REGISTERED AT THE DEPARTMENT OF POSTS UNDER NO. DOP/NEWS/76/2023

SLMA NEWS+

The Official eMagazine of The Sri Lanka Medical Association

WWW.SLMA.LK

JANUARY 2022 | VOLUME 16 | ISSUE 01 ISSN : 1800 - 4016 (PRINTED) 2550 - 2778 (ONLINE)

Cover Story

Induction of the President of the SLMA - 2023

SCAN THIS CODE TO READ ONLINE

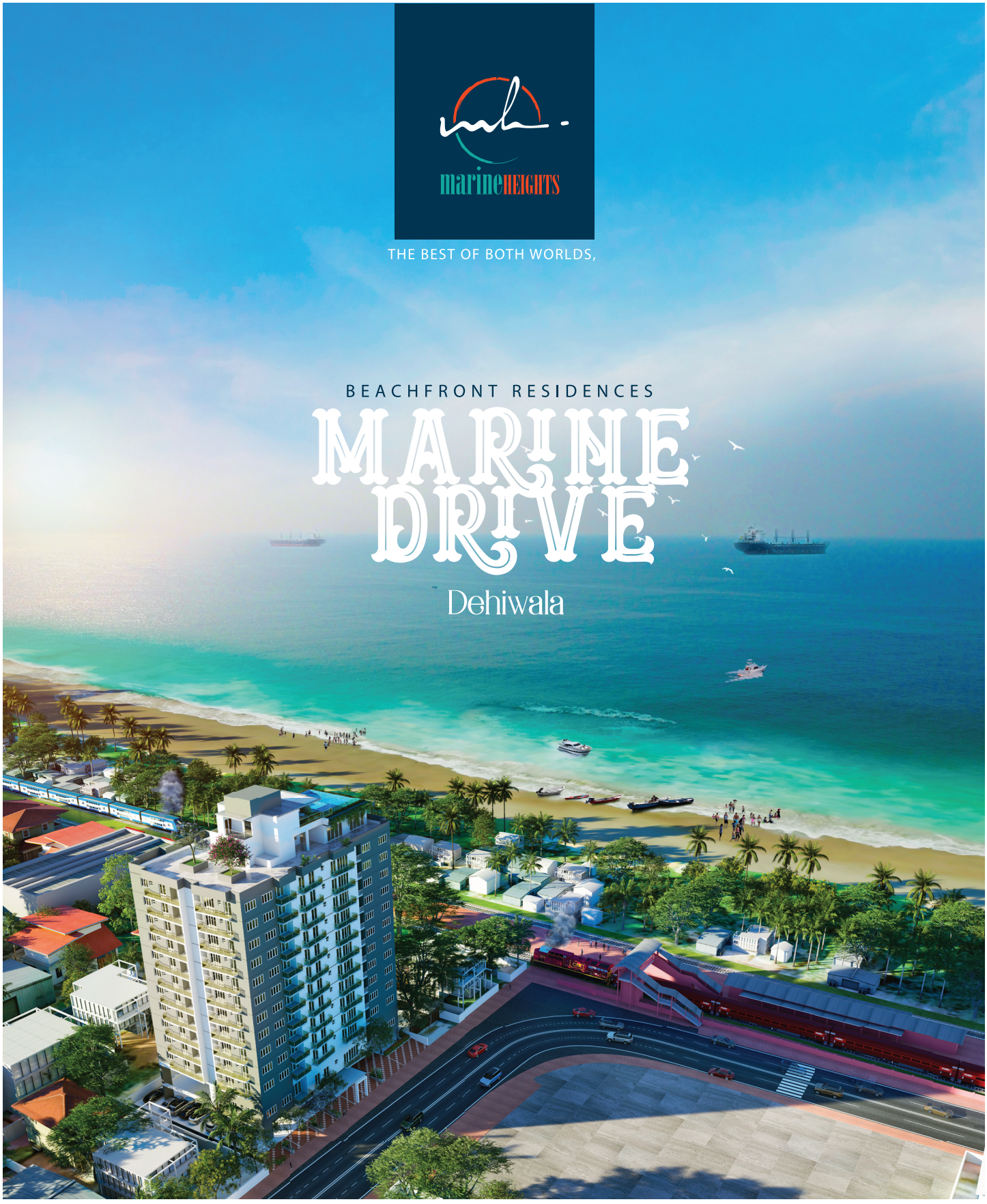
marineHEIGHTS

THE BEST OF BOTH WORLDS,

BEACHFRONT RESIDENCES

MARINE DRIVE

Dehiwala



ROOF TOP TERRACE | GYM | POOL | 24 HOURS SECURITY

55Mn UPWARDS

0710 777 444

PRIME RESIDENCIES

SLMA NEWS+

ISSN : 1800 - 4016 (PRINTED) 2550 - 2778 (ONLINE)

"Wijerama House", No. 6, Wijerama Mawatha, Colombo 07, Telephone: +94 112 693 324, Email: office@slma.lk

CONTENTS

SLMA President

Dr Vinya Ariyaratne
MD, MPH, MSc Com. Med. MD Com, Med., FCCPSL
Specialist in Community Medicine,
Past President of College of Community Physicians of Sri Lanka,
President of Sarvodaya Movement

President's Message

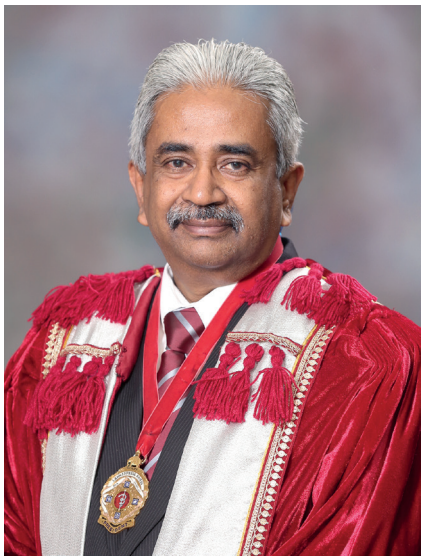
Dear SLMA Members,

It is with a profound sense of humility that I undertake the esteemed position of 129th President of the Sri Lanka Medical Association (SLMA), a pioneering Medical Association in the region. The honour of being elected to this role is one that I hold in the highest regard. As a medical professional who has dedicated a significant portion of a career to advancing community-based health interventions and policies outside of the state, private sector, as well as academia, I am deeply appreciative of the confidence and trust placed on me by the Past Presidents and the members of SLMA.

I have proposed not only a theme for 2023 but also a call to action. In these challenging times we as medical practitioners must work on the theme '**Towards Humane Healthcare: Excellence, Equity, & Community',** more than ever. I will lead the SLMA Council and our wider work efforts to promote this collective ambition.

To achieve a high degree of proficiency in the various sectors of healthcare, it is imperative that we implement effective governance mechanisms that promote accountability, transparency and inclusivity in practice. A central aspect of this effort must be a focus on equity in the delivery of healthcare services; a principle that holds great significance to me.

SLMA utilizes specialized 'Expert Committees' consisting of subject matter experts in various fields of healthcare. To achieve the goal of providing 'Humane Health Care', in this year we propose to strengthen existing committees and to create new ones to expand their scope.



Exploring sustainable financing options for Universal Health Care (UHC) in these tough times is crucial to continue healthcare services. The shortage of professionals, medicines, and instruments will largely impact the wellbeing of our people. We need to actively lobby and pursue sustained action in responding to the crisis.

Addressing social determinants of health disparities and fostering active engagement with the community are essential components of our mandate. Furthermore, it is crucial that we actively involve citizens, in health promotion efforts, to enhance overall health and well-being and thereby ensure the sustainability of our impact.

Medical professionals, as members of the healthcare community, have a bigger say to affect social change by advocating for laws and procedures that will improve the health and well-being of both people and the communities. In an era where people, particularly the youth of our country are continuing to demand justice and equity, this can be accomplished by putting the emphasis on tackling the social determinants of health, which have a significant impact on health outcomes. These factors also include poverty and limited access to healthcare and education. Furthermore, doctors can actively promote public health focused policies by acting as crucial lobbyists, public educators and legislators, thanks to their specialized knowledge and influential positions. We also have a duty to advance equity and deal with access and performance gaps in healthcare in assuming the role of social change agents.

Throughout the year the SLMA intends to host a series of dialogues, workshops, seminars, and academic endeavours, to enrich our professionals as well as our impact. I invite everyone to take part in these activities as well as in our annual entertainment events to network with each other and expand horizons.

As medical professionals, it is our duty to prioritize the well-being and welfare of all Sri Lankans, especially during difficult and uncertain times. We must take active steps to fulfil this responsibility without delay, in alignment with our shared vision '*Lankadipassa kiccesu ma pamaj'*. Let us work for the good of All Sri Lankans without delay, in promoting our nation's overall health, wellbeing, and prosperity.

The Council of the SLMA and I extend our warmest wishes for a prosperous and joyful new year filled with happiness, good health, and contentment for you and your loved ones.

Dr Vinya Ariyaratne
President - SLMA

Presidential Address at the Induction Ceremony - 2023

Professor Samath Dharmaratne, the outgoing President, Chairman and Members of the Board of Trustees of the Sri Lanka Medical Association, Past Presidents, Council Members and members of the Sri Lanka Medical Association, Excellencies, invitees representing Government Ministries, State Institutions, Academia, UN agencies, Statutory Bodies, National and International Civil Society and Professional Organizations, Professional Colleges, Academic Colleges, and all other distinguished invitees.

It is with great pride and sincere humility that I stand before you as the 129th President of the Sri Lanka Medical Association.

When I first applied and obtained Life Membership of the SLMA on 2nd of October 1998, 8 years after qualifying as a doctor, I never dreamt of assuming this coveted position of SLMA President 25 years later. I consider it a singular honour, especially as a medical professional who has spent a larger part of his life in health care interventions and policies promoting health and wellbeing of communities outside the State and private health sectors or academia. I sincerely thank the Past presidents and the members of SLMA for the confidence and trust placed on me to hold this prestigious role.

I wish to first provide a brief overview of the evolution of the health care system in Sri Lanka to provide a contextual basis for presenting my plans for the year.

Health and Wellbeing

Disease has affected humankind since the beginning of human civilization. Causality of disease and illness have been attributed to various causes including supernatural forces. Various systems of healing (which are called health systems in the modern era) too have evolved based on this socio-cultural milieu.

As a Nation with a recorded history of over 2500 years and where Buddhism has taken deep root, the teachings of the Buddha has influenced notions of health and wellbeing than any other social phenomena. In Buddhism, health is regarded as the highest gain in life and the Dhammapada states:

"Arōgyā paramā lābhā
Santuṭṭhiparamaṃ dhanaṃ
vissāsa paramā ñāti
Nibbānaṃ paramaṃ sukhaṃ"

That is:
"Health is the greatest gain,
contentment is the greatest wealth,
a trusted friend is the best relative,
Nibbana is the greatest bliss."

Additionally, Buddhism holds that providing care for the sick is a highly virtuous act of the highest merit.

Evolution of the health care system in Sri Lanka

The history of the health care system in Sri Lanka dates to over 02 millennia. One of the critical factors that positively affected and continues to affect the health status of the people of Sri Lanka is our geographical positioning as an island nation. Medical historians agree that this surmounts to be an important physical characteristic and observes that Sri Lanka was insulated to a larger extent from external forces. However, foreign relations, invasions and colonial encounters influenced our systems of medicine, diseases and shaped our cultural attitudes and practices towards health.

Introduction of Buddhism from North India in the third century BC during the reign of King Devanampiyatissa (247-207 BC), marked the beginning of the tradition of medical care in ancient Sri Lanka. During the pre-colonial era, royal patronage was offered to preserve health and to extend health care for ordinary people. A few of the ruling Kings were native physicians themselves.

From ancient times, the health care systems in Sri Lanka have evolved in the most diverse and fascinating ways to be what it is today.

The traditional systems of medicine in Sri Lanka have two components. The truly indigenous system, which existed prior to the advent of King Vijaya which were handed down through the generations and came to be known as *Deshiya Chikitsa* or *Hela/Sinhala Vedakama*. The second component is Ayurveda.

Prior to the 19th century, the indigenous population of Sri Lanka relied almost entirely on traditional medicine for health care. Even after the introduction of allopathic medicine, a sizable proportion of the population continued to rely on traditional medical systems. However, the Deshiya Chikitsa system does not seem to exist in its original form today due to the influence of other systems of medicine including Ayurveda and allopathic medicine.

