



# SLMA NEWS+

The Official E Magazine of The Sri Lanka Medical Association

WWW.SLMA.LK

AUGUST 2024 | VOLUME 08 | ISSUE 08 ISSN : 1800 - 4016 (PRINTED) 2550 - 2778 (ONLINE)



## Common surgical problems

Hand infections

Haemorrhoids:  
Diagnosis and  
Treatment

Mpox  
(monkeypox)  
public health  
considerations

How to get the  
best out of  
ChatGPT

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Sri Lanka Medical Association

# DOCTORS' DANCE

Excellent Band  
Prizes & surprises!

**6<sup>th</sup> December 2024**  
7PM Onwards  
at the  
**Grand Ballroom, Hotel Galadari**

Ticket prices will be revealed soon.

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S & S Printers (Pvt) Ltd  
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Colombo 10

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**LIFE and TIME are the world's best teachers.  
LIFE teaches us to make good use of TIME.  
TIME teaches us the value of LIFE.**

A P J Abdul Kalam



# President's Message

Dear SLMA Members,

The month of August dawned with the horrendous news of a young school girl being sexually assaulted by not just one person, but twenty two persons over several months. The most appalling thing about this incident is that the school authorities had been aware of it for quite some time, but they had not taken any action whatsoever regarding this occurrence, in the mistaken belief that it could have a major detrimental effect on the reputation of the school.

Even before the dust could settle on this tragic incident, we hear the very sad news of a young postgraduate medical doctor being raped and then killed while resting after attending to her daily duties in a very reputed teaching hospital in Kolkata, India.

One does wonder as to whether these acts against women and girls are truly increasing over the years or is it really due to more situations being reported by the media, especially the social media.

In 2023, just last year, the following statistics were reported by the National Child Protection Authority (NCPA); sexual abuse – 08, incest – 07, rape – 50, trafficking – 32, sexual harassment – 469, seduction/prostitution – 09, etc.

As indicated above, sexual harassment is one of the most commonly reported abuse in our society now. This may mostly occur due to lack of a formalized sexuality education in the country and sexual frustration, especially among the males.

Although, some facts about the reproductive system, and its functions may be included as well as taught in the selected subject 'health', no knowledge or skills is provided to the children regarding sexual protection, safety such as good and bad touch, sexual abuse, etc. It is noteworthy to understand that most sexual abuse occurs by persons known and close



to the family, as that person is seen as a friend or a trustworthy individual by them. To make this worse, the subject of 'Health' is not a mandatory subject for Ordinary Level students and therefore, many do not get the opportunity to learn whatever the little is included in the curriculum.

The Sri Lankan government tried to introduce 'udawu yawuwanaya' in 2012 and 'the hatha ape potha' in 2020, but due to strong opposition by some fractions of the clergy and some persons with vested interest including some politicians, these efforts were scuttled. Their main grouse was that the content in these books were not culturally and religiously acceptable and considered to be vulgar.

The most worrying aspect of the entire scenario is that the number of crimes against the vulnerable persons may be more than reported and what we may be seeing is only the 'tip of the ice burg'. This is usually due to non-reporting of the incident due to the possibility of family stigma, lack of education, lack of awareness of the parents on sexual and reproductive health, as well as negative effects on the victim, the time taken for the settlement or the legal verdict of the case, etc.

In this back drop, I have to ask you

what the SLMA, as the premier medical organization, and all of us as medical professionals for that matter, can do to reduce and prevent this heinous crime of 'sexual abuse'?

1. Pressurize the government, together with the assistance of other interested parties, to include the already developed educational material on sexuality into the school syllabus and share among the school children.
2. Advocate as one voice to the National Institute of Education (NIE) to include age appropriate comprehensive sexual and reproductive health as well as rights (SRHR) to be taught in schools as a compulsory subject from Grade 1
3. Insist on supporting the training of teacher trainers who will be training the identified teachers in schools throughout the country in dealing with sex education

I would like to solicit the support of all medical doctors, both members and non-members of the SLMA in this timely effort to make a stop to sexual and gender based violence in the country.

*'Don't turn your face away. Once you've seen, you can no longer act like you don't know.*

*Open your eyes to the truth. It's all around you. Don't deny what the eyes to your soul have revealed to you.*

*Now that you know, you cannot feign ignorance. Now that you're aware of the problem, you cannot pretend you don't care. To be concerned is to be human. To act is to care'.*

Vashti Quiroz-Vega

**Dr Ananda Wijewickrama**  
MBBS, MD, MRCP(UK), FCCP  
Consultant Physician  
National Institute of Infectious Diseases  
President - SLMA

# Activities in Brief

(15<sup>th</sup> July 2024 – 16<sup>th</sup> August 2024)

## Saturday Talks

**3<sup>rd</sup> August** - 'Urological emergencies' by Dr B Balagobi, Senior Lecturer & Urological Surgeon, department of Surgery, Faculty of Medicine, Jaffna.

**SRI LANKA MEDICAL ASSOCIATION**  
**Saturday Talk Series**  
**Urological Emergencies**

**Dr B Balagobi**  
 Senior Lecturer and Urological Surgeon,  
 Department of Surgery,  
 Faculty of Medicine,  
 University of Jaffna.

**3<sup>rd</sup> August, 2024**  
**7PM Onwards**

Meeting ID: 831 8551 5631  
 Passcode: 040690

To obtain previous Saturday Talk recordings email to [lt@slma.lk](mailto:lt@slma.lk)  
[www.slma.lk](http://www.slma.lk) 94-112693324



Dr Ananda Wijewickrama, President, SLMA & Professor Hasini Banneheke, Vice President & Academic Chair, Medical Congress attended a discussion on TV1/ Sirasa TV, 'Jathika Mehewara' programme on **9<sup>th</sup> August** to present the 137<sup>th</sup> Anniversary International Congress 2024 to the public.



Dr Ananda Wijewickrama, President, SLMA & Professor Hasini Banneheke, Vice President & Academic Chair, Medical Congress attended a discussion on Monara TV, 'Varnodhaya' programme on **13<sup>th</sup> August** to discuss the 137<sup>th</sup> Anniversary International Congress 2024 & the role of the SLMA in providing continuous medical education to the doctors & other allied health professional staff.

## Media Activities

Professor Chaturanga Ranasinghe from the SLMA Expert Committee on Sports and Exercise & Dr Lahiru Kodituwakku, Honorary Secretary, SLMA participated in a programme on Rupavahini 'Sanhinda' on **2<sup>nd</sup> August** to discuss the upcoming Doctors Cricket League 2024 and the importance of promoting sports/ exercise among the health professionals and the public.



## Monthly Clinical Meetings

The clinical meeting for July was held in collaboration with the College of Otorhinolaryngologists and Head and Neck Surgeons of Sri Lanka on **18<sup>th</sup> July** on 'Common ENT problems'.

The resource persons and topics of discussion were Dr Sithara Dissanayake, Consultant ENT Surgeon/ Senior Lecturer, Faculty of Medical Sciences, University of Sri Jayawardenapura on 'Clinical approach to a patient with allergic rhinitis' and Dr Visira S Weerasekara, Consultant ENT & Head & Neck Surgeon, Base Hospital, Awissawella on 'Adenotonsillar hypertrophy & Paediatric sleep disordered breathing'.



SLMA will give both technical support and strategic guidance for the development of the platform and its ongoing maintenance.

