NEWSLETTER OF THE COLLEGE OF GENERAL PRACTITIONERS OF SRI LANKA

MY COLLEGE

SEPTEMBER 2020

IN THIS ISSUE

NEWSLETTER OF THE COLLEGE OF GENERAL PRACTITIONERS OF SRI LANKA

MY COLLEGE

No. 06, "Wijerama House", Wijerama Mawatha, Colombo 7.
Tel: 0112 698894 / 0112688775
E-mail: cgpsl@sltnet.lk/ genprac@sltnet.lk
Website: www.cgpsl.com

FROM THE EDITOR

Dear Readers,

It is indeed a great honour to continue as the Editor of "My College" and I am more than thrilled to present to you the current issue of the Newsletter with a 'new look', which also highlights yet another milestone of the College of General Practitioners of Sri Lanka (CGPSL), the Ceremonial Induction of the 20th President, Dr. D.K.D. Mathew.

As I write this message, things seem to be rather uncertain for Sri Lanka, as far as the recent outbreak of COVID is concerned. This issue brings to you a number of interesting articles on much noteworthy topics, including important information relevant to moving on, amidst COVID 19.

By the look of it, the pandemic does not seem ready to pack up anytime sooner, and it is about time that we learn to live and practice with 'the new normal'. With this in mind, our team made sure that COVID 19 is not the only news we have in store for you, and I am excited to share with you, the variety of writing in this issue.

A huge 'thank you' to our readers for encouraging us by expressing interest in the Newsletter through the valuable feedback and ideas for further improvement, and to all who contributed writing the wonderful and inspiring articles, without which there wouldn't have been this issue of the Newsletter.

I would like to thank the President of the College of General Practitioners of Sri Lanka, for his concern and active support given to design and print this issue, the Editorial Board and the CGPSL office staff for the support throughout the creation of this issue.

Read on and enjoy this issue, while staying safe and healthy!

Dr. Kalpanie Wijewardana
Editor-in-Chief

PRESIDENTIAL ADDRESS

AT THE CEREMONIAL INDUCTION OF THE 20TH PRESIDENT OF CGPSL

Saturday, 12th September 2020
at 6.30 p.m., Earls Court,
Cinnamon Lakeside, Colombo 02.

Dr Jayantha Jayatissa, Immediate Past President,

Distinguished Past Presidents,

Members of the Council, Members, Associates, Fellows and Honorary Fellows of the College of General Practitioners of Sri Lanka,

Colleagues, Friends, Ladies and Gentlemen.

Welcome everyone, thank you all for coming. It is great to see you here.

It is customary to use this opportunity to make a speech in front of my peers, at the beginning of my tenure as President of the College of General Practitioners of Sri Lanka.

To lead this College over the next year is an honour and a privilege that is unparalleled throughout my career so far.

The College of General Practitioners of Sri Lanka is a voluntary organisation committed to enhance the medical practice of the General Practitioners of Sri Lanka. It is the apex, academic and professional body of General Practitioners in Sri Lanka. It has its origin in 1969 and was incorporated by Law No. 26 of 1974, followed by amendments to the Act in 1980, which empowers and ensures the College's validity as an academic body of national importance.

Ladies and Gentlemen, the General Practitioner is the first point of care for anyone of any age at their most vulnerable in the community, having physical or mental health ailment.

Our profession does not limit us to any one medical speciality or organ of the body but covers a variety of medical problems requiring us to solve clinical puzzles and make accurate and timely diagnosis of diseases and proper management.

Our approach takes into account the spiritual, cultural, social, economical and emotional aspect of the patient, arriving at treatments and management in a very patient centric manner.

As General Practitioners we adhere to and maintain high professional, clinical and ethical standards in providing best possible care in a cost effective way to patients.

The life of a General Practitioner is an enviable one as it provides professional development, a secure livelihood, camaraderies among colleagues of the profession and most importantly the sense of fulfilment of seeing the joy of healing of our patients.

In 2008 Ms. Margaret Chan, Director General, World Health Organisation stated 'Primary Health care offers the best way of coping with the ills of life in the 21st century: the globalisation of unhealthy lifestyles, rapid unplanned urbanisation, and the ageing of populations.'

The patient demand is soaring, and their needs are becoming more complex - it still is and they still are - but the number of GP's is far from keeping pace.

In the future, our health service will rely on General Practitioners with the capabilities and competence to deliver care closer to home and reduce the state's reliance on hospital care.

We the General Practitioners are

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the foundation on which our health services is built on.

Recognition of General Practitioners will cherish our medical services. Ignore us, and it will crumble.

At present, at least half of the population in the world do not receive the health services they need. About 100 million people are pushed into extreme poverty each year because of out-of-pocket spending on health. This must change.

On 23rd September 2019 a high-level meeting on universal health coverage was held at the United Nations General Assembly. The meeting, 'Universal Health Coverage: Moving Together to Build a Healthier World', was held bringing together heads of state, political and health leaders, policy-makers, and universal health champions to advocate for health for all.

Universal health coverage means all people have access to the healthcare they need, when and where they need it, without facing financial hardship. With a strong foundation of primary health care, universal health coverage is one of WHO's key priorities, making up one of the Triple Billion targets.

The recent Covid - 19 pandemic can be viewed as a disrupting agent which has had a significant impact on the way in which the General Practitioner has operated thus far.

It has become evident that the time is ripe for us to embark on adopting digital solutions which will allow unhindered access to our patients ensuring the relevant security and ethical standards of our practice. We must seek out such digital solutions and online tools that will enable the patient to receive advice, treatments, prescriptions and referrals.

The College has continued with its MCGP Diploma course using available digital platforms and it has proven to be a success.

Ladies and Gentlemen, I am so proud of our College.

I am so proud of the strides we have made for general practice across all of our areas of work.

We now have 140 life members, 68 members, 265 associates, 76 Hon. Fellows and 107 fellows. That is excellent by any membership organisation's standards.

The recent programmes implemented by the College are many.

Community projects such as Non-Communicable Disease (NCD), NCD screening projects, an elderly care project and Talk to your Neighbour Project on NCDs.

Palliative Care - management of terminally ill patients. This innovative venture developed by the College, in partnership with the Institute of Palliative Medicine , Kerala, India , is a two day certificate course on palliative care for the benefit of the medical fraternity in this Country, which led to the formation of the "Palliative Care Association of Sri Lanka" being the national umbrella organisation which engage in the development and spread of palliative care treatment for all those who are in need of such treatment around the Island and the training and education of all interested persons in the field.

Mentoring Programme:

This programme is aimed at improving quality of care to patients attending primary care facilities in the private sector. It targets relatively new, part-time and full-time doctors into General Practice and is done at no extra cost to them.

Providing training for medical students through GP attachments - Our general practitioners have been training students of the Colombo Medical Faculty, Sri Jayewardenepura Medical Faculty, Kelaniya Medical Faculty and General Sir John Kotelawala Defence University, Ratmalana at their clinics.

Better networking capacity for General Practitioners in the State and Private Sector - The average General Practitioner (GP) works in a relatively resource poor setting and needs to compete with advances in the health system in the private and state sectors. Patients are increasingly becoming demanding and often prefer to consult a general practitioner who can provide them access to a set of needed services at affordable prices without compromising on quality.

Patients safety and safety in practice - This project focuses on the social responsibility and accountability of the College towards that segment of society that we are closest to.

MCGP programme and examination - This is a two year GP friendly weekend programme being conducted by the MCGP Board for the past 17 years. The MCGP is one of the admission criteria to qualify for membership of the College. It is the only diploma programme recognised by the Sri Lanka Medical Council outside the University diplomas.

Annual academic sessions:

The College also conducts its

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academic sessions annually. The most recent was conducted in 2019. The sessions provide the members of the College the opportunity to listen to and update themselves in topics of GP relevance as well as to interact with their colleagues.

Continuous professional development (CPD) of members of the College - Partnered with the pharmaceutical industry in organising regional CPD programmes on monthly basis. This is now popularly known as the GP series. This is a relatively new model based on the concept of adult learners being experimented with at these meetings.

Primary Care Systems Strengthening Project of the MoH funded by World Bank - World bank has come to a understanding with the Ministry of Health to empower Primary Health Care Services of the state sector with a greater emphasis of family medicine principles to ensure better quality medical services to be provided to the general population in Sri Lanka at primary care level. The MoH identified Sri Lanka Medical Association (SLMA) to develop a distant educational module on certain important areas where medical services are sought after by the general public. The SLMA sub contracted this assignment to the College of General Practitioners of Sri Lanka which worked closely with the SLMA, MoH and the World Bank in developing these distant education modules which will have a great impact in the delivery of the cost effective health services to the general public all over the Country.

Intended Projects:

The "Talk to your Neighbour Project'", is an initiative by the College of General Practitioners of Sri Lanka (CGPSL), aimed at educating the community at the primary care level on the prevention of NCDs which World Health Organisation has projected to be the leading cause of death over the next 10 years in developing countries.

Spreading the message in a cost effective and efficient manner and then evaluating the effectiveness of this exercise in changing the behavioural pattern in the community were the important aspects considered and implemented in this programme.

The Ministry of Health, the Ministry of Education, Community Development Services (CDS), a reputed Non-Governmental Organisation, Sri Lanka Diabetes and Cardiovascular Initiative (SLDC), The College of Endocrinologists (COE) and TV Derana 24×7 were the stakeholders and the project was funded by Ceylinco Life Insurance.

