a crown jewel of Sri Lanka's public health structure, but it must now evolve alongside demographic changes. As the nation experiences a rapidly aging population, the traditional framework focused primarily on maternal and child health must undergo a strategic paradigm shift. This transition involves expanding national immunization protocols to systematically incorporate adult vaccines, booster schedules, and preventive care tailored to senior citizens. Adapting to these changing life-course requirements is essential to safeguarding public longevity and minimizing age-related epidemiological risks.

- **Evidence-Based Practice & Humanism:**

Modern health system reforms require a deeply compassionate approach to healthcare delivery. Drawing from decades of

collective clinical experience, medical professionals must carefully navigate the intersection of scientific data and clinical empathy. True healthcare transformation cannot rely solely on strict, numbers-driven medical tech or standardized protocols. Instead, it requires a delicate, essential balance where evidence-based medicine directly informs clinical decisions, while humanism ensures that every patient receives dignified, empathetic, and culturally sensitive care.

Reimagining our healthcare landscape requires collective dialogue, shared vision, and active engagement from every member of our medical community. I invite you to read through the articles in this issue, reflect on the insights presented, and share your feedback and perspectives with us.

Thank you for your continued dedication to advancing health and health care in Sri Lanka.





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## OPINION

### Dr Hasitha Tissera

Senior Lecturer, Faculty of Medicine, Sabaragamuwa University of Sri Lanka  
Former Consultant Epidemiologist, Ministry of Health, Sri Lanka



# A PERSPECTIVE: NAVIGATING NATIONAL IMMUNIZATION PROGRAMMES IN THE NEXT TWO DECADES

This opinion piece draws on perspectives presented in a keynote address at the Annual Scientific Sessions of the Vaccines and Infectious Diseases Forum of Sri Lanka (VIDFSL), September 2026

## A successful programme facing a changing world

National immunization programmes (NIPs) rank among the most successful public health interventions of the past half-century. Sri Lanka's Expanded Programme on Immunization (EPI), established in 1978, has evolved into a highly effective national programme, achieving sustained and equitable childhood vaccination coverage and contributing to the elimination or control of several vaccine-preventable diseases. The programme's success reflects decades of political commitment, strong public health infrastructure, dedicated healthcare personnel and, above all, public confidence. However, the demographic and epidemiological realities that shaped its original design are changing fundamentally. Therefore, can an immunization programme designed around the population of the 1970s adequately serve the population of the 2050s?

This question is increasingly relevant as Sri Lanka considers the future direction of its NIP.

## Demographic transition: Rethinking whom we protect

When the EPI was introduced, Sri Lanka had relatively high fertility, a larger birth cohort and a predominantly young population. Universal childhood immunization was therefore a logical and highly effective public health priority. Today, declining fertility, fewer births, increasing longevity and rapid population ageing are transforming the population structure. By 2050, Sri Lanka will have a substantially larger proportion of older people, and the relative share of children will decline significantly (Figure 1).

These changes have important implications for vaccine demand, disease vulnerability and healthcare priorities. Older

populations face greater risks of severe outcomes from certain infectious diseases, particularly in the presence of chronic medical conditions. Meanwhile, advances in vaccine science are creating new opportunities to prevent disease during adolescence, pregnancy, adulthood, and older age.

The demographic transition therefore demands more than periodic adjustments to childhood vaccination schedules. It calls for a broader reconsideration of how immunization programmes are designed, delivered and evaluated.

and older populations on an unprecedented scale. Although implemented under exceptional circumstances, this experience illustrated the potential of existing systems to support vaccination beyond childhood. An important question is how these operational lessons can be translated into sustainable, routine life-course immunization services.

The National Immunization Summit held in March 2025 marked an important step towards systematically reassessing national immunization priorities in response to changing population needs and emerging scientific

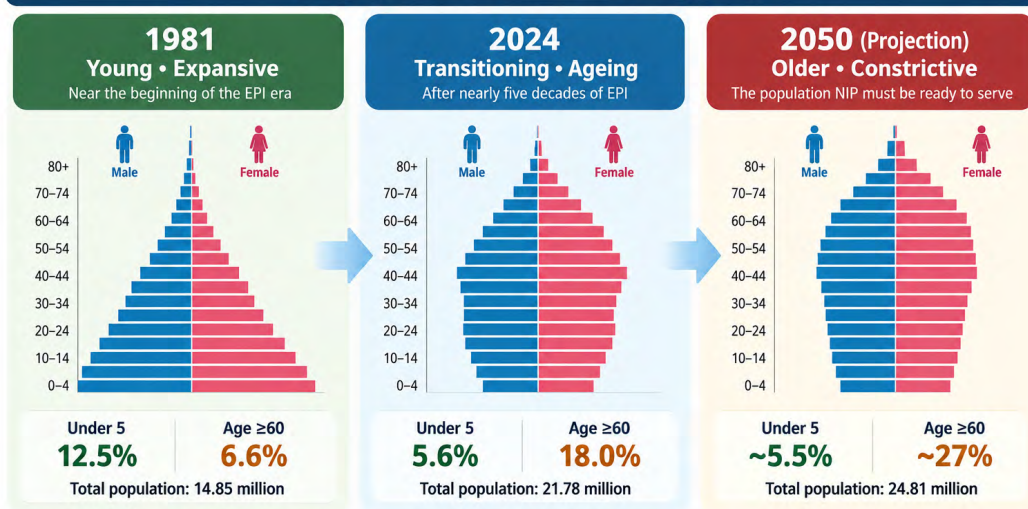
implementation feasibility and financial sustainability. The central lesson was clear: future NIP development should not be driven simply by the availability of new vaccines, but by evidence-informed prioritization of interventions that deliver meaningful population health benefits.

## Five paradigm shifts for the next two decades

The NIP of the future must be about much more than adding vaccines to the existing schedule. It should evolve into a broader, smarter and more resilient

## Sri Lanka's population has fundamentally changed

1981 Census → 2024 Census → 2050 Projection



Under-5s: 12.5% → 5.6% | Older adults (≥60 years): 6.6% → 18.0% → ~27%

Source: UN DESA, World Population Prospects 2024 (medium variant). 2050 is a projection.

## Lessons from COVID-19 and the National Immunization Summit 2025

Sri Lanka's COVID-19 vaccination response showed that the country's established public health infrastructure could rapidly adapt to deliver vaccines to adults

evidence. Its deliberations extended beyond modifications to existing childhood vaccination schedules to consider adolescent and adult boosters, maternal immunization, older populations and potential new vaccines. Importantly, discussions emphasized local disease burden, vaccine performance and safety, cost-effectiveness,

public health platform, extending protection across the life course, demonstrating measurable health impact, integrating vaccination with preventive healthcare, and harnessing data and technology for adaptive decision-making. Ultimately, immunization should contribute not only to disease prevention but also to health promotion and quality of life.

# OPINION

Continued...

**This is not about replacing a successful childhood immunization programme, but building on its achievements and adapting it to changing population needs.** Five interconnected paradigm shifts could guide this evolution (Figure 2).

## 1. From childhood immunization to life-course protection

Childhood vaccination must remain the foundation of the NIP. However, appropriate protection should progressively extend to adolescents, pregnant women, adults, older people and high-risk groups. This approach is consistent with WHO's Immunization Agenda 2030, which promotes vaccination across the life course. The challenge is to establish sustainable delivery arrangements without compromising existing childhood services.

## 2. From coverage to impact

Vaccination coverage has traditionally been the principal measure of programme success. Although essential, coverage alone does not adequately reflect the broader benefits of immunization. Ongoing post-elimination measles outbreaks in Sri Lanka remind us that high national coverage does not eliminate vulnerability. Immunity gaps may persist within particular age groups and communities, as illustrated by recent outbreaks involving young adults as well as young infants. **National coverage averages alone are therefore insufficient to describe population protection.** Future programmes must increasingly assess population immunity and demonstrate reductions in disease incidence, hospitalizations, preventable deaths and health inequities. Strengthened surveillance, laboratory systems and impact evaluations will be essential.

## 3. From vaccines to integrated prevention platforms

Immunization should increasingly become an integral component of broader preventive healthcare. Sri Lanka's ongoing primary healthcare reforms offer opportunities to integrate vaccination with maternal and

immunity gaps and respond to emerging risks. Artificial intelligence may further support forecasting and programme decisions. However, reliable data, appropriate governance, equity safeguards and public trust remain indispensable. Countering misinformation must also become an integral responsibility of modern immunization programmes.

## Are our systems ready for the transition?

These shifts raise an important policy challenge. Are existing governance, financing and service-delivery arrangements sufficiently prepared to support life-course immunization?

Expanding vaccination beyond childhood will require new approaches to programme coordination, sustainable financing, vaccine security, workforce development and information systems. Integration with primary healthcare will be essential, particularly in a resource-constrained setting. Not every available vaccine can or should become part of a universal national schedule. Decisions must balance disease burden, effectiveness, safety, equity, affordability and long-term sustainability. Risk-based approaches may offer greater public health value for selected populations.

Above all, future expansion must preserve the operational discipline, equitable access and public confidence that have underpinned Sri Lanka's childhood immunization achievements.

## Five Paradigm Shifts for National Immunization Programmes

*Navigating Through the Demographic Transition*



“Demographic transition is not just changing who we vaccinate—  
It is redefining the *purpose, design and measurement* of National Immunization Programmes.”

adolescent health services, chronic disease management and healthy ageing initiatives. Rather than creating parallel vaccination structures, existing healthcare platforms could provide accessible and sustainable opportunities for protection throughout life.

## 4. From schedule management to intelligent immunization systems

Traditional NIPs have focused largely on maintaining vaccination schedules, vaccine supply and coverage monitoring. Future programmes must become increasingly adaptive, using digital immunization registries, integrated surveillance and real-time analytics to identify

## 5. From disease control to health promotion and quality of life

The value of immunization extends beyond preventing infectious diseases. Vaccination can contribute to healthy ageing, reduced disability, fewer hospitalizations and improved quality of life. Hepatitis B and human papillomavirus vaccination illustrate how immunization contributes to cancer prevention, bridging traditional communicable and noncommunicable disease agendas. These wider benefits should increasingly inform future immunization policies.