Allopathic Medicine, popularly known as the "Western system",

was introduced by the Portuguese at the beginning of the 19th Century. The Dutch who followed the Portuguese as the next colonial power controlling the coastal areas, built hospitals in different parts of the country. They were run by Dutch physicians and surgeons. The British who ruled the country from 1815, were then responsible for the expansion of the allopathic health care system in Sri Lanka, initially to cater to the colonial workforce but later expanded to serve the local population. Amongst important structures created during the British rule was the establishment of the Health Unit System in Kalutara in 1926 to undertake preventive health work, maternal and child healthcare and in the same year preventive and curative services were brought under one administration.

The granting of universal adult franchise in 1932 had a profound impact on health and education in Sri Lanka. The granting of universal franchise helped to expand health services as the elected representatives were forced to respond to the needs of their constituents. The broad state-led welfare system which also included free education also has a positive impact on the health status of the population even now.

The allopathic system of medical care continued to expand until Independence in 1948. By 1945, the Government had expanded free medical care to almost all parts of the country through a network of rural hospitals, 13 specialized hospitals, 250 central dispensaries and over 600 branch dispensaries and visiting stations.

It has been reported that during the two decades between 1945-1965, the expansion of medical facilities was able to keep pace with the growing population demands; good health at low cost, resulting in a significant decrease in mortality rates.

An important landmark in the evolution of the health system of Sri Lanka has been the Cumpston Report published in 1950. Dr. J. H. L. Cumpston, the Director General of Health Services of Australia was invited by the then Government of Ceylon "to report on the working of the Medical and Public Health Organization of Ceylon and to advice the Government on the nature of the reforms and improvements that are required to be made". An Act of Parliament titled "the Health Services Act" (Act No. 12 of 1952) was enacted and formed the legal basis to operationalise the health services for the next 3 decades.

In the late 1970s, the health system was subjected to a review, most probably influenced by the Alma Ata Declaration of 1978. The result led to adopt an organizational model to restructure the health system based on the fundamentals of primary health care (PHC). However, this model of Gramodaya Health Centres with Divisional Directorates of Health Services (DDHS system) did not last long.

The new Government which assumed office in 1994 appointed a committee to formulate a new health policy. Accordingly, a new National Health Policy was drafted and adopted in 1996. Following the adoption, it erected several new directorates within the Planning and Preventive Division of the Ministry of Health. However, it is claimed that no attention had been paid since 1952 to improve the Curative Care Division which includes the Directorates of Medical Services, Laboratory Services and Dental Services. (Ref)

In 2014, a comprehensive process was initiated to review the health sector over a period of 03 years (2014-2016). As a country which is facing an epidemiological transition from communicable to non-communicable diseases, it was observed that the Primary care for NCDs is not comprehensive, is unlinked to community and specialized care, and thus under-utilized. When it comes to,

1. Human resources for health; there is an Inappropriate skill mix at the primary care level and inequitable distribution of human resources for health,

2. In continuity of care; there is bypassing of primary care, no referral protocols, and few links of facility & curative to community & preventative care,

3. In Supply chain management; there are significant gaps in supply of pharmaceuticals for NCD management at the primary care level,

and

4. In terms of Health information management, Patients are not uniquely identified, information is not shared across providers and databases.

To respond to these and other health sector challenges a new health policy - "Sri Lanka National Health Policy: 2016 - 2026" and the "National Strategic Framework for Health Development 2016 - 2025" were launched in 2016. This proposed implementation of a significant reform in the healthcare system of Sri Lanka represents a pivotal moment in the evolution of healthcare provision in the country. It was a significant step towards improving the overall health and well-being of the population in Sri Lanka. This new health policy, which was adopted In December 2017, aimed to reorganize primary care, improve healthcare provision through data utilization, and strengthen the overall health sector. This policy was developed through a technical consultation

process and interventions were identified for each area of focus.

The World Bank supported Sri Lanka's new healthcare policy through the launch of the Primary Healthcare Systems Strengthening Project (PSSP) in 2018 which is considered a flagship project to implement the new health policy.

The PSSP aims to reorganize the primary health care system and reinforce integration of preventive and curative care. Four years on since the start of inception of this project, we see very significant results towards transformation of our health system adopting innovative tools such as a Grievance Redress Mechanism (GRM) and a citizens engagement mechanism through "Friends of Health Services Committees". It is our fervent hope that these and other successful new tools become mainstreamed in our health care system so that it becomes more efficient, effective and t

Let me now draw your attention to the present crisis that we face as a Nation today. I wish to go beyond the more obvious challenges in the health sector – COVID-19 and emerging pandemics, the changing epidemiological pattern, food and nutrition crisis, shortage of medicinal drugs etc. I wish to focus more on the much deeper social crisis we are facing today and our response as a responsible profession.

Rethinking our morality

Sri Lanka is currently experiencing an unprecedented multifaceted crisis that is rooted in economic, political, and governance issues, as well as a systemic failure. The Peoples Struggle called '*Aragalaya*' of 2022 confirmed this and reflected that people and most importantly the next generation of our country aspire for better systems that are needed to be put in place that includes better health services and related outcomes.

One of the proximate causes of this crisis is attributed to the medical community, leading to increased societal pressure for a redefinition and strengthening of ethical standards within the profession. As politicians are being called upon to listen to the people, support reforms, and uphold justice, there is an equal expectation for the medical community to take responsibility for past mistakes, if any, implement necessary reforms, and uphold ethical principles at the core of the profession.

Is it possible to identify any potential advantages arising from a state of disequilibrium?

The quest for finding the answers to our questions may lie in taking a systematic view of the situation. As a system, we are in a state of disequilibrium. Physicists describe it as a state that is 'far from equilibrium'. These states encourage creativity, innovations, and new thinking. They are characterized by another interesting concept: namely, the 'butterfly effect'. To illustrate, it is a butterfly flapping its wings in Brazil leading to a cascade of evens that ends up as a storm in the Indian Ocean. In other words, a small intervention could have a huge impact on the system.

I am convinced and I believe that the current state of disequilibrium in our society presents a unique opportunity for creativity and growth. The Peoples Struggle or the '*Aragalaya*' presented us this very momentous opportunity and it should be our calling and responsibility as a nation to sincerely respond to it. The Sinhala language has a powerful phrase, "*buddhi kalambanaya*," which speaks to this concept. In ancient mythology, such as the Mahabharatha and the Bhagavad Gita, the eternal struggle between chaos and order is referred to as "*deva asura sangrama*". In this mythical cosmic battle between dharma and adharma the ocean was churned and from the depths of the ocean surfaced kalpavruksha- the tree that fulfils wishes and most importantly the Physician of the Gods known as '*Dhanvantari*' appears, holding amrith or amurtha the supreme medicine of life. Although these references are rooted in mythology and symbolism, the teachings of our ancestors suggest that from a state of disequilibrium or chaos, something long-lasting and transformative could arise. This current moment in our society offers a chance to navigate this tension. emerge stronger and together.

Doctors for social change

It is in this dynamic, unpredictable and non-linear situation, that I propose my theme for the year which is: **"Towards Humane Healthcare: Excellence, Equity, Community"**

I think you may be familiar with this ornamental weapon, the "*Trishula*": a common feature of Hindu art, and literature. The Trishula is a weapon with three spikes, symbolizing various trinities of human existence:

Past, Present and the Future,
Body, Mind, and the Soul,
Also...
Clarity, Knowledge, and Wisdom

The trinity that we hope to carry in our quest for a more humane health care is Excellence, Equity and Community. These are inter-related concepts. By excellence I mean excelling in clinical work, health promotion, prevention, rehabilitation, and palliative care.

This I believe can be achieved through effective governance mechanisms that are transparent, accountable, and inclusive. The demand for equity was a fundamental call by the youth and the citizens of this country. This is a call that is very close to my heart, and I believe we must heed this call through actions at the level of the health system, the social determinants of health inequalities, and community engagement. It is imperative that the healthcare system aligns with the needs of the population, responds to the changing needs, and actively involves citizens to improve overall health and well-being.

Myself and my Council, the composition of which I am proud to say, reflects the diversity of our nation in terms of ethnicity, religion, specialization within the medical profession and most importantly with a set of dynamic and competent young and even not so young professionals in the frontline, backed by 2 generations of "elders" who continue to be the guiding light with their wisdom.

One of the key mechanisms of the SLMA is the "Expert Committees". These consist of subject specialists in different aspects of healthcare ranging from health promotion, prevention, clinical care, research, rehabilitation and palliative care. While we continue to strengthen the existing Expert Committees, I propose to create some new ones or broaden the scope of expert committees to achieve the goal of "Humane Health Care". We need to work on finding sustainable financing options for providing Universal Health Care (UHC), how we address issues related to human resources in the health sector, shortages of medicinal drugs, improving efficiency, enhancing ethical practise and accountability. We will continue to engage with the public and policy makers more vigorously.

I, together with our Council and the membership of the SLMA commit wholeheartedly to pursue on this noble mission and I seek your support as fellow professionals and Sri Lankan citizens who love our Nation.

"Lankadipassa
Kiccesu Ma Pamaji"

"ලංකා දිපස්ස කිච්චේසු මා පමාජි"

Let's work for the good of ALL Sri Lankans without delay

නොපමාව සියලු ශ්‍රී ලාංකිකයින්ගේ හිතසුව පිණිස වැඩ කරමු

Acknowledgements

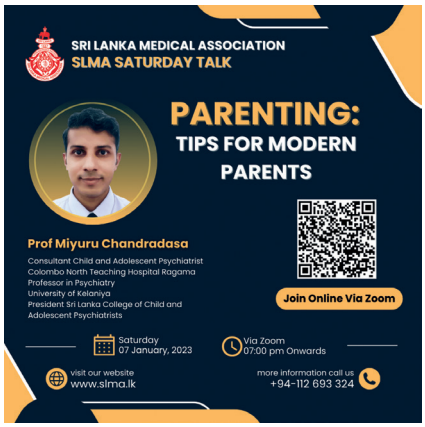
First and foremost, I wish to pay my homage of gratitude to my beloved parents Dr. A. T. Ariyaratne and Mrs. Neetha Ariyaratne for educating me and also bringing me up in a way to be compassionate, and to be of service to others. My loving wife Madara and my two children Hasala and Aseni for their patience and support to allow me to follow a different path.

It is with deep gratitude that I remember late Professor Nandadasa Kodagoda, late Professor Carlo Fonseka, late Professor Dulitha Fernando, and my father-in-law late Professor Nandasena Ratnapala and my mother-in-law Mrs. Neetha Ratnapala, who have encouraged and motivated me to study medicine and become a Community Physician. I am also indebted to Professor Lalani Rajapakse and Professor Rohini Seneviratne for their guidance and support throughout my career. I wish to also sincerely extend my appreciation to Professor Leela Karunaratne, Professor S. Sivayogan, Professor Antoinette Perera, Professor Narada Warnasuriya and Professor Mohan de Silva, who were my mentors and colleagues at the Faculty of Medical Sciences of the University of Sri Jayawardanapura. Last but not least, I wish to thank my colleagues at Sarvodaya, the staff and hundreds and thousands of volunteers from all parts of Sri Lanka belonging to all communities, to serve humanity through the community health work I have undertaken throughout the last two and half decades.

Activities in Brief
(24th December 2022 – 15th January 2023)

SLMA Saturday Talks

7th January



The first SLMA Saturday Talk for the year 2023 was on 'Parenting: Tips for Modern Parents' by Professor Miyuru Chandradasa, Consultant Child & Adolescent Psychiatrist, Colombo North Teaching Hospital, Ragama/ Professor in Psychiatry, University of Kelaniya

Other Activities

28th December

Dr Vinya Ariyaratne President, SLMA was interviewed by Sirasa TV - 'Pathikada' on the current economic, social and healthcare issues faced by the people and SLMA's response in mitigating them.

2nd January

As was customary in the last few years, a religious ceremony to invoke blessings on Dr and Mrs EM Wijerama, who gifted the 'Wijerama House' to the SLMA, the President, Council, membership and staff of the SLMA and all citizens of Sri Lanka was held at the SLMA premises on 2nd January 2023. The President, Past Presidents, Council Members and staff of the SLMA Office participated.

Clergy representing main religions, Buddhist, Hindu, Christian and Islam, delivered brief sermons. Later they engaged in a short discussion with the council members present on the current brain drain affecting the country and stressed the need for all to find ways of solving the present crisis.

The participants were served with kiribath and sweetmeats afterwards.

13th January

The first council meeting for the year 2023 and the unveiling the photograph of Professor Samath D Dharmaratne, the Outgoing President of Sri Lanka Medical Association (SLMA) was held.