Ten (10) health messages prepared by the NCD Committee of the College of General Practitioners of Sri Lanka were the basis of this project. Ten handpicked students and two teachers each from ten schools from Western Province underwent a two day training programme on the importance of these health messages and were also given an insight on how to propagate these messages in an efficient manner to the community. This was followed by many inter school activities conducted in the respective schools spanning over a period of one year which were closely monitored by our team. At the end of the year, inter school competitions were also held and the best three schools were selected after considering all the activities they had conducted over the one year in propagating these messages to the community in an efficient and cost effective manner as well as their performance in the inter school competition.

The second phase of this project is planned with the Sri Lanka Scouts Association and the project proposal is already prepared. The College is having a dialogue with sponsors to carry this project forward in an island-wide manner.

The future of Sri Lankan General Practice in the Pre and Post COVID Era of a 'New' Normal.

The negative effects of COVID - 19 to the economy, medical education, and the medical system are countless. COVID - 19 has brought about a turning point in how medicine is practiced around the world.

We at the College quickly embraced digital based medical education to deliver the content of the MCGP course to our trainees on a digital interface. This was a tremendous success and I thank the younger members of the College for setting this up and the senior members for using the interface in a confident and effective manner.

It is our vision to deliver more CME programmes on digital platforms to disseminate up-to-date knowledge to our membership who are predominantly based out of Colombo. We will explore the possibility of setting up necessary infrastructure and build up capacity of the Faculty of Teachers to deliver more content, training workshops and indeed introduce new courses in general practice using the digital medium which will of course be blended with traditional modes of teaching and one to one interaction with patients in order to sustain and preserve the art of Sri Lankan general practice.

During the height of COVID lockdown Consultation was

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exclusively remote and more often than not relied on audio or audio/visual consultation. I propose that the College take the lead to introduce a course open to all doctors in Sri Lanka and even from overseas to follow an online based course on audio/visual consultation skills to be developed by the College of General Practitioners of Sri Lanka.

I am very confident with the abundance of teaching material in College prepared by our members of the Faculty of Teachers in the yester years and the experienced teachers we have amidst us we can help the General Practitioners all over the Island on how to set up and administer a proper GP practice as well as common aspects which we should be familiar with as a GP. An online course could be held to meet this need.

Eldery Care - If we do not find better, smarter ways to help the growing elderly population remain healthy and independent, our hospitals will be overwhelmed - which is why we need effective, strong and expanding general practice more than ever before in the history of our medical services.

Our College's Elderly Care Subcommittee has planned to enhance the knowledge of GP's in this field by conducting regular CPD sessions in collaboration with other committees of the College and also to organise regular visits to Elders homes - 'spend the day' programme to provide psychological support for the occupants.

Under the College's Continuous Professional Development (CPD) programme we propose to establish a CPD point system for members and associates, on a non-compulsory basis, to encourage self and assisted learning. Also to improve knowledge, skills and attitude of members by organising lectures, workshops and publication of Continuous Medical Education (CME) bulletins on a variety of topics such as medical and non-medical competencies covering managerial skills, communication and interpersonal relationships and other chosen topics. Also proposes to initiate inter- committee collaboration with other committees of the College.

Also to encourage synchronised and non synchronised learning by means of the College website, WhatsApp broadcast group, live streaming online and seminars.

The College's Faculty of Teachers of Family medicine has been revamped at present and proposes to train teachers and examiners for the MCGP Diploma course in collaboration with the College of Medical Educationists. Also to conduct a College diploma course on Palliative Care in collaboration with the Palliative Care Association of Sri Lanka.

The MCGP Board has appointed a curriculum review committee to improve and up-grade the MCGP course prospectus.

We propose to set up an Alumni Association for MCGP Diplomates. There are currently 122 MCGP Diplomates from five batches.

We have to address the outdated practice preventing the General Practitioners from being listed on the Sri Lanka Medical Council as a GP Register as it does not reflect the increasingly important role GP's play in the delivery of personalised, preventive healthcare. We will work with the Sri Lanka Medical Council to change this and include GP's on the Sri Lanka Medical Council's register at the earliest opportunity.

The College intends to have a premise of our own for the College.

In 2013 we printed a Desktop Directory, comprising the details of all the members and associates of the College, all private hospitals, medical laboratories & related fields and government health information & related organisation of the health service which was issued to our members and associates free. We raised a sum of Rs. 3.5 million from this venture and we opened an account for the 'Building Fund' and this was the first deposit to the account.

In this regard we know how the government at that time acquired the North Colombo Medical College which was set up by the College of General Practitioners of Sri Lanka without paying any compensation. We propose a request from the government to provide us a plot of land in lieu of the compensation due to the College of General Practitioners of Sri Lanka for the acquisition of our property.

I would like to take this opportunity to thank everyone who has helped and supported me over the last seven years when I was a council member of the College holding responsibilities of the College.

Well, frankly, there are too many people to mention. And too big a risk of forgetting to thank someone, if tried.

So - and please don't think this is a cop out - but I would like to say a huge, great big thank you to all our fantastic members and our fantastic staff.

I thank all of you who attended this Induction Ceremony at the request of the College Council.

Thank you

Dr. D. K. D. MATHEW

Ceremonial Induction of Dr. D. K. D. Mathew as the 20th President of the CGPSL



















COUNCIL OF THE COLLEGE OF GENERAL PRACTITIONERS OF SRI LANKA 2020/ 2021

Seated (L to R) : Dr. Sankha Randenikumara (Hony. Asst. Treasurer), Dr. Dilini Baranage (Hony. Treasurer), Dr. Carmel Fernandopulle, Dr. Eugene Corea, Dr. K Sri Ranjan, Dr. Pushpa Weerasinghe (Vice President), Dr. D K D Mathew (President), Dr. Jayantha Jayatissa (Immediate Past President), Prof. Leela de A Karunaratne, Dr. Preethi Wijegoonewardene, Dr. K Chandrasekher, Dr. Dumindu Wijewardana (Hony. Secretary), Dr. Thivanka Munasinghe (Hony. Asst. Secretary)

Standing (L to R) : Dushyanthi Weerasekera, Dr. Sanath Hettige, Dr. H D Wijesinghe, Dr. Buddhika Raigamkorale, Dr. Suneth Rajawasan, Dr. Bihan de Silva, Dr. Namal Ulluvisheva, Dr. Dhilshan Thahir, Dr. M R Haniffa, Dr. Shobhavi Kohombange, Dr. Kalpanie Wijewardana (Public Relations Officer)

VACCINES FOR COVID-19

Professor Suranjith Seneviratne
Professor and Consultant in Clinical Immunology and Allergy Institute of Immunity and Transplantation, Royal Free Hospital and University College London, UK and Department of Surgery, Faculty of Medicine, University of Colombo, Sri Lanka

Coronavirus disease 2019 (COVID-19) is caused by Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). This virus originated in Wuhan, China in December 2019. It is currently pandemic, and as of 10th October 2020, there have been more than 37 million cases worldwide and over one million deaths. The availability of an effective vaccine is the best long term answer to the current COVID-19 pandemic. There has been an international response to COVID-19 vaccine development. More than 150 candidate vaccines have come into development since the start of the pandemic. Eleven vaccines (ten of them specifically directed against SARS-CoV-2) have entered phase 3 clinical trials (Table 1). Five of these vaccines have also been approved for early or limited use. The categories of vaccines for protection against SARS-Cov-2 infection and or disease includes: genetic/nucleic acid (mRNA or DNA) vaccines, non-replicating viral vector vaccines, recombinant spike or RBD-protein vaccines, inactivated virus vaccines and live attenuated virus vaccines (Table 2).

The Spike(S) glycopreotein mediates host cell attachment and is required for viral entry. It consists of two subunits; S1 and S2. S1 is responsible for attachment to the receptor present on the host cell and S2 for the subsequent fusion of the cell membranes of both virus and the host. The S1 subunit has a receptor-binding domain (RBD). Most of the COVID-19 vaccines in development are intended to induce antibody responses that neutralise SARS-Cov-2. The expectation is that this would prevent the virus from entering target cells and infecting the host. In some cases the vaccines may also induce antibody and/or cellular immune responses that can kill and eliminate already infected cells. A major driving force behind many of the existing programs appears to be the speed at which a vaccine product can be manufactured at scale using existing production facilities.

COVID-19 causes harm in three broad ways: death or long term organ damage, constrains on the operation of effective healthcare systems and adverse effects on national/regional economies. Equitable and simulataneous access to new COVID-19 vaccines is the hope for stopping the progression of the pandemic. Once effective COVID-19 vaccines are developed and approved, questions of how to distribute them equitably across different countries would arise. Aspects relating to 'Vaccine Nationalism' should be strongly guarded against at all cost, by ensuring ethical and effective frameworks are in place for international COVID-19 vaccine allocation and distribution. Reducing premature death would take precedence in any COVID-19 vaccine allocation programme. It is likely that persons at greatest risk of COVID-19 (healthcare workers, nursing home residents, persons with underlying health conditions, the elderly) would be the first to be given access to a COVID-19 vaccine.

COVAX is one of three pillars of the Access to COVID-19 Tools Accelerator. It is coordinated by the WHO, Gavi, the Vaccine Alliance, the Coalition for Epidemic Preparedness and Innovations (CEPI). It was set up to ensure research, purchase and distribution of any new vaccines is shared equally between the world's rich countries and developing states. Since the first useful COVID-19 vaccines would be in short supply, any approved vaccines would be targeted to 3% of the population of each of the countries in the coalition. China has recently become a partner of this coalition.