## Protect, realign and future-proof

The demographic transition is not simply changing who we vaccinate. It is redefining the purpose, design and measurement of NIPs. Over the next two decades, Sri Lanka must protect its remarkable childhood immunization achievements, realign programme priorities with changing population needs, and future-proof immunization systems through evidence, innovation, sustainable financing and resilience. The success of yesterday's immunization programme should provide the foundation for tomorrow's—but not necessarily its blueprint.

## FEATURE ARTICLE

### Professor Mandika Wijeyaratne

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## BEYOND EVIDENCE-BASED MEDICINE: RE-BALANCING SCIENCE AND HUMANISM IN HEALTHCARE

I have practised medicine since 1984, paying scant *conscious* attention to patient experience beyond demonstrable clinical outcomes. In the latter stages of my career, I have had more time for conscious reflection, which has resulted in the following article, among other more frivolous aspects of life.

### Medicine has always had two sides

Medicine has always had two inseparable dimensions: science and art.

Like the two sides of a coin, neither can exist meaningfully without the other. Throughout history, however, the balance between them has shifted dramatically.

For most of human history, medicine was predominantly an art embedded in philosophy. Physicians relied on observation, experience, intuition and compassion because scientific knowledge was limited. Diagnosis depended largely on careful listening and clinical judgement, while treatment was based as much on wisdom and experience as on the little formal evidence available.

Fast forward to the 21<sup>st</sup> century and medicine has fundamentally changed. Extraordinary advances in anatomy, physiology, pathology, microbiology, pharmacology, imaging and invasive interventions transformed healthcare into one of the most scientifically rigorous professions. The ability to identify disease accurately, understand its mechanisms, and treat it with evidence-based therapies dramatically improved both measurable survival and quality of life.

Few would argue that this scientific revolution has been anything other than one of humanity's greatest achievements.

Yet every advance brings unintended consequences.

As scientific knowledge expanded, medical education naturally focused on acquiring and applying

that knowledge. Increasingly, success became measured by diagnostic accuracy, technical competence, and adherence to evidence-based guidelines, in the treatment of individuals and populations. The scientific side of medicine flourished, with demonstrable health outcomes reflecting this progress.

The human experience of illness received comparatively less attention.

Today, the challenge is no longer choosing between science and art. It is learning how to integrate both.

### Beyond treating provable disease

Modern medical curricula are rightly built upon three fundamental pillars: understanding pathology, making accurate diagnoses and delivering evidence-based treatment. In recent decades, a fourth pillar has emerged—communication. Medical students are now taught how to explain diagnoses, discuss risks and benefits, obtain informed consent and involve patients in shared decision-making. This represents an important advance in patient-centred care.

However, communication is only part of the solution.

A more fundamental question often remains unasked: **How do physicians positively influence the patient's experience of illness?**

Disease and illness are not identical. Disease describes biological abnormality. Illness describes the patient's lived experience of that abnormality.

Two patients with identical pathology are likely to experience different levels of suffering. One adapts remarkably well; the other becomes overwhelmed by anxiety, uncertainty, and/or loss of identity. Laboratory results and imaging may appear identical, while their emotional and functional realities differ profoundly with immediate and compounding effects on their lives going forward.

Medicine excels at treating disease. It is less systematic in addressing illness.

Perhaps this is the next frontier of clinical practice.

### Why feelings matter

Every illness produces more than physical symptoms. It disrupts the manufactured heuristic of certainty in our lives. It threatens independence. It creates fear of disability, pain, and death. It affects family relationships, employment, finances and future plans.

These experiences are not secondary to illness—they are part of illness.

How patients feel influences adherence to treatment, willingness to undergo procedures, trust in clinicians, recovery and overall quality of life. Emotional distress may amplify symptoms, as well as affect decision-making with what we might professionally classify as negative consequences.

Despite this, medical education devotes relatively little structured discussion and exposure to understanding how patients experience illness, or how clinicians can deliberately influence those experiences in therapeutic ways.

Empathy is encouraged, but is difficult to 'train' as a disciplined clinical skill. Understanding suffering should perhaps receive the same educational emphasis as understanding pathology.

### The paradox of patient expectations

Patients often ask physicians to satisfy conflicting needs.

They want complete honesty but fear hearing bad news. They seek certainty while understanding that biology is inherently uncertain. They wish to participate in decision-making but frequently look to their doctor for guidance. They want realistic expectations without losing hope.

These contradictions are not signs of irrationality. They reflect

the global human experience of vulnerability.

The physician's task is not simply to communicate information but to help patients navigate these competing emotional needs without compromising scientific integrity.

That is the art of medicine.

### Truthfulness vs. Beneficence:

When clinicians realize that emotional states dictate health outcomes, they encounter an immediate ethical dilemma: *How do we address emotional vulnerability without compromising scientific integrity and patient autonomy?*

Clinicians must navigate two fundamental principles

Evidence-based knowledge should never be altered. Its delivery, however, should be personalized.

### Personalising 'truth'

Patients differ in education, health literacy, cultural background, religious beliefs, previous experiences, personality and coping styles – in short, their reality, or personal 'truth', of life. Some want every statistical detail. Others prefer only broad explanations. Some require time before discussing prognosis. Others wish to know everything immediately.

Some don't know what they want. Some may have what turns out to be a deleterious perception of what they want or don't want to know.

Providing identical information in identical language to every patient is neither compassionate nor effective.

Good clinicians adapt their communication while preserving scientific accuracy. Equally important, difficult conversations should not end with diagnosis alone.

Patients should leave consultations understanding not only what has happened but also

# FEATURE ARTICLE

Continued...

what happens next. Even when cure is impossible, there is always something meaningful that can be done, through consultation and/or clinical planning—relieving symptoms, preserving function, supporting families, maintaining dignity or planning future care.

## The Triage of Truth: Strategic Silence and Non-Correction

Clinicians often encounter patients and families who hold non-scientific societal-cultural beliefs about their health. Rather than correcting every inaccuracy, I suggest we “triage the truth”:

Fabricating medical information is unethical and unacceptable.

Misconceptions that directly threaten wellbeing or impair necessary treatments (e.g., special diets and alternative medicine instead of colonoscopy for rectal bleeding) must be systematically corrected using clear, empathetic dialogue.

However, refraining from challenging a comforting, harmless narrative e.g., believing a Vitamin or a specific tea cures a viral cold or that a healed leg ulcer needs a special dressing preserves the therapeutic alliance, while disagreement risks breakdown of rapport and non-compliance with key instructions.

## Clinical Utility and “Medical Theatre”

Patients often expect, or sometimes even request investigations and/or interventions as suggested by friends, relatives, and more recently, children who have migrated overseas, that have little or no scientific justification but appear psychologically reassuring. The situation is further worsened by prior advice from ignorant medical practitioners and AI chat-bots given the wrong prompts.

Examples include requests for imaging and sometimes invasive interventions for long-standing asymptomatic uncomplicated varicose veins in the elderly, non-disabling claudicants, uncomplicated atherosclerosis on extremity and carotid scans, and acute leg swelling from soft-tissue infections, to name a few. This presents an ever-growing ethical dilemma.

Guided by clinical judgment, non-correction of harmless myths,

and intentional low-risk diagnostic procedures serve a vital function. They represent compassionate clinical tools that prioritize beneficence and non-maleficence alongside autonomy.

## “Diagnostic Sedation” and Placebo Mechanisms

A previously healthy 35-year-old feeling unwell for two days and nothing on physical exam is most anxious and demands immediate concrete action: the clinician faces a common choice: Deliver a blunt reassurance, say no tests or drugs are required for now and say to return if symptoms don’t settle in a couple of days. In an era where patients have a choice in the way they are cared for, a more acceptable action plan would be to provide a structured, low-risk plan: rest, take 3 L of fluids daily, and two eggs daily usually serves as a psychological stabilizer.

Today I see healthcare is sliding more and more towards

**Diagnostic Sedation:** Ordering routine blood tests, X-rays or ultrasounds—even when clinically redundant—to provide visual and physical evidence of health. This tangible feedback calms an overactive nervous system more effectively than verbal assurance.

**Therapeutic Placeholders:** Recommending benign vitamins or dietary adjustments fulfill the patient’s expectation of active care, and prevents them from pursuing risky self-medications.

**Visual Care Cues:** Applying simple dressings to healed surgical wounds or offering detailed lifestyle routines provides patients with a sense of control and ongoing care.

**Complementary Pathways:** Safe non-pharmacological routines (mind-body practices, holistic therapies) offer psychological structure, helping patients retain personal agency while undergoing rigorous medical protocols.

## The Economics of Reassurance

Reassurance is not free; it carries measurable financial, systemic, and temporal costs for patients and healthcare systems alike. From the patient’s perspective, paying for a low-yield ultrasound or routine bloods can be a practical trade-off. They are not paying strictly for a diagnosis;

they are paying for **relief from acute anxiety**. If a low-risk test alleviates days of distress, the patient considers it a worthwhile investment in their quality of life.

Clinical environments place high demands on physician time. Deescalating an anxious patient without ordering tests requires substantial emotional energy, patience, advanced communication skills, and 15 to 30 minutes of focused dialogue. Ordering a low-risk scan takes under a minute, satisfies immediate patient expectations, reduces conflict, and provides defensive documentation in litigious environments. Fee-for-service frameworks reimburse diagnostic procedures and physical tasks, not time spent in complex counselling, subtly incentivising technology over conversation.

