



SLMA NEWS

THE OFFICIAL NEWSLETTER OF THE SRI LANKA MEDICAL ASSOCIATION

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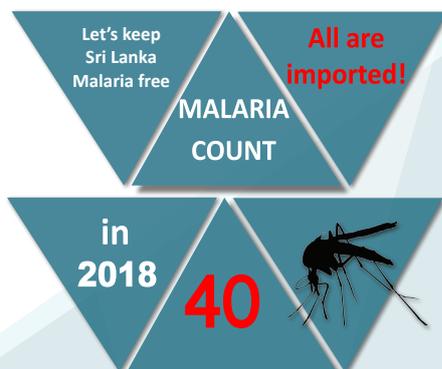
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SLMA Theme 2018

Shifting Focus from
Diseases to Patients:
Today's Vision,
Tomorrow's Reality

OFFICIAL NEWSLETTER OF
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President's Message

Dear Member,

November 2018 began with the country being plunged into deep political uncertainty. This insecurity though political, has permeated through into all our day-to-day lives in a very negative manner. We at the SLMA would like to remind our political leaders of the motto of the SLMA *'Lankadipassa Kiccesu Ma Pamajii'* (to act without delay for the betterment of our nation) and hope they would act as we do at the SLMA to be true to our motto on a daily basis. In keeping with tradition, the SLMA conducted three of our long established regional meetings in Avissawella, Wathupitiwala and Matara in November. It was encouraging to note the enthusiasm for such regional meetings which were of the highest clinical and academic quality among the medical communities in the respective regions. I must confess that the keenness shown by our regional colleagues and members for such Continuous Professional Developmental (CPD) and Continuous Medical Educational (CME) activities was far higher and a lot more appreciated than by those who are based in Colombo and its suburbs. This interest in CPD/CME activities is evidence enough for an organised, well-coordinated, regularized, formal and voluntary CPD/CME programme for the profession throughout the island. As one of the main CPD/CME providers for all grades of doctors both in the state and private sectors in the country, the SLMA has for quite some time been advocating for a national level voluntary CPD/CME programme. Though the medical profession in principle accepts the urgent need for a formalized voluntary CPD/CME delivery mechanism to further improve care delivery for our citizens, there are many grey areas which are causing some degree of apprehension among certain sections of our profession, which is currently holding up the establishment of a national voluntary CPD/CME system. The SLMA will continue to champion the concept of a national voluntary CPD/CME programme with the single-minded objective of further improving the quality

of care received by our citizens and for which they pay for by way of indirect and direct taxes.

Amidst this busy schedule of other commitments, the routine in-house CPD/CME activities carried out at 'Wijerama House' were continued. The Communicable Disease Expert Committee organized two well-attended Symposia on Salmonellosis and Influenza, both of which were very timely and well attended. The Symposium on Influenza was streamed live as a Webinar from the SLMA. The monthly clinical meeting was held in collaboration with the Sri Lanka College of Psychiatrists on the topic 'Understanding medically unexplained symptoms and treatment by psychodynamic approach'. The Therapeutic Update Lecture Series organized by the Medicinal Drugs Committee of the SLMA was delivered by Professor Shalini Sri Ranganathan on the topic 'Prophylactic Use of Antibiotics'. In addition to these routine activities there was a Guest Lecture by Dr. Matthew Quaife, Assistant Professor and Discrete Choice Experiments (DCE), London School of Hygiene and Tropical Medicine, UK on the topic 'What are Discrete Choice Experiments?' May I take the liberty to very briefly explain what DCEs are – They are a health economic tool to understand what influences the choices patients and physicians make. The Guest Lecture enlightened the participants on how DCEs can become useful in practice and policy. The Medicinal Drugs Committee conducted its second training workshop for pharmacy sales assistants in the Gampaha District in collaboration with the Sri Lanka Chamber of Pharmaceutical Industry (SLCPI). The SLMA considers this to be an important activity to improve the knowledge, skills and attitudes in dispensation of pharmaceuticals by pharmacies in Sri Lanka with a view to ensuring patient safety in the dispensation of medicinal product.

All arrangements for the Medical Dance 2018 are now finalized. The Dance is scheduled to be held on Saturday 14th December 2018 at the Shangri La, Colombo. The tickets can now be purchased from the SLMA office.

The Annual General Meeting of the SLMA will be held on Friday 21st December 2018 at the Lionel Memorial Auditorium at the SLMA from 7pm onwards. I invite all members to attend this important meeting as this is the main forum for members to express themselves.

Kind regards

Dr Ruvaiz Haniffa
President
SLMA.

'Up' is a very strange word in the English language!

There is a two-letter word that perhaps has more meanings than any other two-letter word, and that is the word 'up'.

At a meeting, why does a topic come **up**? Why do we speak **up** and why are the officers **up** for election and why is it **up** to the secretary to write **up** a report? We call **up** our friends and we use something to brighten **up** a room, polish **up** the silver; we warm **up** the leftovers and clean **up** the kitchen. We lock **up** the house and some guys fix **up** the old car.

At other times the little word '**up**' has real special meaning.

People stir **up** trouble, line **up** for tickets, work **up** an appetite and think **up** excuses. To be dressed is one thing, but to be dressed **up** is special. A drain must be opened **up** and we open **up** a store in the morning but we close it **up** at night.

We seem to be pretty mixed **up** about **up**! To be knowledgeable about the proper uses of **up**, look the word **up** in the dictionary. In a desk-sized dictionary, it takes **up** almost 1/4th of the page and can add **up** to about thirty definitions.

If you are **up** to it, you might try building **up** a list of the many ways **UP** is used. It will take **up** a lot of your time, but if you don't give **up**, you may wind **up** with a hundred or more.

When it threatens to rain, we say it is clouding **up**. When the sun comes out we say it is clearing **up**. When it rains, it wets the earth and often messes things **up**. When it doesn't rain for a while, things dry **up**.

One could go on and on, but I'll wrap it **up**, for now my time is **up**. So....it is time to shut **up**!

And now it's **up** to you to do **up** your language with this knowledge!