At the same time, COVID-19 vaccine hesitancy is an important aspect to be discussed and considered. Recent reports suggest between one sixth and one half of the UK population may refuse to receive a COVID-19 vaccine. This in turn would pose a serious threat to achieving widespread SARS-CoV-2 immunity.

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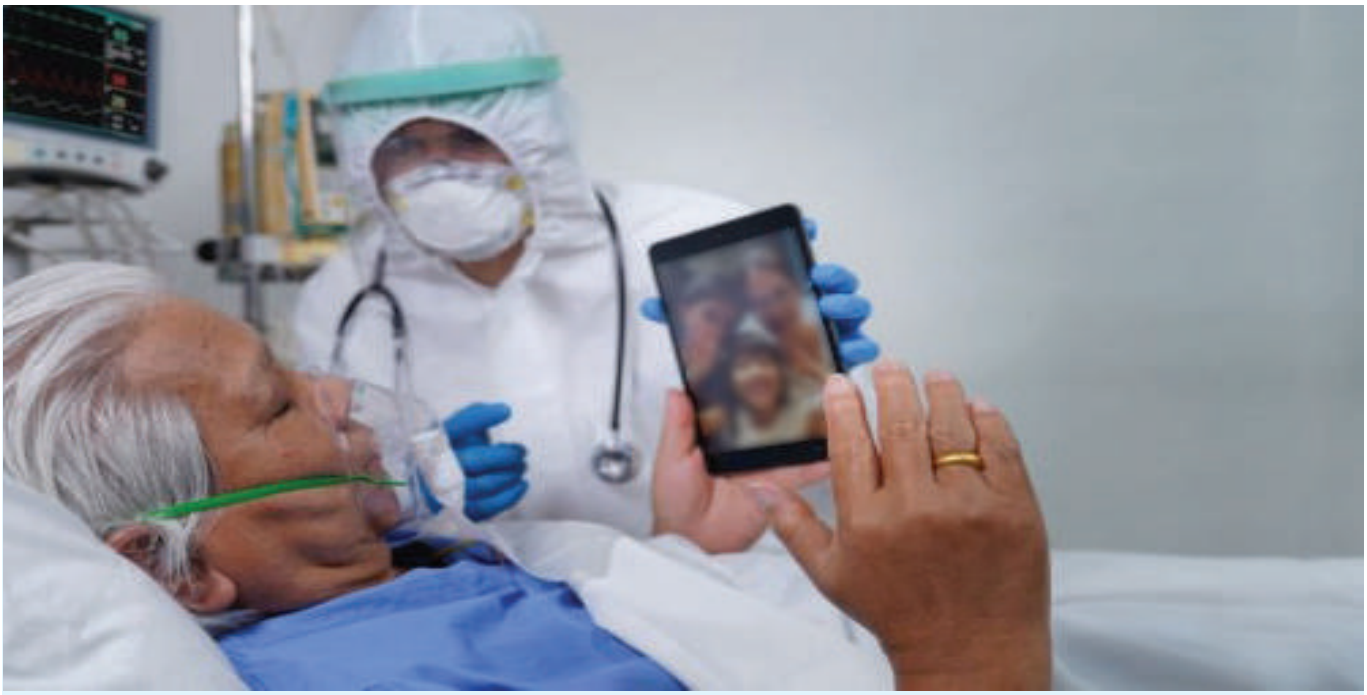
Table 1:
Vaccines that have entered Phase 3 Trials

Class of vaccine	Vaccine candidate	Developer	Vaccine platform
Genetic vaccines	mRNA-1273 BNT162	Moderna/NIAID BioNTech/Fosun Pharma/Pfizer	LNP-encapsulated mRNA Three LNP-mRNAs
Viral vector vaccines	Ad5-nCov AZD1222 (formerly ChAdOx1 nCov-19 Adeno-based (rAd26-S+rAd5-S) Ad26COVS1	CanSino Biological Inc/ Beijing Institute of Biotechnology University of Oxford/Astra Zeneca Gamaleya Research institute Janssen Pharmaceutical Company	Non-replicating viral vector Non-replicating viral vector Non-replicating viral vector Non-replicating viral vector
Protein based vaccines	Protein subunit	Novavax	Full length rSARS-CoV-2 glycoprotein nanoparticle vaccine adjuvanted with Matrix M
Inactivated coronavirus vaccines	Inactivated Inactivated	Beijing institute of Biological Products/SinoPharm Wuhan Institute of Biological Products / SinoPharm	Inactivated virus Inactivated virus
	Inactivated	Sinovac	Inactivated virus
Repurposed vaccines	Bacillus Calmette-Guerin (BCG)	Murdoch children's Research Institute	Attenuated *Mycobacterium bovis*

Table 2 :
Categories of vaccines for COVID-19

Platform	Target	Are there existing licenced human vaccines using the same platform	Pros	Cons
Genetic vaccines - RNA vaccines	S protein	No	No infectious virus needs to be handled, Rapid production possible Typically immunogenic	Some safety issues with reactogenicity
Genetic vaccines - DNA vaccines	S protein	No	No infectious virus needs to be handled Rapid production possible Easy to scale up Low production costs high heat stability	Needs specific delivery devices to reach good immunogenicity
Viral vector based vaccines	S protein	Yes - Ervebo (for Ebola virus disease - usng the Vesicular Stomatitis Virus)	No infectious virus needs to be handled Excellent pre-clinical and clinical data	Vector immunity may negatively affect vaccine effectiveness
Recombinant protein vaccines	S protein	Yes (HPV, Influenza, HBV)	No infectious virus needs to be handled , adjuvants can be used to increase immunogenicity	Global production capacity might be limited , Antigen integrity needs to be confirmed
Inactivated vaccines	Whole virion	Yes	Striaghtforward manufacturing process Used for several licenced human vaccines Existing infrastructure can be used adjuvants can be used to increase immunogenicity	Large amounts of infectious virus need to be handled Antigen integrity needs to be confirmed
Live attenuated vaccines	Whole virion	Yes	Striaghtforward manufacturing process Used for several licenced human vaccines Existing infrastructure can be used	Creating infectious clones for attenuated coronavirus vaccine takes time Extensive safety testing will be needed



PALLIATIVE CARE
IN THE TIME OF COVID

DR SURESH KUMAR
Director
WHO Collaborating Center
for Community Participation
in Palliative Care and
Long Term Care,
Technical Advisor
Institute of Palliative Medicine
Kerala, India.
Ashoka Fellow

COVID pandemic has unfolded multiple challenges to health care systems across the world, and one of the areas affected is palliative care.

One of the related issues that came up in the beginning itself was the issue of triage and 'rationing of care' as the number of patients in need of care far exceeded the capacity of the health care system. During the current pandemic, such situations have many times resulted in patients dying because of the lack ventilators or ICU beds. It has been suggested that patients with less life expectancy be 'screened out' and offered comfort care instead of Covid-oriented intensive treatment. This approach obviously has both ethical issues and logistic challenges of carrying out decision-making. This came sharply into focus in many regions of the world where healthcare resources were limited and the demand high. Triage of patients remains challenging and controversial in pandemics when resources are overwhelmed. Triage algorithms in place during the current pandemic are generally based on clinical estimations of the incremental survival benefit (looking at how many life-years can be saved) provided by the intensive care made available.

On the other extreme, the pandemic has also thrown bare, existing issues related to futile and inappropriate medical interventions in certain contexts. When life-sustaining therapies are unable to meet the patients' goals, or paradoxically may result to be more burdensome than beneficial, withdrawal and withholding of aggressive therapies need to be considered.

In fact, Palliative care has been recommended to be initiated as early as possible in Intensive Care Units to allow more focused interventions to anticipate or minimize unnecessary suffering.

In the current pandemic, this becomes relevant when people with severe advanced diseases are admitted to critical care facilities on testing positive for COVID. People with comorbidities are well recognised to have higher mortality when infected with COVID. However, aggressive treatment when COVID positive may be inappropriate and cause needless suffering in at least some patients with pre-existing severe advanced diseases. In many countries with rapid increase of the number of COVID patients, there is valid concern due to existing low traction of End of Life Care principles and practice as well as huge socioeconomic impact of ineffective medical care.

Palliative Care for Covid patients is particularly difficult because of multiple issues including barriers to

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communication (isolated patient, family members often in quarantine with no access to patient, and professionals attired in Personal Protection Equipment).

In most of the South Asian countries, almost three fourths of the Covid patients present with no or mild symptoms. Less than 3% require admission to critical care units. There is often a tendency to admit even those with severe advanced comorbidities to critical care. For example, more than 25% of documented deaths in Covid ICUs in Kerala are patients who died in hospital of severe comorbidities.

There are multiple reasons for this:

1. Globally, majority of those who need palliative care do not have access to such services.

2. Practical challenges faced by treating teams:
   a. Difficulties in predicting the course of disease even in the case of patients with advanced systemic diseases.
   b. Treatment discussions with patient and family becoming a communication challenge due to barriers in the communication process mentioned above.