Key stakeholders in attendance included: - Dr Ananda Wijewickrama, President of SLMA, Dr Lahiru Kodithuwakku, Honorary Secretary of SLMA, Dr Surantha Perera, President-Elect of SLMA, Dr Dayanath Ranatunga, Assistant Representative, UNFPA, Ms Sarah Soysa, National Program Analyst for Sexual and Reproductive Health and Rights, UNFPA, Dr Ruchitha Perera, Executive Director, FPA Sri Lanka, Dr Nuzrath Nasoordeen, Medical Director, FPA and Ms Damayanthi Pieris, Project Coordinator for the CSE (Digital) Platform.



## Advocacy

A meeting took place on **18<sup>th</sup> July** at the SLMA between representatives of the SLMA, FPA Sri Lanka & UNFPA. The discussion centered on a partnership with SLMA to provide technical support and guidance for the development and maintenance of the Virtual Comprehensive Sexuality Education (CSE) digital platform.

Initiated by FPA Sri Lanka and UNFPA Sri Lanka, the platform aims to deliver essential, age-appropriate information on reproductive health, healthy relationships, and lifestyles in an interactive and engaging manner.

SLMA collaborated with the National Institute of Infectious Diseases (NIID), the National Dengue Control Unit (NDCU), Ministry of Health and World Health Organization (WHO) for the first ever Regional Training of Trainer programme on Dengue Clinical Management at the NIID from **22<sup>nd</sup> July - 28<sup>th</sup> July**.

A batch of doctors and nurses from the Ministry of Health, Bangladesh underwent an extensive week-long hands-on training at the CeRT, NIID, which signifies Sri Lanka's efforts in regional cooperation in dengue management.

The resource persons were Dr Ananda Wijewickrama, Senior Consultant Physician, NIID, Dr Shanthi Ganesan, Consultant Paediatrician, CSTH, Dr Damayanthi Idampitiya, Consultant Physician, NIID, Dr Thisara Perera, Consultant Physician, NIID, Dr Sri Lal De Silva,

Senior Consultant Paediatrician, Dr Jagath Amarasekara, Consultant Community Physician, NDCU, Dr Anoja Dheerasinghe, Consultant Community Physician, NDCU, Professor Anuradha Dasanayaka, Professor of Pharmacology, Faculty of Medicine, University of Kelaniya, Professor Neelika Malavige, Professor of Immunology & Molecular Medicine, Faculty of Medicine, University of Sri Jayawardenapura, Dr Nayomi Rodrigo, Consultant Haematologist, NIMH & NIID, Dr Lahiru Kodituwakku, Medical Officer, NDCU and Ms Geethani Udugamkorala, Chief Special Grade Nursing Officer, NIID.



## Pre-congress Workshop

The sixth pre-congress workshop titled 'Colombo Wound Meeting 2024' was held on **29<sup>th</sup> July** in collaboration with the College of Surgeons Sri Lanka at the Noel & Nora Bartholomeuz Auditorium, College of Surgeons Sri Lanka, Colombo.

The resource persons & the topics of discussion were as follows;

Dr Duminda Ariyaratne on '*Burden of wounds & wound healing*', Dr Rezni Caseem on '*Wound assessment and wound bed preparation*', Dr Shashanka Rathnayake on '*Acute post traumatic and post-surgical wound care – Concepts*', Dr Gayan Ekanayaka on '*Wound dressings - correct application and myths*', Dr Kolitha Karunadasa on '*Wound cover & reconstruction*', Professor Mandika Wijeyaratne on '*Diabetic foot*', Dr Ranjuka Ubayasiri on '*Varicose veins & venous ulcers*', Dr Thushan Gunarathne on '*Diabetic foot assessment (demo video)*', Dr Chandana Karunathilaka on '*Amputations and rehabilitation in wound care*', Dr Renuka Jayatissa on '*Optimizing nutrition in wound care*', Dr Shirani Chandrasiri on '*Battling difficult infections*', Dr Indira Kahawita on '*Caution! Not just ulcers*', Dr Arunajith Peiris on '*Lymphoedema reduction surgery*', Dr Kavinda Rajapaksa on '*Lymphoedema drainage surgery*' and Dr Yasas Abeywickrama on '*Pressure ulcer prevention and treatment*'.





The seventh pre-congress workshop titled 'Academic publications & manuscript writing' was held on **13<sup>th</sup> August** at the SLMA Auditorium.

The resource persons & the topics of discussion were as follows;

Professor Athula Sumathipala & Professor Mahesh Nirmalan on 'Introduction to Scientific Writing', Professor Shamini Prathapan on 'Understanding the Publication Process, Preparing a Quality Submission, Writing the Discussion and Conclusions & Resources and Tools for Manuscript Writing', Dr BJC Perera & Professor Mahesh Nirmalan on 'Structure of a Manuscript', Dr Buddhika Fernando & Dr BJC Perera on 'Writing Techniques and Style', Professor A Pathmeswaran on 'Data Presentation and Statistical Considerations', Professor Athula Sumathipala & Dr Buddhika Fernando on 'Ethical Considerations in Research and Publication', Dr BJC Perera on 'Artificial Intelligence in Medical Publishing: The good, the bad, and the ugly' and Ms Sameeha Jabeer on 'Tips for Effective Literature Review'.



## Doctors in sports action

The 2<sup>nd</sup> edition of the Doctors Cricket League organized by the Doctors Cricket Club in collaboration with the SLMA Sports Forum kicked off at the Welagedara Stadium, Kurunegala on **28<sup>th</sup> July**.

The Doctors' Cricket League is a celebration of cricketing talents within the medical fraternity of Sri Lanka. This event aims to foster camaraderie, sportsmanship and healthy competition among medical professionals.

The tournament this year featured five teams, Colombo Super Kings was led by Dr Tharindu Kalinga, Kandy Knights led by Dr Rasitha Manathunga, Galle Titans led by Dr Akalanka Muthukumarana, Jaffna Healers led by Dr Sriitharan Ganesha Moorthy and Dambulla Royals led by Dr Shehan Niluka.

The finals was held on **4<sup>th</sup> August** at the Welagedara Stadium in Kurunegala between Kandy Knights & Colombo Super Kings.

Kandy Knights emerged as champions.

Dr Vinya Ariyaratne, Immediate Past President & Dr Asitha K Thanippularachchi participated at the award ceremony representing the SLMA.



# Hand infections

## Dr Salinda Pathirana

MBBS

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## Dr Melanie Amarasooriya

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### Introduction

Hand infections are a common problem presenting to the family physicians, orthopaedic surgeons, outpatient departments and emergency units (McDonald et al., 2011). While data on disease burden is limited, it is recognised that two thirds of the hand infections occur in men with an average age of 40. Trauma, bite wounds in particular are the leading causes resulting in the infection of the hand.

Majority of the hand infections affect the superficial tissues, such as skin and subcutaneous tissue. Superficial hand infections include cellulitis, paronychia or pulp space abscesses (McDonald et al., 2011). Early diagnosis and prompt management leads to good outcomes whereas late or missed diagnosis can lead to deep infections and complications (Ong & Levin, 2009). Deep hand infections include necrotising fasciitis, flexor sheath abscesses and deep palmar space abscesses. Deep hand infections are surgical emergencies that should be promptly referred for surgical debridement and antibiotic therapy.



Figure 1 First webspace abscess (a) Before surgical intervention (b) After surgical intervention

### Hand Cellulitis

The common pathogens causing hand cellulitis are *Staphylococcus aureus* and *Streptococcus pyogenes* (McDonald et al., 2011). The initial assessment should include patients' temperature, vital signs and basic investigations such as complete blood count (CBC), C-reactive protein (CRP) and ESR. Always aim to differentiate cellulitis from more sinister infections such as necrotising fasciitis. Inflammatory markers in simple hand infections can be normal, hence management decisions should be guided by the clinical picture.