Compiled by Dr. B.J.C.Perera

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Therapeutic Update Lecture Series: Childhood

Meningitis

A lecture on Childhood Meningitis was organised by the Medicinal Drugs Committee of the SLMA as part of the Therapeutic Update Lecture Series, which aims at providing updated

information on therapeutics to post-graduate trainees, House Officers and Senior House Officers. The session was held on 26th October, 2018 at the Professor N. D. W. Lionel Memorial Auditorium,

SLMA, and was chaired by Professor Gita Fernando, Past President, SLMA. The lecture was delivered by Dr. Piyara Ratnayake, Consultant Neurologist, Lady Ridgeway Hospital for Children.



Antivenoms in the Treatment of Neurotoxic Snakebite: Effectiveness and Limitations

A synopsis of the Dr. S. Ramachandran Memorial Oration 2018, delivered at the SLMA 131st Anniversary International Medical Congress, 2018

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Snakebite remains a part of the daily lives of millions of rural, agricultural communities across South and South-East Asia, Sub-Saharan Africa and Latin America¹⁻³. Literature-based estimates suggest that 5 million snakebites, 1.8 million envenomings and 94,000 deaths due to snakebites occur annually across the globe¹. Sri Lanka records one of the highest snakebite incidence rates in the world with the recent community based estimates of 398 snakebites, 151 envenomings and 2.3 deaths per 100,000 population per year⁴. Local effects at the bite site leading to tissue necrosis, venom induced consumption coagulopathy, neuromuscular paralysis and acute kidney injury are the commonest and

most important acute clinical effects of snake envenoming^{3,5-7}. Among many key knowledge gaps, poor understanding of the patho-physiology and the interventions hamper the global combat against snakebite envenomation^{8,9}. Neuromuscular paralysis is a common effect of envenoming by elapids such as Kraits (Genus: Bungarus) and Cobras (Genus: Naja) in Asia and Taipans (Genus: Oxyuranus), tiger snakes (Genus: Notechis) and death adders (Genus: Acanthophis) in Oceania^{7,10}. Some cobra species in Africa and coral snakes (Genus: Micrurus) in Americas are also capable of causing paralysis in humans¹⁰. Snakebite paralysis has classically been described as a 'descending-type paralysis' because of the unique sequence of the muscle involvement, irrespective of the snake species involved in envenoming. The paralysis begins with ptosis and ophthalmoplegia followed by a gradual involvement of facial and neck muscles,

followed by the bulbar and respiratory muscles^{11,12}. The greatest challenge for snakebite victims in the rural tropics is to reach a healthcare facility capable of intubation and mechanical ventilation, before the bulbar and respiratory paralysis compromises survival.

Snake venoms are cocktails of many different toxins with diverse pharmacological properties. Snake venom neurotoxins primarily act on the neuromuscular junction, either acting pre- or post-synaptically, disrupting the neurotransmission across the neuromuscular junction. Pre-synaptic neurotoxins (β -neurotoxins) possess phospholipase A2 activity. These toxins enter the motor nerve terminals and lead to a depletion of acetylcholine vesicles by affecting the recycling of acetylcholine vesicles.

Contd. on page 06

Antivenoms in the...

Subsequently, the motor nerve terminals get structurally damaged 12 hours from the toxin exposure, causing a denervation that is unlikely to be reversed by any therapeutic intervention until the motor nerve recovers naturally over the next 3-5 days¹³. Post-synaptic toxins (α -neurotoxins) bind to the nicotinic acetylcholine receptors in the motor-end plate and antagonize the receptor, causing a neuro-muscular block, similar to the action of non-depolarising neuromuscular blocking agents such as atracurium¹³.

Antivenom: far from being a 'magic bullet'

Antivenom is the only specific treatment available that has become standard practice in the treatment of snakebite over the last 120 years across the globe¹⁴. Antivenoms are polyclonal whole IgG molecules (150kDa) or its fragments such as F(ab')₂ (110kDa) or Fab' (50kDa), raised against one or several snake venoms in animals such as horses and sheep¹³. Their action is primarily by binding with the venom antigens in the circulation to form large venom-antivenom complexes which enables trapping of the toxins within the circulation to facilitate their elimination. If the antivenom molecules are able to disseminate within the circulation, they might be able to reach the neuro-muscular junctions and neutralise the neurotoxins at their target site. However, it is unclear how effectively the large antivenom molecules such as IgG and F(ab')₂ can reach the neuromuscular junctions, compared to their target neurotoxins which are several times smaller. Interestingly, several observational clinical studies conducted across different settings, have observed failure of antivenoms to prevent or reverse the neuro-muscular paralysis in snake envenoming¹⁵⁻¹⁷.

Although antivenom has strongly been established as the standard, specific treatment for treating snake envenoming, its role in treating the neuromuscular paralysis in snakebite has not been explored in-depth. For example, if a patient who has developed paralysis following a common krait (*Bungarus caeruleus*)

envenoming recovers after several days following antivenom; one may not be sure whether the recovery was due to the antivenom and not the natural history of the snakebite paralysis.

Treatment seeking pattern of snakebite victims in Sri Lanka has changed over the years. With Western medicine being increasingly accessible for rural communities along with the improvement of transport facilities in rural areas, the bite-to-hospital time has drastically shortened in Sri Lanka^{11,18,19}. Most patients with neurotoxic snakebites reach the hospital before they develop life-threatening paralysis¹² and some patients present to the hospital even before they develop any paralysis¹¹. With the patients having done their part by seeking treatment without a delay, are we sure that what we give as treatment (antivenom) really works for them or are we actually seeing the natural history of the paralysis? Antivenom

Sri Lanka records one of the highest snakebite incidence rates in the world with the recent community based estimates of 398 snakebites, 151 envenomings and 2.3 deaths per 100,000 population per year

has never been a safe treatment option, particularly in our part of the world²⁰. Do we understand the benefits of antivenom therapy in order to outweigh the risks, to provide the best care for our patients?

Is antivenom therapy for snakebite paralysis based on high quality evidence?

