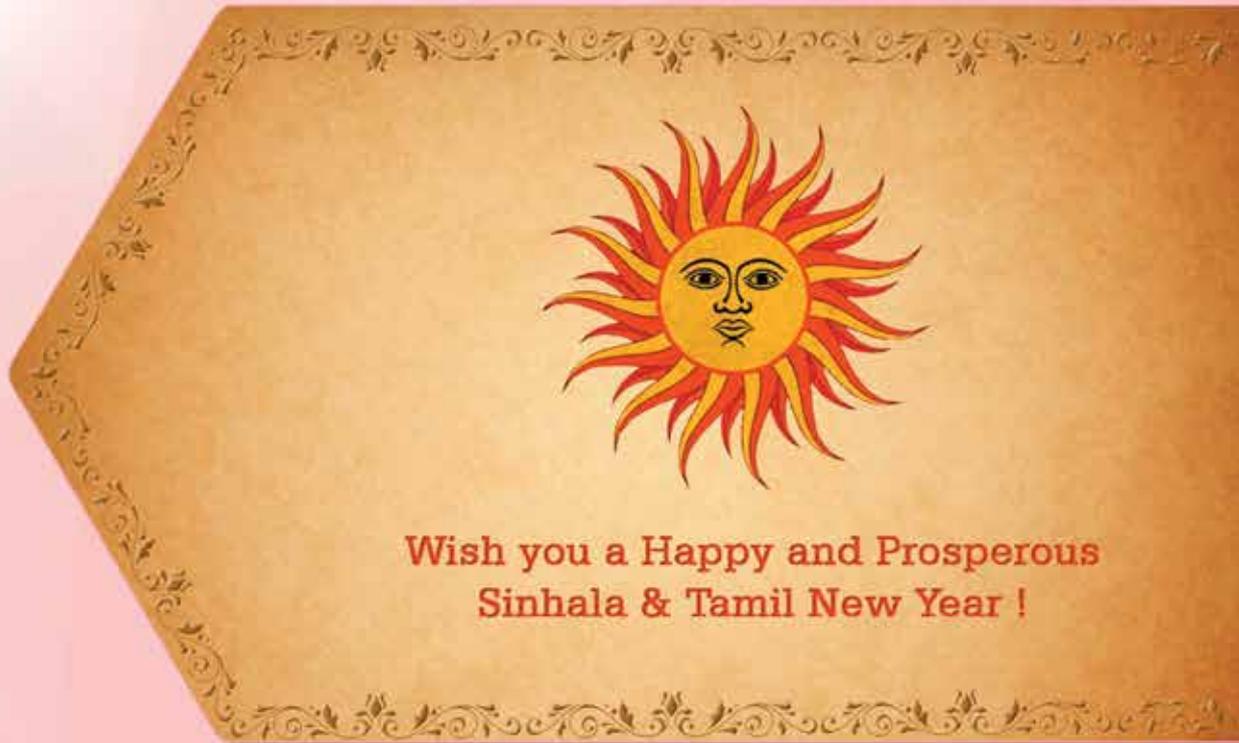




SLMA NEWS

THE OFFICIAL NEWSLETTER OF THE SRI LANKA MEDICAL ASSOCIATION

APRIL 2017, VOLUME 10, ISSUE 04



TOWARDS A HAPPY (AND HEALTHIER) NEW YEAR!

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04-08

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Dear Members,

Reflecting on SLMA outputs in the first quarter of 2017 is indeed most fulfilling. Much has happened due to the enthusiasm and commitment of SLMA's Executive Committee, Council and the numerous Expert Committees. The existing activities that gathered momentum and those that commenced afresh are quite remarkable. The monthly clinical meetings were well planned by Assistant Secretary Dr Yamuna Rajapakse and were ably enhanced by the Colleges of Paediatrics, Haematology and Anaesthesiologists respectively. We acknowledge their unstinting support with gratitude. The chosen topics were very appropriate to today's learning needs of our membership and were well attended and received. The special guest lecture session held in mid-March on 'Good Death and Legal Implications of End of Life Issues' attracted an unprecedented mixed audience of young and not so young committed clinicians, legal fraternity, media personnel and members of the lay public. Members of SLMA from many a relevant field volunteered their time and service to the Task Force on Palliative Care to help us define some simple guidelines on an evidence based rational approach to End of Life issues. I am also very grateful to the Medicinal Drugs Committee for arranging excellent lectures that addressed common therapeutic related topics on managing Influenza, Chronic Wounds and Leprosy.

Meanwhile the two regional meetings held monthly in Homagama and Ratnapura were very successful. I thank the local Clinical Societies. These meetings were designed to address SLMA's four main themes for this year and we are aiming to target all provinces of Sri Lanka during the year. Our efforts have been well received so far. I am very grateful to the groups working on a) Unmet needs of COPD, b) Palliative Care, c) Food based dietary guidelines and d) Wound care and their prevention

of pressure sores; for their continued dedication and commitment. These initiatives have an overall objective of improving the quality of care in these specific fields, throughout the country along with the regional leads and experts. I look forward to the active participation of regional Clinical Societies and regional members to join hands in taking these initiatives to culminate with a meaningful outcome. We need to appreciate that the SLMA's role is mainly catalytic, while the regional commitment is what will sustain the good practices, audits and thereby further improvements.

All these activities need a more formalized system of CPD quantification. I am thrilled to share with you how such a programme can be made user friendly with wider electronic access to our membership based on the actual piloting of the electronic version of CME activities by Prof Kumara Mendis and his technical team from the University of Kelaniya. Ably led by Past President Dr Sunil Seneviratne Epa and well supported by the Government Medical Officers Association in concurrence with the Ministry of Health the process seems to have all ingredients for a successful start. So please watch out for this and do not forget to contact the SLMA office and get your membership status updated.

I would fail in my duties if I do not acknowledge the progress made by assigned Task Forces and Expert Committees. The newly initiated Task Force in Palliative Care & End of Life Issues has clearly outlined their advocacy document and strategic plans by engaging with all stakeholders. Their effort in lobbying for funding from philanthropists is also very gratifying. The further progress made by the Diabetes Prevention Task Force that now exceeds 12 years in maturity, witnessed the happy inclusion of being cited in the Annual Report of 2017 of the World Diabetes Foundation (WDF) (<https://www.worlddiabetesfoundation.org/files/hip-%E2%80%93lifting-maternal-diabetes-care-national-level>), which

is reproduced on pages 12-13 of this issue. I am very grateful to the Director General of Health Services and all officials in charge of the prevention and control of NCDs from within and outside of the Ministry of Health for their excellent support and cooperation over the years. The site visit made by the Programme Manager Ms Hanne Standgaard MSc on behalf of the WDF donors in March 2017, enabled one and all to witness the excellent progress of grass root level initiatives made by the newly located Health Promotion Graduates in 7 districts, under the supervision of the Health Education Bureau and the NCD Bureau with co-funding by the World Bank/SHSDP project. The sustained commitment of the Chairperson of the NCD Subcommittee Dr Palitha Karunapema and Dr Ajith Alagiyawanne, Consultant Community Physician for Health Promotion (HEB) are greatly appreciated. More recent plans to initiate a national level Task Force on prevention of Road Traffic Accidents clearly indicates the need for an advocacy and leadership role by SLMA and related professional groups in conjunction with non-health and private sectors. It is noteworthy that the World Health Day theme on "Depression – let's talk" was well organized and supported by all stakeholders on 7th April 2017 with SLMA supporting the efforts of the NCD Alliance.

I draw your attention to two major events arranged by SLMA this year. The first being the Health Run & Walk which is arranged for Sunday 4th June 2017. It is focusing on international days assigned to address Environment, Asthma and anti-Tobacco related issues. Please join hands with us in supporting the College of Pulmonologists in advocating for clean air and a more effective prevention and control of chronic respiratory diseases starting from childhood. It is noteworthy that this event will have a wider participation of sectors aligned towards addressing Environmental, Educational, Sports, NATA and the Corporate Sectors' roles in achieving set targets.

