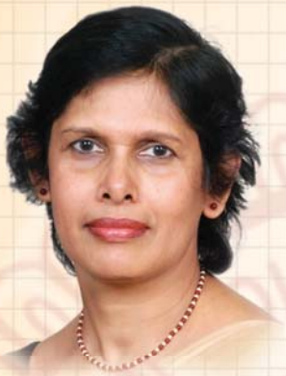
CEYLON COLLEGE OF PHYSICIANS

College News 2011/3

PRESIDENT'S MESSAGE



My Dear Fellows and Members,

I feel proud and privileged to release this message at a time when we have successfully concluded two major academic events that were advertized in the previous CCP News Letter.

It is with great pleasure that I inform you that the Annual Academic Sessions held at the Cinnamon Grand, Colombo in September was a great success. The academic programme that covered wide range of up-to-date topics was highly commended by participants that exceeded 350. The local and foreign faculty consisted of experts with wealth of experience to address at plenary, symposia and interactive sessions. While engaging in an academic exercise the attendees enjoyed the fellowship by making new friends.

The inaugural Foundation sessions held at Hotel Tourmaline in Kandy in July this year with the participation of more than 160 outstation physicians were tremendously successful. The opinion of participants clearly indicated their desire and the need to hold similar academic programmes of high standard throughout the island. I am optimistic that foundation sessions will be a regular event in the calendar of the Ceylon College of Physicians from this year onwards. It would be an opportunity to bring together the physicians who are providing the services at every corner of the Island at present.

An e-mail data base of the membership of the CCP is mandatory to widen the scope of activities and for closer collaboration with members. In the present days context where majority of our members are in the practice of using emails it would be quick and inexpensive to communicate using electronic media. It would be a great help if the fellows and members could facilitate the college activities by calling 011 2888146 or e-mailing "Ceylon college of Physicians" <ccp@eureka.lk>, to complete the data base.

With best wishes,

Dr. Padma Gunaratne MD (SL), FRCP (Glasg), FCCP
President 2011,
Ceylon College of Physicians
E mail: pagunara@hotmail.com

PRESIDENT'S VISIT TO RACP - AUSTRALIA

Dr. Padma Gunaratne, President, Ceylon College of Physicians was awarded. Fellowship of the Royal Australasian College of Physicians (Honorary) at the ceremony held at the RACP Congress in Darwin, Australia on 22nd May 2011.

Electronic data base of Ceylon College of Physicians

Ceylon College of Physicians has decided to develop an updated electronic data base of all its membership. It is important to have an updated database to contact the membership via emails and also to send the electronic version of the newsletter and other College activities for those who wish to receive them via e mail. Therefore, the membership is kindly requested to send their names, designation and current place of work, postal addresses, e mail addresses and telephone numbers to the college office. Kindly indicate whether you would like to receive the electronic version of the newsletter and other College news via email.

For further details contact:

Ceylon College of Physicians
Address : 341/1, Kotte Road, Rajagiriya.
Phone : + 94 (0)11 2888 146
Fax : + 94 (0)11 2888 119
E-mail : ccp@eureka.lk

ANNUAL ACADEMIC SESSIONS 2011 - AWARDS

- **Dr. E. M. Wijerama Award for the Best Presentation at the Young Physicians Forum**

  Dr. Nadeeka Rathnamalala

- **The Most Innovative Outstation Physician**

  Dr. G. Elangkumarabahu

- **Dr. Soma de Sylva Award for the Best Performance in the Selection Examination in Medicine**

  Dr. V. Jeevagan

- **Dr. Nanda Amarasekara Award for the Best Performance in the MD (Medicine) Examination** ***jointly awarded to***

  Dr. N. C. Lokunarangoda
  Dr. T. J. Wijetunga

- **Dr. E. M. Wijerama Award for the Best Oral Presentation**
  "Screening an urban Sri Lankan community for Cardiovascular risk: Implications of applying WHO guidelines"

  Wijekoon CN, Pathmeswaran A, Ranawaka UK, Pinidiyapathirage MJ, Kato N, Wickremasinghe AR

- **Dr. K. Rajasuriya Award for the Best Poster Presentation**
  "Consumption of fiber diets decrease the glycaemic indices"

  S.Pirasath, S. Balakumar, V. Arasaratnam

- **Dr. Henry Rajaratnam Award for the Best Free Paper in Endocrinology, Diabetes and Metabolism –** not awarded