A recent systematic review¹⁰ found no randomized placebo-controlled trials of antivenom for neuromuscular paralysis in

snake envenoming, showcasing a lack of high quality evidence for an intervention that has been in practice across the globe for over a century. The majority of the studies on antivenom for snakebite paralysis were cohort studies and case reports. Hence, the systematic review showed that the current 'knowledge' is largely based on observational studies. It is impossible to conduct fresh randomized placebo-controlled trials of antivenom for paralysis due to the obvious ethical reasons. Hence, observational clinical studies are the way forward in understanding the effectiveness of antivenom for snakebite paralysis.

Efficacy vs. effectiveness of antivenom for snakebite paralysis

There are two pharmacological principles related to antivenom, namely 'efficacy' and 'effectiveness', which are often confused and used interchangeably in the literature. Efficacy of antivenom is the ability of antivenom molecules to bind with the venom toxin antigens under optimal conditions. Ideally, efficacious antivenoms contain antibodies for all types of toxins in homologous snake venoms, in high concentrations. Poor efficacy of an antivenom might be due either to antivenom simply not having antibodies against certain toxins or not having the antibodies in adequate concentrations. The effectiveness is the ability of antivenom to cause clinically measurable improvement in the patients. Poor efficacy of antivenom can lead to insufficient neutralization of venom antigens thus leading to poor effectiveness. However, poor effectiveness may be observed even in the case of highly efficacious antivenoms, purely because of the irreversible injury at the neuromuscular junction caused by the neurotoxins, such as in the case of pre-synaptic neurotoxins.

The long established, standard laboratory assay recommended by the World Health Organisation for testing antivenom efficacy is the rodent lethality prevention test²¹. This test calculates the median effective dose (ED₅₀), which is the median antivenom dose that could prevent

Antivenoms in the...

50% of deaths in rodents injected with 5 times the median lethal dose (LD_{50}) of the venom. However, experiments on the efficacy of Indian polyvalent antivenom against four major Sri Lankan venomous snakes revealed that the WHO recommended lethality prevention assay (ED_{50}) is inconsistent and the prevention of rodent death is unlikely to be a measure of the relevant efficacy outcome for humans²². Further recent molecular pharmacology work demonstrated that some snake toxins that are lethal to laboratory rodents may not be clinically relevant to humans, questioning the validity of these efficacy tests²³.

After snakebite, the venom toxins are gradually absorbed into the circulation from the bite site and the neurotoxins distribute from the circulation to the neuromuscular junctions. When the patient receives antivenom, depending on the efficacy as well as the dose of antivenom, the antivenom molecules bind with the circulating venom antigens. When a snakebite patient with neuromuscular paralysis was treated with antivenom, and no apparent clinical improvement was detected, one of the most important questions that come to the physician's mind is whether he or she has given enough antivenom to the patient. This doubt may lead to a decision to repeat the antivenom.

Antivenom is efficacious but ineffective for treating paralysis in Indian krait and Russell's viper envenoming.

In an observational study conducted in Anuradhapura, 25 of 33 common krait bite patients developed neurotoxicity¹². Seventeen of them developed respiratory paralysis by seven hours of the bite, despite patients receiving 20 vials of Indian polyvalent antivenom at a median of 3.5 hours from the bite. Among the patients with mild neurotoxicity on admission after common krait envenoming, the sfEMG showed markedly high jitter and blocks in patients who later developed life threatening paralysis compared to those who later did not

progress to life threatening paralysis¹². sfEMG abnormalities corresponded well with the clinical picture of the common krait bite patients. Although all patients with common krait envenoming had no clinically detectable paralysis on discharge from the ward, the sfEMG still showed prolonged jitter and blocks, which lasted for even 6 weeks in some patients, indicating a more prolonged recovery. However, at 6 months, no neurophysiological abnormalities were detected in patients, suggesting the occurrence of complete recovery.

Both clinical and neurophysiological evidences from the above study suggested that the antivenom was unable to prevent or reverse the neuromuscular paralysis in common krait envenoming. After the first dose of 20 vials of Indian polyvalent antivenom, the circulating free venom was immediately undetectable in all patients indicating that the 20 vials of antivenom is sufficient for efficacious binding of circulating antivenom molecules with the venom antigens. However, as evident from sfEMG and the clinical picture, efficacious binding of antivenom with venom antigens did not prevent life threatening paralysis as a certainty. In simpler terms, the antivenom has cleared venom from the circulation, but there was no apparent response at the neuromuscular junction. In pharmacological terms, the antivenom was efficacious but ineffective. However, the antivenom therapy was certainly beneficial since the free venom was cleared from the circulation, preventing possible further damage of the neuromuscular junctions. Furthermore, this study provided evidence that the routine 20-vial Indian polyvalent antivenom dose is sufficient for efficacious binding of the circulating venom antigens; hence no repeated antivenom doses are required for treating paralysis. In contrast, Russell's viper envenoming led to neuromuscular paralysis limited to ptosis and ophthalmoplegia in 130 of 245 (53%) patients¹¹. Unlike in common krait bite patients, the jitter abnormalities were mild in the Russell's viper bite patients with paralysis. All patients with neurotoxicity received the dose of

antivenom at a median of 3.75 hours of the bite. On admission, 52 patients had no clinically detectable paralysis and 31 of them developed paralysis within eight hours of receiving antivenom despite the antivenom having promptly cleared the free venom from the circulation. No life-threatening paralysis was observed and the paralysis resolved in 80% of the patients within 3 days. This showed that the paralysis in Russell's viper envenoming is mild, yet refractory to antivenom.

The patho-physiological explanation for the failure of antivenom is the action of β -neurotoxins in the snake venom. It could be assumed that the motor-nerve terminal damage by the pre-synaptic neurotoxins had already begun before the antivenom therapy was instituted. Hence the antivenom was ineffective for treating paralysis in common krait envenoming. Once the pre-synaptic neurotoxins enter the motor nerve terminal and initiate the irreversible damage structurally, it would be impossible for the antivenom to reverse the nerve terminal damage.

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Call for Nominations for Election to the SLMA Council 2019

Dear members,

I hereby call for nominations for the posts of Council Members (20 positions) of the Sri Lanka Medical Association in 2019. Nomination Form for Election to the SLMA Council – 2019 can be obtained from the SLMA office, or downloaded from the SLMA web site.