Elevation is of paramount importance in managing hand cellulitis. Marking the area of redness enable repeated assessments to see the response to empirical antibiotics. Oral antibiotics such as cefalexin is a good first line choice. However, consider intravenous antibiotics in severe cases where clinical parameters indicate systemic infection and in patients with immunosuppression. Where there is an increase in MRSA infections in the community, early reassessment and taking microbiology opinion is helpful (Türker et al., 2014).

### Paronychia

Inflammation of tissue immediately surrounds the nail is called 'paronychia' (Shafritz & Coppage, 2014). If left untreated simple erythema can lead to suppuration and destruction of germinal matrix ultimately causing nail growth arrest. Acute Paronychia is commonly caused by *Staphylococcus aureus*, and *â-haemolytic streptococci* and *Klebsiella spp.* Recurrent acute infections and occupational exposure to chemicals can cause chronic paronychia. Fungal infection with *Candida albicans* is also a recognised cause of chronic paronychia. Diabetes mellitus, frequent manicures and nail biting are risk factors for acute paronychia. Patients with psoriasis and patients with frequent exposure to alkaline solutions and detergents are more prone to chronic paronychia.

Patients with acute paronychia present initially with erythema, swelling, and tenderness immediately adjacent to the nail. In late stages infection can spread to encircle the entire nail causing suppuration and lift up the nail plate. Initial stages of acute paronychia can be managed with nonsurgical methods such as soaking in warm solutions and oral antibiotics. Suppuration additionally requires incision and drainage. Late stages are preferably managed with nail plate removal. For chronic infections topical corticosteroids, oral and/or topical antibiotics/antifungal agents together with exposure prevention are recommended. Eponychial marsupialization is the recognized surgical management for chronic paronychia.



Figure 2 Acute paronychia requiring drainage in (a) a child and (b) an adult. From "Infections of the hand: an overview" by Flevas DA, Syngouna S, Fandridis E, Tsiodras S, Mavrogenis AF. (2019) EFORT Open Rev. 2019, 10;4(5):183-193. [used under Creative Commons CC-BY license]

**Pulp space abscess (Felon)**

Open injuries to fingertip such as cuts, prick injuries can lead to infection in the closed space compartment of the fingertip pulp. Poorly treated paronychia can also lead to pulp space abscesses. Most common bacteria known to cause pulp space abscess is *Staphylococcus aureus*. Increased pressure secondary to infection may reduce the blood flow and lead to necrosis of the skin and pulp. Rarely osteomyelitis can develop in the finger. Patients present with pain and swelling of the volar side of the fingertip usually not extending past the distal interphalangeal joint. Pulp space abscesses generally need incision and drainage followed by antibiotics (Canales et al., 1989).



Figure 3 Complications of felon: Late presentation with necrosis of tissues and ascending infection

**Necrotising fasciitis**

Necrotising fasciitis is a dangerous infection that spreads along the fascial planes. Hence, the actual tissue destruction can more than the area of erythema or inflammation. This is a life and limb threatening condition often leading to amputations and even death (Flevas et al., 2019). The pathogens are commonly *Staphylococcus sp* and *Streptococcus sp*. Necrotising fasciitis can occur due to multiple bacteria, especially in immunocompromised patients. Diagnosis of necrotising fasciitis remains a clinical decision, supported by deranged laboratory parameters. When in doubt The LRINEC score (laboratory risk indicator for necrotizing fasciitis) is helpful assess the likelihood of patient having necrotising fasciitis (Wong et al., 2004).

Table 1 Laboratory Risk Indicator for Necrotizing Fasciitis (LRINEC) score

Parameter	Range	Score*
Hb (g/dl)	>13.5	0
	11–13.5	1
	<11	2
White cells (10 <sup>9</sup> /L)	<15	0
	15–25	1
	>25	2
Sodium (mmol/L)	<135	2
Creatinine (µmol/L)	>141	2
Glucose	>10	1
C-reactive protein	150	4

\* Score ≤5 = <50% risk (low); 6–7 = intermediate risk; ≥8 = >75% risk (high).

Basic blood investigations, aspiration of fluctuant areas for culture and blood culture followed by empirical antibiotics should be started as early as possible together with elevation of affected limb. Surgical debridement is the mainstay in management to release fascial compartments and drain the classic "Dishwash water like fluid". All necrosed tissues are required to be excised in a radical fashion, which sometimes may require amputation of a limb. If required repeat debridement in 24-48 hrs is also advised (Goldstein et al., 2007). Patients are very likely to require combinations of antibiotics and intensive monitoring. Early aggressive management of necrotising fasciitis gives 90% survival rate.

**Flexor sheath infection**

Infections can affect the flexor tendon sheath of fingers or the thumb. Spread proximally along the tendons can cause life and limb threatening infections and functional disability. Most common causative organisms include *S. aureus* and  $\beta$ -hemolytic *Streptococci* and *P. multocida* in animal bites. *E. corrodens*, *Listeria monocytogenes*,

and mixed gram-positive and gram-negative infections in immunodeficiency are the other pathogens that cause flexor sheath infections.

Four Kanavel's signs describe the classic clinical features of flexor sheath infection (Kanavel, 1921).

- Semi flexed position of fingers
- Symmetrical enlargement of whole digit
- Excessive tenderness limited to the course of the flexor tendon sheath
- Excruciating pain on passive extension of fingers

Urgent surgical drainage and irrigation of the tendon using closed or open irrigation techniques and early start of broad-spectrum antibiotics are crucial. Application of povidone iodine-soaked wicks, frequent dressing change, regular assessment and if necessary repeated irrigation are important steps in management. Adequate analgesics is mandatory to encourage the patient for early mobilization that minimize the risk of contractures.

The best outcomes are related to early empiric antimicrobial therapy and early irrigation or debridement when necessary (Neviaser & Gunther, 1980). Poor prognostic factors of infectious tenosynovitis include infection by *Streptococcus pyogenes* or multiple agents, delayed antibiotics and surgical intervention, purulence of the tissue, diabetes mellitus, renal failure, and peripheral vascular disease. Disease involving necrosis and destruction offers the worst outcomes, with possibility of amputation.

### Deep space abscesses

Infections of potential spaces of the hand namely thenar, hypothenar, mid palmar and web spaces can cause increased pressure in these tight compartments. Tight deep hand compartments can cause tissue ischemia and destruction. Origin of infection could be an extension proximally from fingers, following prick injuries, fissure between fingers or infected distal palmar callus.

Swelling of the hand is marked on relatively loose dorsal aspect. Tenderness can be elicited over involved compartment and patient keeps the fingers in semi flexed position or abducted from each other to minimize pain providing maximum room for the collection.

This condition is a surgical emergency which requires Incisions and drainage of involved compartments and immediate broad-spectrum antibiotics that covers *Staphylococcus sp.* As for other hand infections post operative wound management, antibiotics, pain management and early mobilization is mandatory for a better outcome.

### Fight bites

Hand infections following human bites are common among males. They typically affect the 3<sup>rd</sup> and 4<sup>th</sup> metacarpophalangeal joints. Presence of various aerobic

and anerobic pathogens from oral cavity increase the risk of infection in these injuries (*Staphylococcus aureus*,  $\alpha$ -haemolytic and  $\beta$ -haemolytic *Streptococci species*, *Eikenella corrodens*, *Neisseria species*). Fight bites need surgical assessment due to the possibility of septic arthritis of the metacarpophalangeal joint. Evaluate the wounds for traumatic arthrotomy, associated fractures, tendon rupture and presence of foreign bodies that can complicate the injury causing septic arthritis, spread of infections and disability. Thorough wound debridement, antibiotics and delayed primary wound closure are advised.