3. Socio-political pressure on the treating team as COVID death is often seen as failing healthcare.

Palliative care experts like Sebastiano Mercadante have suggested Integrative and consultative models of palliative care into ICU to improve quality of care in patients admitted to ICU. There have been attempts to suggest ways of reducing inappropriate admissions to ICU through collaborative work by critical care and palliative care groups in India. In the context of COVID, further recommendations have come out about approaches to reduce inappropriate hospitalisations including exclusion from critical care in the context of severe cerebral injury and metastatic cancer with poor prognosis. Palliative care integration with disease modifying care is an aspiration that remains unachieved. An interdisciplinary approach where palliative care and critical care approaches fragment their boundaries and overlap their expertise to meet the challenging dynamic of patient needs is called for. Perhaps the current pandemic is an opportune moment for bringing together these two strands of clinical care to ensure the best quality of care for all patients. ■

From: CDC (USA)

The emerging scientific evidence on CORONAVIRUS transmission:

1. Very low risk of transmission from surfaces.
2. Very low risk from outdoor activities.
3. Very HIGH risk from gatherings in enclosed spaces like offices, religious places, cinema halls, gyms or theatres.

These findings that have been emerging for a while need to be applied by people to manage the situation in the best possible manner. Time to reduce panic about surface transmission, and not be too eager to go back to office.

Q- Who is expected to catch CORONAVIRUS?
Q- What does it take to infect?

TO SUCCESSFULLY INFECT A PERSON, THE VIRUS NEEDS A DOSE OF ~ 1000 VIRAL PARTICLES (vp)

The typical environmental spread of activities:

- Breath : ~ 20 vp/minute
- Speaking : ~ 200 vp/minute
- Cough : ~ 200 million vp (enough of these may remain in air for hours in a poorly ventilated environment)
- Sneeze : ~ 200 million vp

FORMULA

SUCCESSFUL INFECTION =
(Exposure to Virus x Time)

SCENARIOS

1. Being in vicinity of someone (with 6 ft distancing): Low risk if limit to less than 45 minutes
2. Talking to someone face to face (with mask): Low risk if limit to less than 4 minutes
3. Someone passing you by, like walking/jogging/ cycling: Low risk
4. Well-ventilated spaces, with distancing: Low risk (limit duration)
5. Grocery shopping: Medium risk (can reduce to low by limiting time and following hygiene)
6. Indoor spaces : HIGH RISK
7. Public Bathrooms/ Common areas : HIGH FOMITE/SURFACE TRANSFER RISK
8. Restaurants: HIGH RISK (can be reduced to medium risk by surface touch awareness)
9. Work places/ Schools (even with social distancing) : VERY HIGH RISK, including high formite transfer risk
10. Parties/ Weddings : VERY HIGH RISK
11. Business networking/ conferences : VERY HIGH RISK
12. Arenas/ Concerts/ Cinemas: VERY HIGH RISK

RISK FACTORS

The bottom line factors you can use to calculate your risk are:

- indoors vs outdoors
- narrow spaces vs large, ventilated spaces
- high people density vs low people density
- longer exposure vs brief exposure

The risks will be higher for former scenarios.

COVID-19 IS HERE TO STAY...

Dr. K. Chandrasekher
Past president-College of General Practitioners of Sri Lanka

Experts are continuing to warn that the disease caused by the SARS-CoV-2 virus will remain part of our lives for the foreseeable future. While COVID-19-related health measures will continue to remain in place for years to come, they believe it's possible to live healthy, fulfilling lives even while the pandemic is continuing. So what will "living with the pandemic" look like?

Here's are some facts that I was able to find in the literature. As General Practitioners (GPs) we have a more responsible role to play by providing clear evidence-based information to those who visit us. All of them, and this includes us as well, are yearning for an end to this menace. It is the fervent hope of everyone for a miracle vaccine to emerge from somewhere so that our anxieties will be over. Yet, it is sobering to note that even if such a vaccine is made available by early 2021, according to experts. it would be first made available to healthcare workers, then to those with co-morbidities, and after that to the elderly. The last to receive it are likely to be the younger generation by which time it could be the end of 2023.

So let us accept that we, as a society, need to adapt and change our behaviour so that we can try our best to lead a life as normal as possible under the circumstances.

One of the ways we'll be able to respond to the fluctuating COVID-19 caseloads is by adopting the concept of "social distancing." It is one of the effective measures that could be adopted to keep the threat at bay. Wearing a mask and washing of hands with soap and water regularly are other measures which need no explanation as we preach these to our patients regularly. I do not want to elaborate on other self-explanatory health measures we have been flooded with continuously.

I like to elaborate on how society has been adopting newer health measures when similar threats emerged in the past and threatened humankind. I think we could draw parallels from the lessons learnt from past responses to HIV/AIDS and tuberculosis.

Some may argue that this kind of reasoning is not valid since the above scenarios have marked differences compared to Covid. While there are indeed marked differences, there are some important common aspects which, we are relevant and applicable. In the case of HIV.AIDS, as scientists learned more about the disease, public health practices and guidelines changed to better protect against the spread, even leading to the modern safe sex campaigns that still exist. By and large, I think it has really transformed the way that we look at sexuality. HIV/AIDS has really transformed how we look at sexuality and how we society has adapted related practices.

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Similarly, in the case of tuberculosis, when research led to the conclusion that germs were responsible for the illness, we suddenly became conscious that there were microscopic organisms that could cause diseases and we needed to live differently as a result.

The reality is slowly evolving where we have started to realize the present situation as the "new normal". As our understanding improves based on evidence, we are adapting to new ways of behaviour. We will continue to adapt and evolve.

As GPs, the faster we digest this fact, it will be much better for our patients who look up to us for guidance and advice. Talk to them of the reality and explain to them the imperative of the new reality than living in the past.

Some facts I feel will help you in better decision-making are as follows.

- The World Bank predicts that almost 150 million will be pushed into extreme poverty by the end of 2021 (i.e. living on less than US $1.9 a day).

- The World Bank also predicts that the Sri Lankan economy will shrink to 6.7 % this year. It is next to India (-9.6%) and Maldives (-19.5%)

The above statistics from World Bank gives us a clear indication as to the urgency with regard to the change in our mindset to adjust to the "new normal" and encourage our patients, too, to do so.

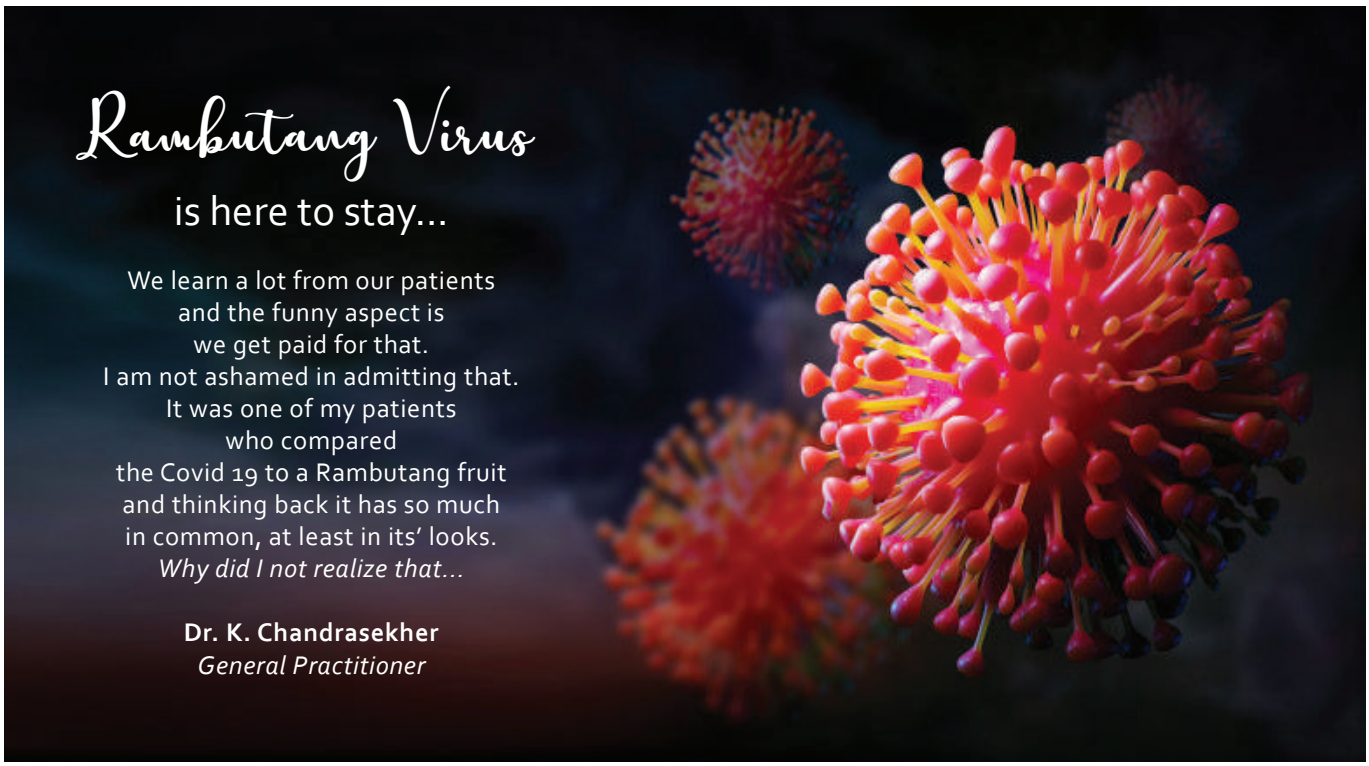
Some data to learn from our closest neighbour India are as follows. A study conducted in Tamil Nadu and Andhra Pradesh on 500,000 Covid positive patients has led to the following findings. (https://science.sciencemag.org/content/early/2020/09/29/ science.abd7672)