Eligibility and other details regarding submission of nominations

- The nominee should be a member of the Sri Lanka Medical Association
- Each nomination should be proposed and seconded by a member eligible to vote and shall bear the candidate's name and signature confirming his/her willingness to be so nominated.
- Members who have obtained a registerable medical degree within 10 years preceding the date of such election is eligible for less than 10 years category. (Maximum of 04 positions only)
- Members from outside the Western Province are encouraged to apply for council positions.
- The Council shall verify the accuracy of the information supplied.

For any further details, please contact the SLMA office.

Thank you,
Sincerely,

Dr. Hasini Banneheke
Honorary General Secretary
Sri Lanka Medical Association

The duly completed Application Form should reach Dr. Hasini Banneheke, Honorary Secretary, No. 06, Wijerama Mawatha, Colombo 07 by post or delivered by hand on or before 14th December 2018 4.00pm. Please remember to send a soft copy to office@slma.lk.

The AGM will be held on 21st December 2018 at 7.00pm in the Professor N. D. W. Lionel Memorial Auditorium of the Sri Lanka Medical Association.

Doctors' Ability To Deal With Cultural Issues: A Need Of The Day

Prof. Madawa Chandratilake
 Department of Medical Education
 Faculty of Medicine
 University of Kelaniya

Doctors in Sri Lanka come across various culture-related issues in providing patient care. On very rare occasions, such issues may be 'dramatic like for example, refusal of blood transfusion by a patient in a life-and-death situation. In many instances, however, they may be more subtle and implicit. Although they are subtle they may have a considerable impact on health seeking behaviour and patients' compliance with management plans, which determine the ultimate outcome of patient care.

There can be instances where the elements of dealing with culture-related issues are addressed in the formal teaching / learning programmes at undergraduate or postgraduate level. However, frequently, the doctors' responses for such issues and dilemmas are intuitive and spontaneous. How they respond may be influenced by their own cultural beliefs, the reactions and response of colleagues, and their own personal experiences. However, in an era where the provision of patient-centred care has become the corner-stone of medical practice, dealing with cultural issues effectively has become a key attribute of modern-day professionalism.

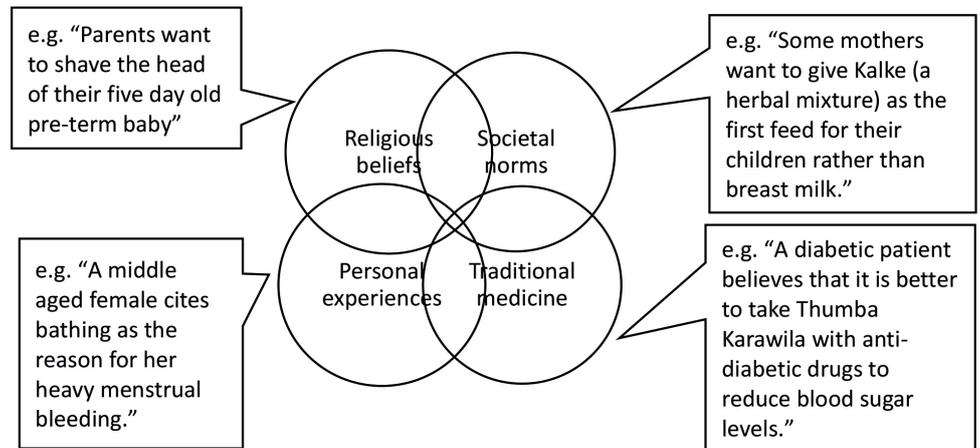
Culture-related issues

The origins of cultural beliefs that doctors face in their day-to-day practice appeared to be related to religious beliefs of patients, norms of society which they live in, patients' own interpretation of personal experiences, and the influence of traditional medicine.¹ Although some beliefs are prominently related to one of

these origins, certain beliefs may share features of multiple origins (Figure 1). Based on the behavioural outcomes

(Table 1). Again, these categories of response are not mutually exclusive and overlaps may exist.

Figure 1 – Origins of cultural beliefs



of these beliefs they can also be categorized into three main areas: beliefs of cautiousness (patients want to be extra cautious about their illness beyond doctor's advice or in the absence of any advice), beliefs of alternatives (patients have no faith in doctor's course of action about the illness or the outcomes of the course of illness, and they look for an alternative) and beliefs of contradiction

Cultural competence

'Cultural competence' means having a set of learned skills, knowledge or assumptions which will be helpful to deal with cultural issues encountered in practice.² It has its roots in the field of transnational business where entrepreneurs attempted to globalize their business more effectively and more efficiently by understanding and

Table 1 – Broad categories and examples of cultural issues commonly encountered by Sri Lankan doctors in their practice.

<p>Beliefs of cautiousness</p> <p>e.g.</p> <ul style="list-style-type: none"> • Relatives of an asthma patient believe that she should bathe in the morning only and definitely before 12 noon. • A young girl believes that eating chocolate aggravates her pimples • A female patient believes that she puts on weight if she does not menstruate monthly.
<p>Beliefs of contradiction</p> <p>e.g.</p> <ul style="list-style-type: none"> • A female fortune teller with haemoglobin at 4mg/dl refuses blood transfusion with her belief on favourable astrology • A diabetic patient believes that long-term use of medicines for her illness is not good as it will make her dependent on them • A grandmother suggests squeezing the breast of a neonate, who has enlarged breasts to take the 'liquid' out .
<p>Beliefs of alternatives</p> <p>e.g.</p> <ul style="list-style-type: none"> • A patient has sought help of sasthanakaraya (a soothsayer) for his incurable cancer. • A patient with psychiatric illness wants to go for balithovil (healing rituals performed by a witch doctor) with the belief that western medicine has no cure.