Contd. on page 03

PRESIDENT'S MESSAGE...

The second is our Annual International Congress that is being held in conjunction with the National Science Foundation at Hotel Galadari Colombo from 13th to 16th of July 2017. There is an exciting array of plenaries, symposia and workshops that address new frontiers in science to explain modern day diseases like the Human Microbiome & Metabolomics to disease specific issues that well address current challenges and the need for better

patient engagement as per SLMA's theme for this year. Please visit our website and keep your diaries free.

I invite doctors and allied health professionals from all sections of care in Sri Lanka to join hands with our future members, the medical and health science students, to be the main participants of SLMA in achieving a successful outcome to our planned efforts. Please remember that SLMA's

doors are always open to you to learn novel aspects, reflect on current evidence and transfer good practices for the benefit of society.

I wish each and every one of you my best wishes for a Happy and Prosperous Sinhala & Tamil New Year.

Chandrika Wijeyaratne
President SLMA

TOWARDS A HAPPY (AND HEALTHIER) NEW YEAR!

Saroj Jayasinghe,
Professor of Medicine,
University of Colombo.
Council Member of SLMA.

Aluth Avuruddha in Sinhala (or Puthandu in Tamil) is a cultural event that has been celebrated for several centuries by many agricultural societies. Similar events based on the lunar calendar are observed by Hindus in southern India, and in regions of Bangladesh, Myanmar, Cambodia and Thailand.

In Sri Lanka, it is a national cultural event bringing together families, neighbours and loved ones and there are activities which are carried out to strengthen bonds and partake in festivities. Observations of traditions and religious rituals with a deep feeling of interconnectedness have many health and social benefits. Social scientists may call this an accumulation of social capital, while for most of us it's a sense of belonging and solidarity.

Amidst all this celebrations there appears to be at least three hidden health risks. The worst culprit is the culture of alcohol intake, especially by males. This becomes rampant during the Traditional New Year in many villages. There is violence, rowdy behaviours and mayhem in some quarters. The adverse health and social impacts of such behaviours are obvious. Those who have worked in government hospitals will vouch for the number of patients or incidents of accidents, homi-

cides, violent injuries, alcoholism etc that inundate the OPDs, the accident services and casualty wards during this holiday season. An alcohol free traditional New Year should be our target, at least with the future generations.

The next is the dangers of fireworks, especially to the eyes and body of children. This too has led to calls for more caution and safety. The eye surgeons and hospital administrators have done an exemplary job in improving awareness on this area. Fire crackers should NOT be lit by children, who have a higher chance of injuries. Fire hazards should be considered, and eyes protected at all times (.....and please protect your pets from loud noisy crackers).

Finally, there is a more subtle form of behaviour that the Traditional New Year is encouraging or promoting. This relates to our culture in relation to foods we consume during festivities. The Traditional New Year is one event where we indulge in large quantities of refined sugar in different forms! Indulgence is the name of the game as we go from one 'avurudhu table' to the next, eating our hearts out with the sweetest foods that we would ever be offered! I am almost sure that the average blood glucose levels spikes in April in the whole of Sri Lanka!

Do we have more nutritionally appropriate recipes that could give us the same tasty Kavums? Do we have

alternatives to oil dripping Kokis? Has the Aasmi got to be laced with sweet syrup? Over to our nutritionist colleagues who could give us similarly tasting alternatives so that the SLMA could begin to publicize a 'Towards a Healthier Aluth Avuruddha and Puthandu'

There is also growing concern about the inroads being made by some of the industries that are sponsoring New Year celebrations in the media. The hypothesis is as follows "Are food manufacturers or sellers of calorie dense foods (or fast foods) making a special attempt to capture the Traditional New Year celebrations?"

In order to confirm or refute this hypothesis, shall we observe as to who is sponsoring media events relating to the festivities in April 2017?

Subha Aluth Avuruddhak We-waa!..... Puttāṇṭu Vāṭtukka!

SLMA

Doctors' Concert 2017

The SLMA Doctors' Concert will be held on the 15th of July 2017 at 7.00 pm at the Ballroom of Hotel Galadari, Colombo.

Doctors and family members who are interested in performing at this Concert are requested to contact Dr. Christo Fernando on **0777 393930** or **drmlcfd@gmail.com** at your earliest.

Suhashini Ratnatunga¹,
Madhubhashinee Dayabandara²

¹Lecturer, ²Senior Lecturer,
Department of Psychiatry,
Faculty of Medicine, University of Colombo

The complexity of suicide has been reiterated in studies involving neurobiology, cognitive psychology and clinical psychiatry. Suicidal behavior can be conceptualized as an interaction between affective, cognitive, motivational, physiological and behavioral schemata that once activated simultaneously by relevant environmental stressors/events culminate in a goal directed behavior. Many explanatory models have aimed to explain suicidal behavior. One such popular model in the past was the stress model. It was based on the observation that stress or negative life events precipitated suicidal behavior. However, such models refute the role played by individual biological and psychological factors. Furthermore, this model was unable to explain the observations that even under extreme stress some individuals do not exhibit suicidal behavior. In light of these reflections a stress diathesis model was offered.

The stress diathesis model recognizes stress as an activating factor in diathetic individuals ⁽¹⁾. A diathetic individual will respond in a pathological manner to life's stressors that are borne by many individuals without consequence. Hence diathesis can be conceptualized as a risk factor. Therefore, the diathesis alone is insufficient to produce suicidal behavior but requires other potentiating factors (e.g. stress) for the final outcome. It can be rightly assumed then that individuals differ with regard to suicidal behavior depending on the degree of diathesis and experienced stress.

Suicide and self-harm remain one of the most important causes of mortality and morbidity in Sri Lanka. It is important to understand the epidemiology and trends in suicide and self-harm in this country for intervention at individual and community levels.

Epidemiology of suicide and self-harm in Sri Lanka

Suicide rates in Sri Lanka gradually increased from 1950 to 1995. The highest suicide rate was reported in 1995 at 47/100,000. Since then rates have gradually reduced in both males and females. A greater decline in suicide rate was seen in females than in males ⁽²⁾.

In 2012, the age standardized suicide rate was reported as 17.1/100,000. A higher rate of suicide was reported in males when compared with females (males 27.7/100,000: females 7.7/100,000). This would rank Sri Lanka in 22nd place when considering suicide mortality data from other countries ⁽³⁾.

Overall the suicide rates remain higher in males in all age groups except in 10-19 years age group where the female suicide rate is slightly higher. Suicide rate was highest in females in 20-29 years age group (13.9/100,000). It was highest in males in the >60 years age group (49.95/100,000) in 2011⁽²⁾. It must be noted that Sri Lanka has high suicide rates in young adolescents when compared with other countries. Suicide rate in 16-24 years age group in males was 25.8/100,000 and in females 15.47/100,000 in 2011⁽²⁾.

The reduction in suicide rate is attributed to many causes. The main factor identified was the restriction on import and sale of WHO Class I pesticides in 1995 and endosulfan in 1998 ⁽⁴⁾. The initial increase in suicide rates post 1950s coincided with increase in reported pesticide poisoning. The reduction in suicide rates after 1995 was associated with reduction in deaths due to self-poisoning and reduced case fatality. Establishment of a National Poison Centre, availability of antidotes, improvement of intensive care facilities and better transport facilities may have contributed to above.

No association has been identified with levels of unemployment, alcohol consumption or divorce rates ⁽⁴⁾.

In contrast to suicide rates, rates of deliberate self-harm are increasing in Sri Lanka ⁽⁵⁾. The annual incidence of hospital admission due to poisoning by any substance was 321/100,000 in 2007.

