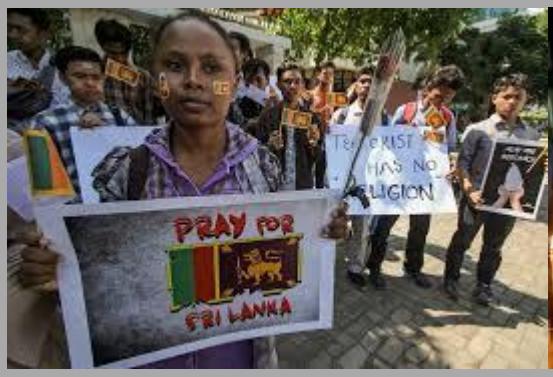
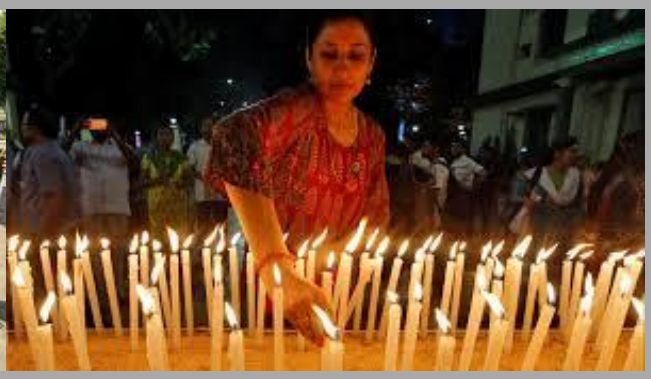
CCP News

Newsletter of the Ceylon College of Physicians

April 2019

Contents





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President's message

Dear Fellows and Members,

I write to you at a time when all of us are trying to come to terms with the horrific crimes committed against humanity in general, and fellow Sri Lankans in particular. Easter Sunday, which should have been a joyous celebration, turned into our worst nightmare within seconds. That,this barbaric act should be condemned unreservedly by all, is but indisputable.

Many of us have lost someone near and dear in the Easter Sunday's blasts. Closer to home, our Fellow, Dr Sunil Bowattage, VP Gampola lost his beloved wife in this carnage. The College offers its heartfelt condolences to Dr Bowattage and all those who have lost their loved ones and wish all who are injured a speedy recovery.

All of us have lived through a time of terror in the not too distant past. The scars we carry were only beginning to fade and the mistrust between communities were just beginning to lessen when this horrific massacre took place. We are now again surrounded with fear and mistrust, unable to distinguish between friend and foe in our midst. It is a sad time to all Sri Lankans, one that we hoped never expected to witness again.

Yet, amidst all chaos and heartbreak, Sri Lankans rallied round to help their fellow countrymen. They transgressed all divides and boundaries and united in an unprecedented manner which was truly remarkable. One can only hope that this will continue and together we will defeat the ugly head of terrorism that threatens to put this Land of ours asunder, again.

I would like to leave this quote from Ann Frank, a Jewish girl who lived during the 2nd World War, in her "Diary of a Young Girl", with you.

> "In spite of everything I still believe that people are really good at heart. I simply can't build up my hopes on a foundation consisting of confusion, misery, and death.

Cont...

Back to contents

President's message

> I see the world gradually being turned into a wilderness, I hear the ever approaching thunder, which will destroy us too, I can feel the sufferings of millions and yet, if I look up into the heavens, I think that it will all come right, that this cruelty too will end, and that peace and tranquility will return again."

Let us hope, pray and work towards rising against this adversity, united and stronger than ever before.

With best wishes,

Professor Chandanie Wanigatunge
President
Ceylon college of Physician

Back to contents

Message from editors of JCCP

Dear Members of the Ceylon College of Physicians,

The Journal of the Ceylon College of Physicians is the flagship medical journal published by the Ceylon College of Physicians. It is an open access medical journal which publishes outstanding research in all areas of clinical medicine, clinical practice, medical advances and general topics of interest to the medical community in Sri Lanka and Asia. It also publishes comprehensive reviews and series of questions and answers providing continuous medical education on a wide array of topics, case reports and short communications.