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Doctors' ability to...

responding to the characteristics of local cultures in different countries.² Although this has been discussed more prominently in shifting businesses from North America or Europe to Asia or Africa, culture has been an important element in doing business even between the UK and the rest of Europe. In the healthcare context, it entails understanding the importance of social and cultural influences on patients' health beliefs and behaviours, and their effect on healthcare provisions and access to ensure a quality of delivery to diverse patient populations.³

With increased globalization and migration, it has become a point of discussion in the field of medicine and healthcare; people from various countries, especially in the East, move to other countries, particularly in the West, in search of greener pastures. Doctors originally from the West then need to understand the cultures of migrant populations to deal with their health issues and doctors originally from the East need to understand the culture of the Western country to survive and succeed in their practice. Therefore, cultural competence has been discussed in terms of 'understanding' the values and beliefs of patients and responding appropriately. However, as Betancourt argues "today, cultural competence is fundamental to patient-centred care, effective communication, and the delivery of quality care to all patients minimizing disparities and inequalities rather than being a set of skills necessary for physicians to care for immigrants, foreigners, and others from 'exotic' cultures"⁴

It is true that allopathic or Western medicine has been developed on the scientific basis of bio-medical sciences, and it works (or at least should work) equally on every human body despite its culture, colour or race unless there are physiological or biological differences. However, bio-physiology of a human body is only a single aspect of a human being; multiple aspects determine the acceptance and adaptation of practices and behaviour of human beings. Although allopathic medicine was developed and it evolved in the Western cultural context,

issues of acceptance and adaptations have been widely discussed even within those cultures.⁵

Importance of cultural competence to a country like Sri Lanka

As a developing country, doctors practicing in Sri Lanka are yet to face the challenge of dealing with migrant populations. However, many of the doctors have grown in the local culture and at least the vast majority of them have been exposed to and even subjected to cultural practices related to health and well-being. Subsequently, as doctors, they may perceive such culture-related practices as unimportant or non-scientific. When patients bring in such culture-related issues to doctor-patient encounters, some doctors may completely ignore them based on the bio-medical model of thinking while others may entertain them based on culturally biased thinking. Neither approach will help achieve the desired patient outcome.

Dealing with cultural issues

Cultural competence in modern terms (which is described as inter-cultural competence in recent literature) focuses on the concept of negotiating reality: high advocacy/high inquiry process of generating mutual cultural awareness and reflection in dealing with culture-related issues.² 'Inquiry' means exploring and reflecting upon culture related issues from the point of view of the client or the patient, and 'advocacy' involves expressing doctor's or advisors point of view.² Based on the levels of inquiry and advocacy, the approach adopted by a particular doctor can be of several combinations: high advocacy/low inquiry, high inquiry/low advocacy, low advocacy/low inquiry, and high advocacy/high inquiry.

Doctors may be prone to a high advocacy/low inquiry approach in dealing with cultural issues, where the doctor exhorts his/her own values without considering

the views of patients.⁶ Such practitioners tend to believe that biomedical science is always 'right' and that 'non-scientific' belief systems are to be challenged rather than engaged with. This approach is facilitated especially in Non-Western cultural contexts, which are characterized by hierarchical relationships between doctors and patients; doctors enjoy more social power than patients in doctor patient encounters. The cultural beliefs of patients may not be brought forward in such instances or even if they are brought forward, they will be ridiculed and suppressed by the doctor. Some doctors, however, possess attributes of learning from others, empathy, acceptance, inquisitiveness and respect which are consistent with a high inquiry/low advocacy approach. Such practitioners explore the views and values of patients, but may not advise for or against such beliefs and patients may still be uncertain about how to deal with their cultural perspectives. This can be detrimental to patient care. A low advocacy/low inquiry approach can be a complete withdrawal from a cultural-related dialogue. Doctors simply ignore the cultural issues brought forward by patients. The outcome of the management plan prepared by the doctor for a particular patient can be at risk as the doctor is almost unaware of the patient's line of thinking. High advocacy/high inquiry is the most desirable approach and it involves an open exchange of views in the spirit of exploration, discussion and mutual understanding. This will help the doctor to be more aware of what the patient is going to do with regard to his/her illness, in order to advice on management or to control damage. In high advocacy/high inquiry context, the majority of patients tend to comply with the doctor's management plan overlooking their own cultural perspectives. High advocacy/high inquiry approach has become more important in dealing with the challenge of battling with non-communicable diseases.

Doctors' ability to...

Compliance has a very special and important role to play in the management of non-communicable diseases, as life-style modification is entirely a process of self-conversion on the part of the patient. Doctors can do little for patients by dispensing 'jabs' and 'pills' compared to what they did for communicable diseases with antimicrobials and/or immunization. Therefore, cultural competence is fast becoming an essential set of skills to be developed by practising doctors and a set of skills to be taught and learned by students and trainees in medical education programmes. It is an integral component of modern-day doctor-

patient communication, the primary goal of which is convincing patients to achieve their health and well-being.

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The Medical Practitioner's Oath

Dr. Sarath Gamini De Silva
Consultant Physician and Council Member,
SLMA

Hippocrates, (460-370 BC), a Greek Physician, is universally credited as the father of modern medicine. Apart from his many pioneering contributions to medicine, he is immortalized by the Hippocratic Oath which he formulated. This was administered to physicians in that era on being inducted to the practice of medicine. However, its contents were based on the cultural values in existence

so many centuries ago. The Oath in its original form is regarded as outdated now. As such various modifications are being used the world over to suit the realities of the practice in modern times.

Contrary to popular belief, the Oath was not administered to newly inducted doctors in Sri Lanka until very recently. A modified version has been used during the past few years by the Sri Lanka Medical Council to be administered to doctors when they receive full registration. The Colombo Medical School Alumni Association (CoMSAA), in 2017, noting

the many deficiencies in the document so used, voluntarily took on the task of formulating a comprehensive version of the Oath. After much deliberation the version given below was accepted by CoMSAA.

This was submitted to the Sri Lanka Medical Council for formal approval and a response is awaited. It was also circulated among the Deans of all the medical faculties in the country. We publish it here in the Newsletter and feedback will be much appreciated.

I sincerely pledge to dedicate my life to the service of mankind.

I recognise that the practice of medicine is a privilege which comes with considerable responsibility.

I will ensure that the health and well-being of the patients would be my primary consideration at all times.

I will practise my profession with conscience, dignity, integrity, honesty and compassion.

I will uphold, with all means within my capacity, the honour and the

traditions of the medical profession.