Methods used for suicide and self-harm

Prior to 1960s hanging was the predominant method used for suicide in Sri Lanka. In 1960s acetic acid poisoning (used in rubber industry) emerged as a new method. From 1970s pesticide poisoning became the main method used in suicide attempts. Since 1995, the reduction in suicide rates has been associated with changing trend in method used too. While remaining the main cause, suicide by pesticide poisoning has gradually decreased over time. Incidence of fatal poisoning by medicinal drugs and non-poisoning methods (hanging, drowning, jumping from a height or in front of a moving vehicle, firearms etc.) has not shown significant change during this period ⁽⁵⁾. Deliberate self-harm on the other hand has shown a notable trend towards self-poisoning by drugs used for medicinal purpose. Easy availability of medicines bought over-the-counter, social acceptance of drug overdose as a method of self-harm and increased knowledge of the lethality of pesticide ingestion may have led to this change.

Motives for self-harm in Sri Lanka

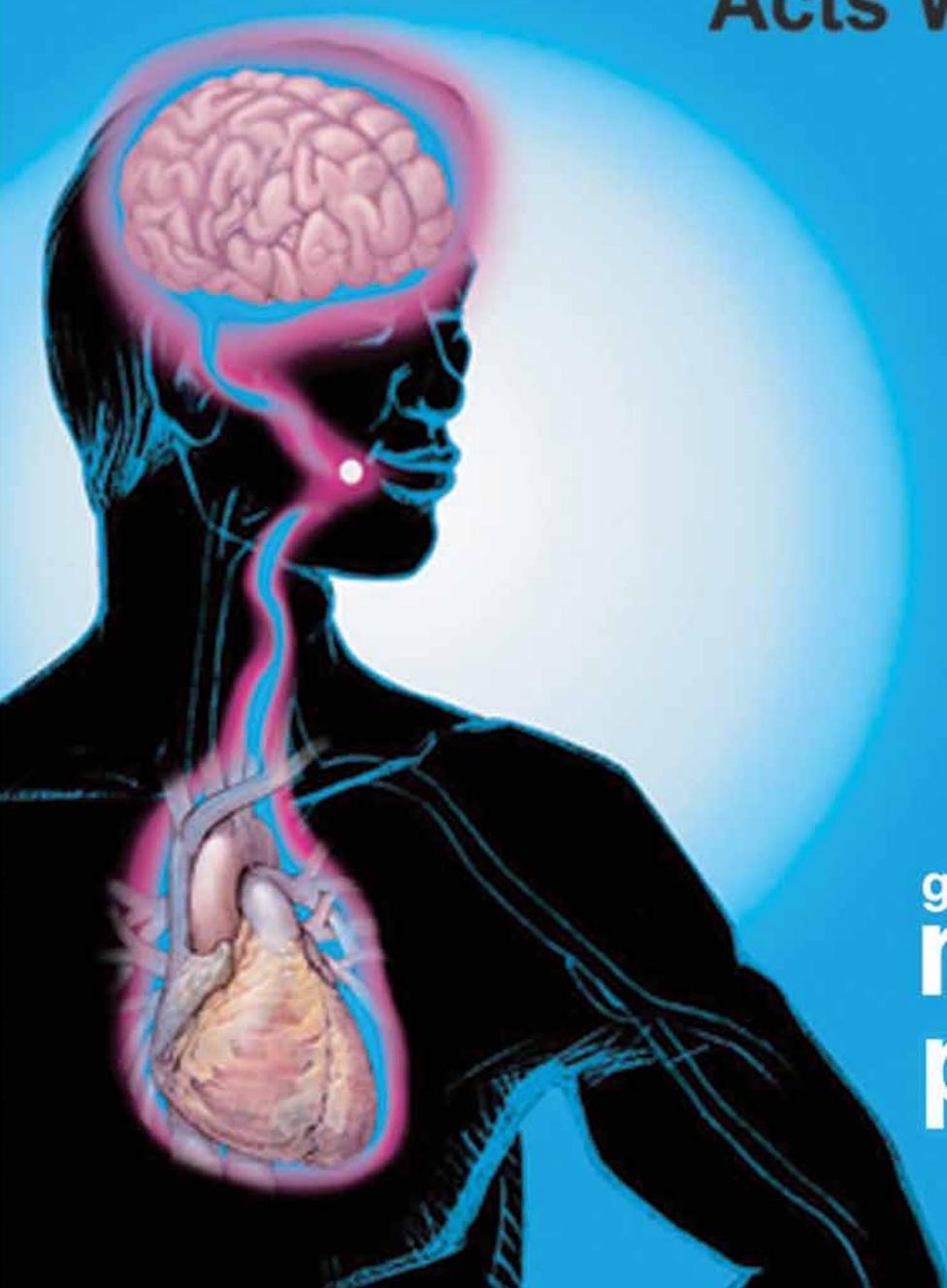
Interpersonal conflict has emerged as the commonest trigger for self-harm in all age groups in a study done in patients admitted after a self-harm attempt to Teaching Hospital, Peradeniya ⁽⁶⁾. Severe pain and intense financial stressors were also identified as causative factors leading to self-harm. The qualitative component of this study identified interpersonal conflict to have occurred within 24 hours of the act and with a close family member. Escape or wish to die was described as the motive associated with the trigger.

Contd. on page 06

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SUICIDE IN SRI LANKA...

These ideas were not present in majority before the trigger occurred⁽⁶⁾. Findings of this study highlights the acceptance of self-harm culturally as a method of expressing anger and frustration.

Importance of intervention

The impact of a suicide or a deliberate self harm event extends far beyond the consequences to the individual.

Often the family and close associates of a person who committed suicide or self-harm experience a mixture of emotions. Anger, feeling of betrayal, helplessness and hopelessness are some of the emotions expressed by family and friends⁽⁷⁾. Healthcare professionals who were involved in the care of the person may experience complex emotions of guilt and loss..

Stigma on the family is another significant issue. Suicide was decriminalized in Sri Lanka in 1997. However, suicide and self-harm of a person in the family continues to have adverse impacts on the person and other family members with regard to employment opportunities and marriage prospects. Social inclusion is also sometimes affected according to the various religious teachings regarding suicide.

High self-harm rates also imply higher costs of health care. Total cost of treating patients presenting with self-poisoning in 2006 in Anuradhapura district was estimated at 2.8% of all health care costs incurred by the government for the Northcentral province.⁽⁸⁾

However, the main consideration in prevention is evidence that persons who harm themselves have a higher risk of repetition of self-harm and suicide. A recent meta-analysis concluded that one in 25 patients who present with self-harm will later die of suicide within the next five years⁽⁹⁾. The rate of repetition of self-harm in Sri Lanka at one year has been estimated to be 2.5%, considerably lower than those in developed countries⁽¹⁰⁾. This brings

us to the fundamental issue of recognizing vulnerable individuals and what we can do as clinicians to prevent suicide and better manage at risk individuals.

What are the risk factors a clinician should look for?

Demographic factors

Gender

As discussed above males are at higher risk of completed suicide than females.

Age

The risk for suicide increases with age, international studies indicate that the risk peaks for males at 45 years and 55 years for females. However, it is apparent that locally this trend tends to fluctuate.

Race and religion

In Sri Lanka Sinhalese Buddhists had the highest suicide rate followed by Sri Lankan Tamils who were predominantly Hindus⁽¹¹⁾.

Marital Status

Marriage appears to be a protective factor. The rates of suicide appear to be lower in married persons of both sexes compared to divorced and separated individuals and individuals who had never married. Marriage appears to be reinforced by having children as well as the availability of a social support network⁽¹⁾.

Occupation

Gainful employment appears to protect against suicide. The rates of suicide are higher during economic recessions and times of high unemployment⁽¹⁾. An excess mortality from suicide is also seen in some occupational groups such as healthcare workers and agricultural workers⁽¹²⁾.

Psychiatric diagnosis and related factors

The principal risk factor for suicide is psychopathology.

It has been estimated that 90% of

individuals who commit suicide have a primary psychiatric diagnosis⁽¹⁾. Major depressive disorder is considered a chief culprit. Studies on depression emphasize that risk of suicide increase with increased level of hopelessness. Up to 15% of patients with a depressive disorder die by suicide. Suicide in individuals with substance dependence is often overlooked. Seven percent of patients with alcohol dependence will die by suicide in their lifetime⁽¹⁾. The lifetime risk for schizophrenia is 5%⁽¹⁾.