## The crux: ethical use of reassurance via transparency and informed patient preference

Rejecting every anxiety-driven request may preserve scientific purity but damage the therapeutic relationship. On the other hand, accepting such requests risks unnecessary investigations, incidental findings, increased healthcare costs, and the subsequent medicalisation of ‘normal’ life, and perpetuating this culture. Furthermore, the potential abuse and exploitation of the vulnerable is my real concern. Thus, medical theatre must remain safe, low-risk, intentional and above all, transparent. Physicians should clearly explain when a test or treatment is unlikely to provide meaningful clinical benefit, discuss possible harms, including incidental findings and unnecessary interventions, and clarify the financial implications. Following such disclosure, respecting informed patient preferences must be the only reason for such practices.

## Trust is medicine’s greatest privilege

Society has historically, and still does, endow physicians with extraordinary trust.

Patients disclose their deepest fears, accept invasive procedures, and make life-changing decisions based upon professional advice.

This privilege carries equally extraordinary responsibilities.

However, physicians are also human. They work under time pressures, financial constraints and institutional demands. They are not immune to personal or collective ignorance, unconscious bias, or conflicts of interest.

The knowledge and communication skills that comfort patients can also be misused to justify unnecessary investigations, procedures, or treatments for personal gain.

The safeguards that **must** be selected for and cultivated in medical education and practice are honesty, transparency, accountability and professional **self-reflection** and regulation. The profession must continually examine its own behaviour to maintain public trust rather than waiting for external regulation to do so.

Trust, once lost, is difficult to restore.

## Rethinking medical education in the era of AI

The full impact of AI-assisted medical education and practice is yet to be seen.

AI systems already retrieve evidence, summarise the literature, interpret imaging, recognise diagnostic patterns and assist clinical decision-making with remarkable speed and accuracy. These capabilities will continue to improve and will likely result in at least partly autonomous invasive interventions as well.

If technology increasingly supports access to knowledge, scientific reasoning and treatment delivery, the physician’s unique contribution may increasingly lie elsewhere—in judgement, wisdom, ethical reasoning, compassion, communication, and the ability to help patients live with uncertainty.

This trajectory raises an important educational question.

Should future medical curricula devote relatively more time to cultivating the uniquely human dimensions of medicine alongside contextual analysis and application of AI-generated management protocols?

## SPECIAL ARTICLE

### Professor Shehan Williams

Professor in Psychiatry

Faculty of Medicine, University of Kelaniya



# A PRACTICAL APPROACH TO DIAGNOSIS AND MANAGEMENT OF DEPRESSIVE DISORDER IN PRIMARY CARE

## Introduction

Depressive disorder is a common, potentially disabling mental health condition that is frequently encountered in primary care. It affects emotional well-being, cognition, physical functioning, interpersonal relationships, and occupational performance.

Although effective treatments are available, depression may remain unrecognized because patients often present with physical symptoms, attribute their difficulties to life circumstances, or hesitate to see a mental health professional due to stigma.

Primary care physicians are therefore ideally positioned to identify depressive symptoms, assess their severity, initiate treatment, monitor recovery, and coordinate specialist care when necessary.

## Understanding depressive disorder

Depressive disorder is characterized by persistent low mood, diminished interest or pleasure, and associated emotional, cognitive, physical, and behavioural symptoms that cause clinically significant distress or functional impairment.

It differs from ordinary sadness in its persistence, breadth of symptoms, and impact on daily life. Depression can occur in response to adverse life events, but the presence of an identifiable stressor does not exclude a depressive disorder.

Major depressive disorder may occur as a single episode or recurrent episodes.

Depression may coexist with anxiety disorders, chronic pain, diabetes, cardiovascular disease and other chronic conditions.

The causes are multifactorial. Genetic vulnerability, neurobiological processes, psychological factors, adverse childhood experiences, bereavement, relationship difficulties, financial insecurity,

social isolation and chronic illness may contribute.

These factors interact rather than acting independently. Understanding a patient's circumstances helps the physician develop an individualized treatment plan.

## Recognition of the clinical presentation

Patients may present with psychological symptoms such as sadness, hopelessness, guilt, irritability, loss of motivation, or diminished enjoyment.

Cognitive symptoms include impaired concentration, indecisiveness, negative self-evaluation and recurrent thoughts of death.

Physical symptoms may include fatigue, sleep disturbance, appetite or weight changes, reduced libido, and unexplained aches or pains.

Some patients primarily report headaches, gastrointestinal complaints, dizziness, or persistent fatigue. Others present with poor adherence to treatment for chronic diseases or repeated consultations without a clear physical explanation. These presentations should prompt sensitive exploration of mood without prematurely attributing physical symptoms to psychological causes.

## When to SUSPECT

Primary care physicians should maintain a high index of suspicion in people with a previous depressive episode, chronic medical illness, persistent pain, major life stressors, substance misuse, or significant functional decline.

When depression is suspected, two brief questions can support initial recognition:

- During the past month, have you often felt down, depressed, or hopeless?
- During the past month, have you often had little interest or pleasure in doing things?

A positive response should lead to further clinical assessment rather than an automatic diagnosis. Screening tools are useful when linked to diagnostic evaluation, treatment, and follow-up.

## Diagnostic criteria

The diagnosis of a major depressive episode is based on a clinical interview, using recognized diagnostic criteria such as those in the DSM-5-TR or ICD-11. Symptoms generally need to persist for at least two weeks, represent a change from previous functioning, and cause significant distress or impairment.

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The DSM-5-TR describes nine principal symptom domains:

1. Depressed mood for most of the day.
2. Markedly diminished interest or pleasure in activities.
3. Significant weight loss or gain, or a change in appetite.
4. Insomnia or excessive sleeping.
5. Psychomotor agitation or retardation observable by others.
6. Fatigue or loss of energy.

7. Feelings of worthlessness or excessive or inappropriate guilt.
8. Reduced concentration or ability to make decisions.
9. Recurrent thoughts of death, suicidal ideation, or suicidal behaviour.

At least five symptoms, including depressed mood or loss of interest or pleasure, are generally required for a major depressive episode. Symptoms must not be better explained by substances or another medical condition, and a history suggestive of mania or hypomania requires assessment for bipolar disorder.

These criteria guide diagnosis but should not replace clinical judgment. Symptom duration, severity, cultural context, previous episodes, and functional impairment must all be considered.

## History and mental state examination

A comprehensive assessment should explore symptom onset, duration, progression, precipitating events, sleep, appetite, energy, concentration, self-esteem, daily functioning, and relationships. Ask about previous episodes, past treatment, adherence, treatment response, adverse effects, family history of mood disorders, and any history of elevated or irritable mood with increased energy or reduced need for sleep.

Assess alcohol and other substance use, prescribed medications, recent medication changes, pregnancy-related factors where relevant, and psychosocial stressors.

A mental state examination should document appearance, behaviour, speech, mood, affect, thought processes, thought content, cognition, insight, and judgement.

## Screening tools

Validated instruments can assist with assessment and monitoring. The Patient Health Questionnaire-9 (PHQ-9) is

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commonly used in primary care; the PHQ-2 can be used as an initial screen. However, neither questionnaire establishes the diagnosis independently. The PHQ-9 suicide-related item should prompt direct questioning, regardless of the total score.

## Differential diagnosis and investigations

Important differential diagnoses include bipolar disorder, adjustment disorder, grief, anxiety disorders, post-traumatic stress disorder, substance-induced depressive symptoms, and medication-related mood changes. Physical conditions such as hypothyroidism, anaemia, nutritional deficiencies, sleep disorders, and selected neurological or endocrine disorders may produce similar symptoms.

Investigations should be guided by the history and examination rather than ordered routinely for every patient. Depending on clinical indications, tests may include a full blood count, thyroid function tests, metabolic investigations, or other targeted studies. Consider sleep apnoea, chronic infection, nutritional deficiencies, and medication effects where appropriate.

A diagnosis of depression should not obscure the possibility of co-existing physical disease.

## Assessment of suicide and self-harm risk

Suicide risk assessment is an essential component of every initial depression assessment and should be repeated when clinical circumstances change. Ask directly and compassionately about thoughts of death, suicidal ideation, intent, plans, access to means, previous attempts, recent self-harm, and the person's perceived ability to remain safe.

Explore protective factors, including supportive relationships, reasons for living, willingness to accept help, and access to care. Do not rely solely on a risk score or label a patient as low risk without considering the full clinical context.

Immediate emergency or specialist psychiatric assessment is indicated when there is imminent suicidal intent, a recent serious attempt, inability to maintain safety, severe self-

neglect, psychosis, or another acute psychiatric emergency.

Arrange safe supervision and urgent review by a psychiatrist.

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**Review antidepressant treatment within two to four weeks of initiation, with earlier contact for patients at increased risk. For patients aged 18–25 years or those with particular suicide concerns, a review at approximately one week is recommended by NICE.**

For patients who can be managed outside hospital, develop a collaborative safety plan that identifies warning signs, coping strategies, trusted contacts, professional crisis resources, and steps to reduce access to potentially lethal means.

Arrange close follow-up and involve family or carers with the patient's consent when appropriate. Risk should be reassessed throughout treatment, particularly during periods of deterioration or medication changes.

## Management of depressive disorder

The primary care physician should establish a treatment plan with clear goals, regular review, and arrangements for escalation when necessary.

It is useful to establish whether it is mild, moderate or severe depressive disorder. Studies in primary care settings suggest that around 20% of those with a diagnosis of depressive disorder may have severe depression. The rest are equally divided among mild and moderate.

## Psychological and psychosocial interventions

**Psychoeducation** is an important first step. Explain that depression is a treatable health condition, not

a personal weakness. Discuss expected recovery, treatment options, the importance of follow-up, and the possibility of recurrence.

Encourage patients to identify trusted sources of support and address stigma or misconceptions about mental illness.

For less severe depression, active monitoring may be appropriate when symptoms are improving or the patient does not wish to begin formal treatment.

Provide information, agree on practical self-management measures, and arrange reassessment, usually within two to four weeks. Persistent symptoms, deterioration, or increasing risk should prompt active treatment.

**Psychotherapy** is effective for depression and may be used alone or alongside medication. Cognitive behavioural therapy (CBT) helps patients identify and modify unhelpful patterns of thinking and behaviour.