Figure 4 Fight bite over the dorsum of the hand

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## Sri Lanka Medical Association Annual Child Art Creation 2024



**When I grow up: What I'll be**

**Let's draw and send without delay  
Sky's the limit for our paintings today**

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

**Colouring Medium: any medium**

**Paper Size: A4 Paper**

Submissions should include:

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

Drawings need to be certified by Principal or  
Class Teacher of the child.

The drawing should not be copied from the  
internet or any other source.

One child can submit up to a maximum of 2  
**drawings.**

All drawings need to be sent **ONLY** by post or hand  
delivered to

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

**Deadline: 30<sup>th</sup> September 2024**

For more information please con-  
tact SLMA office at  
011-2693 324



# Haemorrhoids : Diagnosis and Treatment

## Professor Ishan De Zoysa

MBBS (Colombo), DM (Colombo), MS (Colombo), FRCS (England), FRCS (Edinburgh)

Professor in Surgery, Department of Surgery, Faculty of Medicine, University of Colombo

### Introduction

Haemorrhoids are a common anorectal condition affecting a significant proportion of the adult population, with prevalence rates estimated between 4% and 15% [1]. They can cause considerable discomfort and impact quality of life, necessitating a thorough understanding for effective management.

### Pathophysiology

Haemorrhoids are classified into internal and external types based on their location relative to the dentate line of the anal canal. Internal hemorrhoids originate above the dentate line and are covered by anal mucosa, while external hemorrhoids develop below this line and are covered by anoderm [2].

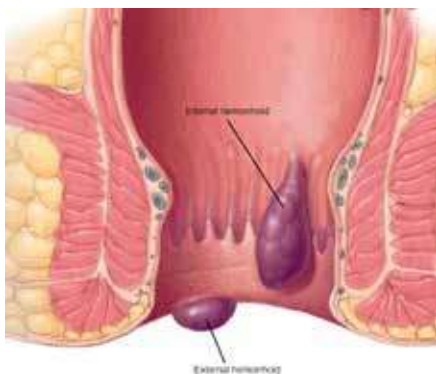


Diagram showing internal and external haemorrhoids



Prolapsed Haemorrhoids

The pathogenesis of hemorrhoids is primarily linked to increased venous pressure within the haemorrhoidal plexus. Factors contributing to elevated venous pressure include chronic constipation, prolonged sitting, pregnancy, and straining during defecation [3]. These factors lead to engorgement of the haemorrhoidal veins and subsequent development of symptomatic hemorrhoids.

### Clinical Presentation

Patients with hemorrhoids often present with symptoms such as rectal bleeding, pain, itching, and prolapse. Internal hemorrhoids may cause bright red blood on the toilet paper or in the stool, but are typically painless due to their mucosal innervation. Both external and internal hemorrhoids are usually painful if thrombosed [4].

### Diagnosis

The diagnosis of haemorrhoids is largely clinical and involves a detailed patient history and physical examination. Digital rectal examination (DRE) and visual inspection enables differentiation between internal and external hemorrhoids. A proctoscope may be required to visualize internal hemorrhoids and exclude other conditions such as anorectal tumors or polyps [5].

### Differential Diagnosis

Haemorrhoids must be distinguished from other anorectal conditions, including anal fissures, abscesses, and malignancies. Conditions such as Crohn's disease, ulcerative colitis, and rectal cancer may present with similar symptoms but require different management strategies [6]. A thorough examination and a flexible sigmoidoscopy or colonoscopy are crucial especially to exclude sinister pathologies.

### Management

Management of hemorrhoids can be conservative or surgical, depending on the severity of symptoms and the presence of complications.

1. **Conservative Management:** For mild symptoms, conservative measures are often effective. These include:

**Dietary Modifications:** Increasing fiber intake through fruits, vegetables, and whole grains can alleviate constipation and reduce straining [7].

**Topical Treatments:** Over-the-counter preparations containing hydrocortisone or can relieve itching and inflammation [8].

**Sitz Baths:** Warm sitz baths can provide symptomatic relief by reducing discomfort and promoting blood flow to the area [9].

2. **Pharmacologic Treatments:** For more severe symptoms, topical analgesics, anti-inflammatory agents, and oral medications may be necessary [10]. Laxatives may also be used to prevent straining [11].
3. **Minimally Invasive Procedures:** For persistent symptoms despite conservative treatment, office-based procedures may be indicated:
  - o **Rubber Band Ligation:** This technique involves placing a rubber band around the base of each internal hemorrhoid, which leads to necrosis and sloughing off [12].
  - o **Sclerotherapy:** Involves injecting a sclerosing agent into the hemorrhoidal tissue to induce fibrosis and reduce bleeding [13].
4. **Surgical Interventions:** In cases where hemorrhoids are severe or complicated (e.g., thrombosed internal hemorrhoids or recurrent prolapse), surgical options such as hemorrhoidectomy or stapled hemorrhoidopexy may be considered [14]. Hemorrhoidectomy is typically reserved for grade III and IV hemorrhoids and is associated with significant post-operative pain and recovery time [15].

**Prevention**

Preventive measures focus on reducing risk factors for hemorrhoid development. Recommendations include:

- o **Adequate fluid intake :** The recommended water intake is approximately 4L per day for males and 3L per day for females OR 1L for every 20kg body weight
- o **Adequate Fiber Intake:** To prevent constipation and reduce straining during bowel movements [16].
- o **Regular Exercise:** To promote healthy bowel function and reduce intra-abdominal pressure [17].
- o **Avoiding Prolonged Sitting:** Especially on the toilet, to minimize pressure on the anal region [18].

**Patient Education**

Educating patients about lifestyle modifications and proper bowel habits is crucial. Patients should be advised to:

- Avoid prolonged sitting and straining during defecation.

- Maintain a high-fiber diet and stay hydrated.
- Seek medical advice if symptoms persist or worsen, especially if there is significant bleeding or pain.

**Haemorrhoids in Special Situations**

*Haemorrhoids in Pregnancy*

Pregnancy and vaginal delivery predisposes to haemorrhoids because of hormonal changes and increased intra-abdominal pressure. It has been estimated that 25% to 35% of pregnant women are affected and in certain populations, up to 85% of pregnancies are complicated by haemorrhoids during the third trimester .

Treatment is mainly symptomatic for most patients. Most forms of the condition can be treated by increasing fibre content in the diet, administering stool softeners, increasing liquid intake, and training in toilet habits. Topical creams provide symptomatic relief. Although none of the topical anti-haemorrhoidal agents commonly used have been assessed for safety in pregnancy, the constituents (local anaesthetic, corticosteroids, and anti-inflammatory agents) are unlikely to harm the third-trimester infant. In most women, symptoms are likely to resolve spontaneously after delivery. Surgery should only be offered to those who are at risk of sepsis. Delivery by caesarean section is preferable for patients with complicated haemorrhoids [19].

*Haemorrhoids in patients with portal hypertension*

In patients with portal hypertension, it is important distinguish haemorrhoids from rectal varices as the treatment options for the two conditions is different. The majority of bleeding haemorrhoids in patients with portal hypertension is not life threatening. Therefore, conservative management with correction of coagulopathy is the preferred initial treatment. Sclerotherapy is preferred to rubber band ligation in patients who continue to bleed from haemorrhoids as the latter could result in torrential secondary haemorrhage. In refractory cases suture ligation of the bleeding vessel is recommended [20]. Haemorrhoidectomy is performed, as a last resort in these patients when other treatment options have failed.