A personality disorder is diagnosed in up to one third to half of people who commit suicide. Persons with borderline and antisocial personality disorders appear to be at high risk⁽¹⁾. Other strengths and weaknesses in personality (traits) have also been attributed to confer a vulnerability to suicide; poor coping skills, deficient problem solving skills, aggression and/or impulsivity, hopelessness and neuroticism.

Clinical studies have also indicated reported childhood adversity; physical and /or sexual abuse and deprivation as a risk factor for later childhood psychopathological phenomena and later adult depression and suicide⁽¹⁾.

Suicide rates also appear to be high in patients with chronic medical illnesses such as malignancies, HIV/AIDS and following head injury⁽¹⁾.

Assessment of suicide risk

Clinicians should endeavor to perform a comprehensive suicide risk assessment in any patient who presents following a deliberate self harm attempt, directly expresses active ideas of suicide and most importantly portray some of the risk factors that that have been illustrated above.

The objective of a risk assessment is to identify individual suicide risk and protective factors. However, prediction based on these factors has a rather low sensitivity and specificity.

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SUICIDE IN SRI LANKA...

Also when the risk is assessed as high it is difficult to predict when the act will take place. Therefore, clinical intuition/experience also plays an important role in the assessment.

The initial assessment involves building a therapeutic rapport, expressing empathy and gentle inquiry into suicidal behavior.

A collateral history is invaluable to corroborate information obtained as patients with high intent may conceal the severity of suicidality. An essential component in the evaluation is assessment of suicidal intent following a deliberate self harm act. This includes the duration and extent of planning, belief about lethality and after effects, availability of means, behaviors done to conceal the act from others and whether any final acts were performed (writing a will or suicide note) prior to the act. The motivation for the act should be assessed – end suffering, hopelessness, reunite with loved ones etc.

Past behavior predicts future behavior. Therefore, assessment of past suicidal behaviors such as number of attempts, methods used, triggers for the attempt and consequences.

The next step in assessment should be careful evaluation of the above mentioned risk factors.

Following this a mental state examination should be performed and recorded. The mental state should highlight the degree of agitation or retardation, current mood and its severity, ongoing ideas of suicide, depressive cognitions such as hopelessness and helplessness, psychotic features such as delusions of control or command hallucinations asking the patient to end his life.

Scales have been introduced for screening in the general practice however it cannot be overemphasized that a thorough clinical examination cannot replace scales in assessing suicide risk.

The Beck's scale for suicidal ideation, Columbia suicide severity scale, Pierce suicide intent scale and the psychological autopsy checklist are some of the scales that have been translated to Sinhala (some to Tamil as well) and some have been validated to the Sri Lankan population⁽¹³⁾.

The final step involves identifying targets for intervention. Timely diagnosis and appropriate management of mental illness, identifying modifiable stressors and appropriate psychological interventions for maladaptive traits and coping skills (problem solving therapy, supportive psychotherapy etc.)

Conclusion

Our reservations in making contact with high risk patients and managing them may originate from the fact that we may never be able to prove our success. This was expressed eloquently by one clinician, "If suicide prevention is successful the patient will live. A suicide will have been prevented. Yet to quantify this effect is impossible. It is important to realize that the absence of a suicide generates no data. Thus we can never prove what has been accomplished. Yet we can hardly doubt that it occurs"⁽¹⁴⁾. We are constantly reminded of our so called failures which continue to haunt us and question our judgment. However, it is important that we rise willingly to this challenge of suicide prevention whilst acknowledging that the task is complex, individuals vary, the causes are multifactorial and the consequences of assessment so great that even the best standards of care can at times fail to prevent it.

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SLMA MONTHLY CLINICAL MEETING

Dr. Yamuna Rajapakse
Assistant Secretary / SLMA

The Monthly clinical meeting of the SLMA was held on the 21st of March 2017, from 12.15 to 1.15 pm at the SLMA auditorium. This month's meeting was held in collaboration with the College of Anaesthesiologists and Intensivists of Sri Lanka. The theme was Obstetric Haemorrhage and the very well attended session was Chaired by Prof. Chandrika Wijeyaratne, President, SLMA and Dr. Harshini Liyanage, Consultant Anaesthetist, De Soysa Maternity Hospital, Colombo. The Clinical Case discussion on management of obstetric haemorrhage was done by Dr. Erandi Siriwardena MBBS, MD (Anaesthesiology), FRCA, Senior Registrar in Anaesthesia at the De Soysa Maternity Hospital, Colombo (The transcript of this lecture is published below). The interesting and informative lecture was followed by an MCQ session. The audience participated very enthusiastically in the MCQ session with many questions and comments.

MAJOR OBSTETRIC HAEMORRHAGE

Dr. H Liyanage (Consultant Anaesthetist – De Soysa Maternity Hospital)

Dr. E. M Siriwardena (Senior Registrar – De Soysa Maternity Hospital)

CASE HISTORY

A previously healthy 30 year old primi para was admitted at 28 weeks gestation with a diagnosed intra uterine death (IUD). Congenital heart disease was diagnosed in the baby previously at 23 weeks of gestation. Expectant management was carried out and she went in to active labour only after a week from the initial diagnosis. She was provided epidural analgesia by the anaesthetic team for this potentially prolonged labour. She delivered a macerated still birth after being in labour for nearly 22 hours with effective epidural analgesia. Active management of the third stage was carried out and she was given an oxytocin bolus of 5 units as well. However despite above measures she was noted to have a lax uterus with continuous bleeding. The estimated blood loss at this point had been about 800 ml. She was started on an oxytocin infusion at 10 units per hour and was also given misoprostol 800 mcg per rectal in an attempt to aid uterine contraction. Her pre delivery haemoglobin was 9.8 g/dL and she was transfused two units of blood at this point.

One hour later her bleeding had still not settled with the estimated blood loss approaching 1500ml. A rotational thrombo elastometry (ROTEM) done at this point revealed a severe coagu-



lopathy and transfusion of 20 units of cryoprecipitate was recommended by the consultant haematologist. Shortly afterwards she was taken to theatre for an examination under general anaesthesia. Further ongoing blood loss of 500 ml was noted (total blood loss approaching 2000 ml) and she was transfused another unit of blood. Oxytocin bolus of 10 units and ergometrine 0.25mg iv and 0.25mg im was given to aid uterine contraction. Tranexamic acid 1g and 10% calcium chloride was also given and active patient warming was carried out in this major haemorrhage setting.

During the surgery a vaginal tear was identified and it was repaired. Some products were removed. A bukri balloon was inserted and the vagina was packed. Continuous oozing of blood from the vagina was noted. The total blood loss was estimated to be around 2500ml. The repeat ROTEM was still abnormal and a further 10 units of cryoprecipitate and 6 units of platelets were given as advised by the

haematologist. (In total 5 units packed red cells, 40units cryoprecipitate and 6units platelets were given) She was extubated at the end of the procedure as she remained stable and was transferred to the intensive care unit.

Her postoperative course was complicated by sepsis, thrombotic thrombocytopenic purpura and acute kidney injury which required haemodialysis. She was discharged from ICU after a 12 day stay but continued to be dialysis dependent in the ward. She is presently under investigation for the possible development of chronic kidney disease.

DISCUSSION

Major obstetric haemorrhage (MOH) is defined as an acute blood loss in excess of 1500ml, a drop in haemoglobin of 4g/dl or more or an acute transfusion requirement of 4 units of packed red cells or more. It remains a major cause of maternal mortality worldwide with an incidence of nearly 25%.

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It still remains the highest direct cause of maternal mortality in Sri Lanka according to the last analysed data. MOH can be classified as ante partum haemorrhage where bleeding occurs after 24 weeks of gestation but before delivery or postpartum haemorrhage where bleeding occurs after delivery. Postpartum haemorrhage (PPH) is further classified in to primary PPH where bleeding occurs within 24 hours of delivery and secondary PPH where bleeding occurs between 24 hours post-delivery to six weeks after delivery.