Behavioural activation encourages gradual re-engagement in meaningful activities and reduces avoidance.

Interpersonal psychotherapy focuses on relationship difficulties, grief, role transitions, and interpersonal conflict.

Lifestyle interventions complement, but do not necessarily replace, formal treatment. Encourage regular physical activity suited to the patient's abilities, consistent sleep routines, balanced nutrition, meaningful daily activities, and gradual social re-engagement.

Address harmful alcohol use and other substance-related problems. Practical support with employment, debt, caregiving, housing, or relationship difficulties may be central to recovery.

## Antidepressant medication

Antidepressants are appropriate for many patients with moderate or severe depression, persistent symptoms, recurrent episodes, or a preference for pharmacological treatment.

They may also be considered when psychological interventions are unavailable or insufficient.

Selective serotonin reuptake inhibitors (SSRIs), such as fluoxetine, sertraline and escitalopram, are commonly used as first-line medications because they are generally well tolerated and have a relatively favourable safety profile.

Other options include serotonin-noradrenaline reuptake inhibitors (SNRIs) like venlafaxine, and other antidepressants like mirtazapine.

Check for a history of mania or hypomania because antidepressant monotherapy may be inappropriate in bipolar disorder.

Start at an appropriate dose. It is best to start low and go slow. Most Sri Lankans are sensitive to antidepressants. Therefore start at the lowest possible dose and adjust according to response, and tolerability.

Meaningful benefit often takes several weeks, and lack of immediate improvement should not automatically be interpreted as treatment failure.

Common adverse effects include gastrointestinal symptoms, headache, sleep disturbance, and sexual dysfunction. Monitor for worsening agitation, emerging suicidal thoughts, symptoms of mania, and clinically important drug interactions. Patients should be advised not to stop treatment abruptly.

Review antidepressant treatment within two to four weeks of initiation, with earlier contact for patients at increased risk. For patients aged 18–25 years or those with particular suicide concerns, a review at approximately one week is recommended by NICE.

## Duration and discontinuation of treatment

Once remission is achieved, antidepressants are generally continued for at least six months, including the period after symptoms have resolved. Longer maintenance treatment may be indicated for recurrent depression,



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# DENGUE AT THE FRONT DOOR: THE CRUCIAL ROLE OF THE PRIMARY CARE DOCTOR

Recognising deterioration early, guiding safe home care and referring the right patient at the right time

Dengue remains one of the most important infectious diseases encountered by doctors in Sri Lanka. Although most patients recover uneventfully, a relatively mild-looking febrile illness can sometimes evolve, first quietly and then rapidly, into plasma leakage, shock, bleeding and organ dysfunction.

Good dengue care does not begin in the intensive care unit—or even in the hospital ward. **It begins at the first medical consultation.**

Doctors in the Primary healthcare (PHC) are often the first clinicians to assess a patient with suspected dengue. Their task extends well beyond making a diagnosis. They must recognise patients at risk, arrange appropriate investigations and follow-up, provide clear instructions for home care, identify the warning signs which suggests possible transition to the critical phase, and refer patients before serious deterioration occurs. They also have an important role in dengue notification, prevention and outbreak control within the community.

### Dengue is a dynamic illness

One of the most important concepts in dengue management is that **the patient's condition today does not necessarily predict the condition tomorrow—or even several hours later.**

Following an incubation period of approximately 3–14 days, symptomatic dengue usually begins abruptly. The illness then progresses through a febrile phase, sometimes a critical phase, and finally a recovery phase. Dengue fever generally progresses directly from the febrile to the recovery phase. Dengue haemorrhagic fever (DHF), however, is characterised by plasma leakage during the critical phase. Plasma leakage in most DHF patients will not cause any significant impact. However, significant plasma leakage, if not recognised and appropriately managed, can result in dengue

shock syndrome and other complications. This can be made worse with associated bleeding, another important feature in DHF, which may not be detected as it is often occult.

This natural history explains why **serial assessment is more valuable than a single snapshot.**

below 5,000/mm<sup>3</sup> and/or thrombocytopenia below 150,000/mm<sup>3</sup> strongly support a diagnosis of dengue in the appropriate clinical setting.

NS1 antigen testing can assist early diagnosis, particularly during the first three days of fever. However, sensitivity varies considerably, and an important

### The most dangerous moment may be when the fever settles

Perhaps the most important message to communicate to patients and families is that **defervescence does not necessarily mean recovery.**

Clinically significant plasma leakage typically occurs around the time the fever settles. A patient may therefore feel worse rather than better at defervescence. A falling platelet count—particularly below 100,000/mm<sup>3</sup>—a rising packed cell volume (PCV), decreasing urine output and ultrasonographic evidence of impending fluid leakage should raise concern about entry into the critical phase.

The critical/leaking phase generally

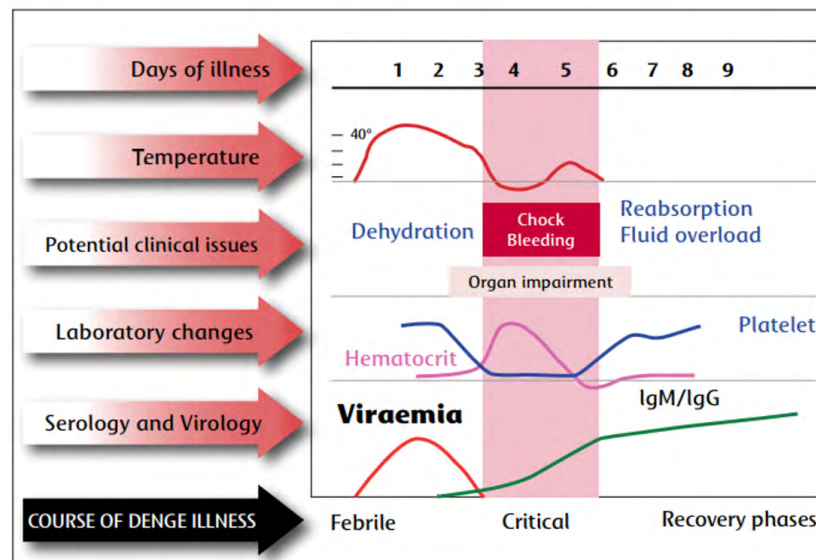
lasts only 24–48 hours, but it is during this relatively short period that major complications can develop. These may be apparent towards the later part of the critical phase or few hours after the critical phase. Significant plasma leakage can lead to shock, while bleeding may further compromise the circulation.

The primary care doctor's challenge is therefore to identify the patient **approaching** this phase rather than waiting for established shock.

### Warning signs should trigger action

Patients and caregivers should receive clear instructions about warning signs and be told to seek immediate medical review if they occur.

Important warning features described in the National guideline



Adapted from WCL Yip, et al. 1980 (28).

Figure: Phases of dengue illness

### The febrile phase: suspect, assess and follow

The febrile phase generally lasts two to seven days. Typical symptoms include high fever, headache, retro-orbital pain, myalgia, arthralgia, nausea or vomiting, facial flushing and rash.

During this stage, distinguishing uncomplicated dengue fever from a patient who will subsequently develop DHF can be difficult. The practical response to this uncertainty is not necessarily to admit every patient, but to ensure **appropriate monitoring and follow-up.**

A full blood count (FBC) is central to this process. Guidelines recommend obtaining the first FBC after completion of 48 hours of fever and repeating it at appropriate intervals. Leucopenia

message for both doctors and patients is:

**A negative NS1 antigen result does not exclude dengue.**

Clinical judgement and follow-up therefore remain essential.

**Probable case (in the endemic setting of Sri Lanka)**

Acute febrile illness with two or more of the following;

- Headache
- Retroorbital pain
- Myalgia
- Arthralgia/bone pain
- Rash
- Haemorrhagic manifestations
- Leucopenia WBC  $\leq$  5000/mm<sup>3</sup>
- Thrombocytopenia (platelet count  $<$  150,000 cells/mm<sup>3</sup>)
- Rising haematocrit (5 – 10%)

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include severe abdominal pain, persistent vomiting, increasing lethargy or restlessness, confusion, reduced or absent urine output for four to six hours, mucosal bleeding, haematemesis, melaena, excessive menstrual bleeding, haematuria and pale, cold or clammy extremities. Deterioration or failure to improve around defervescence is itself important.

Rather than simply telling a patient to “come back if you feel worse”, it is much safer to explain these specific warning features.

## A simple approach at every consultation

Every assessment of a patient with suspected dengue should answer several practical questions:

1. Could this be dengue?
2. Are there warning signs?
3. Is there evidence of plasma leakage?
4. Is the patient haemodynamically stable?
5. Is hydration adequate and is urine output satisfactory?
6. Is there evidence of bleeding?
7. Are there comorbidities or other high-risk circumstances?
8. Can the patient be safely managed at home, or is admission required?

The guideline specifically recommends assessing pulse, blood pressure and capillary refill time, fluid intake, urine output over the preceding 6–8 hours, warning signs, FBC including haematocrit, comorbidities and the patient's access to healthcare.

The last point is sometimes overlooked. A clinically stable patient who lives close to a hospital, understands the warning signs and can return promptly is very different from an apparently similar patient living several hours from medical care.

### Initial assessment

- Making the probable diagnosis of dengue
- Assess the haemodynamic status (pulse rate, blood

pressure, capillary refill time (CRT)

- Adequacy of fluid intake and the urine output for the last 6–8 hours
- Presence/absence of warning signs
- Complete blood count
- Presence of comorbidities and high-risk factors
- Accessibility to healthcare facility

## Who can be managed at home?

According to the National guideline, a clinically stable patient without warning features and with a platelet count above 150,000/mm<sup>3</sup> on a recent test may be considered for outpatient and home-based management.

But “home care” should never mean simply sending the patient home.

It is a **structured management plan**.

Patients should undergo periodic clinical review with documentation of relevant symptoms, signs and serial blood counts. The guideline recommends daily blood counts while the platelet count remains above 150,000/mm<sup>3</sup> and twice-daily assessment once it falls below this level; a rapid fall should prompt consideration of admission.