- **Dr. J. B. Peiris award for the Best Performance in the Neurology Quiz**

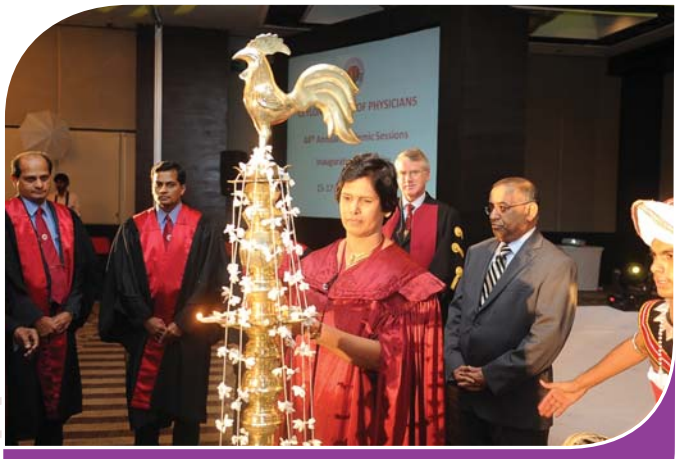
  Non- Neurologists Category jointly awarded to

  Dr. Shamin Lamabadusuriya
  Dr. Sanjeewa Wijekoon

  Neurologists Category
  Dr. Senaka Bandusena

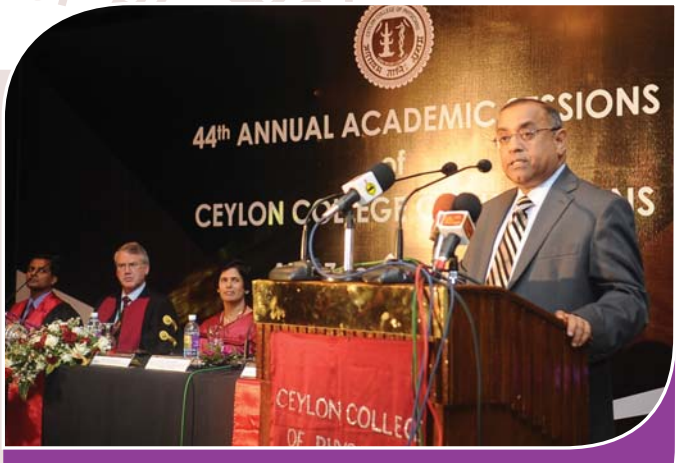
HIGHLIGHTS OF ANNUAL ACADEMIC SESSIONS - 2011

Ceremonial Processionv

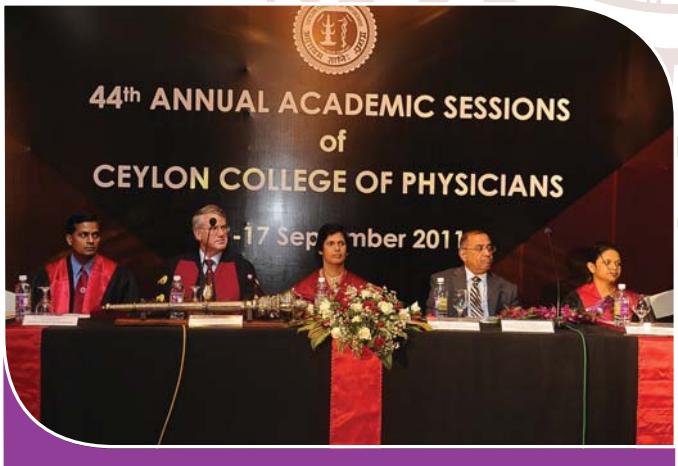


Dr. Padma Gunarathne, President of the Ceylon College of Physicians lighting the lamp of learning

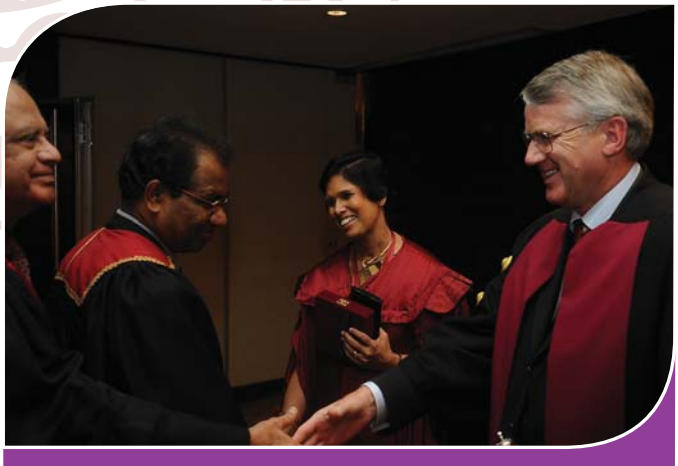
Dr. Padma Gunarathne, President of the Ceylon College of Physicians welcoming the guests