Several physiological changes in pregnancy such as blood volume expansion, increase in stroke volume and cardiac output are actually protective if significant bleeding occurs. But certain other changes such as increase in uterine blood flow by nearly 10% and aortocaval compression can be quite detrimental in the event of a major haemorrhage compounded by the fact that bleeding from the utero-placental bed can be brisk and difficult to control.

In addition tachycardia may be the only sign of haemorrhage until 30-40% of blood volume has been lost making diagnosis difficult.

Causes of ante partum haemorrhage are -

- ▶ Placenta Praevia
- ▶ Placental abruption
- ▶ Uterine rupture
- ▶ Trauma

Causes of postpartum haemorrhage are –

Primary PPH

- ▶ Uterine atony (80%)
- ▶ Retained products of conception
- ▶ Genital tract trauma
- ▶ Acute uterine inversion
- ▶ Abnormally adherent placenta
- ▶ Coagulopathy

Secondary PPH

- ▶ Retained products
- ▶ Puerperal sepsis

Initial management of MOH involves providing high flow oxygen, placing the mother left lateral to prevent aortocaval compression if ante partum. Achieving wide bore access is paramount and blood needs to be sent for basic investigations and cross matching of at least 6 units of blood. A major haemorrhage call needs to be put out to alert the anaesthetist, obstetrician, senior midwife, blood bank and theatres. Warmed crystalloids should be given fast until blood is available. Ideally blood, fresh frozen plasma and platelets needs to be transfused at a ratio of 1:1:1 especially if the blood loss is in excess of 1500 ml. Tranexamic acid 1g bolus is recommended in the MOH setting following the recommendations of the CRASH2 trial in the trauma setting. Calcium replacement may also be needed. Point of care testing needs to be used to monitor haemoglobin and coagulation and haemacue or blood gas for Hb and thromboelastography (TEG) for coagulation parameters are commonly used. Transfusion of other products such as cryoprecipitate, fibrinogen concentrate and platelets should ideally be guided by TEG. The place of activated factor seven in the MOH setting is not well established but it can be given to enhance coagulation provide the fibrinogen level is more than 1 g/L and platelet count more than 20,000/mm³. The ultimate treatment goals are a haematocrit of at least 30%, platelet count more than 100,000/mm³, fibrinogen level of more than 2g/L, ionised calcium more than 1mmol/L and temperature more than 36°C.

Appropriate use of available uterotonics which are oxytocin, ergometrine, misoprostol and carboprost play an important role in the management of PPH particularly in the setting of an atonic uterus. Oxytocin is usually given as a 5 unit bolus followed by an infusion of 10units per hour. Ergometrine is usually given intramuscularly in a dose of 0.5mg but can also be given

in a dose of 0.25mg intravenously and the rest of the 0.25mg intramuscularly when really needed. Misoprostol dose is 400mcg to 1000mcg and can be given rectal, sublingual or oral although the rectal route is commonly used. Carboprost is administered in a dose of 250mcg and can be repeated every 15 minutes to a maximum dose of 2g. Various surgical methods are also to improve uterine contractions in order to halt bleeding. Uterine massage, bi manual compression, balloon tamponade, compression sutures to the uterus, interventional radiological methods such as balloon occlusion or coil embolization of uterine arteries, surgical pelvic vessel ligation are some of the more common techniques used with hysterectomy being the last resort. Out of the above mentioned methods the bukri balloon and the B-lynch compression sutures have gained popularity in present day practice.

It is important to focus on preventive aspects and it is advisable to anticipate the occurrence of a MOH in patients with risk factors such as multiple pregnancy, fetal macrosomia, prolonged labour, existing coagulopathy and abnormal placentation. The use of modified early warning scores in the early detection of deteriorating mothers due to bleeding plays a key role and should be employed by every obstetric unit. Additionally the availability of a local major haemorrhage protocol and regular practice drills contribute towards enhanced effectiveness in the actual setting of a MOH.

The anaesthetists role in the management of MOH is very important. They are usually involved in the initial resuscitation of the mother with stabilisation of the airway, breathing and the circulation. It is the anaesthetic team who usually liaise with the blood bank as well as the haematologist to transfuse blood and blood products appropriately to the patient.

SLMA CLINICAL MEETING...

The anaesthetist would be requested to administer uterotonic agents in a timely manner and hence sound knowledge of drug doses and relevant routes of administration is required. Provision of general anaesthesia may be required to facilitate any surgical procedure and it needs to be a carefully controlled cardio-stable anaesthetic to prevent further maternal compromise. Finally it is the anaesthetist's responsibility to care for these patients in the ICU providing necessary organ support and other treatment.

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Multiple Choice Questions

► 1. The following are causes of post partum haemorrhage (PPH)

- A. Vasa praevia
- B. Placenta praevia
- C. Abruptio placentae
- D. Atonic uterus
- E. Use of syntocinon after delivery

► 2. Post partum Haemorrhage (PPH)

- A. Can be divided in to primary and secondary PPH
- B. Genital tract trauma is the commonest cause
- C. When due to uterine atony, it should be treated with a rapid bolus of 10 units intravenous oxytocin
- D. Hypotension is a late sign
- E. The use of intra operative cell salvage in obstetrics is contraindicated

► 3. Obstetric Haemorrhage

- A. Is no longer a major cause of maternal deaths globally.
- B. Women who have had two or more caesarean sections (CS) and placenta praevia are deemed to be at high risk of placenta accreta.
- C. Patient safety guidelines recommend that a level 2 critical care bed should be available for a woman at high risk of placenta accreta undergoing CS.
- D. Primary PPH is defined as a blood loss of 100ml or more from the genital tract within 24 hours of the birth of the baby.
- E. Recombinant factor VII is an appropriate adjuvant treatment in the management of major PPH.

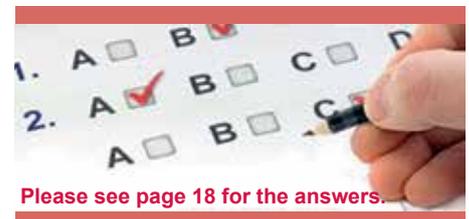
► 4. A 30 year old with placenta praevia has a caesarean section under general anaesthesia. Which of the following is contraindicated in this patient with uterine atony?

- A. Intramuscular ergometrine
- B. Hemabate suppository
- C. Misoprostol suppository
- D. Intravenous terbutaline
- E. Prostaglandin E2 suppository

► 5. A 28 year old multi para at 35 weeks gestation presents with vaginal bleeding. On examination her BP is 90/60, pulse rate is 116/min and respiratory rate is 16. Which of the following is the most important next step in the management?

- A. Emergency referral to the obstetrician
- B. Obtain venous access with two large bore cannula
- C. Immediate caesarean section
- D. Check FBC, PT/INR and APTT
- E. Internal vaginal examination

Major obstetric haemorrhage (MOH) is defined as an acute blood loss in excess of 1500ml, a drop in haemoglobin of 4g/dl or more or an acute transfusion requirement of 4 units of packed red cells or more. It remains a major cause of maternal mortality worldwide with an incidence of nearly 25%.



Please see page 18 for the answers.



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HIP – LIFTING MATERNAL DIABETES CARE TO THE NATIONAL LEVEL



IN SRI LANKA, YEARS OF EFFORTS TO **IMPROVE THE PREVENTION AND TREATMENT OF HYPERGLYCAEMIA IN PREGNANCY** HAVE CULMINATED IN A NATIONAL NCD RESPONSE.

A speaker at the Pragmatic approach to Gestational diabetes/HIP workshop.

In a crowded hotel conference room in Colombo, Sri Lanka, in September 2016, a diabetes nurse educator steps up to the microphone. Speaking in a combination of Sinhala and English, she asks: is a breastfed baby affected by maternal insulin levels? Behind her, others wait with more questions about how to keep pregnant women and their babies safe.