The journal is at present undergoing a series of changes with the aim of being a recognized indexed journal in the country. We would like to invite you, to continue submitting articles to our journal. Without your support we cannot move forward. Our ultimate goal is not only to be the leading medical journal in the country but also in the region. With your continued contributions we can make this goal a reality. This would in return make the journal a tool that promotes good clinical practice and be instrumental in policy making processes of the country.

Please request all your colleagues working as university academics, researchers and scientists, as well as students, in medical and allied health fields to submit articles to our journal. Encourage your postgraduate trainees to submit the case reports and research articles. We assure an unbiased peer reviewing process by the Editorial Board and relevant specialists when required.

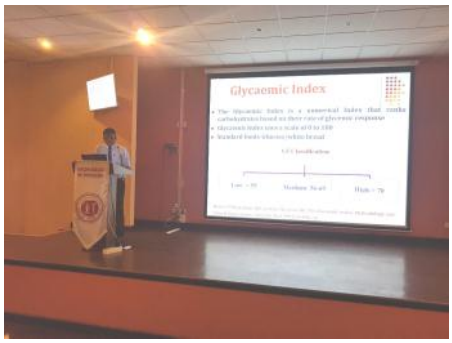
Instructions on submission of article is available at https://jccp.sljol.info/

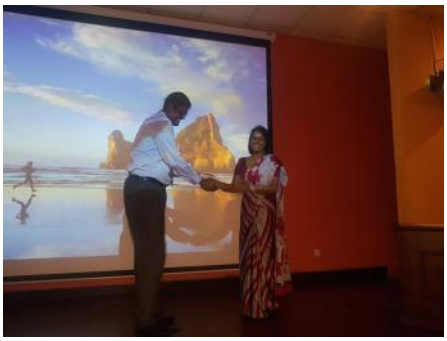
The Editors
Journal of the Ceylon College of Physicians

Back to contents

YPF and College lecture

The April YPF and College lecture was held on the 2nd of April at the ClinMARC auditorium at the NHSL and the event was well attended. There were two YPF presentations. The first presentations was done by Dr. Selladurai Pirasath, Senior Registrar from Colombo South Teaching Hospital and the topic was "Glycaemic index: the physician's perspectives". The second presentations was done by Dr. Sameera Asanga Kumarasinghe, Senior Registrar in Medicine, North Colombo Teaching Hospital Ragama on "Medical disorders in alcoholism". The College lecture was delivered by Dr. F. H. D Shehan Silva, Consultant Physician, National Institute of Mental Health, Angoda, on "To err is human. What about physicians?"
The event was sponsored by CIPLA.



Glycaemic Index: The Physician's Perspectives

Dr Selladurai Pirasath, Senior Registrar in Medicine, North Colombo Teaching Hospital

Glycaemic Index (GI) can be considered in simple terms as the blood-glucose raising potential of a food item which is the rate at which carbohydrate in food is digested and absorbed into the blood stream as glucose. The concept was first proposed by Dr. David J. Jenkins and colleagues in 1981 from the University of Toronto. GI is defined as "the incremental area under the blood glucose response curve of 75g of the carbohydrate portion of a food expressed as a percent of response to the same amount of carbohydrate from a standard food taken by the same subject". It ranks foods on a scale from 0-100, according to their actual effect on blood glucose level. Foods with an index number of 70 (or) more are considered to be of high GI, while index number between 55-70 are considered as having a medium GI, and 55 (or) less are considered as having a low GI.

Back to contents

Factors determining Glycaemic Index

The glycaemic effect of foods depends on a number of factors such as the type and physical entrapment of the starch molecule, fat and protein content, presence of organic acids, antioxidants or salts in the given meal. The presence of soluble dietary fiber invariably slows the gastric emptying rate thus lowering the GI. Besides, method and degree of food preparation or processing, speed of eating and time of day the food is consumed also contribute to the GI value of foods.