SRI LANKA MEDICAL ASSOCIATION

CALL FOR ABSTRACTS

136th Anniversary International Medical Congress – July 2023

- All abstracts should be submitted through the **online submission portal in the SLMA website** www.slma.lk which will be open from 1 February 2023.
- One author will be permitted to submit a **MAXIMUM of three (03) abstracts ONLY**.
- **All authors of abstracts** should be members of the SLMA, if they are eligible for membership (doctors & medical students).
- All research studies should have obtained ethics approval. All clinical trials should be registered with a Clinical Trials Registry. Authors should provide the letter of approval from an accepted Ethics Review Committee (ERC) for research studies and registration number for clinical trials, upon request.
- All the authors should declare any conflict of interests during their presentation at the congress.
- The SLMA considers plagiarism as serious professional misconduct. All abstracts are screened for plagiarism and when identified, the abstract and any other abstracts submitted by the same author will be rejected.
- The SLMA reserves the right to make alterations and to edit the contents of the abstract to improve the quality of presentation.

INSTRUCTIONS FOR ABSTRACT SUBMISSION

- The title of the paper should be concise and the SLMA reserves right to modify the title if necessary.
- The abstract should be in *word format*. The File name should be the *Title of the Abstract.*
- The document should consist of two pages, a cover page and the abstract.
- The cover page should contain the following
    - **Title of the abstract**
    - **Authors:** The author(s) name(s) should be in the format of last name followed by initial(s). Please DO NOT use prefixes such as Mr/Dr/Prof.
        - The presenting author must be underlined. A superscript number should be placed after each name to refer to the respective affiliations. (eg.:- Perera AB[1], Silva CD[2])
        - **Affiliations:** must be listed below the authors without their designations BUT only their place of work/ attachment
    - Subject category: Please select the relevant submission category (Eg: Dermatology, Family Medicine etc) from the list at the bottom of the page and mention this in the cover page.
- The second page must contain the following
    - **Title:** BOLD CAPITAL LETTERS
    - **Body of the abstract:** Structured with the following subheadings:
        - Introduction and Objectives,
        - Method
        - Results
        - Conclusions
    - **Font:** Times New Roman
    - **Font size:** 12, single line spacing
    - The body of the abstract MUST NOT exceed 250 words
    - Please DO NOT include the names of the authors, institutions or any tables/graphs/figures or references within THE body of the abstract.

Important notices:

- Please note that NO amendments to the submitted abstracts (including the authors list) would be entertained after closing of submission.
- Abstracts not conforming to the above instructions will be rejected.
- A panel of reviewers will review abstracts anonymously and the decision of the Scientific Committee will be final.
- The presenting author is required to register for the sessions upon acceptance of the abstract.
- Please provide a name of a second presenting author (in case of a situation where the original presenting author is unable to attend).
- Failure to make a presentation (oral or poster) once participation is confirmed will be considered an episode of academic/scientific misconduct and the authors will be liable for punitive action.
- Please provide the e mail address and the mobile number of the correspondent author when submitting the abstract.
- Select the subject categories for the cover page from the list below.

Anaesthesiology	*Genetics*	*Neurology*	*Pathology*
Cardiology	*General Medicine*	*Nephrology*	*Pharmacology*
Community Medicine	*Geriatric Medicine*	*Nutrition*	*Psychiatry*
Dermatology	*Health Informatics*	*Miscellaneous*	*Radiology*
Emergency & Critical Care	*Health Systems Research*	*Obstetrics & Gynaecology*	*Respiratory Medicine*
Endocrinology	*Haematology*	*Oncology*	*Rheumatology*
Family Medicine	*Infectious Diseases*	*Ophthalmology*	*Rehabilitation Medicine*
Forensic Medicine	*Medical Administration*	*Paediatrics & Neonatology*	*Sports & Exercise Medicine*
Gastroenterology	*Medical Education*	*Rehabilitation Medicine*	*Surgery*

AWARDS FOR FREE PAPERS AND POSTERS

The following prizes will be awarded for free papers and posters accepted for presentation at the 136th Anniversary International Medical Congress 2023.

E. M. Wijerama Award	*Sir Nicholas Attygalle Award*	*Special prize in cardiology*	*The SLMA prize for the best poster*
S. E. Seneviratna Award	*Wilson Peiris Award*	*Kumaradasa Rajasuriya Award for Research in Tropical Medicine*	*S. Ramachandran Award for Nephrology*
H. K. T. Fernando Award	*Daphne Attygalle Award for Cancer*	*Sir Frank Gunasekera Award for Community Medicine and Tuberculosis)*	*Best presentation in Pharmacology*

IMPORTANT DATES
Online abstract submission portal open from: 1 February 2023
Abstract submission deadline: 31 March 2023 23.59 Sri Lankan Time

Dr Sajith Edirisinghe
Honorary Secretary
Sri Lanka Medical Association
For further details please contact: The Sri Lanka Medical Association, 'Wijerama House', No.6, Wijerama Mawatha, Colombo-07
Tel: 011-2693324, Email: office@slma.lk

Induction of the President of the SLMA - 2023

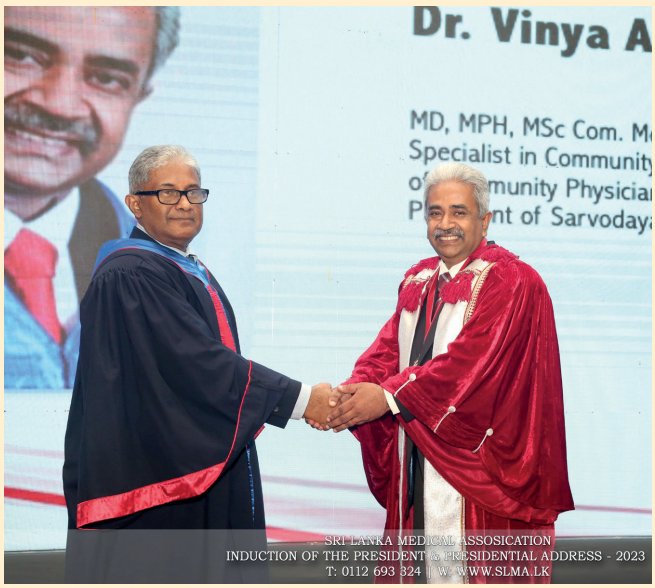
Dr Vinya Ariyaratne was inducted as the 129th President of the Sri Lanka Medical Association (SLMA) at an elegant function held at the Lotus Hall, BMICH Colombo on 14th January. Past Presidents, Council Members, Ministry Officals, invitees from UN organizations, well-wishers and family members participated.

Professor Samath D Dharmaratne, President 2022 shared a brief description of activities undertaken during his tenure as President in 2022.

Dr Vinya Ariyatne, in his address introduced the theme for the year 2023, *'Towards Humane Healthcare: Excellence, Equity, Community'* and presented a comprehensive road map of how he intends to achieve his vision during his presidency.

Mr Jagath Wickramasinghe, entertained the audience with his soulful music.

The ceremony concluded with Dinner at the Sapphire Hall.





















ANNUAL CHILD ART CREATION ORGANISED BY
SRI LANKA MEDICAL ASSOCIATION

THEME: WHAT MAKES ME HAPPY?

SHOULD INCLUDE

Full Name
Age
Grade
School
Home address
Parent Contact Number

Drawings need to be certified by principal or class teacher as original creation of the child. The drawings should not be copied from internet or any other source.

Age : From **Pre-School to Grade 10** (Each Grade is recognised as a category)

Colouring Medium : **any medium** Paper Size : **A4 Paper**

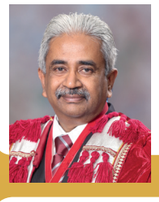
One child can submit up to **maximum of 2** drawings.

All drawings need to be sent **ONLY** by post or hand delivered to
SRI LANKA MEDICAL ASSOCIATION
No. 06, Wijerama Mawatha Colombo 07.

Submission Deadline on 30th April 2023

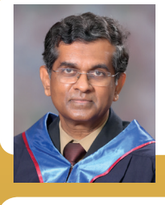
For more information: 011 269 3324 | office@slma.lk

THE SLMA COUNCIL - 2023



President
Dr Vinya Ariyaratne
MD, MPH, MSc Com. Med. MD Com, Med., FCCPSL
Specialist in Community Medicine, Past President of College of Community Physicians of Sri Lanka, President of Sarvodaya Movement

Immediate Past President
Prof (Dr) Samath D. Dharmaratne
MBBS, MSc (Community Medicine), MD (Community Medicine), Director, Postgraduate Institute of Medical Sciences (PGIMS), University of Peradeniya, Chair Professor of Community Medicine, Department of Community Medicine, Faculty of Medicine, University of Peradeniya and Board-Certified Specialist in Community Medicine



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

Vice President
Dr Achala Balasuriya
MBBS (Pera), MD (Col), FRCP (Edin), FACP (USA), FCCP, MSc (UK), Dip in Diabetes (UK)
Consultant Physician
Hemas Hospital, Ragama

Vice President
Prof R. Surenthirakumaran
MBBS, M.Sc. (Community Medicine), PGD (Applied Statistics) MD (Community Medicine).
Dean and Professor in Community Medicine, Faculty of Medicine, University of Jaffna

Honorary Secretary
Dr E.A.S.T Edirisinghe
MBBS(USJ), CTHE(USJ), MSc (Clinical Genetics) (Colombo), MSc(Health Administration) (Malaysia), PhD (Anatomy)(USJ), Senior Lecturer and Clinical Geneticist, Department of Anatomy, Faculty of Medical Sciences, University of Sri Jayewardenepura

Honorary Assistant Secretary
Dr Nimani De Lanerolle
MBBS, MSc Community Medicine,
Registrar in Community Medicine,
Ministry of Health, Sri Lanka

Honorary Assistant Secretary
Prof Kumara Mendis
MBBS, MSc Medical, Informatics (Netherlands), MD Family Medicine (SL), FCGP(SL), FAIDH(Australia)
Consultant Family Physician,
Department of Primary Care & Family Medicine, Faculty of Medicine
Sabaragamuwa University of Sri Lanka

Honorary Assistant Secretary
Dr Chathurie Suraweera
MBBS, MD (Psych), MRCPsych (UK)
Senior Lecturer in Psychiatry,
Faculty of Medicine, University of Colombo

Honorary Assistant Secretary
Dr Lahiru C. Kodithuwakku
MBBS, MSc (Com. Med),
MBA, PgD in Health Sector Disaster Management, Doctoral Researcher at University of Huddersfield, UK
National Dengue Control Unit, Ministry of Health

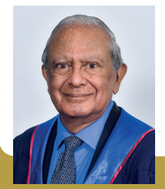
Honorary Treasurer
Dr Sumithra Tissera
MBBS (Col), PG Dip in Health Development (PGIM, Colombo), MSc Sexual & Reproductive Health Research (LSHTM, UK)
University Medical Officer,
The University of Visual & Performing Arts, Colombo

Honorary Assistant Treasurer
Dr Shihan Azeez
MBBS, EMsc(health admin), Dip Occupational Health, Dip Disaster mgt, Medical Officer Vascular and Transplant Unit, NHSL

Public Relation Officer
Dr Preethi Wijegoonewardene
MBBS DFM FCGP FRCGP,
Family Physician / General Practitioner, Past President - CGPSL 2004-2007, Past President - WONCA Middle East South Asia 2007-2010, Pasr President WONCA South Asia 2010-2013, WONCA Honorary Fellow 2013, Chair -MRCGP INT SOUTH ASIA BOARD 2016, International President Medal RCGP UK 2021, President -SLMA 2002

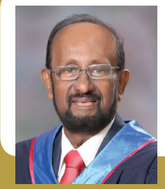
Social Secretary
Dr Pramilla Senanayake
MBBS; PhD; DTPH; FRCOG; FACOG; FSLCOG
Medical Consultant
Reproductive Health

Social Secretary
Dr Nilanka A. Wickramasinghe
M.B.B.S (Col), M.Sc. in Human Nutrition, PG. Cert in Med Ed.
Lecturer, Department of Physiology
Faculty of Medicine, University of Colombo



Dr Lakshman Ranasinghe
FRCP(Edin), FCCP, DCH (Lond), FCGP
Founder President Sri Lanka College of Dermatologists
Past President-SLMA-1984-1985

Prof Senaka Rajapakse
MBBS, MD, FRCP, FCCP, FACP
Chair Professor of Medicine
Consultant Physician
Director, PGIM