This setting was *Pragmatic approach to Gestational diabetes/Hyperglycaemia in Pregnancy*, a two-day training event for Ministry of Health employees, health workers, midwives and nurses. More than 300 people attended the training, which took place prior to the 1st Asia Pacific Congress on Diabetes, Hypertension & Metabolic Syndrome in Pregnancy (see page 9).

The high turnout reflected the growing interest in the problem of hyperglycaemia in pregnancy (HIP) in Sri Lanka, says Chandrika Wijeyaratne, a professor of reproductive medicine at the University of Colombo and WDF Project Partner in Sri Lanka. It's a remarkable change from 7 years ago, when HIP was a low priority in the Sri Lankan health system.

NIROGI shows the way

The change began in 2008, with the National Initiative to Reinforce and Organize General diabetes care In Sri Lanka (NIROGI) project – nirogi means 'healthy' in Hindi. This was started by a volunteer group of doctors who formed the Diabetes Prevention Task Force of the Sri Lankan Medical Association (SLMA). Their ambitious goal: to improve the quality and delivery of preventive and care services for diabetes in Sri Lanka. Professor Wijeyaratne, a member of

the group, approached the World Diabetes Foundation with a proposal.

The resulting project, General diabetes care, WDF09-411, was approved the following following year with NIROGI/SLMA/Diabetes Prevention Task Force as the project partner. By its completion 3 years later, it had strengthened six primary level clinics in the metropolitan Colombo area, trained more than 600 healthcare professionals, reached in excess of 80,000 people through awareness camps, and screened more than 25,000 people for diabetes.

As often happens, however, the first project uncovered new areas that needed attention. One was diabetes foot care. Another was HIP. "Although clinicians – both obstetricians and physicians – were aware of poor pregnancy outcomes from HIP, the enormity of the problem in South Asia was not appreciated," Professor Wijeyaratne explains.

A second project run by NIROGI/SLMA/Diabetes Prevention Task Force, National initiative to reinforce and organize general diabetes care in Sri Lanka, WDF12-683, addressed this, adding HIP – and also foot care – services and training to the infrastructure created in the first project.

The project's achievements within HIP included the training of more than 8,000 healthcare professionals, development of national screening and management guidelines, establishment of a national centre of excellence, and screening of more than 14,000 women using a new, validated screening methodology. The results showed a gestational diabetes prevalence of



Workshop participants practice their injection technique.

between 22–24% in urban areas and 14% in rural areas.

“Before this project, there was no widely accepted screening methodology for pregnant women in Sri Lanka, so the validation of the 2-hour postprandial blood glucose method was important,” says Hanne Strandgaard, WDF Programme Manager. “And the prevalence found was high. This shows that the need is real and the project is addressing a significant public health issue.”

NIROGI worked in close collaboration with other organisations, including The South Asia Initiative on Diabetes in Pregnancy (SAIDIP), an informal network of healthcare professionals in the South Asia Region, and the International Federation of Gynecology and Obstetrics (FIGO), a global organisation uniting professional societies of obstetricians and gynaecologists. As a result, the attention given to HIP in Sri Lanka grew and grew.

High-level and holistic

This combined effort worked. In 2015, the WDF was again approached, this time by Sri Lanka's Ministry of Health, SLMA and the Sri Lanka College of Endocrinologists, about creating a diabetes prevention programme and NCD action plan for the entire island nation.

Sri Lanka Diabetes and CVD initiative, WDF15-1291, was launched in September 2016, during a formal ceremony in Colombo. The project will build diabetes capacity at the primary care level in all 25 districts of Sri Lanka. It will be managed by a steering committee under the chairmanship of the Ministry of Health.

The project's key elements are:

- Refinement of existing training materials and health information systems, and development of protocols and guidelines.
- Organisation of workshops to strengthen collaboration between maternal and child health services, primary health centres and government health facilities.
- Capacity building of health facilities and healthy lifestyle clinics to improve delivery of diabetes, HIP and diabetic foot care services.
- Roll out of screening, care and referral for diabetes, including HIP and diabetic foot.
- Implementation of awareness and prevention activities through health promotion at the grassroots level.

“This is the first WDF-supported national level programme to be implemented in South Asia,” notes Ms Strandgaard. “It represents a culmination of WDF investments in Sri Lanka and of the partnerships established with key stakeholders, including the Ministry of Health.”

For Professor Wijeyaratne, seeing HIP prioritised at the highest levels of her Government is the realisation of many years of hard work.

“My sincere hope is that this sustainable multidisciplinary commitment and holistic approach will improve the lives of women across Sri Lanka,” she says. “Our goal is the prevention and control of GDM and metabolic disease in Sri Lankan women and their families – and now we're several steps closer to achieving it.”

Commonwealth Secretary General, The Right Honourable Baroness Patricia Scotland QC welcomes the newly elected President of the Commonwealth Medical Association Prof. Vajira H. W. Dissanayake of Sri Lanka at the Commonwealth Secretariat.



The Secretary General of the Commonwealth, The Right Honourable Baroness Patricia Scotland QC met the Newly Elected President of the Commonwealth Medical Association, Prof. Vajira H. W. Dissanayake at the Commonwealth Secretariat at the Marlborough House in London on 24 March 2017. She thanked Sri Lanka, the Sri Lanka Medical Association, and the Health Informatics Society of Sri Lanka for hosting the highly successful 24th Triennial Conference of the Commonwealth Medical Association in Sri Lanka in October 2016 and pledged her support to take forward the Colombo Declaration that was adopted at the conference by the Commonwealth Health Professionals Alliance consisting of commonwealth associations representing doctors, nurses, midwives, pharmacists, dentists, and other healthcare professionals.

Baroness Scotland praised the Government of Sri Lanka for supporting the initiative to set up a Commonwealth Institute for Digital Health in Colombo that was proposed by the Commonwealth Medical Association as a health care innovation initiative with the backing of two ministries - Ministry of Health and Ministry of Science, Technology and Research. In wide ranging discussions that followed with the participation of Dr. Josephine Ojiambo, Deputy Secretary General of the Commonwealth and the former Ambassador and Deputy Permanent Representative of Kenya to the United Nations; Dr. Joanna Nurse, the Head of the Health and Education Unit of the Commonwealth Secretariat; Mr. Anoop Singh, the Acting Chairperson of the Commonwealth Institute for Infrastructure Development; and Prof. Sir Michael Marmot, Immediate Past President of the World Medical Association

wide ranging discussions were held on how the proposed Institute could be supported by the Commonwealth Secretariat and how it could serve as a training, research and innovation hub for the Commonwealth bringing about transformative change across health systems in the commonwealth.

The Institute would be launched at the Commonwealth Health Ministers Meeting on 21 May 2017 in Geneva by Honourable Dr. Rajitha Senarathne, Minister of Health, Nutrition, and Indigenous Medicine and Honourable Susil Premajayantha, Minister of Science, Technology and Research. This would be followed by a high level launch of the Institute in London during the Commonwealth Heads of Government Meeting (CHOGM) in April 2018 by His Excellency Maithripala Sirisena, President of Sri Lanka.

THE FIRST STAKEHOLDERS' MEETING OF THE PALLIATIVE CARE AND END OF LIFE CARE TASK FORCE OF THE SLMA

Dr. Sankha Randenikumara
Secretary,
Palliative Care and End of Life Care
Task Force

The first stakeholders' meeting of the Palliative Care and End of Life Care Task Force (PC&EoLC Task Force) of the Sri Lanka Medical Association was held on the 28th of February 2017 at the SLMA Auditorium. Dr. V T S K

Siriwardena (Director, NCD Unit of the Ministry of Health), Prof. Chandrika Wijeyaratne and Dr. Dilhar Samaraweera (Chairperson of the Palliative Care and End of Life Care Task Force) co-chaired the meeting.