Benefits and effect of GI in disease

Low GI diets help people to lose and control body weight among obese people. It has been shown that post-meal hyperglycemia and insulin levels were significantly higher and plasma triglycerides were threefold greater when high GI food items were eaten. In addition, they are useful in improving glyaemic control by increasing the body's sensitivity to insulin among diabetic patients. Clinical studies in individuals with diabetes have shown that low GI diets control diabetes, lower the postprandial glucose, lower the insulin level, and lower the incidence of hypoglycemia. It should be noted that low GI diets are indeed linked to high HDL -cholesterol and low LDL levels which subsequently reduces the risk of development of atherosclerotic plaques and cardiovascular disease. Moreover, low GI carbohydrates prolong physical endurance and increases sports performances among regular sportsmen. Endurance athletes have become increasingly aware of the GI index of foods taken before and during training and competition. Evidence that high overall dietary GI is related to cancer risk is somewhat inconsistent with breast cancer among postmenopausal women and risk of colorectal cancer in men. All high GI foods cause a rapid rise in blood glucose level, which causes a temporary surge of energy and hyperactivity among children with attention deficit disorders subsequently resulting in a hypoglycaemia with irritability, poor sleeping habits and lack of concentration.

Back to contents

Current concept of Glycaemic Index

The GI has been a subject of scientific research for 20 years. It was originally developed as a dietary strategy to help people with diabetes gain better control over their blood glucose levels. Today, GI is an accepted part of medical nutrition therapy in Canada, Australia, and much of Europe and its use has expanded to include treating obesity, cardiovascular disease and various other health problems.

The first edition of International Tables of Glycaemic Index, published in the American Journal of Clinical Nutrition in 1995 with 565 entries has been cited as a reference in many scientific papers. In particular, these tables provided the basis for GI to be used a dietary epidemiologic tool, allowing novel comparisons of the effects of different carbohydrates on disease risk, differing from the traditional classification of carbohydrates into starches and sugars. An issue that is still being debated, particularly within the United States, is whether GI has practical applications for the clinical treatment of diabetes and cardiovascular disease. However; some experts have raised concerns about the difficulties of putting advice about GI values into practice and of the potentially adverse effects on food choice and fat intake. For this reason, the American Diabetes Association does not recommend the use of GI values for dietary counseling. However, the European Association for the Study of Diabetes, the Canadian Diabetes Association, and the Dietitians Association of Australia all recommend high-fiber, low-GI foods for individuals with diabetes as a means of improving postprandial glycaemia and weight control. In Sri Lanka, GI is still under evaluated among food items, even though two major studies conducted in Northern and Southern Sri Lanka showed GI of locally available food items and mixed meals. Furthermore, large-scale intervention studies are underway and more are required to define the therapeutic utility of the GI concept related to chronic diseases.

Despite controversial beginnings, the GI is now widely accepted as a reliable, physiologically based classification of foods according to their postprandial glycaemic effect. The concept of GI is rapidly evolving which will result in GI being an accepted goal in the near feature and will be part of nutritional management of several non communicable diseases globally.

Back to contents

Acute Medical disorders in Alcohol use

Dr. D. S. A. Kumarasinghe , Senior Registrar in Medicine, North Colombo Teaching Hospital

Alcohol related disorders are a commonly encountered dilemma to general physicians. There are several medical, psychological and social problems which need a multidisciplinary holistic approach for a better outcome. Therefore, physicians have a pivotal role both in identification and management of medical disorders associated with alcohol use.

Currently the prevalence of alcohol consumption is 39.6% among males and 2.4% among females in Sri Lanka. The per capita consumption of alcohol is 7.3 litres for males and less than that for females. However, the total per capita consumption of alcohol among males may amount to 16 .2 litres when unrecorded consumption is also considered. This figure found in Sri Lanka is the highest among the SAARC countries.