I will maintain utmost respect for human life from its very beginning.

Even after the demise of the patient, I will respect the confidentiality of information divulged to me.

I will seek to promote the advancement of medical knowledge through teaching and research.

I will not allow considerations of religion, race, nationality, caste, social standing or political affiliation to compromise my dealings with the

patients.

I will not use my profession for exploitation and abuse of my patients.

I will not use my medical knowledge to harm human life, to contravene laws of the land or the basic principles of behaviour expected of civilised mankind.

I make this pledge solemnly, freely and upon my honour.

Prepared by the Colombo Medical School Alumni Association (CoMSAA) in 2017.

SLMA Joint Regional Meeting with the Avissawella Clinical Society

Dr. Shihan Azeez, Assistant Secretary, SLMA

Dr. Sumithra Tissera, Assistant Treasurer, SLMA

The Seventh SLMA Regional Clinical Meeting, organized in collaboration with the Avissawella Clinical Society (ACS) was held at the BOI Auditorium, Free Trade Zone, Avissawella on 16th November 2018 with the attendance of around 100 participants. The programme commenced with the Welcome Addresses delivered by Dr. Sanath Wanigasooriya, President ACS and Dr. Ruvaiz Haniffa, President SLMA.

The first session was chaired by Dr. Kosala Ranathunga, Consultant Surgeon and Dr. Ruvaiz Haniffa. The session comprised

lectures by Dr. AKN Abeyjeewa, Consultant Surgeon, National Hospital of Sri Lanka, who spoke on 'New Trends in Trauma Management'; Dr. Duminda Abeysinghe, Consultant Rheumatologist who updated the audience on "Back Pain" and Dr. Isuru Wimalasiri, Registrar in Psychiatry, Colombo North Teaching Hospital who briefed the audience on a most timely topic: "Ethics in Clinical Practice".

The second session was chaired by Dr. Priyantha Jayalath, Consultant Physician and Dr. AMS Jayasiri, Consultant Obstetrician & Gynaecologist. Lectures were delivered by Prof. Nirmala Wijekoon, Consultant Physician and Senior Lecturer in Pharmacology, University of Sri Jayewardenepura on "Antibiotic use for

common infections"; Dr. Udayangani Ramadasa, Consultant Physician, on "A journey towards a good death" and Dr. Lasantha Malavige, Sexual Health Specialist, on "Improve sex life: premature ejaculation". The final presentation was by Dr. Phillip Veerasingam, Senior Consultant Surgeon on "Some memorable poems from my childhood".

The meeting concluded with the vote of thanks by Dr. DI Dharshana Wijesekara, Secretary, ACS.

The lectures were very interactive with ample time for discussion and were highly appreciated by all present. The participants were awarded a certificate of participation with CPD points.



SLMA Joint Regional Meeting in Wathupitiwala

Dr. Shihan Azeez,
Assistant Secretary, SLMA
Dr. Sumithra Tissera,
Assistant Treasurer, SLMA

The Eighth SLMA Regional Clinical Meeting organized in collaboration with the District Base Hospital (DBH) Wathupitiwala Clinical Society was held at the hospital auditorium on 24th November 2018 with the attendance of more than 125 participants.

The programme commenced with the joint welcome delivered by Dr. Champa SD Jayamanna, President, Clinical Society, DBH Wathupitiwala and Dr. Ruvaiz Haniffa, President SLMA. In the first session, chaired by Dr. Ruvaiz Haniffa and Dr. Saman Wijethunga, Past President and Consultant Physician, General Hospital Negombo, lectures were delivered by Prof. Jayamini Seneviratne, Consultant Dermatologist on "Common sense in Dermatology" and Prof.

Narada Warnasuriya, Past President SLMA and Consultant Paediatrician on "Being a Good Clinical Teacher".

This was followed by Tea and a Musical Interlude.

The second session was chaired by Dr. Mihiri Rubasinghe, Consultant ENT Surgeon, Lady Ridgeway Hospital and Dr. Bimal Kudavidanage, Consultant Anaesthetist, DBH Wathupitiwala. Lectures

were delivered by Dr. Chinthaka de Silva, Consultant Cardiologist, DBH Wathupitiwala on "Recent Guidelines in Management of ST elevation MI (STEMI)", Dr. Lushan Hettiarachchi, Consultant Forensic

Psychiatrist, National Institute of Mental Health Angoda, on "Ethics & Law", and Dr. Bimantha Perera, Consultant ENT Surgeon, DBH Wathupitiwala on "Clinical Assessment of Vertigo".

The meeting concluded with the vote of thanks by Dr. Rangika Atukorala.

All the participants were awarded a certificate of participation with CPD points.



Sir Nicholas Attygalle Oration

The Sir Nicholas Attygalle Oration was held on 14th November, 2018 at the NDW Lionel Memorial Auditorium, SLMA amongst a distinguished gathering. The oration

titled, 'Biomarkers in breast cancer: Broadening the horizons', was delivered by Professor Lakmini Mudduwa, Professor of Pathology, Faculty of Medicine, University of Ruhuna.



ANNUAL GENERAL MEETING: 21ST DECEMBER 2018

The Annual General Meeting (AGM) of the Sri Lanka Medical Association will be held at 7.00 p.m. on Friday, 21st December 2018, at the Lionel Memorial Auditorium, "Wijerama Mawatha, Colombo 7. All members are cordially invited to be present.