A multi-faceted group of professionals were present at this meeting, including Consultants from various specialties, medical officers, nursing officers



and other paramedical staff, officials from the Department of Social Services, representatives from several NGOs and journalists.

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FIRST STAKEHOLDERS' MEETING...

The Director General of Health Services had delegated higher officials from the Ministry of Health for the meeting. Mr. Yasantha Kodagoda, the Additional Solicitor General, was unable to attend the meeting but promised to extend his fullest support by advising regarding legal aspects.

Prof. Chandrika Wijeyaratne welcomed the participants and elaborated that SLMA would play a catalytic role in improving palliative care and end of life care in Sri Lanka. Dr. Dilhar Samaraweera explained the objectives of the meeting.

The gathering was addressed by the following speakers.

Dr. Udayangani Ramadasa (Convener, PC&EoLC Task Force) gave an introduction to the Task Force and discussed her first-hand experience at PGH Ratnapura.

Dr. Darrel Mathew (President, Palliative Care Association of Sri Lanka) described what they have done since 2013 to uplift the field of palliative care and how they could contribute in future.

Dr. Sujeewa Weerasinghe (Secretary, College of Oncologists) spoke about the palliative care for cancer patients and stressed the importance of establishing Palliative Care Units in hospitals and assigning trained medical officers to them.

These speeches were followed by a brainstorming session where important suggestions were made by the participants.

Emeritus Professor Antoinette Perera stressed on the importance of delivering palliative care through the family doctors/general practitioners as they are the closest to the patients and their families. She stressed that primary care doctors should be strengthened



for this. Prof. Perera also pointed out the discrepancy between the positions held by the doctors and the PG training received by them.

Dr. Kanishka Karunaratne said that palliative care policies should be implemented from the diagnosis of the disease. He also added that treatment, counseling and improving their spiritual wellbeing should go hand in hand. He also pointed out that death should be considered as a human right and a comfortable death should be recognized. Moreover, Dr. Karunaratne stated that pain should be considered as an emergency. No patient should suffer in pain. He suggested that there should be a separate budget for palliative care and that palliative care should be a statutory care of the country. Further he stated that regulations for morphine and other drugs used for pain should be revised and strengthened.

Mr. Samantha Liyanawaduge, the Executive Director of HelpAge Sri Lanka, pointed out that the general public is not aware of palliative care and a program should be developed to educate the family members to take care of these patients to facilitate a good death and palliative care.

Dr. Shyamalee Samaranayake brought attention to the fact that patients are unaware of their condition most of the time despite their need to know it and this is a drawback in their management. So it is important that we always educate the patient about their disease and the treatment required.

Mrs. Kumudini Hettiarachchi, representing 'The Sunday Times', raised a question about the pain manage-

ment in the private sector and vowed to give their support as journalists to raise awareness of the general public regarding this matter. An official from the Department of Social Services stated that there is a deficiency in coordination with the health sector. Even though they have the capacity and resources to help extend palliative care to the general public their services are overlooked.

Dr. Thashi Chang mentioned that we needed to have a service provision as well as an education provision and elaborated on this. He also stressed that the Ministry of Health should recognize palliative care as a postgraduate specialty.

Dr. Panduka Karunanayake suggested that all the activities happening in the country should be mapped out and to be community based as much as possible as this is the best way to reach a large number of the general public.

Dr. Suharsha Kanathigoda, Chairman of the Shanthy Foundation contributed to the discussion from Australia by phone.

Dr. Thilak Siriwardane pledged to convey the key messages generated at this meeting to the Ministry of Health in order to take necessary policy decisions. Prof. Chandrika Wijeyaratne stated that the task force will embark on developing an advocacy document on palliative care and the end of life care within the next few months.

The participants were invited to join the core-working group of the Palliative Care Task Force. The task force will be mainly working on developing end of life care guidelines, research, audit and training.



META-COGNITIVE SKILLS FOR COMPREHENSIVE CLINICAL REASONING IN UNCERTAIN SITUATIONS

Wasantha Gunathunga
Professor and Consultant
Community Physician
Department of Community Medicine
University of Colombo

Doctors struggle in managing certain aspects of patient care in situations such as taking end of life decisions, removing organs for transplant and disconnecting life support, and avoiding personal biases in patient care, to name a few. Lack of a critical skill that penetrates into the interplay of body, brain, mind and consciousness has been a major obstacle in taking well informed decisions in these areas even in technologically advanced present milieu. As medical teams have a very limited knowledge on the phenomenological components of the epistemology of these gray areas they are compelled to use conventional guidelines to manage such clinical situations with ethical and psychological cost to its team members, patients and their families. This article discusses several issues trying to shed new light on these areas of uncertainty in patient care.

End of life decisions

Who takes decisions towards the end of the life of a patient whose mental functions are seriously affected or has serious communication difficulties is a conundrum to physicians who care for them. This is further complicated by the nature of interplay of body, mind and the memory and the changing nature of individual, contrary to a seemingly a permanent individual. This sometimes become visible when fully conscious and rational people change their hard held values or fundamentals in changing milieus. When the basis for clinical ethics is the individual patient in relation to beneficence, non-maleficence, justice and autonomy, where there is no permanent individual such constructs do not hold much water as expected. Modern medicine has not been able to study the minds of patients systematically though the brain functions could be

studied. Hence, special skills of seeing through one's body, mind and memory has to be developed to support clinical decision making in these areas. These skills are beyond the perimeters of the normal cognitive process and need innovative approaches.

Removing organs for transplant

One may believe that if a person is "brain dead" he or she does not feel pain and totally unaware when the organs are removed. Guidelines on diagnosing brain death do not consider the existence of a mind⁽¹⁾. It has been observed that, even though the person was totally incapable of responding and was on life-support machines, they were still able to think⁽²⁾. There is a dearth of phenomenological studies that determines how the mind behaves in such situations hence, the need for such studies.

There is something more to this than what the conventional researchers found. According to phenomenological science the mind will leave the body in the event the mind cannot remain any more in that body⁽³⁾ and modern science has no capabilities to determine when the mind leaves the body particularly when the patient is on life support. If that is the case, would the brain dead person still have his mind in place and thinking, feeling and knowing while the organs are being removed?

While it is important that organs should still be viable when removed for transplantation, it leaves the doctors in a dilemma whether the life of a person from whom an organ is removed has already come to an end. If so, who is capable of deciding the presence or absence of the mind at the time the organs are removed?

Personal biases in patient management

In the past, traditional healers treated patients considering it a part of their moral obligation often without a fee. Even then, such healers were also not without their other personal

biases such as the over confidence in the method of treatment and over-dependence on the poorly described methods. Modern day doctors are faced with more complex socio-economic and cultural circumstances and loaded with personal biases, prejudices, values and attitudes that sometimes influence patient management. Hence, the clinical decisions are, sometimes, not purely in the interest of the patient. It is necessary to free themselves from the shackles of these prejudices in order to take unbiased and well-informed decisions in patient management.

Mind and the normal cognitive process

As any other human being all the healers in allopathic medicine depend on their normal cognitive process for regular day to day functioning. Normal cognitive process includes receiving information from three sources namely the external environment, the physical body and the stored memories and processing those in the mind as thoughts. Hence, diagnosing, treating and after care are all dependent on the cognitive process, the platform on which the human being functions.

However, the normal cognitive process has its uniqueness and limitations. It depends on the nature of one's mind to select which information, from the external world, is taken in through five sensory organs eye, ear, nose, tongue and the whole body and which ones to ignore.

Minds' preferences are different in different individuals. These differences determine the diversity between individuals in their thinking, attitudes, behavior, prejudices and socio-cultural values. The mind operates like a processor in a computer. The computer receives information from the input devices such as key board, mouse, scanner, camera etc. and processes the information with a central processing unit before storing it in the hard disk.

Contd. on page 18

METACOGNITIVE SKILLS...