Heavy drinkers are more susceptible for pneumonia and some infections like Pneumococcal, Pseudomonas, gram-negative sepsis and Tuberculosis. Gastritis and duodenitis are commonly observed acute complications. Alcoholic hepatitis can be seen 10%-15% of alcoholics while acute pancreatitis is also not uncommon. Haematological effects are macrocytosis, thrombocytopenia and anemia. Cardiac effects such as elevated blood pressure (with or without alcohol withdrawal), various arrhythmias, increased risk of ischemic heart disease and cardiomyopathy are observed commonly. Neurologically, patients might present with headache, sleep disorders, Wernicke's syndrome, Korsakoff psychosis, organic brain disorders and peripheral neuropathies. Alcoholic ketoacidosis is seen in malnourished chronic alcoholic patients with a history of binge ingestion. They usually present with nausea, vomiting and generalized abdominal pain. Patients with alcoholic ketoacidosis are alert and lucid despite severe ketoacidosis.

Back to contents

Acute Medical disorders in Alcohol use

Alcohol withdrawal syndrome is characterized by a set of symptoms such as anxiety, shakiness, sweating, vomiting, fast heart rate, mild fever and seizures which appears 6-36 hours after the last drink. Withdrawal seizures are single or a brief flurry of generalized tonic clonic seizures with a short post-ictal period. Alcoholic hallucinosis presents as visual, auditory with or without tactile hallucinations and normal vital signs. Delirium tremens are the most severe form of alcohol withdrawal syndrome where delirium with deranged vital signs can be observed. Alcohol intoxication can range from diminished fine motor coordination to respiratory depression.

Psoriasis, rosacea, discoid eczema are common cutaneous conditions aggravated by alcohol. Other effects of alcohol include: the enzyme inducing effect of alcohol which affect the metabolism of other drugs , electrolyte imbalances, re-feeding syndrome, sexually transmitted diseases and hidden surgical complications such as sub-dural hemorrhage, esophageal rupture, abdominal hollow viscus perforation, internal fractures and rabdomyolysis.

Even though moderate alcohol consumption is widely regarded as having cardiovascular benefit, current evidence based medicine recognizes “no safe limit in alcohol consumption”.

Back to contents

To Err Is Human. What about us Physicians?

Dr. Shehan Silva, Consultant Physician, National Institute of Mental Health

A study by the Institute of Medicine (IOM) USA in 1999 - To Err is Human; Building a Safer Healthcare System, highlighted that approximately 44,000 – 98,000 deaths are due to preventable medical errors. It compared the mortality rate to 3 jumbo jet crashes once every 2 days[1]. This resulted in increased awareness of US medical errors. Although there is a large body of anecdotal narratives from patients, caretakers and doctors, no published statistics are available in Sri Lanka. Moreover, there is no categorisation in the 'Indoor morbidity and Mortality Reports' on patient safety or medical errors in the Annual Health Bulletin.

We as physicians are bound by the Hippocratic doctrine of primum non nocere and must make the care of your patient our first concern. Safety is the first part of quality in health care which professionals must guarantee its' delivery. More net clinical benefit will be achieved by improving quality. Harm is physical or psychological damage to an individual. A hazard is something that has the capacity of harming an individual while risk is the likelihood of causing harm.

A near miss is an unplanned event that did not result in injury, illness, or damage but had the potential to do so. An adverse event is an injury caused by medical management rather than the underlying condition of the patient while a preventable adverse event is an adverse event attributable to an error. Serious, largely preventable patient safety incidents that should not occur (if the available preventative measures have been implemented) are defined as never events (e.g. amputation on a wrong leg)

Errors occur due to active and latent failures. Active failures are unsafe acts that can be directly linked at the level of operator which occur at the time of incident with repercussions felt immediately. Latent failures are not under direct control of operator and could happen due to fatigue, stress & emotions, interruptions, complexity (poor design and organisation) and transition (handover). Most incidents occur due to a series of failures lining up (Swiss Cheese Effect – 'trajectory of accident opportunity')[2].