Chief Guest Dr. P B Jayasundara addressing the audience

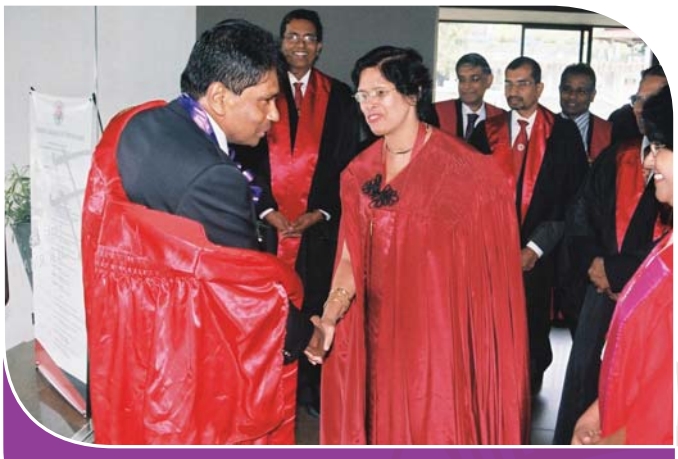


Dr. Padma Gunarathne President CCP, Dr. P B Jayasundara Chief Guest, Dr. Neil Dewhurst Guest of Honour, Dr. Nirmala Wijekoon and Dr. Uditha Bulugahapitiya the joint Secretaries



Dr. Padma Gunarathne, President CCP introducing Professor Sarath Lekamwasam , the President Elect to the Guest of Honour Dr. Neil Dewhurst

HIGHLIGHTS OF INAUGURAL FOUNDATION SESSIONS of the Ceylon College of Physicians held in collaboration with Kandy Society of Medicine on 29th July 2011 at the Hotel Tourmaline, Kandy

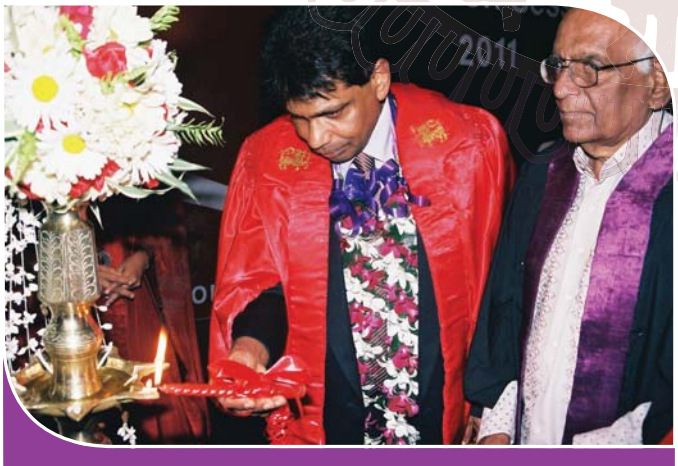


Dr. Padma Gunarathne President CCP welcoming Professor Nimal Senanayake, the Chief Guest

Ceremonial procession

Dr. Padma Gunarathne, President Ceylon College of Physicians lightening the lamp of learning

Professor Chandrika Jayasinghe, President Kandy Society of Medicine lighting the lamp of learning



Professor Nimal Senanayake, Chief Guest lighting the lamp of learning

Dr. Padma Gunarathne President CCP, Prof. Chandrika Jayasinghe President KSM, Prof. Nimal Senenayake, Chief Guest, Dr. Indika Gawarammana, K Rajasuriya Orator and Dr. Nirmala Wijekoon and Dr. Uditha Bulugahapitiya, the joint Secretaries of CCP

Dr. Indika Gawarammana delivering the K Rajasuriya oration

Members of the Council

COLLEGE JOUNAL

June 2011 issue of the journal is out in print and will be posted to all the members. Members are invited to submit reviews, research articles and case reports for December 2011 issue by 30th November 2011.