Patients should generally be followed through the first seven days from onset. Importantly, the disappearance of fever must not be interpreted automatically as recovery because plasma leakage may begin around this time.

## Fluids: enough, but not indiscriminately

Maintaining adequate hydration is a cornerstone of outpatient dengue management.

Patients should be encouraged to take appropriate oral fluids to maintain satisfactory urine output. Fluids containing electrolytes—such as oral rehydration solution, fruit juice, coconut water, kanji or soup—are preferable to plain water. While it is not necessary to fluid each and every hour, even during the night, regular fluid intake spread across the day is important.

Additional fluid replacement may be necessary when vomiting or diarrhoea causes further losses.

Monitoring urine output is particularly useful because a gradual reduction may be an early indication of haemodynamic compromise. When practical, patients or caregivers can record both fluid intake and urine output.

This turns the vague instruction to “drink plenty of fluids” into measurable home monitoring.

*Table 1: the recommended fluid intake to maintain normal urine output*

| Body weight/ Kg | Recommended fluid volume per hour |
|-----------------|-----------------------------------|
| 05              | 20 ml                             |
| 10              | 40 ml                             |
| 20              | 60 ml                             |
| 30              | 70 ml                             |
| 40              | 80 ml (Twice the weight)          |
| 50              | 100 ml (Twice the weight)         |
| >50             | 100 ml (maximum)                  |

*Table 2: Desired urine output*

| Body weight | Urine output for per hour | Urine output for 4 hours |
|-------------|---------------------------|--------------------------|
| 20 kg       | 10 - 20 ml                | 40 - 80 ml               |
| 40 kg       | 20 - 40 ml                | 80 - 160 ml              |
| 60 kg       | 30 - 50 ml                | 120-200 ml               |

## Keep medication simple

For fever, the guideline recommends **paracetamol**, while NSAIDs such as ibuprofen, diclofenac and mefenamic acid should be avoided. Steroids such as dexamethasone and prednisolone should also not be given unless the patient is on long-term steroids.

Particular attention is required for patients already receiving medicines such as aspirin, clopidogrel, warfarin, NSAIDs or steroids. Rather than making an arbitrary decision to continue or discontinue important long-term therapy, appropriate specialist advice should be obtained.

## Do not focus on the platelet count alone

Platelet counts are useful, but dengue management should

never become simply a search for a particular platelet number.

The **trend**, together with PCV, haemodynamic status, urine output and the patient's clinical condition, is much more informative.

A progressive rise in PCV towards 20% above baseline, particularly in association with falling platelets and decreasing urine output, suggests clinically important plasma leakage. Conversely, an unstable patient with a normal or unexpectedly low PCV should raise suspicion of significant bleeding.

## Criteria for admission

- All patients with a platelet count of  $\leq 130,000$  cells/mm<sup>3</sup> (done within the last 4 hours) should be closely and regularly monitored and admitted based on clinical judgement.
- Increase in haematocrit  $>10\%$
- Any patient with warning signs (page 11)
- Following patients may need early admission:
  - pregnant women
  - infants
  - people with comorbidities
  - elderly people
  - adverse social circumstances etc.

This distinction is clinically important because shock in dengue may result from plasma leakage, bleeding, or a combination of both.

## Recognising shock before hypotension

Waiting for hypotension for diagnosing dengue shock is dangerous.

Early features of impending shock include sweating, dizziness, abdominal pain, vomiting, restlessness, altered consciousness, cold extremities, tachycardia, a low-volume pulse and prolonged capillary refill. Narrowing pulse pressure and hypotension indicate more advanced circulatory compromise.



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A patient presenting in shock should be stabilised before transfer. An intravenous line should be secured, appropriate fluid resuscitation commenced according to clinical guidelines, hypoglycaemia identified and corrected where necessary, oxygen administered, and vital signs closely monitored. If facilities permit, blood should be obtained for FBC and PCV before the initial fluid bolus.

The principle is straightforward:

**Recognise early, resuscitate promptly and transfer safely.**

### Referral is a clinical intervention

A good referral is not merely a letter requesting admission.

Probable DHF, suspected significant bleeding and stabilised dengue shock syndrome require transfer for specialised management. The reason for referral, clinical findings,

### The primary care doctor can change the outcome

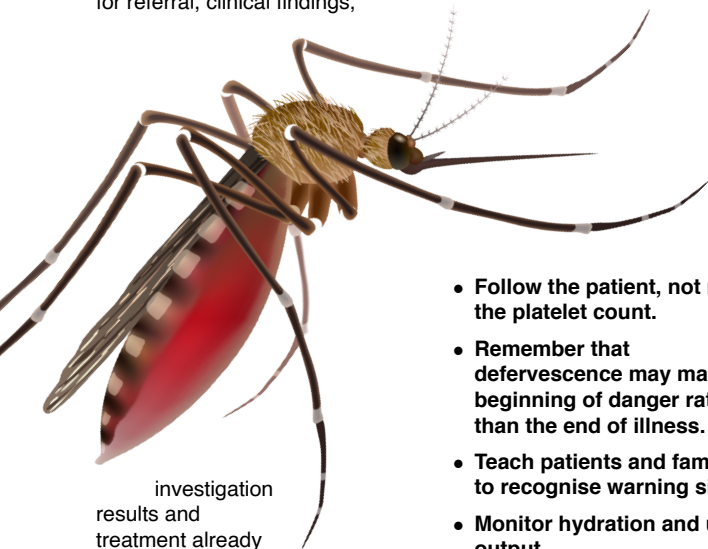
The majority of dengue patients first present before they become critically ill. This creates a valuable window of opportunity.

The PHC doctor who recognises probable dengue, arranges serial assessment, explains warning signs, ensures appropriate hydration, monitors urine output and haematological trends, and refers the patient at the correct time is performing one of the most important interventions in dengue care.

Sophisticated intensive-care treatment can save lives once complications occur. But an equally important achievement is **preventing the patient from reaching that stage.**

The key messages are therefore simple:

- **Suspect dengue early.**



investigation results and treatment already administered should be clearly documented. Whenever possible, the patient's condition should be discussed with the receiving institution before transfer.

This continuity of information can be particularly important when a patient's condition is changing rapidly.

- **Follow the patient, not merely the platelet count.**
- **Remember that defervescence may mark the beginning of danger rather than the end of illness.**
- **Teach patients and families to recognise warning signs.**
- **Monitor hydration and urine output.**
- **Identify plasma leakage, bleeding and shock early.**
- **Refer before deterioration becomes irreversible.**

In a dengue-endemic country such as Sri Lanka, these principles should be part of everyday primary care practice. When applied consistently, good care at the community's first point of medical contact can prevent complications, reduce unnecessary hospital burden and, most importantly, **save lives.**

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residual symptoms, severe previous episodes, or other factors associated with relapse.

Before discontinuation, review the patient's recovery, previous episodes, relapse risk, and preferences. Reduce the dose gradually using an individualized tapering plan.

Explain that withdrawal symptoms can include dizziness, nausea, sleep disturbance, irritability, and sensory disturbances. If symptoms are severe, reconsider the tapering schedule and seek specialist advice when needed.

### Treatment according to severity

The following approach provides a practical framework:

- **Less severe depression:** Consider guided self-help, behavioural activation, psychological therapy, and active monitoring where appropriate.
- **Moderate depression:** Offer an antidepressant, according to clinical need and patient preference.
- **Severe depression:** Consider combined antidepressant medication and structured psychotherapy, with close monitoring and specialist input when indicated.
- **Depression with psychotic symptoms, severe self-neglect, or imminent safety concerns:** Arrange urgent specialist assessment and consider hospital-based treatment.

### Follow-up and monitoring

Regular follow-up is essential because depression may fluctuate, adherence can be difficult, and treatment effects may take time to emerge.

### When to refer for specialist opinion

- Depression during pregnancy and the postpartum period requires careful assessment of maternal well-being, infant safety, treatment history, and the risks and benefits of available therapies.

- Symptoms are severe or complex, psychotic features are present, suicide risk is substantial, or there is significant functional deterioration.
- Depressive symptoms in children and adolescents.
- Bipolar disorder is suspected.
- Treatment-resistant depression, recurrent severe episodes, complex comorbidity, or circumstances requiring treatments not routinely available in primary care such as Electro Convulsive Therapy (ECT) or Transcranial Magnetic Stimulation (TMS).

### Conclusion

Depressive disorder is a common and treatable condition that requires systematic recognition, comprehensive assessment, and individualized management. Primary care physicians play a central role in identifying symptoms, confirming the diagnosis, assessing suicide risk, initiating appropriate psychological or pharmacological treatment and monitoring recovery.

A compassionate therapeutic relationship, shared decision-making, regular follow-up and timely specialist referral are fundamental to good outcomes.

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# VOICES FROM THE PERIPHERY

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## BEYOND HBA1C: RETHINKING TYPE 2 DIABETES CARE IN PRIMARY CARE

### A Person-centered, Holistic, Organ-Protective Approach

Diabetes is one of the fastest-growing global health challenges, especially in low- and middle-income countries. In Sri Lanka, one in five adults has diabetes or prediabetes, and a third of cases are undiagnosed [1]. Type 2 diabetes is no longer a disease of old age: incidence in people aged 15–39 years rose by about 50% globally between 1990 and 2019 [2,3]. Young-onset disease is more aggressive, with faster beta-cell failure, a weaker response to medicines, earlier complications and greater loss of life-years [4–6].

Using the case of a young man with newly diagnosed diabetes, this article outlines a person-centred, organ-protective approach to type 2 diabetes and its associated multiple long-term conditions (MLTCs) in general practice, aligned with the latest international and local guidelines [6–8].