Back to contents

To Err Is Human. What about us Physicians?

Root cause analysis is carried out to learn from mistakes to reduce the likelihood of repetition. It is done so not to apportion blame (unless in cases of recklessness, maliciousness or incapability where disciplinary actions should be taken). The process consists of gathering/mapping information, identifying care and service delivery problems, analysis (using tools such as Ishikawa/Fishbone diagram), generating recommendations and solutions, implementing them with dissemination of information.

In Sri Lanka, the concept of quality in health care till 2009 mainly focused on implementation of the 5S concept. In 2010 the Ministry of Health guidelines recommended establishment of Quality Management Unit (QMU) & Work Improvement teams in each hospital/institution. A reporting system for adverse events and readmissions similar to notifiable diseases was introduced in 2016. This utilises the Health 1259 and 1260 forms, where reporting could be done by any member of the team with root cause analysis carried out by the director/ superintendent/consultant involving the parties involved in the incident. Specialist grade medical officers should encourage the practice of this procedure in terms of clinical governance.

To build a safe health care system, changes need to be implemented in terms of principles and practices. It is essential that senior members of the team cure themselves of the 'God Phenomenon' (The consistently inflated feelings of personal ability privilege or infallibility, and refusal to admit possibility of error or failure, even in irrefutable evidence, intractable problems or difficult or impossible tasks, often pointed out by subordinate colleagues.) This leads to irritation in the working environment, rigidity and unwillingness to accept suggestions, refusal of offers of assistance, reluctance to take breaks and confusion. A culture which welcomes reporting of events, with justice and openness should be welcomed and fostered. Safety related information should be channeled to higher levels of management. Protocols and procedures should be designed to streamline and to achieve uniformity in provision of care (e.g. WHO Surgical Safety List). Health care professionals should be cautious of burnout, fatigue and wellness of performance.

Back to contents

Health care teams should adopt the practice of maintaining a 'sterile cockpit' - having good inter and intrapersonal relationships (milieu externa and interna). Errors are inevitable and can happen to any individual. When errors happen there should be acknowledgement of responsibility, mitigation and containment of harm, and thereafter necessary parties should be informed and apologized (Duty of Candour). The acronym SAFETY is a useful practice to ponder upon (Sense the error, Act to prevent it, Follow guidelines, Enquire into event, Take remedial action and it is Your responsibility).

"Lord, grant me the courage to realize my daily mistakes so that tomorrow I shall be able to see and understand in a better light, what I could not comprehend in the dim light of yesterday" (Maimonides)

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2. Reason J. Human error: models and management. BMJ 2000;320(7237):768-70.

Back to contents

CCP cricket

Compiled by Dr. Nihal Gunathilake

Physicians defeat cardiologists

A superb all-round bowling performance coupled with excellent leadership from Athula Weeraratne helped physicians to defend a modest 97 runs and gain a well-earned victory by 6 runs against the strong cardiologists.

Sent in to bat on a difficult pitch with variable bounce the physicians were bowled out for 97 runs in 20.5 overs. Highlight of the innings was 32 runs made by veteran batsman Saman Kularatne until he was tragically run out by a direct hit from the deep by Sumudu Wickramasignhe. There were 2 valuable partnerships in the innings with 34 runs between Saman and Krishantha (13) for the 4th wicket and 25 runs for the 9th wicket between Nishantha (12) and Yapa (13). Unstoppable Thushara had best figures of 2 for 11 in 5 overs. Nishan 2 for 19, Sumudu 2 for 14 and Ajith 2 for 24 also bowled well.