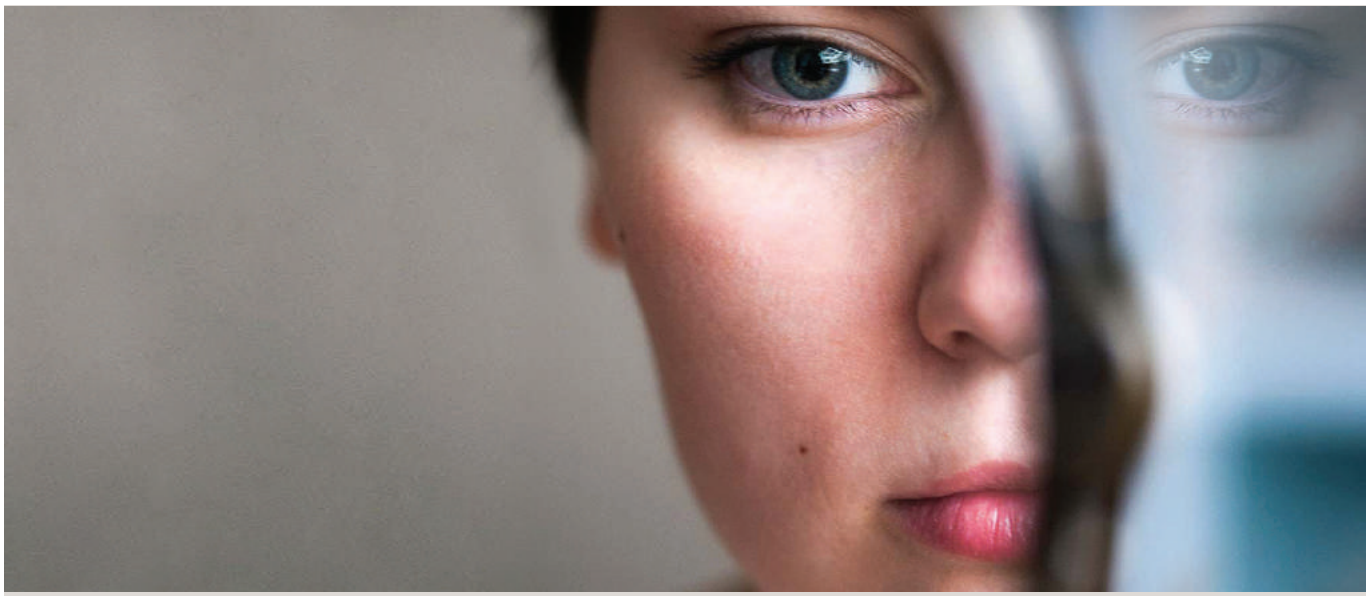
- Almost 70% of patients who are Covid positive have not spread the disease to others. 8% of Covid patients were responsible for the disease spreading to 60 % of patients

- Almost 45% of the mortality rate was amongst diabetes patients. The mortality rate amongst the 5-17 years was 0.05 % while in those above 85 years it was 16.6%.

I believe these statistics from our neighbour will be of some use in our decision making when we see patients.

> ***You can't go back and change the beginning but You can start where you are, and change the ending***
>
> - C.S.Lewis





REFLECTIONS;

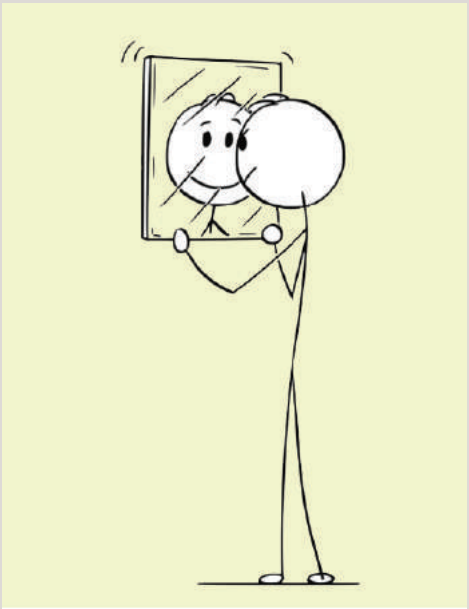
Looking at ourselves in the mirror

Dr Preethi Wijegoonawardene
Past President CGPSL & General Practitioner.

Highlights:

1. Rational Prescribing
2. Cost effective prescribing
3. Legible handwriting
4. Generic vs Trade Names
5. LASA – Look alike & sound alike drugs
6. Pharmacy misuse
7. Educating the patient population
8. Repeating prescription – Please do not repeat seal
9. Labelling the dispensed packets and mixtures
10. Methods of dispensing packs, polythene bags for syrups etc.

In this article, I wish to highlight a few practical issues we General Practitioner's (GP's) should reflect on in our own practices. It has been driven home to all those who have undergone training in General Practice, many practical issues at grass root level in our own practices. How many of us have slipped by in our application of 'Principles of General Practice', which should be in the best interest of our own patient population?



1. Rational Prescribing

It has been emphasized for the need of "Rational Prescribing", in our own practice – which has been signified to all GPs who have undergone some kind of postgraduate training, or followed CME Programmes of the College, time and again.

It is a mandatory requirement that we expect all GPs to abide by the norm that the prescription issued to our patients should be rational, depending on the individual need of the patient and the problem to be solved in each GP consultation.

We can speak volumes on Rational Prescribing, but let us reflect on ourselves daily, weekly, or monthly, whether we have given our patients only what is really needed. Sometimes particularly untrained GP's in the Private Sector prescribe and/or issue unwanted tablets of Vitamins etc. as they feel they cannot charge the patient if they do not – and also misuse of antibiotics.

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This is not the reality, many of the senior/trained GPs will charge their Consultation Fee and explain to the patient that they do not need any medication. For those who have a practice including a Dispensary, they should separate the Consultation Fee from the cost of drugs issued and should be stated in a receipt or voucher. One must realize that the patient comes to the Private Sector to a fee levying system, fully aware, that he is consulting an expert to solve his problem. As long as the consultation fee is not unfair and is reasonable, no patient will grudge or challenge the charges.

2. Cost effective prescribing

We must once again reflect and remind ourselves that we are fully conscious about the capacity of the economic status of our patient and therefore "Prescribe cost effective, affordable medicines". The Doctor, should be aware of the cost of the commonly used medications and prescribe cost effectively. Thus keeping the patient happy and contented.

3. Legible handwriting

One of the commonest complaints of the public and Pharmacists is that the doctor's handwriting is not legible. So as exemplary General Practitioners of quality, we must make sure to write legibly, preferably in block letters and correct instructions - like doses and time period should be clearly spelt out. It is difficult for us to change our handwriting that we have trained for many years, overnight, but at least be mindful of the prescription to be ideally in block letters or issue a printed prescription using new technology. We will be much admired and respected if we do so.

4. Generic vs Trade Name of drugs

There is much of a "hue and cry" about Doctors prescribing in Trade Names only. There is a Ministry of Health Circular issued to all Government and Private sector doctors stating that a prescription should be in Generics, and if there is a preferred Brand Name, it may be mentioned within brackets at the prescriber's discretion.

It is sad to reflect that most of the Doctors, do not adhere to this Circular, and blindly write their medicines with only the Trade Name. There can be many mishaps avoided especially with "look alike and sound alike drugs", and for the sake of the safety of the patients, one must always be conscious of this Ministry rule and fall in line.

6. Pharmacy misuse

There are many pharmacies who misuse the freedom of issuing drugs on old prescriptions and even partly damaged prescriptions. Sometimes the prescriber is dead and gone but the patient who cannot bother to visit another doctor, uses the same prescription. There have been many complaints also that prescriptions of qualified Doctors end up on the tables of quacks who copy the prescription and still remains a dangerous and unsafe practice.

7. Educating the patient population

Every qualified, trained GP spends time educating his patients on current, morbidity patterns, and also teach how to cope with a situation temporarily, until he/she sees the Doctor next at the earliest. The common conditions that one should educate particularly to the mother, in the case of a child is - fever, URTI, LRTI, wheeze, diarrhoea and vomiting, unbearable headache, abdominal pains etc. It is mandatory therefore, to spend time and educate patients and parents on common illnesses and current epidemiological patterns of illness.

8. Repetition and prescriptions

This is another misuse- repeating old prescriptions when the condition of the illness does not warrant treatment given earlier. Some patients avoid visiting the doctor and thinks it is smart to keep, and repeat an old prescription, which can be harmful and dangerous. Therefore many doctors use a seal on the prescription "Do not repeat", which is sensible.

9. Labelling of the dispensed medicines in a packet or bottle

This is a very sad situation that many GPs (trained and untrained) still do not write the names of the drugs dispensed. This is poor quality practice. Every patient has a fundamental right to know what he is being given. Even the National Hospital of Colombo and the Lady Ridgeway Hospital did not label their envelopes, until recently.

When concerned clinicians raised a "hue and cry", and the Medical Association lobbied with hospital administrators it is now written, but it is not clear at all, unless there is a seal on the envelope. Therefore, I beseech all our colleagues in our specialty of General Practice to change their age old practices and be honest, to write the names of the drugs, the doses and instructions on the packet and syrup bottles, ointments, creams and local applications etc. issued from your own dispensaries.

It is also disheartening to see some primary care, GPs dispensing in packets without names and no instructions, syrups and mixtures given in polythene bags. This is a horrendous practice!