Haemorrhoids in HIV and other immunocompromized patients

Conservative management is the mainstay of treatment of haemorrhoids in immunocompromized patients. Interventions or operations should be avoided, or performed with a careful consideration due to the risk of anorectal sepsis and poor tissue healing. In bleeding haemorrhoids injection sclerotherapy appears to be safer than banding or haemorrhoidectomy in these patients[21]. Antibiotic prophylaxis is essential before performing any intervention due to the risk of bacteremia[22].



**Conclusion**

Haemorrhoids are a prevalent condition that can significantly affect a patient’s quality of life. A thorough understanding of their pathophysiology, clinical presentation, and management options is essential for effective treatment. Medical Officers play a pivotal role in diagnosing and managing hemorrhoids, and appropriate treatment often involves a combination of conservative measures, pharmacologic therapy, and, when necessary, surgical interventions.

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**THE NEW SECRETARY .....  
Kevin gets a new Secretary.**

A few days later his wife learns of this new hire, so he faces a volley of rapid, suspicious questions.

Emma (Kevin’s wife): “Does your new secretary have nice legs?”

Kevin: “Didn’t quite notice.”

Emma: “What colour are her eyes?”

Kevin: “Haven’t had the time to check.”

Emma: “What are the nail polish colours she uses, metallic, gel or neon?”

Kevin: “Not a clue in the world.”

Emma: “Does she have a local accent?”

Kevin: “I barely spoke to her, so don’t know.”

Emma: “How does she dress?”

Kevin: “Very quickly.”

**Kevin’s funeral will be held on Tuesday.**

Extracted from <https://www.ba-bamail.com/jokes/cheating-jokes/?jokeid=1491>

Sent by Dr B. J. C. Perera

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# Mpox (monkeypox) public health considerations

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Chief Epidemiologist (Actg), Epidemiology Unit, MoH

### Introduction

Mpox is an infectious disease caused by the monkeypox virus (MPXV). The virus was discovered in Denmark (1958) in monkeys kept for research. The first reported human case of mpox was a nine-month-old boy in the Democratic Republic of the Congo (DRC) in the year 1970. Following the eradication of smallpox in 1980 and the end of smallpox vaccination worldwide, mpox steadily emerged across several African countries, where the disease is endemic. A global outbreak of mpox occurred in 2022–2023. The natural reservoir of MPXV is unknown and various small mammals such as squirrels and monkeys are susceptible.[1]

Each year mpox cases reported in the Democratic Republic of the Congo (DRC) have increased steadily. In 2023, reported cases increased significantly, and the number of cases reported so far this year has exceeded last year's total. Considering the upsurge of mpox in DRC and a growing number of countries in the African region, on the 14<sup>th</sup> of August 2024, the WHO Director-General declared mpox as a Public Health Emergency of International Concern (PHEIC) under the International Health Regulations (IHR) of 2005.

MPXV is an enveloped double-stranded DNA virus of the Orthopoxvirus genus in the Poxviridae family. There are two genetic clades of the virus - clade I (formally known as Congo Basin clade) and clade II (formally known as West African clade), which further divides into subclades IIa and IIb.

Clade I is known to cause a more severe illness and death. Previously some outbreaks have reported a case fatality rate up to 10%, although more recent outbreaks have had lower death rates. Clade I is endemic to Central Africa. In 2024, a new subclade of Clade I, known as Clade Ib, was identified in the African region.

Clade II is the type that caused the global outbreak that began in 2022. Infections from clade II mpox are less severe. More than 99.9% of people survived. Clade II is endemic to West Africa.[2]

### Outbreaks

After 1970, mpox occurred sporadically in Central and East Africa (clade I) and West Africa (clade II). In 2003 an outbreak in the United States of America was linked to imported wild animals (clade II). Since 2005, thousands of suspected cases have been reported in the DRC every year. In 2017, mpox re-emerged in Nigeria and continues to spread among people across the country and travellers

to other destinations. In May 2022, an outbreak of mpox appeared suddenly and rapidly spread across Europe, the Americas and then all six WHO regions, with 110 countries reporting about 87,000 cases and 112 deaths. The global outbreak has affected primarily (but not only) gay, bisexual, and other men who have sex with men (GBMSM) and has spread from person-to-person through sexual networks. [1]

Since early May 2022, cases of mpox have been reported from countries where the disease is not endemic, and continue to be reported in several endemic countries. Most confirmed cases have a travel history reported to countries in Europe and North America, rather than West or Central Africa where the mpox virus is endemic. This is the first time that many mpox cases and clusters have been reported concurrently in non-endemic and endemic countries in widely dissimilar geographical areas. [3]

### Transmission

- Person-to-person transmission of mpox can occur through direct contact with infectious skin or other lesions such as in the mouth or on the genitals. Mpox also can spread via respiratory droplets or short-range aerosols from prolonged close contact. The virus can enter the body through broken skin, mucosal surfaces (e.g. oral, pharyngeal, ocular, genital, anorectal), or via the respiratory tract.
- Animal-to-human transmission of mpox occurs from infected animals to humans from bites or scratches, or during activities such as hunting, skinning, trapping, cooking, playing with carcasses, or eating animal flesh. The extent of viral circulation in animal populations is not entirely known and further studies are underway.
- People can contract mpox from contaminated objects such as clothing or linen, through sharps injuries in health care, or in community settings such as tattoo parlours. [1]

### The natural host of mpox virus

Various animal species have been identified as susceptible to MPXV. This includes rope squirrels, tree squirrels, Gambian pouched rats, dormice, non-human primates and other species. Uncertainty remains on the natural history of the mpox virus and further studies are needed to identify the exact reservoir(s) and how virus circulation is maintained in nature. [3]

### Signs and symptoms

Mpox causes signs and symptoms which usually begin within a week but can start 1–21 days after exposure (incubation period ranges from 2 to 21 days). Symptoms typically last 2–4 weeks but may last longer in those with a weakened immune system. Common symptoms

of mpox are rash, fever, sore throat, headache, muscle aches, back pain, low energy, and swollen lymph nodes.

Typically for mpox, fever, muscle aches and sore throat appear first. Classically, within 1 – 3 days after the fever subsides the mpox rash could distribute from face, palms, soles, body and ano-genital areas (Centrifugal) over 2-4 weeks. Lymphadenopathy (swollen lymph nodes) is a classic feature of mpox. Persons with mpox may be infectious from the onset of any symptoms and can pass the disease on to others until all sores have healed and a new layer of skin has formed. Some people can be infected without developing any symptoms. [1]

**Diagnosis**

- Detection of viral DNA by polymerase chain reaction (PCR) is the preferred laboratory test for mpox. The best diagnostic specimens are taken directly from the rash; skin, fluid or crusts, collected by vigorous swabbing.
- In the absence of skin lesions, testing can be done on oropharyngeal, anal, or rectal swabs. A positive result of an oropharyngeal or rectal sample is indicative of mpox. However, a negative result does not rule out MPXV infection completely.
- Testing for MPXV is available at the Medical Research Institute (MRI), Colombo, Sri Lanka.

**Prevention of mpox**

- Measures must be taken to promptly identify, notify, and manage any suspected cases of mpox to prevent the introduction to and onward spread, in the country [4].
- Necessary steps have been taken to detect any cases entering the country through all ports of entry and to strengthen the surveillance system across the country.

- The National Institute of Infectious Diseases (IDH Hospital) has established dedicated isolation facilities to manage any mpox patients.
- Health workers caring for suspected or confirmed mpox patients and those handling samples should practice standard infection prevention and control (IPC) measures.
- For further information, refer to the Ministry of Health Circular Number EPID/400/mpox/2024) dated 20.08.2024, and titled Surveillance, notification, investigation, and laboratory testing of cases of mpox (monkeypox) virus [4].