Prof Athula Sumathipala
MBBS - Colombo, DFM, MD in Family Medicine, MRCPsych, UK, CCST, UK, PhD, London, FSLCGP, Colombo, FRCPsych, UK, Chairman - National Institute for Fundamental Studies, Hanthana, Kandy, Hon Director - Institute for Research and Development in Health and Social Care

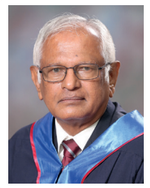
COUNCIL MEMBERS

Prof Anuja Abayadeera
MBBS, MD, FRCA, PGCert (MedEd,Dundee)
Professor in Anaesthesiology,
Department of Anaesthesiology and Critical Care, Faculty of Medicine, University of Colombo

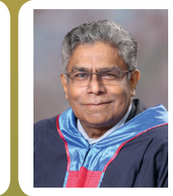
Dr Kaushi. S. Attanayakege
MBBS(Colombo) MO ETU, BH Kanthale

Prof Hasini Banneheke
MBBS(USJ), Pg Dip Med Microbiology (Col), MD Medical Parasitology(Col)
Specialist Medical Parasitologist, Faculty of Medical Sciences, University of Sri Jayewardenepura

Prof 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



Dr M. Sarath Gamini De Silva
MD (Col), FRCP(Lon), FRACP (Hony), FCCP.
Consultant Physician
Colombo



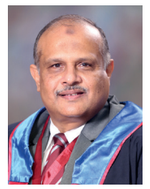
Dr Christo Fernando
MBBS, MACEP, Dipl Hosp Admin, MBA.
Chairman,
Philip Hospital, Kalutara

Dr Harini Fernando
MBBS (Sri Jayewardenepura), MSc in Clinical & Health Psychology (UK)
Programme officer for Family Health International, Sri Lanka

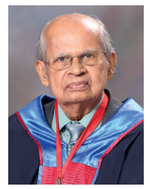
Dr Kalyani Guruge
MBBS (Ceylon),
MD (Paediatrics)
Consultant Paediatrician

Prof Sampatha Goonewardena
MBBS, MSc,MD
Consultant Community Physician/ Professor in Community Medicine
Faculty of Medical Sciences, University of Sri Jayewardenepura, Gangodawila, Nugegoda

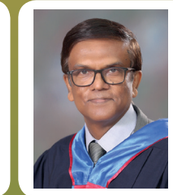
Dr Padma S. Gunaratne
MBBS, MD(SL), FRCP(Edin, Glasg, Lond), FCCP, Hon FRACP, FAAN, FWSO
Consultant Neurologist
President SLMA - 2021



Dr Ruvaiz Haniffa
MBBS, DFM, MSc, MD, FCGP, PgDip, MRCGP
Senior Lecturer, Family Medicine Unit, Faculty of Medicine, University of Colombo
President-SLMA-2018



Dr Lucian Jayasuriya
MBBS (Cey.), DTPH (Lond.), FSLMA,FCMA, FSLCoSHH,
Hony. FCGP
Hony. Senior Fellow Postgraduate Institute of Medicine (Col.)
Founder & Patron Vaccine and Infectious Diseases Forum of Sri Lanka, Additional Secretary Ministry of Health 1995-97, President SLMA 1995

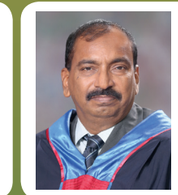


Prof Saroj Jayasinghe
MBBS (Col), MD (Col), MRCP (UK), MD (Bristol), PhD (Col), FRCP (Lond), FCCP, FNASSL
Emeritus Professor of Medicine, University of Colombo, Consultant, Department of Medicine, Sabaragamuwa University of Sri Lanka, Consultant Physician

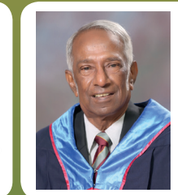
Dr V.S.M.C.K.B. Jayawardena
MBBS, DIPPCA, MCGP (Associate)
Medical Officer (Planning), PDHS Sabaragamuwa,
Vice President, General Practitioners Association Ratnapura

Prof Indika Karunathilake
MBBS (Col.), DMedEd (Dundee), MMEdEd (Dundee), FHEA (UK), FCGP (SL), FCME (SL), FRCP (Edin.)
Head, Department of Medical Education, Faculty of Medicine, University of Colombo
Head, WHO Collaborative Centre for Medical Education
President-SLMA-2020

Dr Pramitha Mahanama
MBBS (Sri Jayewardenepura),
Dip. In World Affairs and Diplomacy, MO Emergency Medicine



Dr V. Murali
MBBS (Jaffna), PGD (Population Studies), MSc (Colombo), MD (Community Medicine), FCCP (SL), FRSPH (UK),
Board Certified Specialist Community Physician Visiting Lecturer University of Colombo & Jaffna, President Jaffna Medical Association 2014/15



Dr B.J.C. Perera
MBBS(Cey), DCH(Cey), DCH(Eng), MD(Paed), MRCP(UK), FRCP(Edin), FRCP(Lon), FRCPCH(UK), FSLCPaed, FCCP, Hony FRCPCH(UK), Hony. FCGP(SL)
Specialist Consultant Paediatrician and Honorary Senior Fellow, Postgraduate Institute of Medicine, University of Colombo, Joint Editor, Sri Lanka Journal of Child Health, Section Editor, Ceylon Medical Journal, Founder Chairman, Sri Lanka Forum of Medical Editors 2016, Past President, Colombo Medical School Alumni Association (CoMSAA)-2015, Founder President, Sri Lanka College of Paediatricians (1996-97), President-SLMA-2013

Prof Jennifer Perera
MBBS, MD(Microbiology) (Col), MBA(Wales),
PgDMedEd(Dundee),
PgDWomen'sStu(Col)
Emeritus Professor, University of Colombo, Consultant, Department of Microbiology, Wayamba University of Sri Lanka.
Consultant Microbiologist,
President-SLMA-2015

Dr Surantha Perera
MBBS(Col) DCH(SL) MD Paed(SL) DCH(UK) FRCP(Edin) FRCPCH(UK)
Vice President Sri Lanka Medical Association (SLMA), Past President, Perinatal Society of Sri Lanka (PSSL), President, Perinatal Association of Private Hospitals in Sri Lanka (PAPHSL), Council Member, Sri Lanka College of Paediatricians(SLCP), Country Rep Federation of Asia and Oceania Perinatal Societies (FAOPS), Managing Editor, Sri Lanka Journal of Perinatal Medicine (SLJPM), Editor, Genesis Scientific Magazine, Consultant Paediatrician & Neonatologist, Neonatal Intensive Care Unit, Castle Street Teaching Hospital for Women, Colombo

Prof Clifford Perera
MBBS, DLM, MD, MA, LLB, DMJ, MFFLM(UK),
Attorney-at-Law
Chair Professor of Forensic Medicine and Consultant Forensic Pathologist
Dept. of Forensic Medicine
Faculty of Medicine
University of Ruhuna

Dr Seneeth Peramuna
MBBS, MRCS (Edinburgh)
Registrar in Orthopaedic Surgery
Postgraduate Institute of Medicine
University of Colombo

Dr. S.B. Anuruddhika S.M. Rathnayake
MBBS (Peradeniya), MSc Com Med (Colombo), FRSPH(UK)
Registrar in Community Medicine, Office of Regional Director of Health Services: Kandy District

Dr Manilka Sumanatilleke
MBBS, MD(Col), MRCP(Lon), MRCP-Diab & Endo(UK), FRCP(Edin), FACE(USA), FSLCE(SL), FCCP(SL)
Consultant Endocrinologist National Hospital of Sri Lanka

Dr K T Sundaresan
MBBS, MD (Col), FRCP (Edin)
Senior Lecturer, Faculty of Health Care Sciences, Eastern University
Honorary Consultant Physician, Teaching Hospital Batticaloa

Dr Asitha Kosala Thannippuli Arachchi
MBBS(Colombo), MCGP, MOH Office Kekirawa 50100

Dr Brammah R. Thangarajah
MBBS, MD (Mos), MD (Col), MRCP ESEneph
Senior Lecturer in Medicine, Dept. of Medicine, University of Jaffna
Specialist Nephrologist Teaching Hospital, Jaffna

Dr Anula Wijesundere
MBBS (Cey), MD. (Cey), MRCP (UK), FRCP (Lond), LRCP, MRCS (Lond.), DCH (Lond), DGM. (Lond), FCCP, Hony. FRACP
Consultant Physician, Founder Professor, Medicine, Sir John Kotelawala Defence Member, Technical Support Group, Anti Malaria Campaign, President-SLMA-2019

SRI LANKA MEDICAL ASSOCIATION

CALL FOR ORATIONS

Applications are called for the following Orations to be delivered at the 136th Anniversary International Medical Congress 2023

SLMA Oration
The SLMA Oration is the most prestigious Oration of the Association. Instituted in 1979, it recognizes outstanding achievement in research. It is delivered at the Inaugural Ceremony of the Annual Scientific Congress.

Dr S C Paul Memorial Oration
The S. C. Paul Oration is the oldest Oration of the Association. Instituted in 1966, it is delivered in memory of Dr S C Paul, an outstanding surgeon. It is delivered on the second day of the Annual Scientific Congress.

Dr S Ramachandran Memorial Oration
It is delivered during the Annual Scientific Congress of the SLMA.

Prof N W D Lionel Memorial Oration
It is delivered during the Annual Scientific Congress of the SLMA.

Murugesar Sinnetamby Memorial Oration
Instituted in 1968, this Oration is delivered in memory of Dr Murugesar Sinnetamby, an outstanding obstetrician and gynaecologist.

Sir Nicholas Attygalle Memorial Oration
Instituted in 1975, this Oration is delivered in memory of Sir Nicholas Attygalle, an outstanding Obstetrician and Gynaecologist, the first Ceylonese Vice Chancellor of the University of Ceylon, and President of the Senate. It is delivered on the Second day of the Foundation Sessions of the Association.

Sir Marcus Fernando Memorial Oration
Institute in 1969, this Oration is delivered in memory of Sri Marcus Fernando, an outstanding physician and the first Sinhala member of the Legislative Council.

Guidelines for Submission

1. The Oration should be written in full, and the script of the Oration should be submitted. The IMRAD format is suggested unless the content requires otherwise.
2. A substantial part of the Oration should be based on original research.
3. Orations based on work published in peer-reviewed journals will be given priority.
4. The cover letter addressed to the Honorary Secretary, SLMA, should consist of
    a) an explanation of why the applicant believes that the work is of sufficient merit to deserve an Oration
    b) a separate sheet stating the list of the original papers/ publications on which the Oration is based
    c) The name of the Oration/Orations for which the manuscript should be considered
        - The Murugesar Sinnetamby Memorial Oration should preferably be on a topic on *Obstetrics & Gynaecology*.
    d) Conference presentations (both oral and poster) of the applicant cited in the Oration.

5. For all research involving human or animal subjects, state 'Ethics Clearance' in the methods section. Randomized Control Trials should have been registered in a WHO-recognized Clinical Trial Registry.
6. The Oration should be typed using Times New Roman, size 12, double line spacing. Harvard or Vancouver's system of referencing can be used.
7. A separate document with the following should accompany the manuscript.
    a) The impact of the research in terms of advancing scientific knowledge, quality of clinical care and improvement of service delivery.
    b) In the case of multi-author research and publications, the applicant should inform the other authors of their presentation and provide details of the contribution to the design, data collection, analysis and writing of the manuscript by the applicant.
    c) A declaration by the applicant that the other authors of the presented research have no objections to the submission of the Oration.
    d) The applicant should declare if all or part of the work included in the manuscript has already been presented as an Oration.
    e) Declaration of financial and other conflicts of interests.

9. Applications consisting of ***seven (07) copies of the scripts should be submitted to the SLMA office addressed to the Honorary Secretary, 'Wijerama House', No.6, Wijerama Mawatha, Colombo-07). Of the seven (07) copies, one (01) copy should be with the name of the author and six (6) copies should be without the name of the author.*** Each copy should be accompanied by a ***brief resume of the salient points*** on ***one sheet of paper (A4 size)*** indicating the contribution made to advances in knowledge on the subject. Further particulars may be obtained from the SLMA office.

All authors of orations should be LIFE MEMBERS OF THE SLMA if they are eligible for membership (If you are not a member at present, please become a life member before forwarding your application).

Closing date for all Orations: 31st March 2023

Dr. Sajith Edirisinghe
Honorary Secretary
Sri Lanka Medical Association

For further details, please contact:
The Sri Lanka Medical Association, 'Wijerama House', No.6, Wijerama Mawatha, Colombo-07
Tel: 011-2693324, Email: office@slma.lk

To stent or not to stent?