I have very briefly highlighted some salient points where quality of the GP can be recognized and appreciated by his own patient population. I wish my peers and colleagues to send in their comments and suggestions to continue these reflections; and initiate a dialogue on the above subject. ■

Climacteric is the time period of ovarian involution, characterised by physiological and psychological changes due to a decrease in reproductive capacity. Climacteric (peri-menopausal) symptoms start when estrogen production gradually reduces. English speakers have long used climacteric for those inevitable big moments encountered on the metaphorical ladder of life. Greek word klimaktēr, meaning "critical point" or, literally, "rung of a ladder."

PREPARING FOR THE CLIMACTERIC

Dr. Romanie Fernando
Consultant Obstetrician and Gynaecologist

Mood swings, irregular menstruation, troubled sleep, fatigue- these could be symptoms of climacteric or menopause-transition. The onset of this phase in a woman's life is several years before menopause. Climacteric is the time when the ovaries gradually cease its function. Ovaries produce the most significant hormone for women that is oestrogen.

Preparing one's self early for this climacteric transition could help a woman navigate this emotionally and physically challenging period more smoothly. "The symptoms- both mental and physical, entail a spectrum which could aggravate once she reaches menopause. Hence empowering one's self holistically is critical to face the transition with ease."

Climacteric period largely starts in a woman's 40s although a small percentage could experience it even in their 30s. The peak period of menopause is usually, between 45 to 55 years. While the average length of climacteric could be around five years, for some women, it could even continue for ten years or more.

During the climacteric, the ovarian functions start to fail and thereby reduce the production of estrogen. The emotional roller coaster of climacteric could be disturbing to many women unless they are aware of their emotions and tune their minds to manage them. "This phase could be emotionally challenging to women and they are often unable to handle stress and get provoked easily. Their mood swings, irritability and aggressiveness could impact others around them as well

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including the family and colleagues at the work place".

The mismanaged stress could manifest in way of frequent headaches which could very often be misdiagnosed. "These tension-induced headaches could sometimes be misread. Hence, a careful diagnosis of a woman prone to frequent headaches during this stage is required." Apart from headaches, a woman during climacteric period could also experience bodyaches and pains. Some of these physical symptoms could mimic other conditions including thyroid problems, vitamin deficiencies or anaemia, hence ruling them out with proper investigations is important.

Insomnia or inability to sleep is another common condition associated with climacteric-induced stress. If unaddressed, this could trigger depression. "Addressing symptoms before a woman reaches a stage of depression is crucial.

Today there are many behavioural therapies to manage them including mindfulness techniques, breathing practices and stress-management sessions conducted by qualified psychologists which women can access. Besides these, incorporating simple activities into the daily routine to relax the mind such as gardening, listening to good music, reading, meditation too are recommended by experts.

Despite climacteric changes being part of the natural course of every woman's life, the reaction to it is determined by the personality of each woman. "Women who are more spiritually-inclined whatever the religion is, those whose minds are relaxed and more aware of their minds can brave this phase better than women who are constantly on the run with little heed to mental relaxation."

Mindfulness practices are strongly recommended for women to be in control of their action and speech and thereby avoiding unpleasant situations created by their careless words and sometimes unintentional anger bouts and mood swings.

Addressing regular headaches and insomnia, is vital as it is a warning sign before they develop into mental depression. These women should have the courage to talk to a trusted family member or friend who would lend an empathetic ear, early as possible as the above symptoms sets in. "Very often speaking to a person, a woman trusts, could help ease her mind. Professional counseling is also available in the absence of a family member or a friend who could offer appropriate counseling."

Altering one's lifestyle with sufficient physical exercise and a proper diet cannot be underpinned during the climacteric. Activities such as yoga, brisk walking and any other regular physical activities which could impact the mental equilibrium are recommended. In addition, regular exercises which could strengthen pelvic floor muscles could prevent urinary incontinence which is also a common symptom of the climacteric.

Irregular menstruation is also common during this stage. Especially heavy bleeding in a woman nearing menopause, needs proper clinical investigations to exclude endometrial cancer or any other gynaecological pathology such as fibroids, endometrial or cervical polyps. In the best interest of the woman above 40s, with heavy flow, should be referred to a gyanaecologist to exclude either endometrial cancer or cervical cancer which about 5% of women could be experiencing at this stage. The best practice is to avoid hormonal treatment as the first line. Tranexamic acid which is classified as an antifibrinolytic should be the first line of drug to be used in heavy menstrual bleeding. Recommended dosage is 500mg -1g, tds or qds, which reduces the menstrual blood flow by 35% -59%. Combined with 500mg mefenamic acid there is an added effect to reduce the menstrual blood flow by reducing prostaglandin levels by the NSAIDs.

Altering one's diet, ideally before the onset of climacteric (around 35 years) can help mitigate many issues. A plant-based diet rich in anti-oxidants and phytoestrogen (plant-based estrogen sources) could supplement the estrogen deficiency during this stage. "Japanese women are reported to be having minimal climacteric and menopausal symptoms largely because of their plant-based diet, in which soya beans occupy a prime place," natural soya beans (NOT the genetically-modified type) as one of the best sources of phytoestrogen. Natural soya milk and soya milk products are recommended for climacteric women.

Revisiting the traditional Sri Lankan diet which is largely a plant-based one is also crucial. "Sri Lankan women who would opt for traditional food sources could also experience minimal symptoms unlike in the west where many women seek hormone-replacement therapy."

Anti-oxidant rich sources such as cinnamon, lime and ginger could also regenerate cells while traditional local foods such as jackfruit and breadfruit can also provide ample nutrition. Green leaves, grains, nuts, legumes (especially dambala) mushrooms, broccoli are among the other highly recommended foods. "Mindful eating without binging on unhealthy food should be avoided at all costs and ideally a woman should increase her calcium intake after 35. Small fish, sprats and wood apple are among high-calcium sources".

Preventing obesity too should be a priority at the perimenopausal age as obesity is the number one cause of Non-Communicable Diseases (NCDs). The NCDs which are on the rise could be worsened with the onset of climacteric, hence managing the lifestyle with appropriate physical activity, correct diet and combatting stress are of utmost importance.

In a country such as ours with the rapidly ageing population and the majority of the population being women, interventions to support women going through perimenopause and menopause are much wanted. "Support groups within a community, workshops on mindfulness and other behavioural therapies at workplace, providing trained counselors at company level and a system of public health nurses who could interact with older women are wants of the hour."

Author could be reached by email **fernandoromanie5@gmail.com** ■

QuantiFERON – TB Gold Plus (QFT-Plus Test)

ALSO KNOWN AS INTERFERON GAMMA RELEASE TEST

Dr. Pushpa Weerasinghe
General Practitioner

QuantiFERON TB Gold Plus is a recent development in laboratory investigations in TB infection.

Until recently the tuberculin sensitivity test (TST)/mantoux test was the only available method for diagnosing latent TB infection (LTBI). However some individuals including those with immune deficiency conditions and some others without these conditions do not respond to tuberculin. Conversely some who are unlikely to have Mycobacterium Tuberculosis infection exhibit sensitivity to tuberculin and have positive results. For example individuals with a history of BCG vaccination or following infection with Mycobacterium other than Mycobacterium Tuberculosis can have positive results.

Quantiferon-TB Gold Plus is a recently introduced laboratory investigation which is a simple blood test that aids the detection of Mycobacterium Tuberculosis infection including LTBI and TB disease. Is the modern alternative to tuberculin test (TST)/mantoux test and also a helpful aid in diagnosing Mycobacterium Tuberculosis complex infection in sick patients. It detects in vitro cell mediated immune responses to T.B. infection and is meant to be used in conjunction with radiography and other diagnostic evaluations.

QFT Plus has 95% test sensitivity and highest specificity of any test for T.B. infection. A positive result is strongly predictive of true infection with Mycobacterium Tuberculosis. However this test cannot distinguish between active T.B. disease and latent T.B. infection. Investigations such as chest X-ray, sputum smear and culture are needed to differentiate LTBI and active infection. QFT Plus should not be used as a sole method for diagnosis of active T.B. which is a microbiological diagnosis. Like any diagnostic aid QFT-Plus cannot replace clinical judgment.

QFT-Plus is an interferon gamma (IFN-) release assay commonly known as IGRA.

This test can be used in all circumstances in which TST is currently used.

Advantages of QFT-Plus over TST/ mantoux test

- Needs only single patient visit to a laboratory.
- Accuracy not affected by prior BCG vaccination.
- Results are not subjected to reader bias (subjective interpretation). It is objective and a controlled laboratory assay.
- Produces more accurate results In LTBI. (Unnecessary follow up and additional treatment due to false positive mantoux test.

Disadvantages

- Cost- expensive test
- Blood sample must be processed within 16 hours.
- Not suitable for children. Under 2 years of age TST is the preferred test.
- False negative results can be due to stage of infection. (Specimen obtained too early prior to the development of cellular immunity)

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Preparation

No special preparation is needed prior to testing.

Explanation of the Test

QFT-Plus is a test for cell mediated immune response to peptide antigen that simulate mycobacterial proteins. These proteins (ESAT-6 and CFP-10) are absent from all BCG strains and from most non tuberculosis bacteria with the exception of M.Kansaii, M.szulgaiand M.marinum. Individuals infected with MTB complex organisms usually have lymphocytes in the blood that recognize these and other mycobacterial antigens. The recognition process involves the generation and secretion of cytokine IFN- . The detection and subsequent quantification IFN- forms the basis of this test.