Professor Saman Gunathilake
Professor Rezvi Sheriff
Co-Editors

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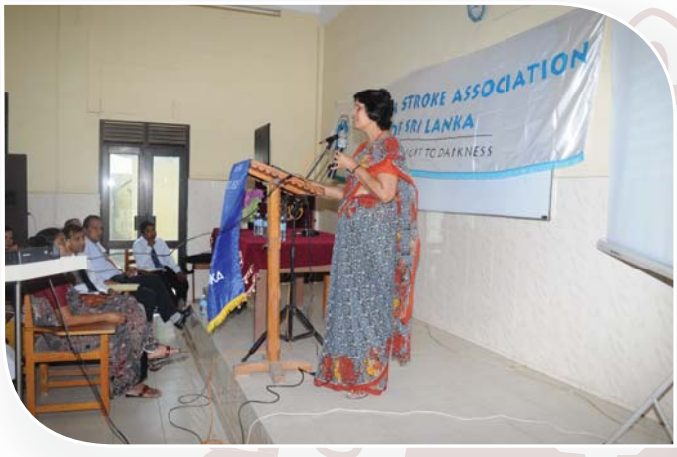
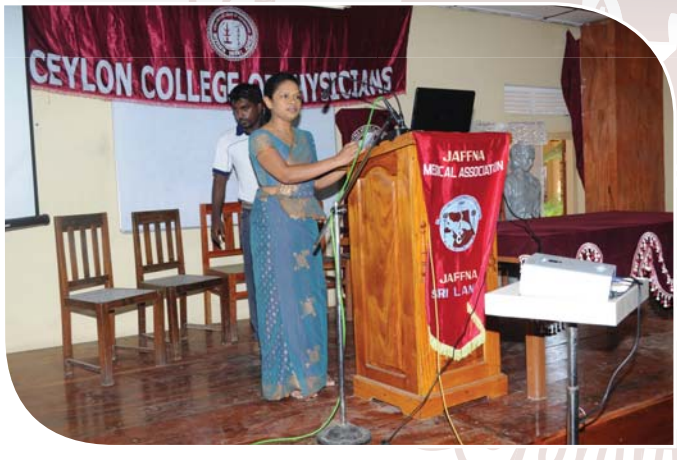
EVENTS HELD

Educational Activities organized jointly with Jaffna Medical Association

A training programme for nurses, physiotherapists, occupational therapists and doctors on 'Physical Rehabilitation of Stroke Victims' and an awareness programme for primary care doctors on 'Cost Effective Interventions on Prevention and Control of Non-Communicable Diseases' was held in collaboration with the Jaffna Medical Association on 18th June 2011 at the Nurses Training School Lecture Hall, Teaching Hospital, Jaffna. Such training programme was organized In Jaffna after so many decades and was very well attended and appreciated.





COLLEGE DAYS:

- Immunology day organized in collaboration with UK-Sri Lanka Immunology Foundation was held on 12th September 2011 and was attended by around 225 doctors. Presentations were delivered by both local and overseas resource personnel.

NEW MEMBERS

Life Members

Dr. K. K. A. O. Walawwatta 131/83, Sri Wajiragnana Mw; Colombo 09	Dr. N. C. Lokunarangoda No. 33, UGD & Sons, Ananda Rajakaruna Mw; Colombo 10	Dr. H. S. Wijewantha 84/5, Bandaranayakepura Rd, Kalapaluwawa, Rajagiriya.
Dr. G. V. T. S. K. De Silva 07, Mahasen Mw; Nawala Rd; Nugegoda	Dr. A. S. Badurdeen No. 08 03rd Lane, Negombo Rd; Kurunegala	Dr. G. Sriram No. 18, 3/1, Perakumba Place, Wellawate, Colombo 06
Dr. B. L. P. P. Balasooriya 86/3, Bonagala, Udatuttiripitiya	Dr. D. C. Kodithuwakku No. 26, Hirimbura Lane, Galle.	Dr. M. N. M. Rushdie 32/ 4 A2, Hill House Gardens, Dehiwala
Dr. S. A. C. U. Gunawardhana 764, Madinnagoda Rd, Rajagiriya.	Dr. K. A. S. Hemachandra 147, Parakandeniya, Imbulgoda.	Dr. A. V. Gamage No. 16, Elliot Place, Borella, Colombo 08

CLINICAL PRACTICE

The threat of dengue, when will we change?

In the year 2009 the disease burden of dengue in Sri Lanka was unprecedented with 35,010 cases and 346 deaths the highest recorded mortality to date. Given the known epidemiological trend we cannot foresee a reduction in the disease burden in the near future. Under the circumstances our role should be to ensure that no patient dies of dengue. This is a realistic goal which responsible clinicians should strive to achieve. This assertion is not speculative but based on an in-depth analysis of dengue related deaths, new knowledge about the disease and personnel experience.