### Case Vignette

Mr OD, a 36-year-old software engineer, attends for a pre-employment medical. He has no symptoms. He sits for long hours, sleeps about five hours a night, smokes five cigarettes a day, and drinks occasionally. His father developed diabetes at 45 and had a myocardial infarction at 52.

| Finding                        | Result                                      |
|--------------------------------|---------------------------------------------|
| BMI / waist                    | 31.2 kg/m <sup>2</sup> / 102 cm             |
| Blood pressure                 | 144/92 mmHg (confirmed)                     |
| Fasting plasma glucose / HbA1c | 192 mg/dL / 9.0%                            |
| Triglycerides / HDL-C / LDL-C  | 248 / 34 / 142 mg/dL                        |
| ALT; liver ultrasound          | 74 U/L; fatty liver                         |
| eGFR / UACR                    | 118 mL/min/1.73 m <sup>2</sup> / 112 mg/g   |
| Examination                    | Acanthosis nigricans; feet and fundi normal |

He has type 2 diabetes with metabolic syndrome, microalbuminuria and MASLD at diagnosis.

### 1. Diagnosing and phenotyping diabetes

Diabetes is diagnosed by HbA1c  $\geq 6.5\%$  (48 mmol/mol), or fasting glucose  $\geq 126$  mg/dL, or 2-hour OGTT glucose  $\geq 200$  mg/dL, or random glucose  $\geq 200$  mg/dL with classic symptoms. Without unequivocal hyperglycaemia, two abnormal results are needed, from two different tests or the same test on two occasions [7].

Diagnosing diabetes is straightforward; confirming the type and phenotype is the real challenge. In a young adult with an atypical phenotype, exclude other types. Consider autoimmune diabetes (type 1 or LADA) in lean patients or those with weight loss or ketosis, and check autoantibodies. Suspect monogenic diabetes (MODY) with onset before age 35, a multigenerational family history, no obesity and negative antibodies, and use the MODY probability calculator before genetic testing. Consider secondary causes such as steroids, antipsychotics, and pancreatitis [6].

*Mr OD has a young-onset, classic insulin-resistant, obese phenotype with MASLD, cardiovascular and kidney risk factors; antibody testing is not essential unless he loses weight rapidly or becomes ketotic.*

### 2. Integrated diagnosis and surveillance for complications and associated multiple long-term conditions (MLTCs)

Every newly diagnosed patient needs structured screening for MLTCs, beyond the conventional microvascular screen, at diagnosis and at regular intervals [6].

| Organ           | Screen at diagnosis                                                                                                                                                            | Red flag                                  |
|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| Heart (ASCVD)   | BP, lipids, ECG, 10-year CV risk, smoking                                                                                                                                      | Established CVD or high risk              |
| Heart failure   | Symptoms, oedema                                                                                                                                                               | If suspected, refer                       |
| Kidney          | eGFR and UACR together                                                                                                                                                         | UACR $>30$ mg/g or eGFR $<60$             |
| Liver           | ALT, FIB-4 score                                                                                                                                                               | FIB-4 $\geq 1.3$ : Fibro scan or referral |
| Eyes            | Retinal photography/ Eye referral                                                                                                                                              | Any retinopathy                           |
| Feet and nerves | Monofilament, pulses, inspection                                                                                                                                               | Loss of sensation, absent pulses          |
| Other           | Sleep apnoea, erectile dysfunction, hypogonadism, PCOS, menstrual irregularity, dental disease, mood and distress, bone health, immunizations, contraception, cancer screening | Ask directly                              |

MASLD affects over 70% of people with type 2 diabetes, and fibrosis of stage F2 or above predicts liver-related, cardiovascular and all-cause mortality [6]. Sleep apnoea is common, and obesity raises the risk of colon, breast and endometrial cancer [6].

Cardiovascular–kidney–metabolic (CKM) staging links these findings into one continuum [9]:

- Stage 0: no risk factors.
- Stage 1: excess or dysfunctional adiposity, prediabetes.
- Stage 2: metabolic risk factors (type 2 diabetes, hypertension, high triglycerides) or CKD.
- Stage 3: subclinical CVD, or very high predicted risk or advanced CKD.
- Stage 4: established CVD (coronary disease, heart failure, stroke, PAD, AF).

*Mr OD is CKM stage 2 with kidney and liver involvement, which makes SGLT2 inhibition and weight-reducing therapy priorities from diagnosis.*

### 3. Personalized lifestyle and behaviour therapy

Intensify lifestyle and behaviour therapy alongside

pharmacotherapy from diagnosis, and revisit it at regular intervals [6,7].

### Medical Nutrition Therapy (MNT):

No single eating pattern suits everyone. Mediterranean, DASH, low-carbohydrate, vegetarian, and intermittent-fasting approaches can all be effective if they are sustainable, although the Mediterranean pattern is preferred for people with ASCVD. Avoid ketogenic diets with an SGLT2 inhibitor [6,7]. The plate method has been widely used in the Sri Lankan context to promote a healthy, balanced diet with smaller rice portions, more vegetables, pulses and fish, and fewer sweetened drinks and bakery snacks.

### Physical activity behaviours:

The management of type 2 diabetes is increasingly guided by a 24 h behavioural approach, in which the five S's (standing, stepping, sweating, strengthening and sleep) provide a practical, framework that brings together daily movement and rest patterns to support cardiometabolic health (6).

# VOICES FROM THE PERIPHERY

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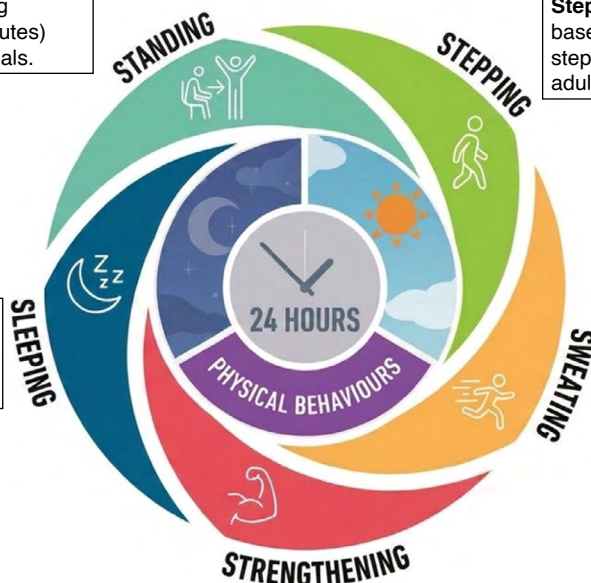
## 24 h behavioural approach framework

**Standing:** break up prolonged sitting regularly (for example, every 30 minutes) with light activity, especially after meals.

**Sleep:** 7–8 hours of good-quality sleep on a regular schedule. Both short (<6 h) and long (>8 h) sleep are associated with higher HbA1c

**Stepping:** add 500–1,000 steps a day from baseline, building towards about 8,000–10,000 steps a day in younger adults (6,000–8,000 in older adults)

**Sweating:** at least 150 minutes a week of moderate-to-vigorous activity (or 75 minutes of vigorous activity), spread over at least 3 days with no more than 2 consecutive days off. Aerobic training lowers HbA1c by about 0.5–0.7%.



**Strengthening:** resistance training 2–3 times a week, covering all major muscle groups. Combined aerobic and resistance training gives the largest HbA1c reduction (about 0.7–0.9%) and helps preserve lean mass.

### Mr OD's lifestyle prescription.

*Nutrition referral; water instead of sweetened drinks; plate model- a smaller rice portion with more vegetables, pulses and fish; a stand-up break every 30 minutes at work and a 30-minute walk after dinner on 5 days a week; two home resistance sessions a week; a fixed 7-hour sleep schedule, with screening for sleep apnoea; stop smoking with counselling; and occasional drinking kept within limits. Set SMART goals and revisit them at each review.*

### 4. Scope for Diabetes remission

Remission, defined as HbA1c below 6.5% (48 mmol/mol) for at least three months off all glucose-lowering drugs [10], is realistic in the first six years and should be discussed with every motivated patient. In DiRECT trial, 46% of people with diabetes for under six years achieved remission at one year on a primary-care low-calorie programme [11]. Predictors for remission are younger age, shorter duration, greater weight loss, no insulin and preserved beta-cell function [6].

### Diabetes remission strategies in practice:

1. A structured very low-calorie diet (VLCD) under supervision by nutrition team
2. Potent weight-loss medicines (semaglutide, tirzepatide)

3. Metabolic surgery: It could be considered from BMI  $\geq 27.5$  kg/m<sup>2</sup> and should be considered from BMI  $\geq 32.5$  kg/m<sup>2</sup> [6].

*Mr. OD is a good candidate for remission, being a young obese T2DM patient, if motivated. It should be emphasized that remission is not equivalent to cure. Regular monitoring for relapse, complications and MLTCs should continue. Relapse is common with weight regain, including after stopping GLP-1-based therapy, so weight maintenance support is essential [6]. Patients who do not achieve remission have not failed, as any degree of weight loss still matters with lasting improvements in glycemic control, cardiometabolic health and organ protection.*

### 5. Initiation and escalation of pharmacotherapy

Pharmacotherapy for T2DM should be selected to achieve intended treatment goals. The choice should take into account each drug's effects on cardiovascular and kidney outcomes, body weight and other relevant comorbidities, as well as hypoglycaemia risk, adverse effects and tolerability, cost and access, and patient preferences. International guidelines recommend starting SGLT2 inhibitors and/or GLP-1-based therapy at diagnosis, independent of HbA1c, for organ protection in

patients with obesity or with high cardiometabolic or kidney risk. [6]. Metformin remains an inexpensive yet effective glucose-lowering agent and is a reliable, cost-effective first-line option in the Sri Lankan setting. Combination therapy (eg: Metformin and SGLT2i or DPP4i) can be considered for initial treatment to shorten time to attainment of individualized glycemic goals.