Collection and Transport

This assay uses four specialized blood collection tubes, which are used to collect whole blood. Tubes are stored in refrigerator until used. At the time of the blood collection the temperature of the tubes should be between 17-25 degrees centigrade. 1ml blood is collected into each tube and shaken well 10 times to dissolve the antigen in the tube walls. The tubes should reach the laboratory within six hours after which incubation of the blood occurs in the tubes for 16 to 24 hours. After incubation plasma is harvested and tested for the presence of IFN- produced in response.

This test cannot be used to monitor TB therapy.

I thank senior MLT Chathurani for the support given in compiling this article.

PRESCRIBING DRUGS TO ATHLETES

Dr. Kavinda Wijesinghe
MBBS, Dip. Sports & Exercise Medicine (Colombo)
MOIC Sports Medicine Unit, DGH Gampaha
Co-editor, Sri Lanka Sports Medicine Association

As a General Practitioner (GP) it is utmost important to know which drugs are to be prescribed and which drugs are to be avoided as far as an athlete is concerned. In Sri Lanka, most athletes seek the help of General Practitioners. So the GP should be familiar with the drugs which he/she can prescribed and also know in which situations the drugs have to be avoided.

The drug which is prescribed by the GP would affect the performance of the athlete and it may enhance the performance of the particular sport or sometimes badly affect the performance of the athlete. It is crucial to be aware that the drug which the GP prescribes may disqualify the athlete, or even be banned from the particular sport. Keeping the above facts in mind, a GP must at all times stress to the athlete that it is his/her responsibility to adhere to The World Anti-Doping Agency (WADA) regulations and that ignorance is not considered a defense.

From 1998, which was a defining oment in the history of drugs in sport (particularly because of the Tour de France scandal), sport administrators, athletes, and the general public have often seen doctors as protagonists in doping. This is as true for team doctors as for other practitioners.

The main accusations made are, firstly, that some are engaged in "medically assisted doping", and, secondly, that they supply athletes, even amateurs, with doping agents, either deliberately or through carelessness.

The World Anti-Doping Agency (WADA) was established in 1999 as an international independent agency composed and funded equally by the sport movement and governments of the world. Its key activities include scientific research, education, development of anti-doping capacities, and monitoring of the World Anti-Doping Code (Code) – the document harmonizing anti-doping policies in all sports and all countries. The Sri Lanka Anti-Doping Agency (SLADA) is responsible for drug testing and education in Sri Lanka.

Substances will be added to the list if they satisfy any 2 of the following three criteria.

1. The potential for enhanced performance
2. The potential for being detrimental to health
3. They violate the spirit of the sport

The most important reason for doping is a big deal is the fact that many of these substances can have harmful and long-lasting side effects which may include the following:

Cardiovascular:
irregular heart rhythm, palpitations, elevated blood pressure, increased blood viscosity, myocardial infarction, sudden death

Central Nervous System:
insomnia, anxiousness, depression, aggressive behavior, suicide, headache, addiction with withdrawal, psychosis, tremor, dizziness, stroke

Respiratory:
nose bleeds, sinusitis, respiratory depression

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Hormonal: infertility, gynecomastia, decreased testicular size, low sex drive, acromegaly, cancer, acne, baldness, Cushinoid symptoms, hypoglycaemia, diabetogenic effect

The second issue is more of a moral dilemma. These banned substances are used to gain an unfair advantage which significantly devalues the spirit of competition.

Usage of prohibited substances and its ill effects is still a new topic to Sri Lanka. General public and people who are engaged in sports as well as many of the Medical doctors, (except those doctors who are trained in doping and Medical Officers who possess postgraduate qualification in sports and exercise medicine) do not have a proper understanding on doping control.

However, the GPs are the people who initially come across and manage the athletes in the case of their general illnesses. So the GPs have to be familiar with the WADA prohibited list prior to prescribing drugs to an athlete. The WADA list is reviewed annually and an updated list commences on 1st of January each year and it is available online at WADA Website.

(https://www.wada-ama.org/sites/default/files/wada_2020_english_prohibited_list_0.pdf)

This list is valid until the 31st of December each year.

The list includes substances which are:

1. **Prohibited at all times**
   - S0- Non approved substances
   - S1- Anabolic agents
   - S2- peptide hormones, growth-factors, related substances and mimetics
   - S3- Beta 2 agonists
   - S4- Hormone and metabolic modulators
   - S5- Diuretics and masking agents

- **Prohibited Methods**
  - M1- Manipulation of blood and blood components
  - M2- Chemical and physical manipulation
  - M3- Gene and cell doping

2. **Prohibited in competition**
   - S6- Stimulants
   - S7- Narcotics
   - S8- Cannabinoids
   - S9- Glucocorticoids

3. **Prohibited in particular sports**
   - P1- Beta blockers

The following drugs are permitted to be used:

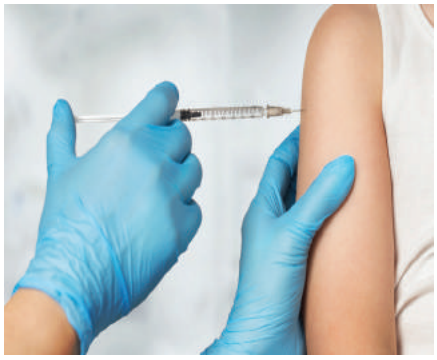
Oral Contraceptives –
desogestrel, drospirenone, ethinylestradiol, etynodiol, gestodene, levonorgestrel, mestranol, norethisterone, norgestimate.

Pain and inflammation –
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), aspirin, codeine, diclofenac, dihydrocodeine, ibuprofen, paracetamol, tramadol.

Skin –
Topical creams and ointments containing corticosteroids are permitted.

Sleeplessness –
alprazolam, diazepam, diphenhydramine, nitrazepam, temazepam, zopiclone, zolpidem.

Vaccination –
all vaccines are permitted



Viral infection –
aciclovir, famciclovir, idoxuridine, penciclovir.

Vomiting and nausea -
cinnarizine, cyclizine, domperidone, hyoscine, meclozine, metoclopramide, prochlorperazine, promethazine.

Athletes may have illnesses or conditions that require them to take banned medications. In such situations, the treatment must not improve performance beyond a return to normal and there must be no other alternative treatment available. In these cases, the athlete may apply for a Therapeutic Use Exemption (TUE) and forwarded it to the SLADA

On the other hand, certain substances listed on the Prohibited List require a Declaration of Use (DoU) rather than a TUE. A DoU can only be made for the following substances and routes of administration:

- salbutamol and salmeterol by inhalation
- The substance or method has the potential to risk the athlete's health.
- Glucocorticosteroids by inhalation
- Glucocorticosteroids administered by localized injection (prohibited when administered by oral, intravenous, intramuscular or rectal routes), any other routes of administration require a TUE.

(Refer WADA prohibited list for detailed description)

The TUE application is freely available at the SLADA Website and it consists of athlete information, medical information, medication details, medical practitioner's declaration and athlete's declaration.

Evidence confirming the diagnosis shall be attached and forwarded with the application. The medical evidence should include a comprehensive medical history and the results of all relevant examinations, laboratory investigations and imaging studies. Copies of the original reports or letters should be included where & when possible. Evidence should be as objective as possible in the clinical circumstances and in the case of non-demonstrable conditions independent supporting medical opinion could assist the application.

TREMORS
IN GENERAL PRACTICE

Dr Shobavi Kohombange
General Practitioner

Tremor is an important clinical presentation in a general practice setting. Though it looks innocent most of the times, tremors can lead to some sinister problem or disease where the patient is concerned.

Tremors are involuntary rhythmic oscillatory movements of a body part, typically involving the hands, head, trunk, vocal cords, or legs. Tremor is usually described based on frequency of oscillations [rapid or slow] and amplitude of movement (fine or coarse).

Tremors may be,

- **Normal (physiologic)-**

Affects both hands equally , fine tremors occurs in otherwise healthy people when stressed [Eg, Anxiety, Fatigue, Exercise, sleep deprivation, withdrawal of alcohol or with certain other CNS depressant drugs, certain therapeutic drugs, certain disorders like hyperthyroidism]

- **Pathologic –**
  - Due to primary disorder (Eg: essential tremor or Parkinson disease)
  - Secondary to a disorder (Eg: stroke)

Classification

- Resting tremors –

Visible at rest, occur at a frequency of 3 to 6 cycles/ sec. Tremors are absent or minimal during activity (Eg: Parkinson disease)

- Action tremors –

Evident when a body part is moved voluntarily. It can occur at different frequencies, usually less than<13 Hz. (Eg: Essential tremor),

Action tremors include:

- Kinetic tremors -

Appear in the last part of the movement towards the target; amplitude is low.

- Intention tremors -

Intention tremors are seen in voluntary movements like finger-to-nose testing where tremor worsens towards the target where amplitude is high, and frequency is low and tremors last during the complete movement (cerebellar tremor)

- Postural tremors -

Postural tremors are elicited when holding the arms stretched out, when a limb is held in a fixed position against gravity

- Complex tremors -

Can have more than one type of tremor

Evaluation

The fact that diagnosis is mainly clinical, a meticulous history and physical examination are essential.

• History

History of present illness such as acuity of illness (gradual/abrupt); age of onset; body parts affected; aggravating provoking alleviating factors are questioned.

Details about drug history, alcohol and substance abuse, trauma, other disorders, family history of tremors in 1st degree relatives, past medical history (such as hyperthyroidism, hyperparathyroidism, liver disease, neurological disorders) probed.