The innings of the heart association had a difficult beginning losing 5 wickets for 24 runs in 8 runs. Hopes were raised when Nishan was joined by fluent Thushara putting on 45 runs for the 6th wicket before Nishan was out LBW to Nuwan for a slow 14 runs. Thushara was 9th out with the total at 87 caught by Nishantha at deep mid-wicket off Champika. The innings ended when skipper Stanley Amarasekara was caught at short cover off Nishantha. Gathika bowled best claiming 3 for 14 runs while Nishantha 3 for 18, Nuwan 2 for 14 and Champika 2 for 15 all contributed well taking vital wickets at regular intervals.

The physicians team were represented by:

- Athula Weeraratne
- Krishantha Jayasekara
- Saman Kularatne
- Yapa Udayakumara
- Dilshan Priyankara
- Champika Samankumara
- DG Nishantha
- Dilrukshan Paul
- Nuwan Madushanka
- Gathika Kodithuwaku
- Mahesh Gunatillaka

Back to contents

CCP cricket

Paediatricians demolished by the Physicians

Physicians secured an easy 8 wicket victory over the Paediatricians in their 22nd annual encounter held at the Wesley College Cricket Grounds on Sunday the 7th of April.

A close tussle was expected when the play began between two evenly matched sides. Paediatricians won the toss and had a long pause before deciding to bat. Lakshitha Samaranayake who scored 98 last year was brilliantly caught by Sumudu on his own bowling in the first over. Thushara, easily the most gifted player from either side threatened to take the game away briefly before he was held magnificently by agile Saman Kularatne to his right, at waist height at mid-wicket for 9. Thereafter the wickets fell regularly until they were bowled out to the lowest in the series for 38 runs in 12.5 overs. Last man Infaq was caught at deep mid on by Dilshan over his head with feet off the grounds. Overall It was a brilliant bowling performance supported by a superb fielding unit marshaled well by the dynamic skipper Athula Weeraratne. DG Nishantha bagged 3 for 11 while Dilshan had the best figures of 3 for 8 runs.

Physicians reached their target comfortably in 6.2 overs. Athula scored a fluent 17 runs with 3 fours and Nishan remained unbeaten on 19 with the help of 4 sweetly timed boundaries.

The victory was the 13th in the series for the physicians as against 8 victories by the Paediatricians.

Dilshan Priyankara won the best bowlers award, Nishan Vaas the best batsman and Saman Kularatne the best fielders award. Skipper Athula Weeraratne received the man of the match award for this brilliant leadership, 3 excellent catches behind the wicket and for making a fluent 17 runs in a low scoring game.

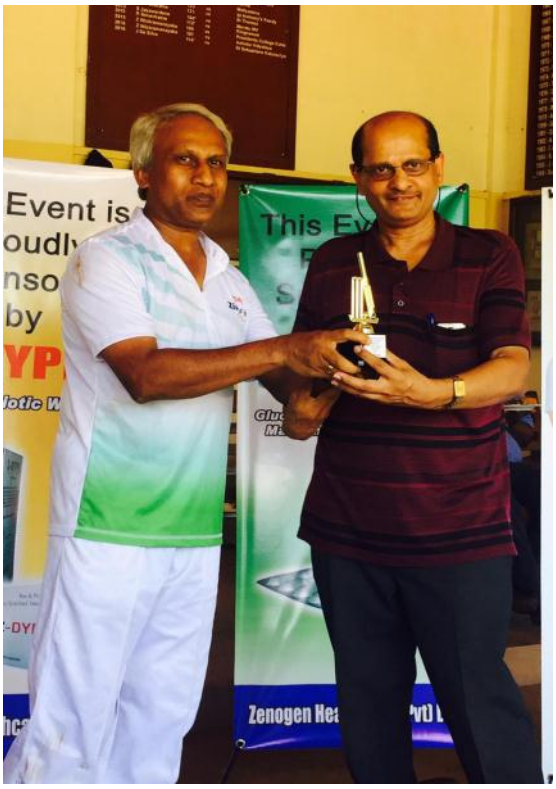
The match was sponsored by Zenogen healthcare.