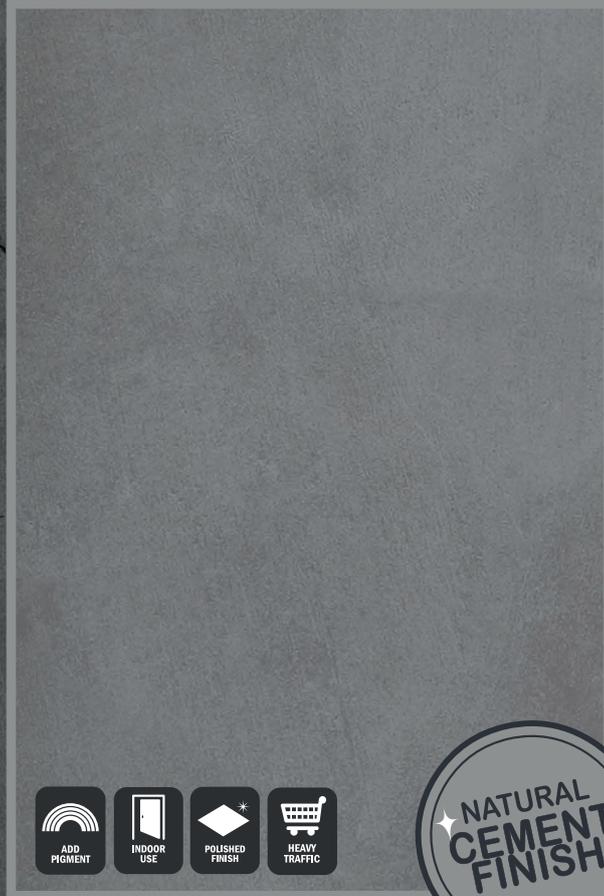
Any proposals or resolutions to be taken up at the AGM should reach the Honorary Secretary, SLMA on or before 30th November 2018.

The agenda of the AGM is given below.

Dr. Hasini Banneheke
Honorary Secretary, SLMA

Agenda for the Annual General Meeting: 21 – 12 – 2018

1. National Anthem
2. Reading of the notice calling for the Annual General Meeting
3. Observation of one minute silence for departed members of SLMA
4. Adoption of the minutes of the last Annual General Meeting held on 15th December 2017
5. Confirmation of new members of the SLMA who joined in 2018
6. Resolutions
7. President's address
8. Secretary's Report for 2018
9. Treasurer's Report for 2018
10. Election of Office Bearers and Council Members for the year 2019
11. Appointment of Auditors
12. Address by the new President
13. Any other business



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Genotoxicity on Exposure to Radiation: Assessment of Micronuclei Frequency Among Persons Resident in the Vicinity of a Mineral Sand Processing Factory In Pulmoddai, Sri Lanka

A synopsis of the Sir Marcus Fernando Oration delivered at the SLMA Foundation Sessions, 2018.

Dr. Tania Warnakulasuriya
Senior Lecturer, Department of Physiology,
Faculty of Medicine, University of Kelaniya

Radioactivity is natural and humans cannot entirely escape radiation from natural sources. Radiation that originates on the Earth is termed terrestrial radiation and radiation from the sun is solar radiation. Eighty-five percent of the annual background radiation that a person receives is due to terrestrial and solar radiation. Man-made radiation is an important part of background radiation that enters the environment through medical diagnostic and therapeutic procedures, as well as through nuclear power plants.

Gamma radiation emitted from natural sources is primarily due to primordial radionuclides. The main primordial radionuclides of interest are ^{232}Th and ^{238}U series, their decay products, and ^{40}K ; these exist in the Earth's crust in trace amounts and in different constitutions depending on the geology and the presence of quarries and springs that alter their constitution and increase background radiation. The dose from terrestrial radiation varies by location. Radiation in certain areas of the world is 200 times the world average. Mining activities have redistributed some of radionuclides in soil.

The effect of radiation on cells is important. Each cell has about 70% of water, and radiation interacts with water molecules to form ions, free radicals and excited molecules. These interact with DNA and cause damage to the DNA helices. Cellular repair mechanisms are able to correctly repair most of the single-strand breaks. When these repair mechanisms fail, the cell may die or cause somatic effects such as cancer.

Micronuclei (MN) can be formed by either chromatin particles that originate from

acentric fragments of the chromosome or whole chromosomes that lag behind in anaphase and do not incorporate to a daughter nucleus. These can form a smaller nucleus or multiple small nuclei earning them the name micronucleus/micronuclei. MN assay has gained popularity as a method of biodosimetry as it requires less time and expertise than other methods. This facility is currently available at the Faculty of Medicine, University of Kelaniya.

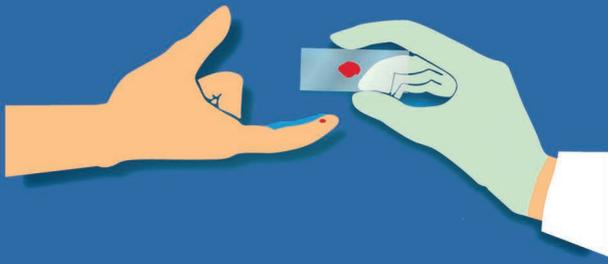
Sri Lanka sits on a placer deposit of monazite. The Lanka Mineral Sands (LMS) factory has been mining mineral sands for rare earth minerals for 60 years. Health effects due to exposure to radiation from radionuclides in the mineral sands have not been highlighted in the past in Sri Lanka. This study addressed some of these concerns by assessing levels of radionuclides and radiation in the region, and the MN frequency in the resident population of the area.

Being a resident of Pulmoddai and being exposed to X-rays were significant predictors of MN frequency. Persons residing within 5 km from LMS had a higher risk of MN formation irrespective of being employed at LMS or not. Background radiation levels and ^{232}Th , ^{226}Ra and ^{210}Pb concentrations of soil samples were highest in the samples collected from the LMS. The median ^{40}K concentration in soil was highest in the samples collected >50kms away from the LMS. The distance from the LMS was negatively correlated with background radiation levels and the activity concentrations of ^{232}Th ($r=-0.305$, $p=0.003$), ^{226}Ra ($r=-0.422$, $p<0.001$) and ^{210}Pb ($r=-0.369$, $p<0.001$). ^{40}K activity concentration was significantly positively correlated with the distance from LMS ($r=0.456$, $p<0.001$). The calculated absorbed dose rate and the background radiation level correlated with each other

($r=0.552$, $p<0.001$). The background radiation measurements positively correlated with the MN frequency ($r=0.176$, $p=0.04$).

Background radiation levels can easily be measured by a survey meter and residents of high background radiation areas can be monitored by this method as it positively correlates with the calculated absorbed dose rate and with MN frequency. A long term surveillance programme will enable the monitoring of adverse health effects among the employees and the residents living near the mineral sand processing plant.