The information is retrieved from the hard disc whenever the need arises. Similarly the mind captures images from the eye, ear, nose, tongue and the body, the input devices. The captured images are further processed by the mind as thoughts. Some thoughts are valued by the mind and with this value addition gets automatically stored in the memory. Once stored, these memories pop up as thoughts again, immediately after or sometimes later. The individual has no control over this value addition, storage and pop up process which creates values attitudes and prejudices of an individual. This is the basic mechanism of operation of the normal cognitive process. All clinical reasoning and judgement operates in this cognitive platform.

The inherent weakness of this normal cognitive process, when it comes to patient care, is the unavoidable influence of personal biases and prejudices on clinical decision making. Though it can be minimized by various means, influence of personal biases and prejudices cannot be eliminated fully. Coupled with this, the limitation of the cognitive perimeters draw a boundary beyond which the physician is unable to comprehend. One such area is on matters related to end of life decisions. As an example, the status of the mind of a brain dead person at the time of removal of organs for transplant cannot be captured by someone else. Existing guidelines of diagnosing brain death does not consider where the mind is or, mistakenly, considers the mind synonymous with brain.

Meta-cognitive domain

The mind can be trained to transform into a tool that can capture, com-

prehend and interpret information in a medium beyond the normal cognitive process. Originally expounded by The Buddha in the sixth century BC, in this method called the Insight Meditation, the practitioner removes the glue like nature of the mind that attaches itself to the external world, physical body and stored memories. It allows a practitioner to go beyond the ordinary cognitive processes ⁽⁴⁾ with capabilities of analyzing his own and others' minds.

Such a person who breaks the cognitive barrier can also switch to the ordinary sensory organ based perception giving him the Dual Perception Capability ⁽⁵⁾. During meditation he switches to the meta-cognitive realm and remains free from all stresses.

Epistemological spectrum of clinical reasoning

Dual Perception Capability leads to an academically important discovery that clinical reasoning can spread across two major epistemological paradigms that make up a complete spectrum of knowledge required to understand the mind, body and memory of a patient. One paradigm is the knowledge acquired through physical sciences that can demonstrate sensory pathways and brain activation through imaging and electrophysiological techniques. The other half of the spectrum is beyond the normal cognitive process, hence called meta-cognitive and needs phenomenological approaches as capture. I name these two together as Epistemological Spectrum (Figure 1) as it spreads across the entire range of knowledge, cognitive and metacognitive, that a clinician can reach up to.

Cognitive understanding	Meta-cognitive understanding
Neural pathways and brain	Mind and memory
Demonstrated by physical sciences	Observed by phenomenological studies

Figure 1. Epistemological spectrum

Application in clinical reasoning

It has become essential now to gain access to the meta-cognitive sphere and use the skills in patient management in special situations that need these skills. The method of training has been developed to the level that it can be used in capacity building. It is necessary to recognize and declare the inadequacies in the present method in dealing with situations needing skills beyond the normal cognitive process. Then only the need for meta-cognitive approaches will be visible and attempts will be made to develop those. Once in place, application possibilities will be numerous and will take medical care to new heights.

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Answers to the MCQs on page 11

1. T T T T F
2. T F F T F
3. F F T F T
4. D
5. B



Thirty years ago, we set out on a journey to improve the health and well-being of all Sri Lankans. Today, backed by a team of highly skilled and experienced health care professionals, we are blessed to be able to lend our hands to build a healthy nation, and give Sri Lankans, young and old, the chance to live strong and live more.



Asiri Health comprises of Asiri Surgical Hospital, Asiri Central Hospital, Asiri Medical Hospital, Asiri Hospital Matara and Asiri Laboratories.



SLMA HEALTH RUN & WALK 2017

IN COLLABORATION WITH

THE SRI LANKA COLLEGE OF PULMONOLOGISTS



The SLMA Health Run & Walk was first held in 2012 under the presidency of Professor Vajira Dissanayake in commemoration of the 125th Anniversary of SLMA. Since then, it has been an annual feature in the association's calendar, held in conjunction with the Annual Medical Congress of the SLMA. The event has enjoyed an ever increasing participation over the years, growing from 1500 participants at its inception to over 3000 participants in 2016.

This year, the SLMA will hold its Annual Health Run and Walk as an event in its own right and in collaboration with the Sri Lanka College of Pulmonologists, to commemorate World Environment Day, World Asthma Day and World No-Tobacco Day.

Under the slogan “පිවිතුරු හුස්මක් සුවබර දිවියක්” or “Clean Air for Healthy Living”, SLMA Health Run & Walk 2017 aims to educate the public on the importance of clean air and its impact on a healthy life. In a time where environmental pollution is rampant and respiratory infections have reached epidemic proportions, the need for ‘clean environment’ solutions is ever important. To this end, this Run & Walk hopes to bring a positive and timely message to the public.

The focus of SLMA this year has been on ‘Neglected’ chronic respiratory diseases, mainly Asthma and Chronic Obstructive Airways Disease (COPD). COPD prevention being one of the major issues that need to be addressed, the causative association with tobacco, bio-mass fuels, other indoor air pollutants, dangers of air-conditioned spaces, outdoor air pollution and unhealthy air in schools and the workplace need to be addressed more openly and to improve awareness and empower the public on combatting the menace.

COPD is defined as a preventable disease. Therefore, this year's SLMA initiative on Clean Air will help ensure

a cleaner and healthier air for all, thus minimizing the adverse effects of air pollution on the lungs. A clean air initiative will help ensure a less polluted environment for asthmatics, thus reducing airborne allergens, irritants, toxins and infections leading to life threatening exacerbations. This year's Health Run & Walk is therefore, a means of bringing all concerned sectors together, to work towards the common goal of “Clean Air for Healthy Living”. The SLMA and SLCP are joined in this venture by the Central Environmental Authority, which is the national authority on all issues related to air quality.

The venue for the Run & Walk 2017 is the BMICH. Both the Run and Walk will be open to all members of the public. We expect participation from schools, universities, environmental societies, NGOs, the armed forces and Police. All participants will have the benefit of free health screening including, medical, physiotherapy, dietary and nutritional advice. The College of Pulmonologists will conduct pre and post run spirometry tests, as spirometry is an essential investigation in the diagnosis and management of asthma and COPD. Healthy food and refreshments will be available to all. Demonstration of yoga and warm up exercises will be done prior to the run. A children's art competition will be held prior to the walk and the best artwork will be displayed at the venue with prizes given to all the children whose creative expressions are chosen to be displayed. There will also be other fun activities for children at the ‘Kids Zone’. The venue will also feature an ‘Environmental Zone’ that will showcase various clean air initiatives so far undertaken by the Central Environmental Authority. A few highlights of this zone will be the exhibit on ‘Sick Building Syn-

drome”, the “Green Hospital” initiative and the effect of nanoparticles in the atmosphere on lung health. There will be stalls featuring clean energy and vehicle emission testing.

The proceedings will commence at 6.30 am with the registration of runners and warm up exercises. The run will precede the walk. The walk is scheduled to commence at 9.00 am and will feature a different route to the run. The proceedings are expected to end close to noon with presentation of awards to the winners of the art competition and winners of the competitive run.

We invite all of you to join us with your families in this unique celebration of Clean Air, Healthy Lungs and Healthy Lifestyle and help us save our air, save our lungs and save our lives.....

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Dr. Yamuna Rajapakse
Assistant Secretary, SLMA

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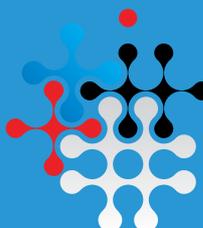
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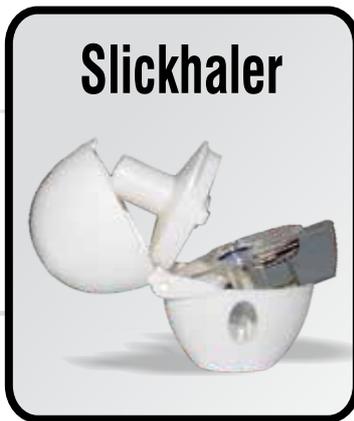
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