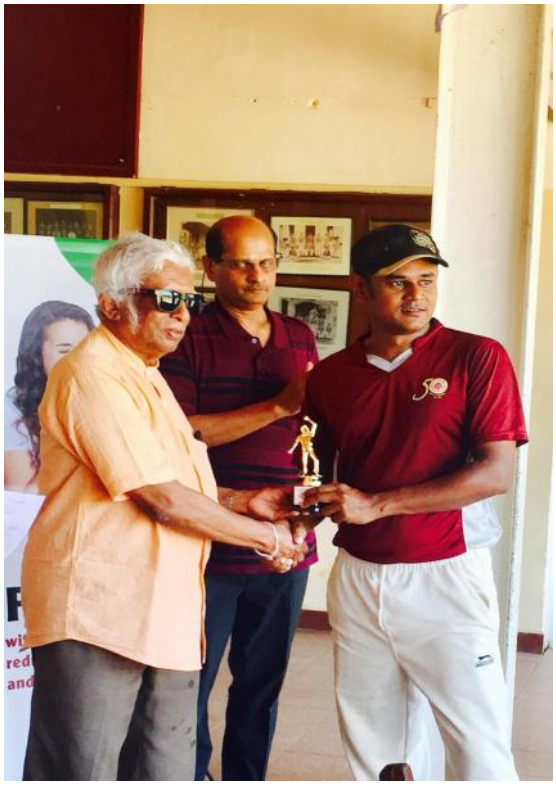
The physicians team was represented by:

- Athula Weeraratne
- Krishantha Jayasekara
- Saman Kularatne
- Nilantha Gamage
- Yapa Udayakumara
- Dilshan Priyankara
- Wasantha Abeywickrama
- Nishan De Vaas Gunawardena
- Sumudu Wickramasinghe
- Janaka Pathiraja

Back to contents

CCP cricket

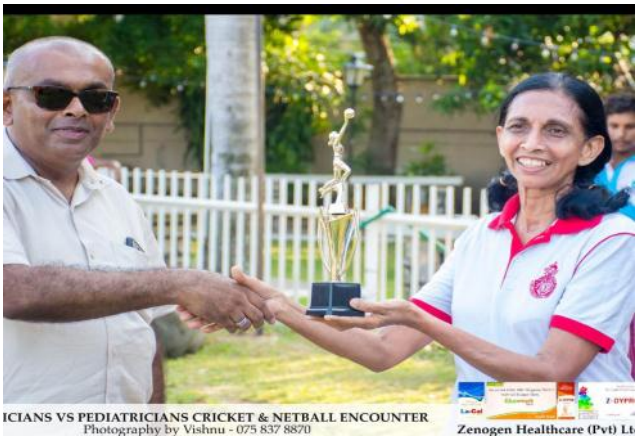




Back to contents

CCP Netball

The netball match between CCP and College of Paediatricians was held on 7th April. This was yet another a clinical performance by the CCP netballers ably lead by Dr Jayanthimala Jayawardena. The score line at the end of the match read 11 to 5 demonstrating total dominance of the CCP netballers over the paediatrcians.



Back to contents

SRI LANKA MEDICAL COUNCIL

Application for inclusion in register of medical specialists

According to the Medical (Amendment) Act No.28 of 2018, The Sri Lanka Medical Council (SLMC) has decided to commence 'Registration of Medical / Dental Specialists' as per the Section 39 B of the Medical Ordinance.

Specimen application form and instructions for application are available at: http://www.srilankamedicalcouncil.org/applicationsdownloads.php

Forthcoming events

- May 3: Maternal medicine Specialty Update, at the ClinMARC auditorium National hospital of Sri Lanka
- May 10: Council meeting, at the College Office
- May 14: Young Physicians' Forum and the College Lecture, at the ClinMARC auditorium National Hospital of Sri Lanka

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Back to contents