Dr Naomali Amarasena

(MBBS, MD, FRCP(Lond.), FACC, FCCP, FRACP(Hon.)
Consultant Cardiologist
Sri Jayewardenepura General Hospital

What is Angina?

In 1772, the English physician William Heberden gave a talk at the Royal Society in London on some account of a disorder of the breast as he called it. He described it in a seminal fashion that remains valid today: 'Those who are afflicted with it, are seized while they are walking (more especially if it be up hill, and soon after eating) with a painful and most disagreeable sensation in the breast, which seems as if it would extinguish life…; but the moment they stand still, all this uneasiness vanishes. …The pain is sometimes situated in the upper part, sometimes in the middle, sometimes at the bottom of the os sterni, and often more inclined to the left than to the right side. It likewise very frequently extends from the breast to the middle of the left arm. The seat of it and sense of strangling and anxiety with which it is attended may make it not improper to be called angina pectoris'. Although Heberden meticulously described the symptom, he did not understand the disease.[1]

Timeline

1793 Edward Jenner noticed thickened coronary arteries at autopsy of his colleague John Hunter who had died suddenly after an angina attack.

1867 Thomas Lauder Brunton was the first to describe the effects of amyl nitrite in angina pectoris in the Lancet.

1958 Mason Sones by mistake performed the first coronary angiography in a 26-year-old gentleman with rheumatic heart disease. Ever since, it was possible to visualize the narrowings of epicardial coronary arteries that were and still are considered the major cause of angina pectoris.

1964 Sir James Whyte Black, (Nobel laureate in 1988) discovered the beta-blocker propranolol.

1967 Rene Favoloro, the Argentinian cardiac surgeon (working in the Cleveland Clinic) used a saphenous vein of the lower limb and sewed it reverse order to the ascending aorta and distal to the narrowing into a diseased coronary artery - and coronary artery bypass grafting (CABG) was born.

1977 Andreas Gruntzig (University Hospital, Zurich) introduced percutaneous transluminal coronary angioplasty (PTCA) and interventional cardiology was born

1985 Julio Palmaz, an interventional vascular radiologist, is known for inventing the balloon-expandable stent, for which he received a patent filed in 1985. This patent has been included on the list of the 10 most important inventions of all times. He worked together with cardiologist Richard Schatz and the 1st Palmaz-Schatz coronary stent was successfully implanted in Sao Paulo, Brazil in 1987.

1994 US-FDA approves Palmaz-Schatz stent following the results of the BENESTENT and STRESS randomized trials, comparing stents with balloon angioplasty.

The rest is history! Stentmania was born

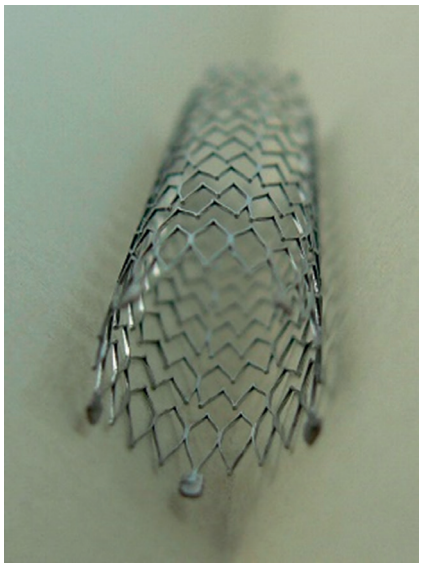
Medication

Following the discovery of nitrates and beta blockers came calcium channel blockers such as verapamil, diltiazem and nifedipine. These three classes of drugs remain the cornerstones of optimal medical therapy (OMT) of angina pectoris.

More recently nicorandil (a hybrid of nitrate and a potassium channel opener), ranolazine (blocks late inward sodium currents in cardiomyocytes) and finally ivabradine, (I_f channel blocker in the sinus node) were added to the medical armamentarium.

Bare metal stents

A bare-metal stent is a stent made of thin, uncoated (bare) metal wire that has been formed into a mesh-like tube. The first stents licensed for use in cardiac arteries were bare metal i.e.stainless steel. More recent "second generation" bare-metal stents have been made of cobalt chromium alloy.

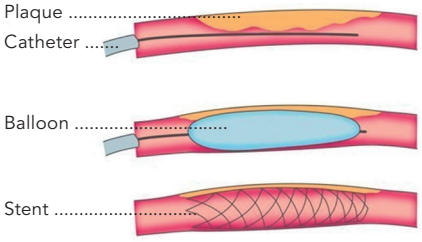


Intra coronary stent

Drug eluting stents

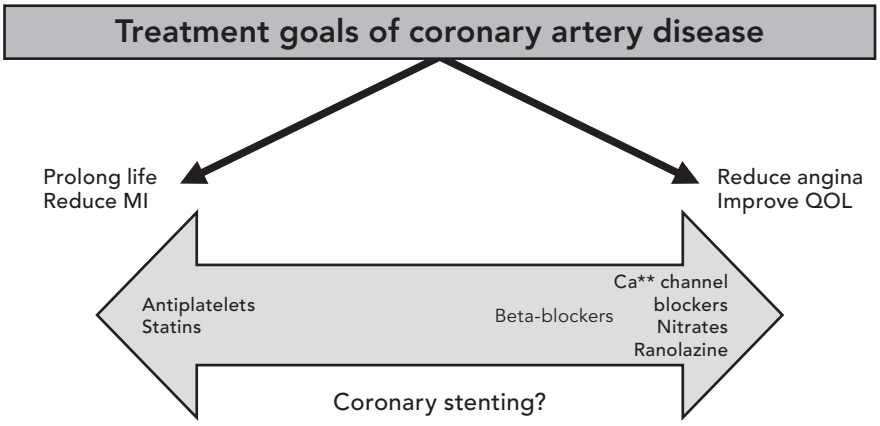
Drug-eluting stents (DES) are balloon-mounted, expandable, slotted tubular or multilink scaffolds constructed of a stainless steel or cobalt chromium matrix. Attached to the stent is a polymer that is embedded with an antiproliferative drug, which allows drug elution into the coronary wall for weeks to months after stent implantation to reduce the local proliferative healing response.

Drug-eluting stents (DES) were developed in the early 2000s to reduce restenosis (ie, recurrent narrowing) rates in stented coronary lesions. These stents are FDA approved for single de novo coronary lesions of limited length within specific diameter size ranges. However, off-label use of drug-eluting stents is extremely common.



Angioplastry and stenting

Major goals of treating patients with Coronary Artery Disease (CAD)[2]



- Reduce risk of major adverse cardiac events
- Prolong life
- Improve - symptoms, functional status & quality of life

Stenting in the setting of Myocardial Infarction

In the setting of acute ST-elevation

In acute ST elevation Myocardial Infarction (STEMI) primary percutaneous coronary intervention (PCI) is recommended instead of fibrinolytics if the presentation isn't significantly delayed with a number needed to treat (NNT) of 16 to prevent 1 death, non-fatal MI or stroke. The benefits of primary PCI over fibrinolysis include: lower rates of early death, re-infarction and intracranial haemorrhage. The best outcomes occur when primary PCI is performed with a door-to-balloon time is less than 90 minutes.

In acute non-STEMI (NSTEMI), routine invasive strategy has been shown to be superior to an ischaemia guided or selectively invasive strategy with a modest improvement in both long-term mortality and long term angina and health status. NNT of 91. Unlike in STEMI identifying the culprit lesion is difficult and which strategy to adopt when stenting varies in differing guidelines. The culprit lesion and other severe lesions can be stented after careful consideration, in a staged fashion if necessary.[3]

Stenting in the setting of Stable Coronary Artery Disease

Many cardiologists, physicians and patients believe that opening an artery with stenting must be better than medical management[4]. There is little evidence that in asymptomatic or minimally symptomatic patients with stable CAD, elective PCI reduces morbidity or mortality outside of a few narrow indications.

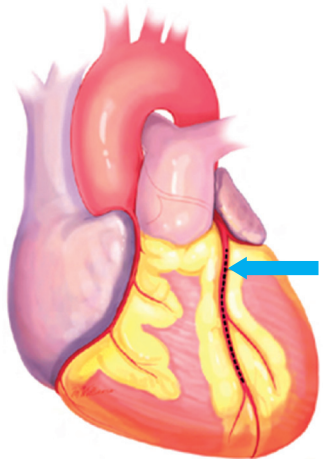
COURAGE trial[5]concluded that PCI did not reduce the risk of death, myocardial infarction or other major cardiovascular events when added to optimal medical therapy.

ORBITA trial (Optimal Medical Therapy of Angioplasty in Stable Angina)[6] showed that among patients with stable angina, PCI does not result in greater improvements in exercise times or anginal frequency compared with a sham procedure

ISCHEMIA trial[7] is the largest randomized controlled trial comparing optimal medical therapy vs. optimal medical therapy plus invasive evaluation and revascularization in patients with stable ischemic heart disease. However, severity of ischemia did not identify a subgroup with treatment benefit on mortality or MI, but in the most severe CAD subgroup, the 4-year rate of CV death or MI was lower in the invasive strategy group. The real message following the trial stressed ***the importance of adherence to medical therapy and risk factor control, irrespective of the management strategy.***

Stenting for proximal left anterior descending artery (LAD) disease

In a sub analysis of the COURAGE trial, more severe obstruction in the proximal LAD was associated with increased risk of death or acute coronary syndrome. Importantly however, PCI in this case did not modify the risk and thus has only a (IIb) indication in the guidelines.



Stenting for symptom relief

PCI can greatly improve symptoms and functional limitations although there is little evidence that it reduces the risk of morbidity and mortality in the majority of patients with stable angina. Chronic angina substantially worsens a patient's quality of life and increases the cost of health care. Treatments that improve angina can have a marked impact on a patients well-being. While PCI was associated with a significant improvement in a patients' quality of life, medical therapy also can be associated with large improvements in symptoms. In the COURAGE trial at 1 year there was only a modest difference between the two groups. Interestingly this is in contrast to the older CABG studies where there was a marked difference in angina-free rates between medical and CABG groups. This reflects both improvements in medical therapy over time and to a lesser extent, better angina relief with CABG vs PCI.

Summary

The current indications for coronary stenting - whether for survival benefit or symptom relief - depends on the clinical situation.

STEMI - Primary PCI - survival benefit

NSTEMI - More modest benefit on survival and symptoms

STABLE CAD - Little evidence of any survival benefit outside of a few narrow indications.

HIGH-RISK ISCHEMIA - impact of stenting on morbidity and mortality is still unknown

While it is generally accepted that PCI relieves angina and improves quality of life in stable coronary artery disease, a question remains as to how much of this relief is due to a placebo effect as medication trials have shown a similar benefit.

Atherosclerotic vascular disease is a systemic process, which makes medical therapy a key piece in the treatment plan for CAD. How revascularization, particularly stenting fits into this plan is an evolving process as we are still learning about the benefits and limitations of this technology.

Referrences

1. Bernard J Gersh, William E Boden, Deepak L Bhatt, Per H Stone, Filippo Crea, Thomas F Luscher. To stent or not to stent? Treating angina after ISCHEMIA - introduction. Euro Heart J, Vol 42, Issue 14, 7 April 2021, 1387-1400. doi.org/10.1093/eurheartj/ehab069
2. Suzanne V. Arnold. Methodist Debakey Cardiovasc. Current Indications for Stenting: Symptoms or Survival. J. 2018 Jan-Mar; 14(1): 7-13. doi: 10.14797/mdcj-14-1-7
3. Mehdi H Shishelbhor Deepak L Bhatt. Treating patients with non-STEMI: stent the culprit artery only or address all lesions. Curr treat options Cardiovasc Med. 2008 Feb;1091):93-7. doi:10.1007/s11936-008-0010-4
4. Rothberg MB, Senthil K Sivalingam, Javed Ashraff et al. Patients and cardiologists' perceptions of the benefits of percutaneous coronary intervention for stable coronary disease. Ann Intern Med.2010 Sep7, 153(5)307-13. doi:10.7326/0003-4819-153-5-201009070-00005
5. William E Boden et al. Optimal medical therapy with or without PCI for stable coronary disease N Engl J Med 2007, 356, 1503-1516 (ClincalTrials.gov number, NCT00007657)
6. Rasha Al-Lamee et al. Percutaneous coronary intervention in stable angina (ORBITA): a double blind, randomized controlled trial. The Lancet. Vol.391, issue 10115, P31-40, Jan 06, 2018. doi.org/10.1016/S0140-6736(17)32714-9
7. ISCHEMIA Research Group N Eng. J Med 2020; 382: 1395-1407. doi:10.1056/NEJMoa1915922

Lifestyle Medicine: the future of chronic disease management?