### Organ-directed choices:

- Heart failure: SGLT2 inhibitor at any ejection fraction; semaglutide or tirzepatide for HFpEF with obesity [6].
- CKD: maximum tolerated ACE inhibitor or ARB plus an SGLT2 inhibitor; add finerenone if UACR stays above 30 mg/g (eGFR above 25); GLP-1-based therapy adds kidney benefit [6,7].
- ASCVD: GLP-1-based therapy with proven benefit or an SGLT2 inhibitor, plus a high-intensity statin [6].
- MASLD/MASH: aim for 5–10% weight loss, using GLP-1-based therapy with proven benefit or pioglitazone; refer F2–F3 fibrosis to a hepatologist [6].
- PAD: semaglutide improves walking distance and limb outcomes [6].
- Sleep apnoea with obesity: tirzepatide or a GLP-1 RA, alongside CPAP [6].

### Safety concerns:

- **SGLT2 inhibitors:** Teach sick-day rules. Stop the drug 3–4 days before planned surgery, and during acute illness or prolonged fasting, because of the risk of euglycaemic diabetic ketoacidosis. Counsel patients about the risk of urinary tract and genital infections.
- **GLP-1-based therapies:** Titrate the dose slowly to minimize gastrointestinal side effects. Perform a baseline retinal examination, and avoid these drugs in patients with a personal or family history of medullary thyroid carcinoma or MEN2. Advise resistance exercise and adequate protein intake to preserve lean body mass [6].
- **Metformin:** Monitor vitamin B12 levels in patients on long-term metformin.
- **Insulin and sulfonylureas:** Hypoglycemia
- **Contraception:** Ensure effective contraception in women of reproductive potential [6].

### A practical sequence for Mr OD:

1. *Start: Metformin, SGLT2 inhibitor, ACE inhibitor or ARB, statin and intensive lifestyle support [6].*

# VOICES FROM THE PERIPHERY

Continued...

2. At 3 months: if weight loss is under 5% or HbA1c is above target,

- Add semaglutide or tirzepatide, where affordable
- Add pioglitazone for persistent fatty liver if there is no heart failure
- Add Sulfonylurea (Gliclazide, Glimepiride) if the cost is the determinant
- Insulin only for marked hyperglycaemia or catabolic symptoms: basal insulin, followed by multiple daily injections

3. Then: consider metabolic surgery if weight and glucose remain uncontrolled

Where GLP-1-based therapy is unaffordable, metformin, a generic SGLT2 inhibitor, ACE inhibitor or ARB, statin and pioglitazone give substantial organ protection; where resources are limited, prioritise the newer drugs for people at the highest absolute risk.

## 6. Monitoring and targets

For a young patient with decades ahead, targets should be tight but safe, and set for every risk factor, not only glucose.

| Parameter                                                   | Target for Mr OD                                | Frequency                                     |
|-------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------|
| HbA1c                                                       | <6.5% (48 mmol/mol) if safe; otherwise <7% (53) | 3-monthly until stable, then 6-monthly        |
| Continuous Glucose Monitoring (CGM) time in range (if used) | >70% at 70–180 mg/dL                            | Each review                                   |
| Blood pressure                                              | <130/80 mmHg (systolic <120 if high risk)       | Every visit                                   |
| LDL-C                                                       | <70 mg/dL; <55 mg/dL if CKM stage 3–4           | 6–12 weeks after starting statin, then yearly |
| Weight                                                      | ≥10–15% loss                                    | Every visit                                   |
| UACR and eGFR                                               | Albuminuria falling or resolved                 | 3–6-monthly while albuminuric                 |
| FIB-4                                                       | Stable or falling                               | Yearly                                        |
| Eyes, feet                                                  | No new disease                                  | Yearly (eyes 1–2-yearly if normal)            |

A lower HbA1c target (6.5% or lower) suits early-onset disease, where the lifetime benefit is greatest and modern drugs carry little hypoglycaemia risk; relax it if insulin or sulfonylureas are used. Weight targets are as essential as glycaemic targets [6]. Avoid therapeutic inertia: reassess every

3–6 months, and intensify or de-intensify as needed [6].

## 7. Diabetes distress: A rarely addressed issue

Diabetes distress, the emotional burden of living with and managing diabetes, is common, distinct from depression, and under-recognized. Distress, depression, stigma and disordered eating are particularly common in early-onset diabetes and undermine self-management [6,7].

Identify diabetes distress by asking “How are you coping with your diabetes?” at every review and screening with DDS-2 or PAID-5, PHQ-2/9 and GAD-2 questionnaires. Manage it with non-judgmental language, small agreed goals, a simpler regimen and peer support [6]. Refer for psychological care if distress is severe or if depression, anxiety or disordered eating is suspected.

## 8. Diabetes self-management education and support (DSMES) and shared care

DSMES is as important as medication, yet it remains underused [6,7]. DSMES is

Always involve the patient and family in shared care for goal setting and treatment decision-making.

## 9. Take-home messages

1. Type 2 diabetes is now a disease of the young; screen adults from 35 years, or earlier with obesity plus another risk factor.
2. Young-onset disease is aggressive: confirm the type and do not “watch and wait”.
3. Screen every organ at diagnosis and stage the patient on the CKM continuum.
4. Protect organs from diagnosis, independent of HbA1c.
5. Aim for remission early: 10–15% weight loss within six years gives the best chance.
6. Set tight but safe targets for HbA1c, BP, LDL-C and weight, and avoid therapeutic inertia.
7. Ask about diabetes distress at every visit.
8. DSMES is as important as medication; involve the family.

Mr OD, one year on, has lost 14 kg on lifestyle measures, metformin, dapagliflozin and semaglutide. His HbA1c is 5.9%,

“

Mr. OD is a good candidate for remission, being a young obese T2DM patient, if motivated. It should be emphasized that remission is not equivalent to cure. Regular monitoring for relapse, complications and MLTCs should continue. Relapse is common with weight regain, including after stopping GLP-1-based therapy, so weight maintenance support is essential.

BP 116/78 mmHg, his albuminuria has resolved and he has stopped smoking. He and his GP are now planning a trial off glucose-lowering drugs, keeping kidney and heart protection in place.

## Conclusion

**Managing type 2 diabetes in Sri Lanka requires a person-centred approach that balances evidence-based therapy with cost, access and patient preferences. Early weight loss makes remission possible. Metformin remains a reliable, low-cost first-line option, while SGLT2 inhibitors and GLP-1-based therapies should be considered early for organ protection in high-risk patients, with careful safety counselling. Self-management education and shared care are as important as medication in achieving treatment goals and preventing or delaying complications.**

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## SPECIAL ARTICLE

### Professor Jennifer Perera

MBBS, MD (Microbiology), MBA, PgD MedEd, PgD Women's Stu, FNASSL, FSLCM  
Emeritus Professor and Past Dean, Faculty of Medicine, University of Colombo



# SLMA LAUNCHES THE 9<sup>TH</sup> EDITION OF THE GUIDELINES AND INFORMATION ON VACCINE

The Sri Lanka Medical Association (SLMA) launched the 9<sup>th</sup> Edition of the **SLMA Guidelines and Information on Vaccines** at a ceremony held on 19 October 2026 at the Lionel Memorial Auditorium of the SLMA. The Deputy Minister of Health graced the occasion as Chief Guest, with Dr Rajesh Pandav and Ms Azusa Kubota, representing the World Health Organization (WHO) and the United Nations Development Programme (UNDP) in Sri Lanka, respectively, attending as special guests. The event brought together healthcare professionals and other stakeholders to celebrate a significant milestone in Sri Lanka's continuing commitment to evidence-based immunisation.

### A Legacy of 26 Years of Professional Commitment

The publication traces its origins to an initiative by Dr Lucian Jayasuriya, a former Additional Secretary of the Ministry of Health and a member of the SLMA's Expert Committee on Communicable Diseases. Recognising the need for nationally relevant guidance on vaccines available outside the National Immunisation Programme (NIP), he joined forces with late Professor Anura Weerasinghe, former Head of Immunology at the Medical Research Institute (MRI) and Professor at the Faculty of Medicine, Rajarata University, to establish a professional reference tailored to Sri Lankan clinical practice.

The first edition, published in 2001 as the **SLMA Guidelines on Non-EPI Vaccines**, comprised 20 chapters authored by seven experts. It addressed an important gap in clinical practice by providing healthcare professionals with locally relevant guidance on vaccines not included in the national programme. Recognising the rapid evolution of vaccinology and the emergence of new vaccines and indications, the SLMA maintained a commitment

to periodic revision and publication.

Over successive editions, the publication expanded its scope and content. The second edition, published in 2004, incorporated both NIP and non-NIP vaccines. For the third edition, Prof Jennifer Perera joined as an editor which was published in 2008, and it adopted the title **SLMA Guidelines and Information on Vaccines**, reflecting its broader role as a source of both practical recommendations and scientific information. The 7<sup>th</sup> edition of the series was dedicated to the late



Professor Anura Weerasinghe, one of the founding editors.

Subsequent editions continued to incorporate new evidence, expert contributions and developments in immunisation practice. The editorial board expanded with addition of Dr Omala Wimalaratne, Dr Geethani Galagoda, Dr Rajiva de Silva as editors. The eighth edition, published in 2023, marked a major expansion, with 40 chapters contributed by 30 subject experts. Its life-course approach addressed vaccination needs beyond childhood and pregnancy, including older adults, people with underlying illnesses and individuals in special clinical circumstances. It also addressed contemporary challenges such as COVID-19, vaccine hesitancy, immunisation during disasters and vaccination for competitive sportspersons.

### The Ninth Edition: Expanding Knowledge and Clinical Guidance

The newly launched ninth edition comprises **498 pages and 41 chapters contributed by 33 experts**.

The current editorial board has been strengthened with



immunisation. She emphasised that the value of these guidelines extends beyond the information contained in the book: they can strengthen clinical confidence, support consistent professional advice and contribute to the prevention of vaccine-preventable diseases.

The ninth edition is dedicated to **Dr Lucian Jayasuriya**, the visionary founder and driving force behind this enduring initiative. Although unable to attend the ceremony due to ill health, he conveyed a message reflecting his continued commitment to the publication. His contribution, together with that of the late Professor Weerasinghe and the many experts who have sustained this work, was warmly acknowledged.