Review of systems seeking for a cause, such as neurological symptoms, recent onset motor weakness, language difficulties, dysarthria, confusion and fever, gait and posture problems, slowness of movement , muscle rigidity, weight loss, diarrhea, increased appetite , signs of alcohol withdrawal, substance abuse .

• Physical Examination

Tremor – observe the patient at rest: the presence of a pill rolling tremor is suggestive of Parkinson's Disease. In addition, there may be expressionless facies, drooling of saliva, Thyrotoxic patient will be thin with wide staring eyes, goiter, exophthalmos with Graves' disease.

The arms are then outstretched, most other causes of tremor will now be visible. Fine tremors can be demonstrated by placing a piece of paper on the outstretched hands. If the arms fully supported , this will cause resolution of benign essential tremor. An intention tremor is demonstrated by the finger-nose-test; there may also be past pointing where the finger overshoots the target.

General Examination -

The gait can be assessed and the difference between Parkinsonian and Ataxic gait of cerebellar disease will be obvious. Further features of cerebellar dysfunction are scanning speech, dysdiadochokinesia, nystagmus and pendular reflexes. Similarly features of thyrotoxicosis such as thyroid gland palpation ocular movements assessed with regard to Graves' disease. Features of prolonged alcohol excess may be present with signs of chronic liver disease.

Investigations

TSH and free T_4, LFT, CT/MRI head (for those with cerebellar disease)

Treatment

• Physiologic tremors -

No treatment necessary unless symptoms are bothersome. Avoiding triggers such as caffeine, fatigue, sleep deprivation, stress and anxiety, causative drugs, will reduce symptoms.

• Treating the underlying cause in case of hyperthyroidism and alcohol withdrawal also helps.

• Oral benzodiazepines [diazepam or lorazepam] given temporarily is helpful .Propranolol [20 to 40 mg orally and other beta blockers are often effective for anxiety or drug induced tremor

• Essential tremors -

Propranalol20-40 mg orally up to 4 times a day; Primidone 50-250 mg up to 3 times a day;

• Second line drugs are Topiramate 25-75 mg orally twice a day; gabapentin up to 300 mg 2-3 times per day; benzodiazepines may be added if indicated.

• Cerebellar Tremors-

No effective drug is available. Physical therapy indicated.

• Parkinsonian Tremors -

Levadopa is usually the treatment of choice

• Anticholinergic drugs may be considered in certain cases.

Note : Geriatrics Essentials:

Tremor

Many older patients attribute development of tremor to normal aging and may not seek medical attention. Still a thorough history and clinical examination are required to rule out other sinister causes. Tremor can affect the functional ability in older patients. Physical and occupational therapy can provide simple coping strategy that may help maintain quality of life. ■

THE FACULTY OF TEACHERS AND YOU

Dr. Eugene Corea
General Practitioner
Chairman, FOT - CGPSL

The Faculty of Teachers (FOT) in Family Medicine of the College of General Practitioners of Sri Lanka (CGPSL) was set up in the mid-1990s. The driving force behind this initiative was Desmond Fernando.

Dr. Desmond Fernando

The aim of the FOT has been the development of the College's core capacity of medical education in family medicine. The ultimate outcome was to be the creation of posts of professors, senior lecturers etc. However this is no longer the focus of the FOT.

Three months ago, the Council set up a Committee to run the FOT. The Committee has already begun work on the undermentioned projects.

1. Advancing your academic aspirations

Of all the College's Committees, it's the FOT that has the mandate to advance the academic development of Members and Associates. The FOT Committee is currently looking at ways and means of supporting our Members and Associates as they work on their DFM, MD and other postgraduate qualifications. You will hear about the FOT's efforts in this regard soon.

2. Examiners training programme

The first leg of this was worked out. Hopefully the second leg will be completed by the 1st of November. This training is conducted by the College of Medical Educationists and organized by the FOT.

Examiners training programme

3. Diploma in Palliative Care for GPs

Work on this has commenced. Prof. Gominda Ponnamperuma is guiding and directing a group comprising of Members and Associates of the College together with representatives of the Palliative Care Association of Sri Lanka (PACSL) as the FOT develops another diploma for doctors in general practice.

Diploma in Palliative Care for GPs

4. Panchakarma project

The FOT is also looking at a Panchakarma project created by Dr. Ananda Perera to bring together Members and Associates on a common electronic platform to improve practice, share experience and role model for others in the profession.

5. More in the pipeline

Clinical Teacher Training and Social Emotional Learning .The FOT will keep you informed about these too in the near future.

The GPs' Café

Case-based Discussion

PROACTIVE CARE IN LIMITED TIME

Dr. K. A. Chandima Iroshani
Family Physician

Case scenario

Mr. DK a 48 year old heavily build restaurant manager who works in the middle east. He is on a 4 weeks' vacation. Mr.DK presented with R/wrist pain for three weeks and locking of R/4th finger for six months. Mr. DK snores at sleep and his sleep gets disturbed with episodes of chalking. He also found to be dozing off daytime especially while driving. He had no history of Diabetes or Hypertension. He was clinically euthyroid. He had a family history of premature CVD. He was a father of 2 children, non-smoker and takes alcohol occasionally. He spends a sedentary life.

Challenge was to provide care to Mr.DK in three weeks, who was found to have following problems.

- R/Wrist - bursitis/tendinitis/ synovitis
- R/4th trigger finger
- Obesity – Grade 3 (BMI of 38.4kg/m²)
- Hypertension (Blood pressure of 159/97mmHg)
- Dyslipidemia (Triglyceride - 512 mg/dl, Total cholesterol - 239 mg/dl, HDL - 49 mg/dl)
- Obstructive Sleep Apnea (Mallampathi grade 4)

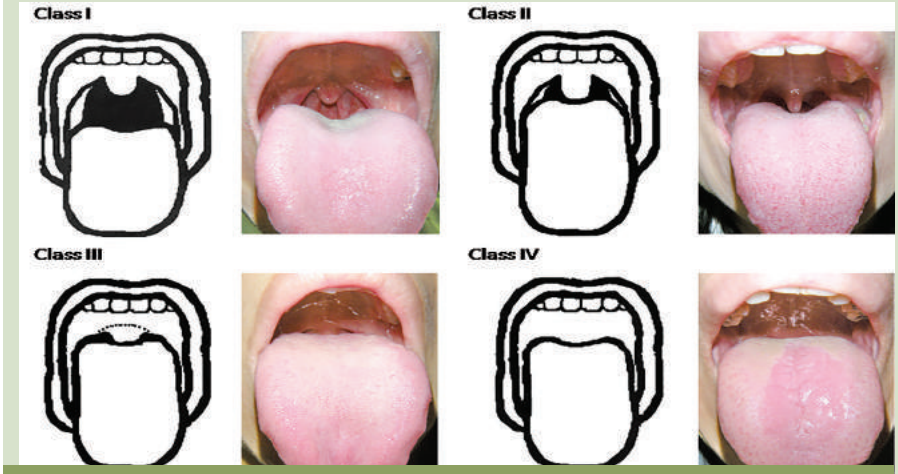
Plan of management

- Patient education on high blood pressure, dyslipidemia, obesity, OSA and CVD risk
- Discussed diet and exercise (target 5-10% weight reduction)
- Sleep on a side, CPAP
- Ix: rpt Lipid profile, FBC, ESR, CRP, RF, SCr/eGFR, AST/ALT, TSH, X-ray hand with reporting
- Prescribed
  - Telmisartan 40mg bd
  - Orlistat 120mg bd
  - Rosuvastatin 10mg nocte
  - PCM 1g PRN

Review visit in 2 Weeks

- R/wrist swelling improved, mild pain
- weight loss 1.9kg
- BP – 137/94mmHg
- Lipid Profile showed Total Cholesterol of 211mg/dl, HDL of 50mg/dl, Triglyceride of 326mg/dl and LDL of 95.8mg/dl.
- Other investigations were normal
- Given steroid injection to trigger finger

contd...



Mallampathi classification

Management of Mr. DK in future

(As he will leave the country in three days)

- Teleconsultation in a month
- Prescription of same medication
- Check BP once a week (self-monitoring)
- Follow-up with the local doctor (if diastole remains above 90mmHg)
- Re-advised on diet and exercise ■

HEALTHY LIFESTYLE KEYWORDS

Congratulations!

Prof. Nandani de Silva
Past President CGPSL

In recognition of the contribution made to the advancement of Family Medicine

Award of Honorary Fellowship from the Royal College of General Practitioners, United Kingdom

We are proud of your extraordinary achievement!

Prof. Shyamalee Samaranayake
Past Secretary CGPSL

Professor of Family Medicine,
Department of Family Medicine,
Faculty of Medical Sciences,
University of Sri Jayewardenapura

Our Best Wishes in reaching the pinnacle of academic excellence of a Professorship!

Digital GP

CGPSL Website Committee

How to mark our emails as non-spam?

Dear Members,

This is to kindly inform you that the College of General Practitioners of Sri Lanka (CGPSL) would be sending out emails to the Membership on Tuesdays and Fridays. As these emails are being sent in bulk, some Members have informed us that the emails sent from CGPSL often reach the "Promotions" category of the inbox.

Therefore, kindly check the "Primary", "Social", "Updates", "Spam", "Forums" and "Promotions" categories of your email inbox. Please note that you could also change your email settings to avoid the CGPSL email going to the Spam.

Steps to follow;
1. Go to the Spam folder
2. Select the Email received from the CGPSL
3. Click on "Not Spam"

Please refer the following picture