Dr Samandika Saparamadu
MBBS, DipIBLM
President, Sri Lankan Society of Lifestyle Medicine

Dr Rasarie Wimalana
MBBS, DipIBLM
Vice President - Membership, Sri Lankan Society of Lifestyle Medicine

Dr Rukshanie de Silva
MBBS, MD
Secretary, Sri Lankan Society of Lifestyle Medicine

Lifestyle medicine collates sound scientific evidence from diverse medical fields to redefine the approach to treating and reversing lifestyle-related diseases, i.e., non-communicable diseases (NCDs), and promoting health in clinical settings. The practice of lifestyle medicine centers around clinical settings, as opposed to community medicine and other public health interventions. Therefore, it fills a significant gap in the global efforts to address the rising trends of lifestyle-related diseases.

A brief history of lifestyle medicine

Even though lifestyle medicine is a new medical discipline, some of its principles can be traced back to ancient civilizations. The Greek physician and the father of modern medicine, Hippocrates, linked disease formation to environmental factors, diet, and living habits. Hippocrates' acclaimed aphorism - if we could give every individual the right amount of nourishment and exercise, not too little and not too much, we would have found the safest way to health - provides evidence of the possibly preeminent hypothesis of the biomedical model of the health of his contemporaries. Besides this, "all things in moderation" has been ascribed to ancient Asian philosophers and civilizations. In modern medicine, the term "lifestyle medicine" was coined as a symposium title in 1989. It first appeared in publication as the title of an article in 1990.

Contemporary definitions of lifestyle medicine

There are many converging contemporary definitions of lifestyle medicine. The American College of Lifestyle Medicine (ACLM) defines it as a medical specialty that uses therapeutic lifestyle interventions as a primary modality to treat chronic conditions including, but not limited to, cardiovascular diseases, type 2 diabetes, and obesity.

The discipline of lifestyle medicine calls for the prevention, management, and reversal of lifestyle-related diseases through its six (6) pillars - whole-food, plant-based eating pattern (WFPB diet), physical activity, restorative sleep, stress management, positive social connections, and avoiding harmful substance use - with a patient-centered approach (Figure 1). This approach enables an individual to develop and sustain a healthy lifestyle in the long run. Incorporating these ideals into an economically viable clinical practice could arguably present the best approach to face the ongoing chronic disease epidemic as health professionals engaged in direct patient care.

A whole-food, plant-based diet

According to the Global Burden of Disease report of 2017, poor dietary practices are now recognized as a major cause of NCDs worldwide. They are responsible for more deaths globally than tobacco or high blood pressure and are accountable for one in every five deaths. Lifestyle Medicine advocates a WFPB diet, which comprises plant-based foods that are minimally processed, such as whole-grains or minimally processed grains and grain products, beans, legumes, whole soy or minimally processed soy and soy products, vegetables, fruits, nuts, and seeds. Low-fat WFPB diets are associated with favorable health outcomes such as weight loss or maintenance, reduced total cholesterol, lower risk of cardiovascular events, fewer medications, and good quality of life outcomes [1].

In lifestyle medicine practice, one of the critical objectives is to help patients achieve dietary changes, i.e., health behavior change. In this regard, often in lifestyle medicine clinics, physicians, with the assistance of a dietitian, nurse clinician, or health coach, perform a nutrition assessment, including but not limited to

1. Anthropometric data, e.g., BMI, waist circumference, and bioelectrical impedance analysis,
2. Biochemical data, e.g., hemoglobin, albumin, urea and electrolytes, glucose, HbA1c, and lipid panel,

3. Clinical assessment, including a comprehensive nutritional history and relevant clinical examination, and

4. A thorough dietary assessment using validated tools such as 24-hour dietary recall, three-day food record, mini nutritional assessment for the elderly, or online tools.

To make this process easier for the patients, clinicians often utilize food models and measuring utensils.

Some specific evidence-based diets, besides nutrition counseling, health behavior change, and nutrition prescriptions, are used in certain medical conditions, such as the DASH diet for hypertension, the Ornish diet, and the Esselstyn plant-based diet for coronary artery disease, and the CHIP program diet for diabetes. Understanding the scientific basis of writing nutrition prescriptions, prescribing macronutrients, micronutrients and food preparation, and using SMART goals in prescription writing are some of the core competencies expected of a lifestyle medicine practitioner.

Physical activity

Physical inactivity is the fourth leading risk factor for global mortality and is responsible for approximately 1 in 10 premature deaths [2]. Interestingly, people who get the most exercise have lost the least years of life, despite being average weight, overweight or obese [3]. The overall benefits of physical activity include increased muscular and cardiovascular fitness, improved bone health and less risk of falls and vertebral fractures, reduced risk of NCDs, and maintenance of a healthy weight.

Physical activity is a vital sign in lifestyle medicine. Physicians are expected to interpret this vital sign and create an exercise prescription where necessary. Beyond the recommendation of Physical Activity Guidelines - adults need 150 minutes of moderate-intensity physical activity and two days of muscle-strengthening activity every week - exercise prescriptions are widely used in clinical practice. These prescriptions include frequency, intensity, type of exercise, and time duration of each exercise - commonly abbreviated as FITT. Furthermore, exercise preparticipation health screening algorithms are used before incorporating patients in physical activity programs/routines [4]. (Figure 2)

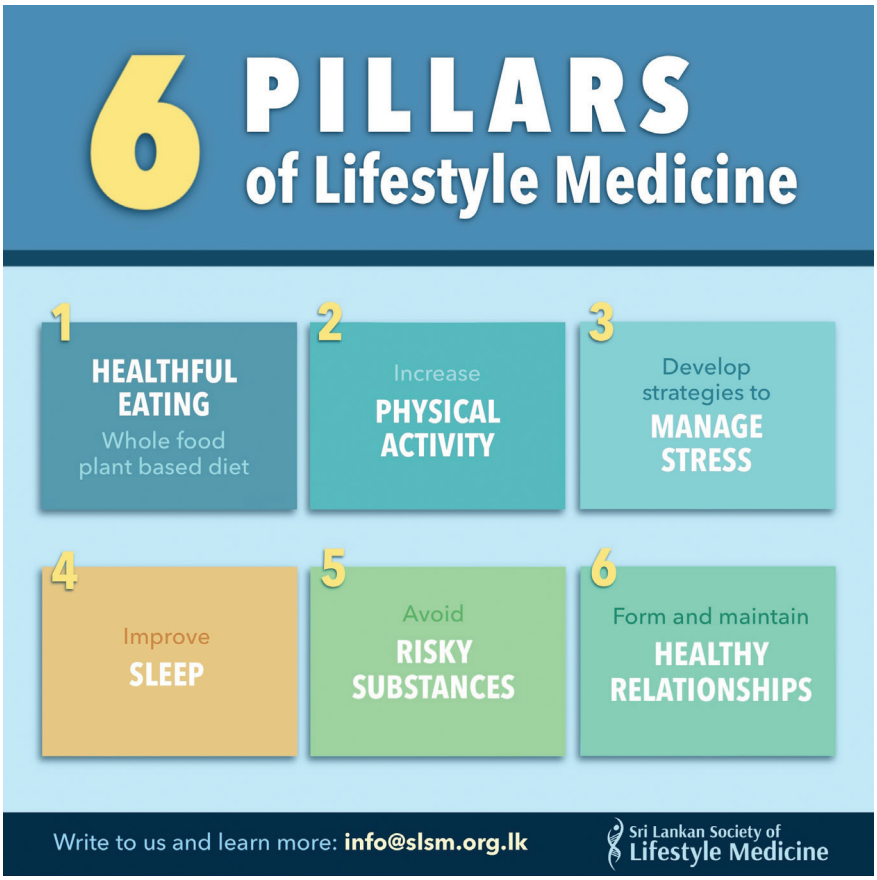


Figure 1: The six pillars of lifestyle medicine

Sleep health and sleep hygiene

Sleep is an often overlooked and sacrificed pillar of health, particularly in shift workers, with detrimental effects. It has been evidenced that poor sleep quality and duration correlate with cardiovascular risk, NCDs, and mortality [5]. In addition, poor quality sleep has also been linked to mood, cognition, learning, memory impairments, and cancer risk. Some core competencies expected of lifestyle medicine physicians in sleep health include a thorough understanding of circadian and sleep physiology, techniques used in sleep assessments, sleep hygiene assessments, and treatment strategies [6]. Interventions for poor quality sleep include,

1. Lifestyle prescriptions, including changes to sleep environment, managing light exposure, dietary changes, and techniques for minimizing stress,

2. Intensive therapies such as cognitive behavioral therapy (first-line therapy for chronic insomnia), behavioral methods,

cognitive methods, and

3. Prescription of Melatonin (hypnotics/sedatives are typically avoided).

Emotional and mental well-being

It is estimated that 70% of primary care provider visits are stress and lifestyle related, while stressed individuals are less likely to engage in healthy lifestyle habits. Stress activates a complex series of hormones and neurotransmitters that alter the cardiovascular and metabolic functions of the body, which, if overwhelming and chronic, can lead to the suppression of the immune system, subclinical inflammation, and long-term organ and tissue damage [7]. Depression is a comorbid illness for many chronic diseases, such as diabetes mellitus, and it is a recognized independent risk factor for cardiac events in patients with coronary artery disease. Lifestyle medicine focuses on building an effective and empathetic patient-physician relationship, incorporating positive psychology, cognitive behavioral therapy, mindfulness, and stress resilience in its practice to address these clinical scenarios.

Tobacco cessation and managing risky alcohol use

Tobacco use is the single most significant preventable cause of mortality and morbidity, with well-known consequences of cancers and respiratory and coronary artery diseases. Smoking leads to many other conditions, such as diabetes, impaired immune function, impaired wound healing, problems with reproduction, and maternal and fetal complications [8]. Similarly, heavy alcohol use has been linked to high blood pressure, stroke, unintentional injuries, and cancers [9]. Lifestyle medicine physicians routinely screen for tobacco use and problematic alcohol use and employ effective evidence-based treatments such as counseling techniques in combination with appropriate pharmacotherapy.

Upon identifying a risk factor such as smoking, enabling behavior change is critical. Among various models used in facilitating behavior change, the 5A's in tobacco cessation and 5A's of behavior change models are well-adopted by clinicians. Furthermore, with motivational interviewing techniques, the frequently used Transtheoretical Model helps guide patients through the change cycle during clinic visits. In addition, pharmacotherapy is routinely used to help patients to quit smoking.

Connectedness and positive psychology

Experts in positive psychology and psychophysiology tell us that positive social interactions and 'micro-moments of connection' lead to longevity and beneficial physiological responses, such as the activation of the parasympathetic nervous system, in contrast to unmanaged stress, which activates the sympathetic nervous system. Lifestyle Medicine allows individuals and communities to thrive through the use of models such as PERMA, which incorporates positive emotion, engagement, relationship, meaning, and accomplishments, which in turn can help facilitate long-term adherence to positive health behaviors. The longest-running study in the world from Harvard has concluded that the single most predictor of happiness and longevity is healthy social connections [10].

Growth of the discipline

Lifestyle medicine has shown rapid growth, especially in developed countries, over the last decade, with evolving practices including group consultations, residency/training programs, diploma certifications, and master/doctoral programs. Among the available training programs targeting practitioners, the International Board of Lifestyle Medicine (a subsidiary of the ACLM) Diploma program is well-received globally. Furthermore, lifestyle medicine has also been successfully incorporated into medical curricula in some of the prestigious universities, such as the University of California San Diego, Imperial College London, and Indiana University.

Sri Lankan Society of Lifestyle Medicine

The Sri Lankan Society of Lifestyle Medicine (SLSLM) was initially formed as a special-interest group in 2019 and slowly evolved into an organization over the last three years. The vision of the SLSLM is a Sri Lanka with a transformed, sustainable healthcare system with lifestyle medicine as its foundation. It aims for a sustainable transformation of the healthcare system by employing the evidence-based practice of lifestyle medicine through medical education, clinical practice, and clinical research to advance the treatment and reversal of chronic NCDs.