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**SYMPTOMS**

- Rash with blisters on face, hands, feet, body, eyes, mouth or genitals
- Fever
- Swollen lymph nodes
- Headaches
- Muscle and back aches

**POSSIBLE TRANSMISSION**

- Through infected individuals returning from high risk countries
- Through very close contacts with an infected person

**PREVENTION**

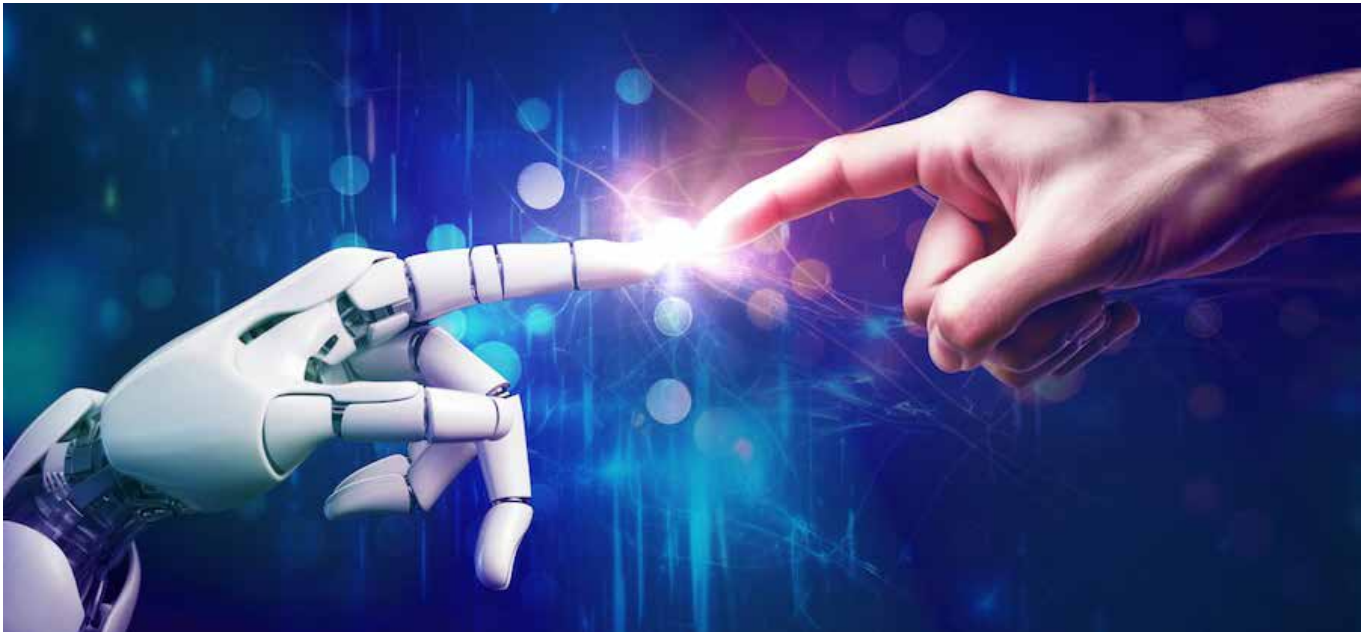
- If you have recent travel history to any country with active mpox transmission, observe yourself for symptoms
- Seek medical advice immediately if fever and rash appear
- Avoid close contacts (skin-to-skin, face-to-face, mouth-to-mouth) with someone who has symptoms of mpox
- Maintain general hygiene and regular hand washing with soap and water to reduce the spread

**Mpox**

If you suspect any of the mpox symptoms, seek medical advice without delay and avoid crowded public places

THE RISK OF MPOX SPREADING IN OUR COMMUNITY IS LOW AT THIS TIME  
Ministry of Health

# How to get the best out of ChatGPT



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## What is ChatGPT

ChatGPT is an Artificial Intelligence powered computer program that can read and write text in a way that sounds like a human. ChatGPT was released in November 2022 by OpenAI and has two versions, a free version and a paid version. The paid version charges 20 US\$ per month and is called ChatGPT Plus (<https://openai.com/index/chatgpt-plus/>). It has features such as Text to Image generation with DALL-E, browsing and advance data analytics.

This article will be about the free version GPT 3.5 and aims to provide a short theoretical background of ChatGPT and hands-on instructions for clinicians to effectively use ChatGPT.

It's important that you have created and have access to the free version of the ChatGPT to obtain maximum benefit from this article.

## How Does ChatGPT work?

ChatGPT consists of two components

- (a) **Chat Interface:** to facilitate the conversation with the human using written text or spoken word
- (b) **GPT - Machine Learning Component:** that uses the *Generative Pretrained Transformer 3 (GPT-3)* to generate different kinds of text such as emails, articles, essays, poetry and even computer code.

**Generative** – Generates text for many purposes like writing articles, answering questions etc.

**Pretrained** – Developers trained ChatGPT on huge amounts of data in text format from the internet, books etc. During this training it has learnt grammar, facts, common sense etc.

**Transformers** - Machine learning models that analyze large amounts of text data and learns to understand and produce text that is similar to human generated text.

Imagine a library with huge filing cabinets with a large number of drawers. This filing cabinet contains different varieties of text documents such as articles, books, web pages, songs, poems and even computer code.

ChatGPT is like a librarian who has read all these material and answer questions about the stored data as well as generate new content based on this extensive knowledge.

ChatGPT data that is stored is not specific to any domain such as Medicine, Geography Computer Science etc. It has stored documents freely available from all domains

including the web as well as other text sources. We cannot expect ChatGPT knowledge to include Point of Care Evidence based Resources (POCER) such as UpToDate, Best Evidence or DynaMed. POCER are not freely available on the web and are paid resources and for this reason ChatGPT will not include these resources.

ChatGPT 3.5 (free version) answers questions from a stored database which was last updated in 2021 September. Therefore, it cannot provide information on recent developments or current events. It is crucial not to rely solely on ChatGPT for critical medical decision-making and to verify information with reliable sources in medical literature.

**Alternatives to ChatGPT**

There are other Large Language Models similar to ChatGPT that is available to the public as free versions. We have listed a few.

**Gemini (formerly Google Bard)** <https://gemini.google.com/>  
Gemini is Google’s conversational AI chatbot that function sourcing the answers from the web, providing footnotes, and even generating images within its chatbot.

**Copilot** <https://copilot.microsoft.com/>  
Copilot is Microsoft’s AI Chatbot. This is designed to help developers with code-related tasks.

**Perplexity.ai** <https://www.perplexity.ai/>  
Up to date current events with access to the internet.

**Jasper** <https://www.jasper.ai/>  
Good chatbot for writing. However, there is only a paid version.

Focuses on written text; has copy-editing features and plagiarism checker

**Med-PaLM** <https://sites.research.google/med-palm/>  
This is a LLM from Google designed for the medical domain. It can be accessed by signing an agreement with Google and there is a payment for the use.

Some of the recent LLMs have incorporated domain-specific text from patient notes, medical guidelines and peer-reviewed literature etc. Examples include ClinicalBERT, Med-PaLM 2 and GatorTron which have collectively outperformed general LLMs in biomedical natural language processing tasks.

Another important advantage of these LLMs is that up-to-date knowledge could be searched from the internet in real time rather than relying on limited stored datasets.

However, errors in medical notes, scientific literature and other internet material will continue to hamper LLM performance.