Of the 80 patients who have died of dengue from January to June in 2011, 70% have been adults. This disparity is not due to a change in the disease but because the pediatricians have changed the way they manage their patients. It is unfortunate however that some of the physicians are resistant to change and have not kept pace with what is new. Consequently patients are deprived of a novel approach of care that has added a new dimension, particularly to fluid therapy which is the corner-stone of management. In view of the relatively good results obtained, clinicians often tend to think and justify their management as correct and remain complacent. This is so because the vast majority of symptomatic patients have dengue fever and will recover in any case. The few who develop dengue hemorrhagic fever are often slow leakers and even when the fluid therapy is less than optimal they too have a high chance of recovery.

Against this background what needs to be appreciated is that vast strides have been made in the understanding of the disease and refinements to fluid therapy. A clear understanding of the course of the disease makes one realize the high predictability of the outcomes. Such insight paves the way for a rational and scientific way to manage each stage of the disease. Blind and empirical therapy is thus neither needed nor advocated in the basic management of dengue fever and dengue hemorrhagic fever. Properly timed appropriate specific interventions regarding both the quality and quantity of fluid as well as adjuvant therapy can thwart progression to a fatal outcome amidst cascading complications triggered by profound shock provided it is detected early and addressed aggressively within 4 hours of onset. Such success stories, of which there have been many in the recent past by both paediatricians and physicians, reflect what can be achieved even from a seemingly hopeless position by those who have mastered the profundity of the disease and are committed to apply national guidelines with diligence to suit individual patient requirements.

The time is ripe, though belated, for those physicians who are still in a slumber to wakeup and cast aside the pervading dogma and open up their hearts and minds to understand the basics of the disease and the subtleties of fluid management. It is only then, that they too can experience the delight of treating scientifically a truly fascinating disease with a highly predictable favorable outcome.

The readers are requested to refer to the National Guidelines on Management of DF& DHF of the Ministry of Health Sri Lanka for details on management. Copies are available at the Epidemiology Unit 231, De Saram Place, Colombo 10
Electronic version is available on: www.epid.gov.lk
For the benefit of busy physicians I have highlighted a few practice points of practical importance aimed to reduce morbidity and mortality.

Practice points

1. **Diagnose** dengue infection **early** (not later than D3) Remember that dengue is hyperendemic in Sri Lanka and hence the need to think about dengue first in all acute febrile illnesses. ***Be vigilant.***

2. **Early diagnosis** requires only the intelligent application of data from **full blood counts** done from D2 or D3 onwards to the clinical features. Always check for **diffuse blanching erythema** which is very common and an exceedingly ***useful sign to diagnose dengue early***

3. Identify the clinical type as **DF or DHF** (evidence of plasma leakage & platelet count equal to or below 100,000/c.mm)

4. **Monitor vital signs and FBC** even if the patient is haemodynamicaly stable to detect entry into the critical phase early. ***Be alert*** *Shock after admission reflects delayed or misdiagnosis,poor monitoring and or improper fluid therapy.*

5. **Confirm plasma leakage** by ultrasonography or CXR (R lateral decubitus) or biochemical data.

6. Determine as accurately as possible the time of onset of plasma leakage and the predicted time of end of the critical phase. This information is a **basic prerequisite for accurate fluid therapy.**

7. **Calculate the fluid quota** for the entire period of plasma leakage i.e. **M+5% for 48 hrs.** Fluid rate has to be **adjusted hour by hour** based on the haematocrit and vital signs during this period to match the dynamics of plasma leakage. **Do NOT give fluid at a flat rate.**

8. **Manipulate** the use of crystalloids, **Dextran**, and tetrastarch intelligently in relation to the point in the time scale of the disease in the critical phase, and the balance of the fluid quota to prevent both shock as well as fluid overload***. Be aggressive.***

9. **Dextran** is given as a **bolus** and NOT as an infusion.

10. Do not give intravenous fluids nor Dextran during convalescence when the leaked fluid is been reabsorbed and tends to augment the risk of fluid overloading. ***Ensure a smooth convalescence.***

11. Always consider dengue shock syndrome first, in the initial diagnostic evaluation of any patient with a history of fever presenting in shock who is found to be afebrile at the time of shock. **Clue** to the correct diagnosis would be a **high haematocrit** with **thrombocytopaenia**. ***FBC is an urgent mandatory investigation***.

12. Accurate and rational management of all stages of the disease from its inception (particularly the beginning of the critical phase) can prevent potentially fatal complications like liver, renal & respiratory failure as well as life threatening bleeding & DIC.