However, these objectives are confounded by a multitude of challenges, including but not limited to the lack of economically viable lifestyle medicine clinical practice models in primary care in Sri Lanka, the dearth of data on practice-based evidence, the lack of incentives for practitioners to employ evidence-based practices, inadequate awareness

both among the general public and clinicians, and limited graduate training programs for lifestyle medicine. Despite various innovative solutions and initiatives of SLSLM to encourage research in lifestyle medicine, incorporate lifestyle medicine into undergraduate medical curricula, make awareness through webinars and social media campaigns, and establish local lifestyle medicine clinics, unprecedented real-world challenges continue to create further headwinds. At the SLSLM, we believe, as a people united under oath, we have a unique call and an ethical obligation to strive for the best practices as informed by evidence. It is no less than an uphill journey further complicated by policy challenges and economic struggles. But if not us, who? If not today, when?

Email:
info@slslm.org.lk

Visit our official website for more information:
https://www.slslm.org.lk

Follow us at:
https://www.facebook.com/lifestylemedicinesl/

Apply for membership:
https://www.slslm.org.lk/membership

For more information on the IBLM examination, visit https://iblm.co

References

1. Wright N, Wilson L, Smith M, et al. The BROAD study: A randomized controlled trial using a whole food plant-based diet in the community for obesity, ischaemic heart disease or diabetes. Nutrition & diabetes. 2017 Mar;7(3):e256-e256. https://doi.org/10.1038/nutd.2017.3
2. Lee IM, Shiroma EJ, Lobelo F, et al, Lancet Physical Activity Series Working Group. Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy. The Lancet. 2012 Jul 21;380(9838):219-29. https://doi.org/10.1016/S0140-6736(12)61031-9
3. Moore SC, Patel AV, Matthews CE, et al. Leisure time physical activity of moderate to vigorous intensity and mortality: a large pooled cohort analysis. PLoS medicine. 2012 Nov 6;9(11):e1001335. https://doi.org/10.1371/journal.pmed.1001335
4. Ferguson B. ACSM's Guidelines for Exercise Testing and Prescription 9th Ed. 2014. J Can Chiropr Assoc. 2014 Sep;58(3):328.
5. Cappuccio FP, Taggart FM, Kandala NB, et al. Meta-analysis of short sleep duration and obesity in children and adults. Sleep. 2008 May 1;31(5):619-26. https://doi.org/10.1093/sleep/31.5.619
6. Blask DE, Melatonin, sleep disturbance and cancer risk. Sleep medicine reviews 2009;13(4):257-64.
7. Mariotti A. The effects of chronic stress on health: new insights into the molecular mechanisms of brain–body communication. Future science OA. 2015 Nov;1(3). https://doi.org/10.4155/fso.15.21
8. Centers for Disease Control and Prevention. Fact sheet: health effects of smoking. April 28, 2020. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/index.htm
9. National Institute on Alcohol Abuse and Alcoholism. Understanding alcohol use disorder. Available at https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/understanding-alcohol-use-disorder
10. Mineo L. Good genes are nice, but joy is better. The Harvard Gazette. 2017 Apr 11;11. Available at https://news.harvard.edu/gazette/story/2017/04/over-nearly-80-years-harvard-study-has-been-showing-how-to-live-a-healthy-and-happy-life/

Key:

§ Exercise participation, performing planned, structured physical activity at least 30 min at moderate intensity on at least 3 d/wk for at least the last 3 months.

* Light-intensity exercise, 30% to <40% HRR or VO2R, 2 to <3 METs, 9–11 RPE, an intensity that causes slight increases in HR and breathing.

** Moderate-intensity exercise, 40% to <60% HRR or VO2R, 3 to <6 METs, 12–13 RPE, an intensity that causes noticeable increases in HR and breathing.

*** Vigorous-intensity exercise >=60% HRR or VO2R, >=6 METs, >=14 RPE, an intensity that causes substantial increases in HR and breathing.

‡ CVD, cardiac, peripheral vascular, or cerebrovascular disease.

‡‡ Metabolic disease, type 1 and 2 diabetes mellitus.

‡‡‡ Signs and symptoms, at rest or during activity; includes pain, discomfort in the chest, neck, jaw, arms, or other areas that may result from ischemia; shortness of breath at rest or with mild exertion; dizziness or syncope; orthopnea or paroxysmal nocturnal dyspnea; ankle edema; palpitations or tachycardia; intermittent claudication; known heart murmur; or unusual fatigue or shortness of breath with usual activities.

‡‡‡‡ Medical clearance, approval from a health care professional to engage in exercise.

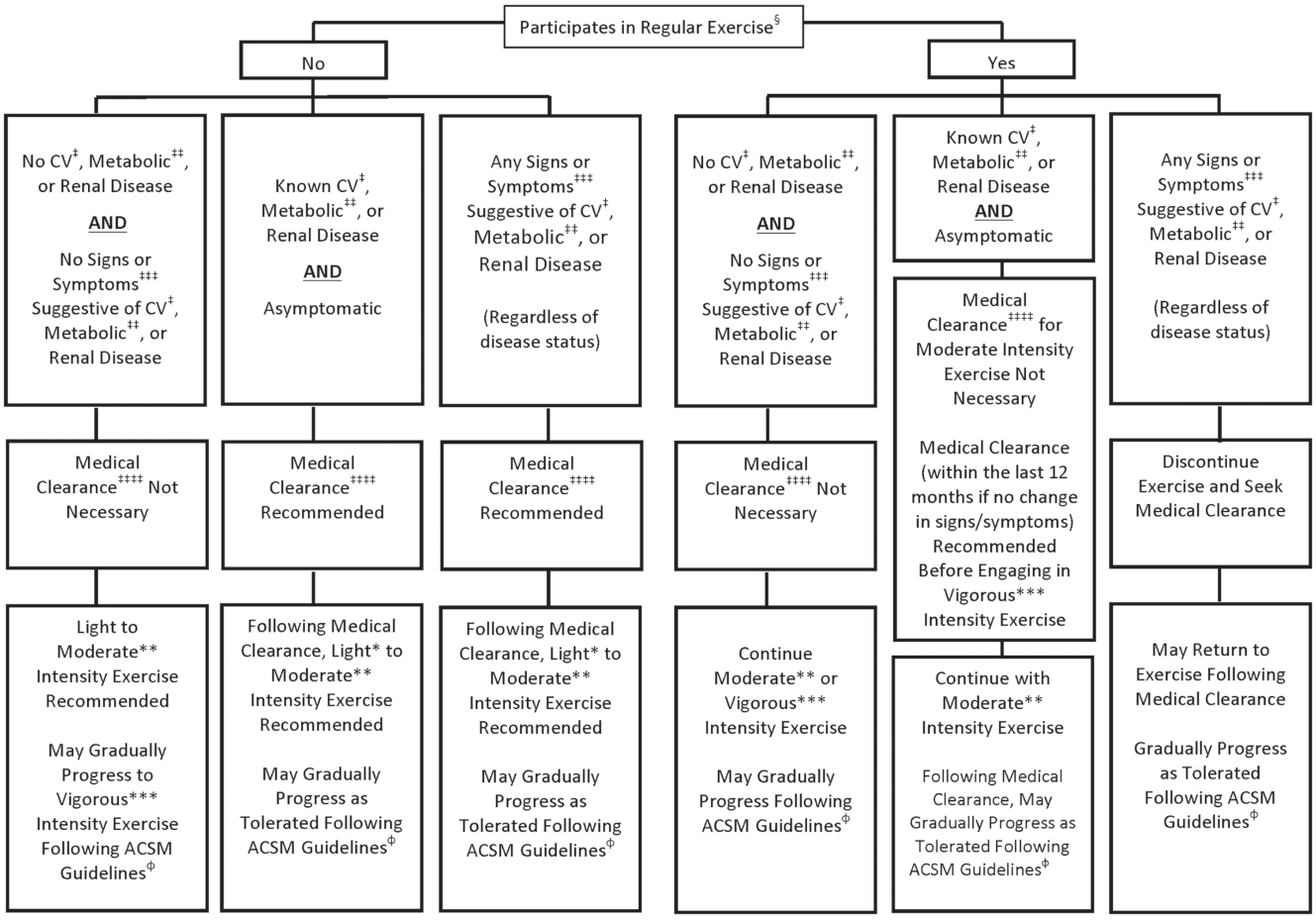
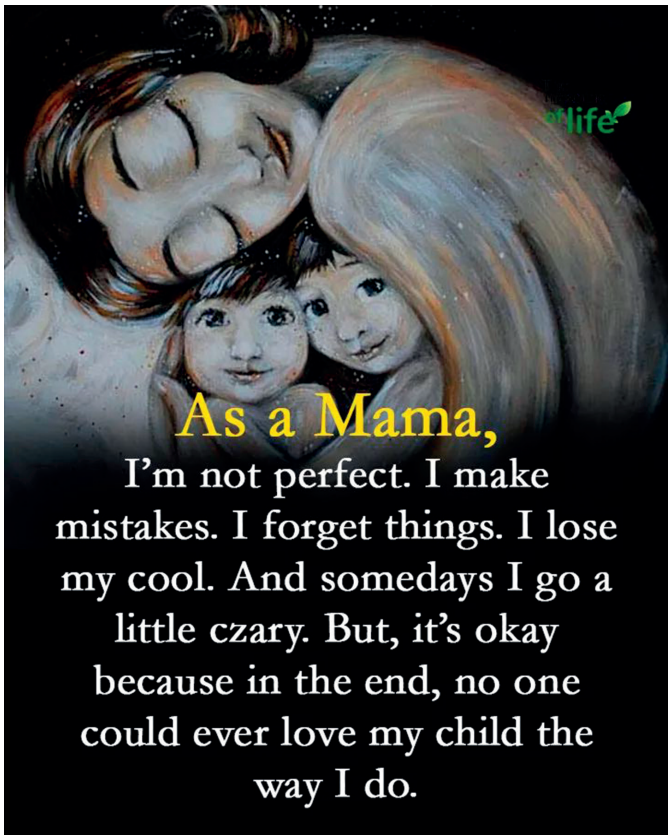


Figure 2: Exercise preparticipation health screening logic model for aerobic exercise participation. Reproduced from reference 4.



Does smoke-free mean harm-free?

Manuja Perera

Board certified specialist in Community Medicine
Senior Lecturer in Public Health, Faculty of Medicine, University of Kelaniya
Editor, Centre for Combating Tobacco

Introduction

The word substance, commonly misused to refer only to illicit substances, also includes the two commonly used licensed substances tobacco and alcohol. Those are still the most lethal so far in the world, due to its high availability and accessibility, causing around 12 million deaths annually around the world. Tobacco, with direct 7.7 million deaths and about half a million deaths due to exposure to second-hand smoke, remains the deadliest of all substances, and the second commonest cause of mortality in the current global context.[1] Tobacco industry, the vector of all the deaths and diseases caused by the products manufactured, promoted, and traded by them, stays a legal industry when the products they manufacture kill its consumers even when they are used the way it is promoted to be used by the manufacturer. For example, the firearm industry claims that firearms are for the protection of the bearer and any suicides or self-harm incidents are either accidental or incidental, deviations from their intended use. Cigarettes and other smokeless tobacco products cause addiction, other psychological and physical disorders and death when used as they are intended to be used.

Harm from tobacco

The harm from tobacco is not limited to the harms on physical and psychological health. Even some health professionals tend to forget this fact when attending to reduce or prevent harm caused by tobacco. The other major part of harm is the harm caused to the economy of the individual and the household, not only because of the direct and indirect health costs related to use, but also because of fathers spending money on tobacco and nicotine products rather than on food, children's education or upgrading living conditions etcetera. The economic harm goes beyond the households and applies at community and country levels as well. Loss of productive life years due to premature mortality and serious chronic illness, loss of productivity not only because of the related diseases, but also the time wasted on the habit. And of course the money in the form of pro!ts that is taken out from countries like ours, in which the monopoly of cigarette trade is held by a direct subsidiary of a multinational company should come into the equation. This is on top of our government or taxpayers needing to bear the cost of treating tobacco related disease, under the principles of free health. Even though tobacco companies bring on arguments against this economic harm, highlighting (most of the time exaggeratingly) the positive economic impact they generate in the terms of employment and contribution to government tax revenue, many scientific studies had proven that it is always a lost course in a country's perspective.[2]

Tobacco addiction

The harm caused by tobacco use is majorly propagated on the addiction to those products, to be more specific, on addiction to nicotine. Currently, tobacco industry is relying increasingly on this fact to sustain their business under the guise of their "harm reduction" and "smoke free future" approaches. Yes… you read it right! Those approaches were propagated by the tobacco industry, the latter more directly and openly than the former, of which, the origin is still being debated about. Both approaches loudly boast about reducing harm related to tobacco and conveniently forget that "harm" includes harm to other aspects of wellbeing other than physical wellbeing, harms caused by addiction and related social, behavioural and economic aspects. These approaches that sustained nicotine addiction, ensured a continuous inflow of profits to the tobacco industry, because all those businesses, including the pharmaceutical industry that manufacture and trade products used in nicotine replacement therapy, is mostly owned by the tobacco industry itself. This was in the context of increasing unpopularity towards tobacco due to plethora of evidence that appeared on the extent of harm it caused to individuals, families and communities. The age-old tobacco industry tactic that was used to market their products for decades - glamourising addiction to tobacco as an individual's right to consume, an expression of empowerment, rather than a psychological and a behavioural issue that may need support to overcome - was the foundation those approaches were built upon.