At the time of writing this article there is evidence that LLMs have performed excellently in medical licensing exams. However, LLMs have failed in assessments of clinical decision-making including information gathering, using guidelines and integrating them into clinical flows, performing significantly worse than a trained physician. (Ref) <https://www.nature.com/articles/s41591-024-03097-1>

**Interface of ChatGPT**

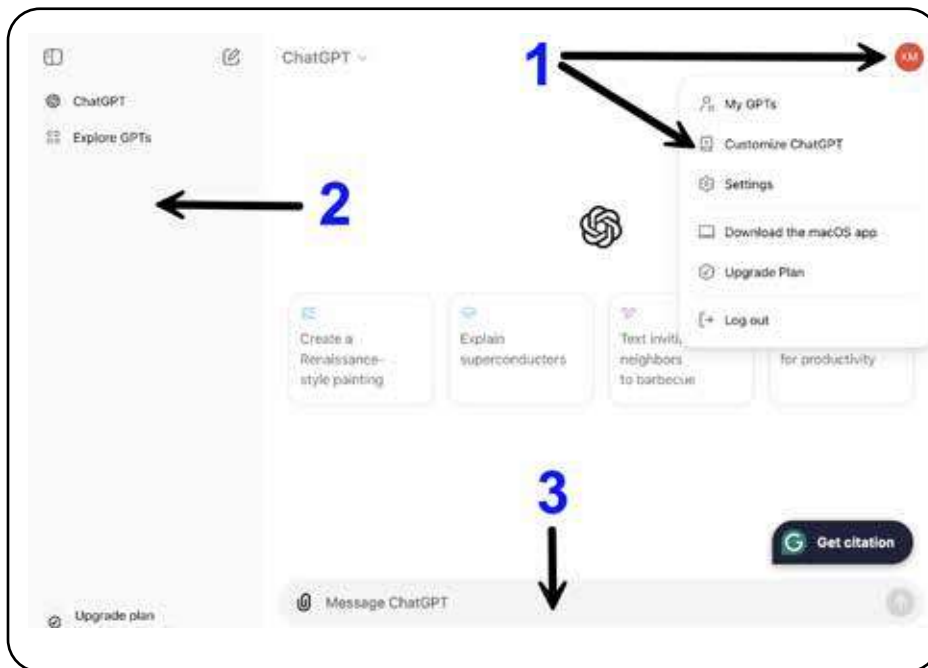


Figure 1

When you first start using ChatGPT its best to customize.

On the top right corner there is your initials (KM) and a click on this will show the menu (Figure1 – 1). Go to **Settings – Customize ChatGPT**

There will be two Text Boxes requesting information to customize the settings. (Figure 2). We have given examples below that you can modify and include in these text boxes.

Filling the two text boxes will give ChatGPT the default context to provide the necessary answers to your questions. However, you can change the context by giving a different context before you ask a question. For example, although you are a doctor, for a specific question you can request ChatGPT to think that you are a ‘medical student’ or ‘A/L student’ or a ‘lay person’. You need to do this before you ask the specific question. You do this by typing the context in to the Message Box (3).

Left side vertical pane (2) will show your past queries and when you first use ChatGPT it will be blank. (Fig 1)

How you interact with ChatGPT is to type in your question in the Message Box found at the bottom of the screen (3) Fig 1. The quality of the response depends on how well you formulate your question, known as the 'prompt'. Here are some tips for effective prompts:

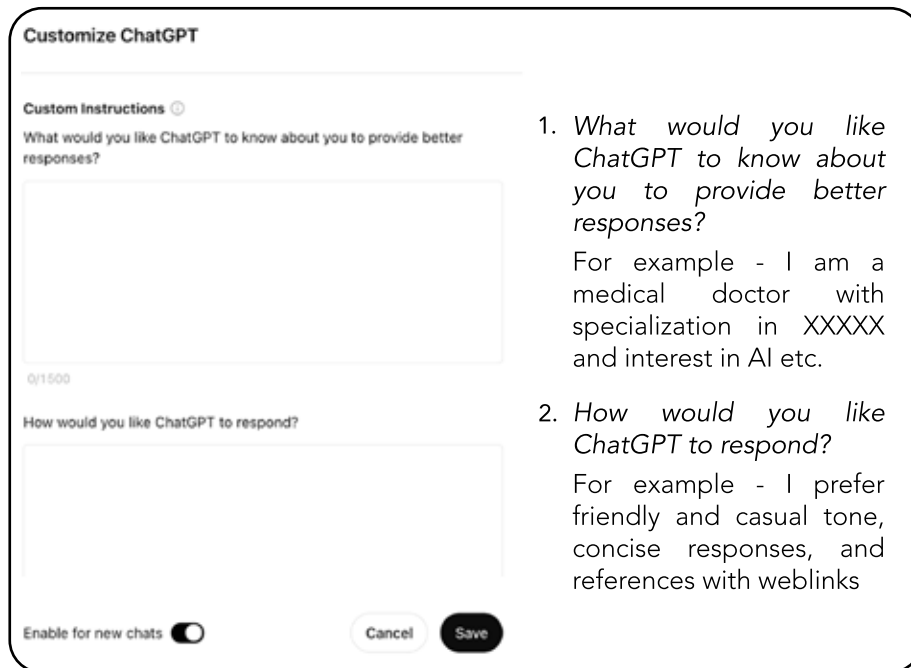


Figure 2

- Be specific and clear.
- Provide context if needed.
- Ask follow-up questions to refine the response.

**Type of Prompts / Questions**

There are different types of questions/prompts you can use with ChatGPT to obtain different kinds of information. Below we list type of prompt (in bold) with an example question.

- 1. Specific facts and Details**  
Who started Evidence Based Medicine and in which year?
- 2. Asking for suggestions**  
Give three books on AI in medicine that is suitable for a beginner
- 3. Comparison**  
Give a comparison between Allopathic and Ayurvedic medical systems.  
Please format it so that it can be given to a student doing Advance Level
- 4. Creative writing**  
Write a story, poem, email, article  
Remember to give context  
eg story about man and dog, that's funny or sad etc,

that is for a group of people on eg training program XXX, in 500 words.

Can ask the story to be written as a poem or song

**5. Summarizing**

Please summarize the article uploaded in 500 words for an Advanced Level student (There is the facility to upload documents)

**6. Brainstorming**

We are planning an Annual Medical Conference. Give some novel activities we can do during the conference

**7. List generation**

Give two top ranking clinical medicine books published in English that is suitable for a final year medical student

**8. Pros and Cons**

Give pros and cons of using a hybrid car

**9. Quotes and Studies**

Give three quotes of Eisenstein on education

Can you list three studies about EBM after the year 2015

**10. Feedback on your text**

I have uploaded an article I wrote about EBM for doctors who have finished their Internship. Can you give feedback to fine tune it and restricting to a word limit of 1500 words?

**11. Role play**

I have got a job interview with Board of consultants plus the CEO of a private hospital as I have applied for a post of an emergency medicine consultant.  
Can you do a role play with me interviewing me as the CEO?