### Available for Healthcare Professionals

The launch celebrated not only a new edition but also more than two and a half decades of professional collaboration and service to public health. The SLMA expresses its sincere appreciation to the editors, chapter authors, reviewers and staff whose contributions have made this publication possible.

**The 9<sup>th</sup> Edition of the SLMA Guidelines and Information on Vaccines is now available for purchase at the SLMA Office at the subsidised price of Rs. 1,000.** Healthcare professionals are encouraged to obtain a copy and use this valuable reference to support informed clinical decisions and promote effective immunisation practices throughout Sri Lanka.

# SLMA IN SEPTEMBER

## Highlights

### High-Level Policy Engagement: National Intercollegiate Committee Convenes

A landmark event of the month was the convening of the National Intercollegiate Committee of the SLMA, co-chaired by the Hon. Deputy Minister of Health, Dr. Hansaka Wijemuni, alongside the President of the SLMA.

The distinguished meeting was graced by Dr. Anil Jasinghe, Secretary to the Ministry of Health, together with the Presidents and Secretaries of leading professional colleges and associations. Discussions focused on crucial policy areas:

- Enhancing the quality of patient care services across all healthcare sectors.
- Streamlining drug procurement processes and ensuring the effective utilization of high-cost medicines.
- Promoting healthy lifestyle choices among the general public to combat the rising burden of non-communicable diseases.



### Expanding Regional Horizons: Joint Regional Meeting in Kurunegala

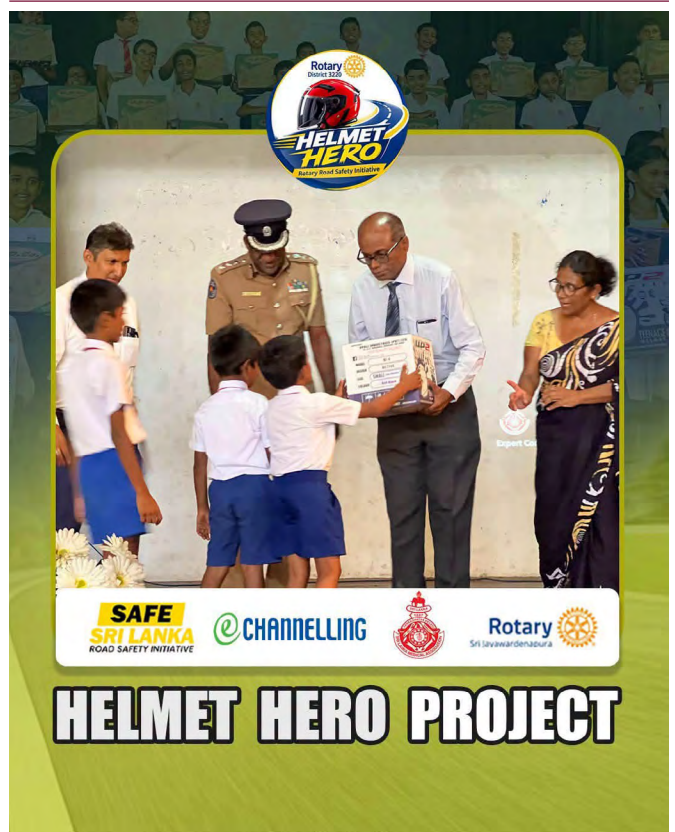
On September 17<sup>th</sup>, the SLMA successfully concluded its Regional Meeting in collaboration with the Kurunegala Clinical Society. Held with the enthusiastic participation of medical professionals from across the Northwestern Province, the event reinforced the SLMA's commitment to bolstering its reach and academic collaboration in key learning centers beyond Colombo.



### Public Health & Safety: The 'Helmet Hero' Project Launch

In line with our commitment to injury prevention, the SLMA, in partnership with the Rotary Club of Sri Jayawardenepura and President's College, Kotte conducted the Helmet Hero Project and Road Safety Programme.

Organized under the auspices of the SLMA Expert Committee on Prevention of Road Traffic Injuries, the initiative featured interactive awareness sessions on road safety and a free helmet distribution drive for school children to enhance their daily commuting safety.



# SLMA IN SEPTEMBER

## Highlights

### Empowering the Next Generation: SLMA Career Guidance Seminar ►

Recognizing the pivotal role of career direction for young practitioners, the SLMA conducted a comprehensive **Career Guidance Seminar** in collaboration with professional colleges across various specialties. Designed specifically for junior medical officers, the session aimed to enhance their understanding of post-internship and postgraduate career pathways, offering valuable insights and mentorship from leaders across different medical disciplines.



# SLMA IN SEPTEMBER

## Highlights

### Continuous Medical Education: Saturday Talks and Monthly Clinical Meetings ▼

- Monthly Clinical Meeting (September 16, 2026): Held in collaboration with The Sri Lanka College of Transfusion Physicians at the SLMA Auditorium, featuring two case-based sessions:
- “Choosing Wisely in Blood Transfusion” was presented by Dr. Trilicia Withanawasam, Consultant Transfusion Physician and

Senior Lecturer in Pathology, General Sir John Kotalawala Defense University and Dr. Sureka Dolamulla, Senior Registrar in Transfusion Medicine.

- “When Maternal Antibodies Harm the Baby” was presented by Dr. Zeena Zanoos Consultant Transfusion Physician, Teaching Hospital Peradeniya and Dr. Nilakshi Colombage Senior Registrar in Transfusion Medicine.



# MONTHLY CLINICAL MEETING

Sri Lanka Medical Association  
In collaboration with  
The Sri Lanka College of Transfusion Physicians

 16th September 2026

 12.30 pm to 1.30 pm

 SLMA Auditorium

 CPD Points and Refreshments will be provided.

## 1.

### “Choosing Wisely in Blood Transfusion”

(Case Based Presentation)



**Dr. Trilicia Withanawasam**  
Consultant Transfusion Physician and Senior Lecturer in Pathology, General Sir John Kotalawala Defense University



**Dr. Sureka Dolamulla**  
Senior Registrar in Transfusion Medicine

## 2.

### “When Maternal Antibodies Harm the Baby”

(Case Discussion)



**Dr. Zeena Zanoos**  
Consultant Transfusion Physician Teaching Hospital Peradeniya



**Dr. Nilakshi Colombage**  
Senior Registrar in Transfusion Medicine

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in SEPTEMBER

# SLMA IN SEPTEMBER

## Highlights

- **Special Update on Asthma:** Dr. Ruwanthi Jayasekara, Specialist in Respiratory Medicine from the Faculty of Medicine, University of Moratuwa, delivered a comprehensive update on modern clinical management strategies for asthma. ▶
- **Approach to Bleeding Disorders (September 12, 2026):** Dr. Wasanthi Wickramasinghe, Consultant Clinical Haematologist and Head of the Department of Pathology and Forensic Medicine at the Faculty of Medicine, University of Moratuwa, delivered an insightful Saturday Talk moderated by Dr. Nipun de Silva, Consultant Endocrinologist and Senior Lecturer at Gen. Sir John Kotelawala Defence University.
- **A Practical Approach to Urinary Problems in Women (September 19, 2026):** Dr. Chinthaka Banagala, Consultant Obstetrician & Gynaecologist at De Soysa Maternity Hospital and National Hospital of Sri Lanka, led another Saturday Talk, moderated by Dr. Marius Suranjan, Senior Registrar in Radiology at the National Hospital of Sri Lanka. ▼

Sri Lanka Medical Association Presents

**Saturday Talk Series**

**Approach to Bleeding Disorders**

Date : 12<sup>th</sup> September 2026 | Time : 6.00 pm to 6.45 pm

**Speaker**  
**Dr Wasanthi Wickramasinghe**  
 Consultant Clinical Haematologist,  
 Lecturer & Head,  
 Department of Pathology and Forensic Medicine,  
 Faculty of Medicine, University of Moratuwa

**Moderator**  
**Dr Nipun de Silva**  
 Consultant Endocrinologist,  
 Senior Lecturer at Faculty of Medicine,  
 General Sir John Kotelawala Defence University

Meeting ID : 875 4521 6382  
 Passcode : 208878

Expert talk followed by MCQ Discussion

For more Details : Call 011 269 3324 or Visit [www.slma.lk](http://www.slma.lk)

Sri Lanka Medical Association Presents

**Saturday Talk Series**

**A Practical Approach to Urinary Problems in Women**

Date : 19<sup>th</sup> September 2026 | Time : 6.00 pm to 6.45 pm

**Speaker**  
**Dr Chinthaka Banagala**  
 Senior Lecturer in Obstetrics & Gynaecology,  
 University of Colombo,  
 Consultant Obstetrician & Gynaecologist,  
 De Soysa Maternity Hospital & National Hospital of Sri Lanka

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

Meeting ID : 863 3569 0658  
 Passcode : 599800

Expert talk followed by MCQ Discussion

For more Details : Call 011 269 3324 or Visit [www.slma.lk](http://www.slma.lk)

Sri Lanka Medical Association

**"Update on Management of Asthma"**

Organized by the Medicinal Drugs Committee of SLMA

**Dr Ruwanthi Jayasekara**  
 MBBS (Colombo), MD, MRCP UK  
 Specialist in Respiratory Medicine  
 Senior Lecturer in Pharmacology  
 Faculty of Medicine,  
 University of Moratuwa

25th September 2026

12.00 noon - 1.30 pm

SLMA Auditorium, 6,  
 Wijerama Mawatha, Colombo 7

Meeting ID: 898 0161 2655  
 Passcode: 809339

0112693324 office@slma.lk www.slma.lk

## Advancing Clinical Sciences: Sleep Symposium

- Recognizing the growing importance of sleep and restorative health, the SLMA partnered with Spa Ceylon and Comfort World to host a dedicated Sleep Symposium. The session brought together clinicians and experts to discuss key developments in sleep science and the clinical management of common sleep disorders. ▼



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