"Non-combustibles"

Thus, entered the market a range of products that tobacco industry named using a range of trending names such as Electronic Nicotine Delivery Systems (ENDS), Electronic Non-Nicotine Delivery Systems (ENNDS), HTP (Heated Tobacco Products). These terms enraptured e-cigarettes, vapes, mods, tank systems and devices that heat tobacco without burning it using electronic systems.[3,4,5] These products, named by the tobacco control advocates as "non-combustibles", sometimes even managed to evade tobacco control laws of countries under the claim of not to being a "tobacco" product. Some claimed to include only artificially manufactured nicotine and are not derivatives of the tobacco plant, and some claimed not to even include nicotine, but only flavoured agents. Many countries, including Sri Lanka is currently struggling to enhance their legislative frameworks to include these broad product ranges, so that marketing and promotion of these addictive products to users and potential users, especially to children and youth, can be restricted. The failure to do so has led to these "non-combustibles" now becoming the main mode of initiation of nicotine addiction which ends up in tobacco smoking in the conventional form in the West and countries like Australia and New Zealand.[5,6]

The adverse effects of those non-combustibles are not limited to being the main initiating agent of nicotine addiction and secondary tobacco use. The health harms range from causing sudden deaths to cardiovascular diseases, cancer and adverse reproductive outcomes, exacerbation of respiratory disorders, and harming developing brains. Nicotine itself is known to harm the developing brains of youth and teenagers that

use tobacco and nicotine products. However, this scenario was more prominently reported among who used products that included Tetrahydrocannabinol (THC), a chemical derivative of Marijuana. Yes. All the big tobacco companies have now invested in cannabis and had already started including its derivatives such as Cannabidiol (CBD) and THC in their non-combustibles. Some companies are even experimenting with actual cannabis cigarettes, in countries like Canada where cannabis is legalised for non-medicinal use.[3,4,5]

Irrespective of the claims made by the tobacco industry, backed by their sponsored research, actual scientific evidence of harm from these "new products" are now emerging. However, evidence on harm due to long-term use is still not satisfactory, simply because these products are relatively new in the market and had not been in use for "long-term". The harms of course should not be visualised in the narrow limits of "physical health". A major component of harm will be in the economic wellbeing, as these products are addictive and much more expensive than regular cigarettes (the main reason for users engulfed by their addiction to nicotine to later shift to regular cigarettes).[3,4,5]

Legal challenges

The other major public health issue is our legal systems not being strong enough to restrict the marketing tactics of these industries, thus creating contexts for more youth to get addicted to them. In Sri Lanka, the National Authority on Tobacco and Alcohol (NATA) Act was amended in 2016 to prohibit trade of "any smokeless tobacco product or mixture that contain tobacco, any flavoured, coloured or sweetened cigarette that contains tobacco and any electronic cigarette that contains tobacco".[7] However, many products are still traded and used within the country as there's no detailed guidelines or a monitoring system to ensure their implementation. The enormous loophole that demands the products to include "tobacco" if to be prohibited, generates opportunities for nicotine products to seep through into the market and is challenging for the law enforcement officers to intervene. The main determinant that had let to low prevalence of use of non-combustibles in Sri Lanka is them being expensive, reducing the accessibility and affordability of these products to majority of youth in our country. In upper-middle and upper social classes in which this determinant is absent, there seems to be an increasing trend of use, even though it is not yet being scientifically investigated or proven.

Regulations

1. These Regulations may be cited as the regulations on Prohibited Tobacco Products No. ..... of 2016.
2. The categories of tobacco products which do not generate smoke shall be as specified in Schedule I hereto.
3. No person shall manufacture, import, sell or offer for sale any tobacco product specified in Schedule I and II hereto.
4. In these regulations –

"Smokeless tobacco product" means any tobacco product which do not generate smoke.

SCHEDULE I

(a) any smokeless tobacco product or mixture that contain tobacco.

SCHEDULE II

(a) any flavoured, coloured or sweetened cigarette that contains toabcco ;
(b) any electronic cigarette that contains tobacco.

09-679

PRINTED AT THE DEPARTMENT OF GOVERNMENT PRINTING, SRI LANKA. 1A
This Gazette Extraordinary can be downloaded from www.documents.gov.lk

Smokeless tobacco products

Apart from the new challenges related to non-combustibles, smokeless tobacco products, the traditional main source of initiation of nicotine addiction, are still a major challenge for stakeholders of controlling tobacco related harm. New products in the category, such as oral nicotine pouches and new flavoured combinations and mixtures available in the market in attractive packages had made those products more attractive to the youth. Unlike the non-combustibles, majority of these products are accessible and affordable for children and youth in rural and urban low-income settings as well, making them a higher public health priority issue. These are also the main culprit substance used in school settings, use of which often misinterpreted and mislabelled by teachers as use of other illicit substances, such as "ice". Thus, control of these substances still requires lots of effort put into education and advocacy of all stakeholders involved.

Tobacco and cannabis

As mentioned earlier as well, the other new challenge for the tobacco control advocates is cannabis, largely invested upon by both tobacco and alcohol industries. The involvement of confectionary and beverage industries, with the interest of including it in sweets, lozenges, carbonated drinks and involvement of cosmetics industry that may lead to addiction via absorption through skin makes cannabis the hugest challenge for the current advocates fighting against addiction related harm. The campaign backed by all those rich big industries to popularise cannabis and make it more accessible and available to potential users by changing the existing legal frameworks that schedule it as an illicit substance is becoming increasingly challenging to fight against.

Tobacco industry, with its range of non-combustibles including cannabis derivatives is a major force behind this global campaign with huge investments for advocacy of policymakers and the public. For them, it is just replacing one leaf with another, as all the infrastructure is available to do it. With the increasing unpopularity of tobacco, they are marketing cannabis as a historically used, traditional medicine, compared to the imported disease generating tobacco leaf. Backed by the commissions from all those rich and powerful industries, many countries' political leaders and policymakers are falling into this trap, risking the health of the populations they are accountable for. I will stop at that as this article is about tobacco and not cannabis, the aim was to highlight the link between the two rather than being comprehensive about the current challenges of controlling cannabis related harm.

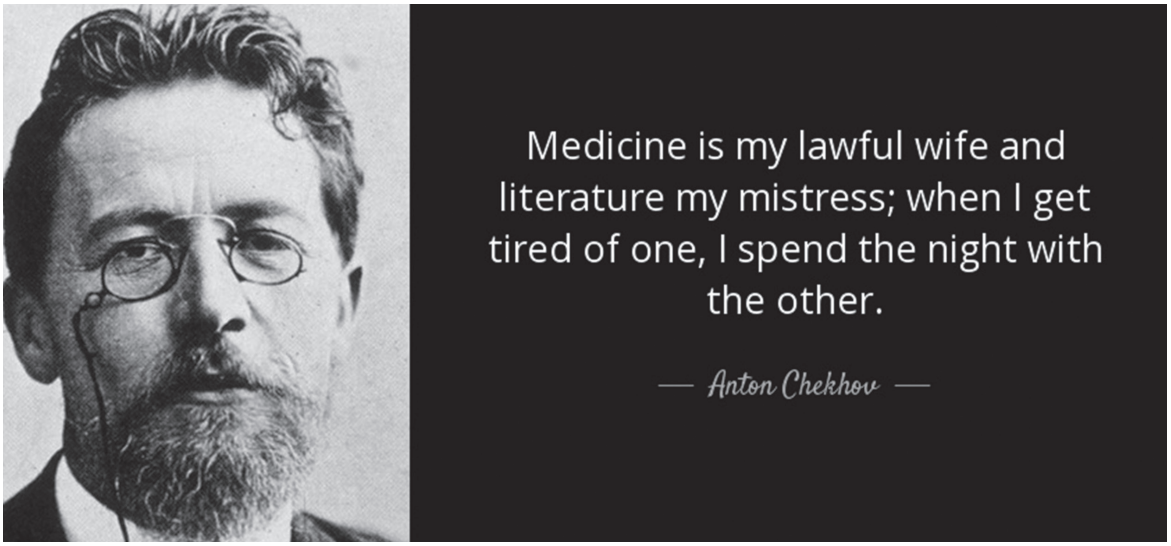
Tobacco industry's continued tactics

The aforementioned product related strategies are on top of their age-old strategies interfering in effective tobacco control policies and actions, namely, hijacking political and legislative processes, exaggerating their economic importance, manipulating the public opinion using direct and indirect public relations campaigns, fabricating support through front groups, discrediting proven science and generating doubt about facts related to harm and intimidating governments with litigations and threats for litigations.[8]

Thus, in a summary, tobacco industry is still the most harmful vector of deaths and diseases, with its new tactics including introduction of non-combustibles, smokeless tobacco products and investments in cannabis and demands continuous attention and efforts from advocates against addiction related harm. Thus, it's of utmost importance to remain vigilant about the tactics of the tobacco industry to improve accessibility, affordability and availability of their products, especially for children and young people, increasing the potential for addiction and related health, social and economic harms.

References:

1. The Lancet. The global burden of tobacco [Internet]. Elsevier Inc.; 2021 May 27 [cited 2023 Jan 16]. Available from: https://www.thelancet.com/infographics-do/tobacco
2. World Health Organization. WHO technical manual on tobacco tax policy and administration. Geneva: World Health Organization; 2021. Available from: https://www.who.int/teams/health-promotion/fiscal-policies-for-health/global-economic-cost-of-smoking-attributable-diseases
3. World Health Organization Regional Office for Europe. Electronic nicotine and non-nicotine delivery systems: A brief. Denmark: WHO Regional Office for Europe; 2020. Available from: https://www.euro.who.int/__data/assets/pdf_file/0009/443673/Electronic-nicotine-and-non-nicotine-delivery-systems-brief-eng.pdf
4. World Health Organization. Heated tobacco products (HTPs) information sheet [Internet]. WHO; 2018 May [cited 2023 Jan 16]. Available from: https://apps.who.int/iris/bitstream/handle/10665/272875/WHO-NMH-PND-17.6-eng.pdf
5. U.S. Food and Drug Administration. Results from the Annual National Youth Tobacco Survey [Internet]. FDA; 2022 Dec 20 [cited 2023 Jan 16]. Available from: https://www.fda.gov/tobacco-products/youth-and-tobacco/results-annual-national-youth-tobacco-survey#:~:text=2022%20Findings%20on%20Youth%20E%2DCigarette%20Use,-In%20October%202022&text=In%202022%2C%20-about%201%20in,(past%2030%2Dday).&text=14.1%25%20(2.14%20million)%20of,reported%20current%20e%2Dcigarette%20use.
6. Virgili, F., Nenna, R., Ben David, S. *et al.* E-cigarettes and youth: an unresolved Public Health concern. Ital J Pediatr. 2022; 48:97. DOI: https://doi.org/10.1186/s13052-022-01286-7
7. Ministry of Health Sri Lanka. The Gazette of the Democratic Socialist Republic of Sri Lanka (Extraordinary) - The national authority on tobacco and alcohol act, no. 27 of 2006. Government of Sri Lanka; 2016 Sep 01 [cited 2023 Jan 16]. Available from: https://www.nata.gov.lk/web/images/downloads/1982-33_E.pdf
8. World Health Organization. Tobacco industry interference a global brief. Geneva: World Health Organization; 2012. Available from: https://www.who.int/teams/health-promotion/fiscal-policies-for-health/global-economic-cost-of-smoking-attributable-diseases



WWW.SLMA.LK

"WIJERAMA HOUSE",
NO. 6, WIJERAMA MAWATHA,
COLOMBO 07,
+94 11 269 3324,
office@slma.lk

STAMP

The Official News Letter of the Sri Lanka Medical Association

To:

.....

.....

.....

.....

If undelivered please return to;
Sri Lanka Medical Association (SLMA),
No. 6, Wijerama Mawwatha, Colombo 07

Registered at the Department of Posts Under No. DOP/NEWS/76/2023