**12. Explain different concepts**

Can you explain the different concepts of Traditional and Ayurvedic medicine

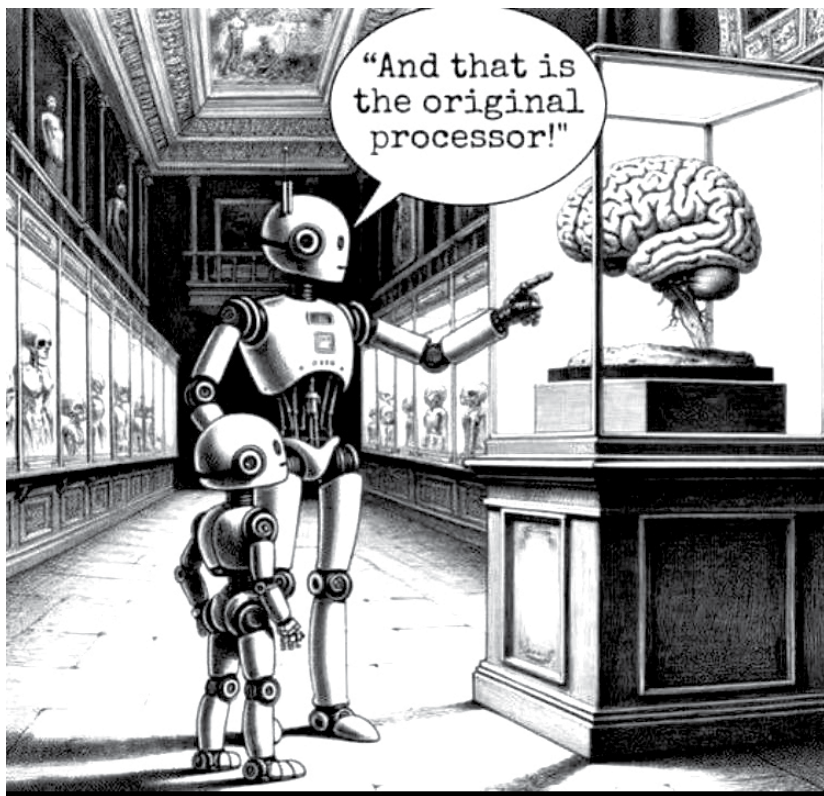
**13. Language translation**

How to say "Good Morning" in French and also how to pronounce it

**14. ChatGPT commands**

You can even ask ChatGPT what commands can be used to clarify a certain issue.

Can you tell me what's the best type of question to use to clarify the issue eg.....



- ChatGPT can exhibit factual errors, context errors, and omission errors, which can sometimes compromise the reliability of the information provided.
- ChatGPT can 'Hallucinate' (Fact Fabricate) and state completely incorrect answers.
- ChatGPT's 'black box' type of processing makes it difficult to explain how the answers are generated.
- It is best not to use ChatGPT to support clinical decisions like diagnostic tests and treatment methods.

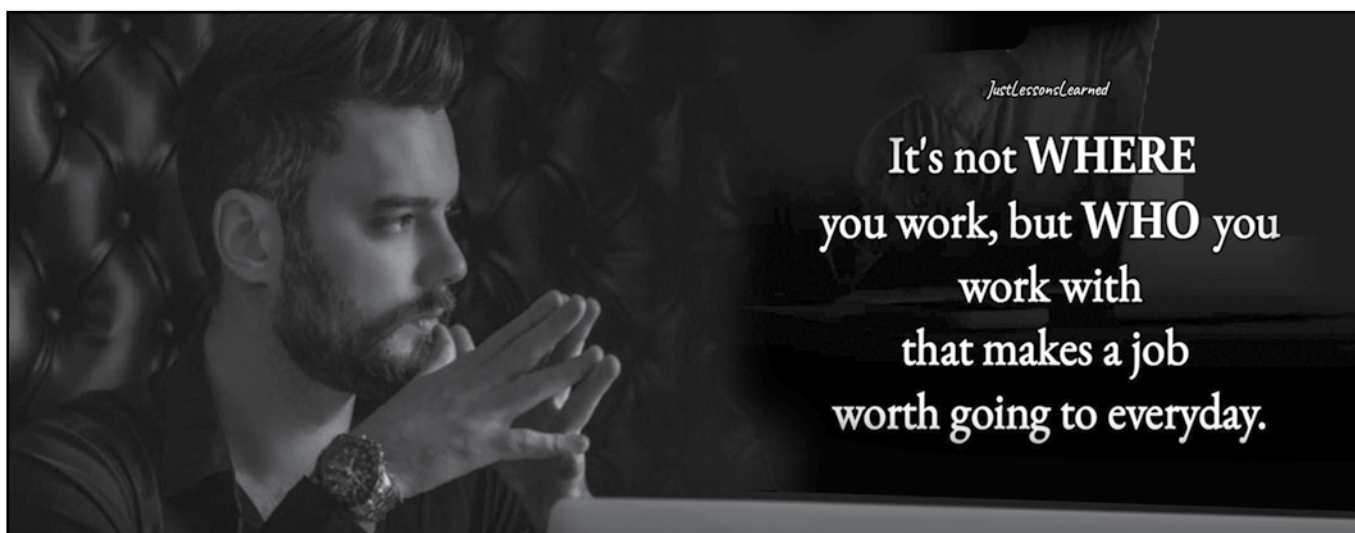
**Common issues when using the ChatGPT API**

- Character limits: Input and output character limits vary by version (e.g., GPT-3.5 has a 2048 character limit)
  - Ensure prompts do not exceed 2048 characters.
- Connection timeout on long responses: Long and complex responses may cause timeouts (sometimes responses are cut off)
  - Keep track of the session duration
- Unfinished responses: Responses might be incomplete; typing "continue" can prompt completion.
  - Regenerate responses: Ask ChatGPT to regenerate responses or start a new chat if responses are incomplete
- Limited messages: There are limits on the number of messages per time period, even for paid accounts.
- Login issues: Account status or session duration can affect access.
  - Ensure proper login and access: Verify account status

After you asked the first question you can keep asking questions to clarify anything that is in the ChatGPT reply. You can ask for extra information about the same topic etc. When you are using the free version, there is a limit of questions that the ChatGPT allows you to use for each day. When you have reached the limit, it will become slower and will not answer. However, if you want to use the free version and get information you want, wait 24 hours and start the conversation as a new topic.

**Limitations of ChatGPT**

- The dataset that is used is not specifically related to healthcare / medicine and it is limited to events only up to 2022 September.





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**Sri Lanka Medical Association**

## **Call for Applications Deshabandu Dr C G Uragoda Oration on the History of Medicine 2025**

This oration was established as a lecture in the year 2012, the 127<sup>th</sup> anniversary year of the Sri Lanka Medical Association (SLMA), to commemorate establishment of the SLMA by a meeting attended by a group of doctors at the Colonial Medical Library in Colombo on 26 February 1887 to discuss the formation of the Ceylon Branch of the British Medical Association, which later became the Sri Lanka Medical Association.

The lecture was renamed the Dr. C. G. Uragoda Lecture on the History of Medicine in the year 2017 to honour the lasting contribution made by Dr. C. G. Uragoda to document, "The History of Medicine in Sri Lanka". In 2020, on the demise of Dr. C. G. Uragoda, the Council of the SLMA decided to elevate the lecture to that of an Oration and also add his national titular honour Deshabandu to the title of the Oration.

This oration is delivered on the 26<sup>th</sup> February of each year.

Applications are called for the Deshabandu Dr. C. G. Uragoda Oration to be delivered on 26 February 2025. Applicants should submit a short abstract of the proposed lecture (no more than 500 words, font size 12 in Times New Roman and margins set at 1 inch right round) and a brief curriculum vita (no more than 3 pages).

The orator should have been considerably associated with and contributed to the field of medicine in his/her chosen topic.

The SLMA will give preference to applications in areas of medicine that have not been covered in previous orations. A list of past orations can be found on the SLMA website – <http://www.slma.lk>. Applicants should bear in mind that they must make themselves available to deliver the oration on 26 February 2025 at the SLMA Auditorium (if selected) as the oration is delivered to mark the founding of the SLMA.

Applications should be submitted to the Honorary Secretary, SLMA, on or before 31<sup>st</sup> October 2024.



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