“Health effects due to exposure to radiation from radionuclides in the mineral sands have not been highlighted in the past in Sri Lanka. This study addressed some of these concerns by assessing levels of radionuclides and radiation in the region, and the MN frequency in the resident population of the area.”



Reduce the Delay

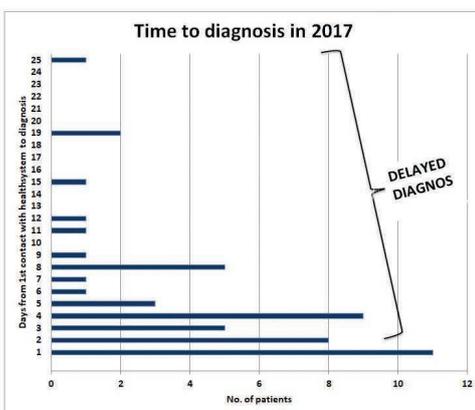
in diagnosing imported **Malaria**

Every single day that a malaria patient is left untreated,

- * His/her chances of survival decreases, &
- * He/she can transmit the disease to others & re-introduce malaria to Sri Lanka



Therefore **malaria should be diagnosed within 24 hours of onset of fever**



Your role:

For all fever patients, always check **travel history** at first interview. If patient has travelled to a malaria endemic country recently, **test for malaria**.

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Public Health Complex, 3rd floor, 555/5,
Elvitigala Mawatha, Colombo 05
Tell: 011 2 588 408/ 011 2 368 173/ 011 2 368 174
Email : antimalariacampaignsl@gmail.com

Call now for free advice, treatment and drugs
011 7 626 626
www.malariacampaign.gov.lk

Doctors win the Professionals League 2018

Dr. Lahiru Senanayake
Member – SLMA Cricket Team

The Doctors cricket team representing SLMA, led by Dr Sritharan Ganeshamoorthy won the championship of the Professionals League 2018.

Five professional bodies including the SLMA, Institute of Engineers of Sri Lanka, Bar Association of Sri Lanka, Sri Lanka Institute of Architects and Pilots Guild of Sri Lanka jointly organized the tournament for the 4th consecutive year. The Doctors team had previously won the trophy in 2016 and had been placed third in last years tournament.

In the league stage, the doctors team achieved comprehensive victories against lawyers, pilots and engineers. Dr Rajiv Nirmalasingham exhibited outstanding all-round performances by becoming Man of the Match in all 3 winning games. Doctors lost a nail biting encounter against the architects, which was decided on the D/L method due to rain interruptions. After a crunch match, the doctors lost on

the last ball of the match.

Having topped the points table, doctors got through to the finals with the architects. The finals were played at the NCC Cricket Grounds on 18th November.

Batting first, doctors scored 134/8 in their 20 overs. In reply, architects lost 4 of their front-line batsmen with just 20 runs on the board and managed to score 76/6 in 16 overs when the game was called off due to bad light and rain. Architects were 18 runs behind D/L par score and Doctors won the finals comprehensively. Dr Heshan Amarathunga bowled brilliantly to capture 4/20 in 3 overs to become the man of the finals. Dr Rajiv Nirmalasingham was awarded man of the series for his excellent all-round performance throughout the tournament. Doctors emerged champions while architects were the runners-up. Lawyers were placed third, beating the engineers and pilots were placed 5th.

Dr. Ruvaiz Haniffa and Dr. Hasini Banneheke, President and Secretary of SLMA respectively, were at the ground to

support and witness the victorious journey of the Doctors cricket team for the year 2018. Prof. Indika Karunathilake served as the team manager for the Doctors team representing SLMA.

Doctors Team

- Dr Sritharan Ganeshamoorthy (Captain)
- Dr Pubudu Senevirathna (Vice Captain)
- Dr Rajiv Nirmalasingham
- Dr Gowribahan Thevaraja
- Dr Lahiru Senanayake
- Dr Rusiru Jayathilake
- Dr Thilina Samarasinghe
- Dr Sadiranga Walpita
- Dr Kasun Wijegunawardena
- Dr Heshan Amarathunga
- Dr Isuru Ahesh
- Dr Isuru Jayathilake
- Dr Thushara Rodrigo
- Dr Suranjith Abeywickrama
- Dr Harindu Subhashana
- Dr Tharindu Kalinga
- Dr Mash Muthuthambi
- Dr Randeer Karunanayake
- Dr Chamika Amila



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Doctors' ability to...



A Medical Metamorphosis.....

Dr. Saroja Siriwardene

Looking for a career with the best prognosis,
'73 Medical batch trained in the basics,
After sophomore learnt clinical diagnosis,
This is the tale of their metamorphosis!

We all had mischievous eyes that twinkle,
Ripples of infectious laughter would tinkle.
Now it is difficult to cover the wrinkles,
Accept the changes like Rip van Winkle!

Then we considered fifty five as 'old',
A ripe age to infarct, as we were told,
Now at thirty, some get stents of gold,
We are girls and boys over sixty years old.

A frock needed just a yard and a quarter,
Sewed it like swimming in shallow waters.
Ugly bulges show up; can't wear a halter,
Reluctant to stitch even for the grand-daughter!

To the hostel kitchen we used to scurry,
For cream from a thin coconut milk slurry.
Obesity has become such a great worry,
Remove fat floating on the chicken curry.

Public transport with a few coins in hand,
Agile jumping in, and out to safely land,
Slowed down since becoming parents grand,
Swollen wallets attract people of many brands.

Once a batch mate, we generally know,
May become a rival, but never be a foe,
Strong bonds bind us from head to toe,
A trusted friend to discuss every woe.

Lifetime of tending to those with a malady,
Doling out for them the best plan of remedy,
Laugh off any dark patch, as if in a comedy,
Come play cricket and whack some 'pol-adi'!



*SRI LANKA MEDICAL ASSOCIATION
PRESENTS*

The Medical Dance 2018

14th December 2018 7.30pm onwards
at Hotel Shangri-La, Colombo
Bands: "Misty" and "Flame"



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THE OFFICIAL NEWSLETTER OF THE SRI LANKA MEDICAL ASSOCIATION

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