Dr Kolitha Sellahewa
Consultant Physician
Epidemiology Unit (formerly NHSL)

CLINICAL UPDATE

Prevention of Osteoporotic Fractures; an Overview

Osteoporosis is a chronic progressive disease of bone, where increased bone fragility leads to increased risk of fractures. Osteoporosis and related fractures are common. Worldwide, one in three women older than fifty years will experience an osteoporotic fracture in their life time1.

Osteoporotic fractures add a significant burden to the individual and to the health system. Only one third of patients return to their previous state of function after a hip fracture. Furthermore in the year following a hip fracture, excess mortality rate can be as high as 20%.

A world-wide projection has estimated an increase in the number of hip fractures, particularly in Asia by 20502. In 1990 26% of all hip fractures occurred in Asia. This figure is predicted to rise to 45% by 2050. Sri Lanka will have to be prepared to bare her share of burden.

Diagnosis of osteoporosis and evaluation of fracture risk

Although osteoporosis is a silent disease that does not become apparent until a fracture occurs, early diagnosis can open up various non pharmacological and pharmacological strategies that effectively prevent fractures.

Osteoporosis is diagnosed by measurement of Bone Mineral Density (BMD). National Osteoporosis Federation (of US) recommends measurement of BMD in following individuals.

- Women aged 65 years and older and men aged 70 years or older
- Younger postmenopausal women and men aged 50-70 years with clinical risk factors for fracture
- Women in menopausal transition with a specific risk factor associated with increased risk for fracture (ie, low body weight, prior low-trauma fracture, use of a high-risk medication)
- Adults who have a condition (eg, rheumatoid arthritis) or who take a medication (eg, glucocorticoids, ≥ 5 mg of prednisolone daily for ≥ 3 months) associated with low bone mass or bone loss
- Anyone being treated for osteoporosis (to monitor treatment effect)

Measurement of BMD

Dual Energy X-Ray Absorptiometry (DXA) is the preferred method to measure BMD in clinical settings. Measurements in hip and spine (central DXA) are used to establish the diagnosis of osteoporosis. The same DXA machine should be used for the initial assessment and follow up scans.
BMD measurement is reported as grams/cm2. It becomes more meaningful when expressed in relationship to BMD of young normal adult. (T-score) Thus a T-score of zero indicate that the patient's BMD is equal to that of a young normal adult. T-score of -1 is equivalent to a BMD 1 SD below that of a normal young adult.

WHO defines osteoporosis using T-score

Normal	BMD is within 1 SD of a "young normal" adult (T-score ≥-1.0)
Low bone mass	BMD is between 1.0 and 2.5 SD below that of a "young normal" adult (T-score between -1.0 and -2.5)
Osteoporosis	BMD is ≥2.5 SD below that of a "young normal" adult (T-score ≤-2.5)

It is important to note that this classification cannot be used for premenopausal women, men younger than 50 years or children.

Predicting fracture risk; The FRAX® Algorithm

Although BMD has a strong correlation with fracture risk, it is not the sole predictor of fracture. In fact most osteoporotic fractures occur in the range of low bone mass (T-score between -1.0 and -2.5) rather than in the osteoporosis range. The FRAX® algorithm (Fracture Risk Assessment Tool) developed by WHO can calculate 10 year probability of hip fracture and major osteoporotic fractures3. FRAX® takes into account other risk factors in addition to BMD. It is available at http://www.shef.ac.uk/FRAX as a computer based program or as one page questionnaire.

Risk Factors used in FRAX® Algorithm
Age
Gender
Weight and Height
Previous history of low trauma fracture
History of fracture in mother or father
Current smoking
Use of glucocorticoids
Rheumatoid arthritis
Secondary osteoporosis
Use of alcohol 3 or more units per day

FRAX® Algorithm is country and ethnicity specific; different algorithms are available for different countries based on local prevalence of fractures. Although constantly being updated, Sri Lanka still does not have a FRAX® Algorithm. According to a study done in Southern Sri Lanka, US (Caucasian) algorithm correlates best with Sri Lankan statistics4.

It should be noted that FRAX® Algorithm only calculates 10 year probability of fracture; it does not advise whom to treat. Decision to commence treatment should be individualized.

Non pharmacological methods for prevention of osteoporotic fracture

Exercise -Exercise improves muscle strength, agility and balance resulting in reduced risk of falls. Regular exercise increase bone density slightly. 30 minutes of exercise on most days of the week is recommended. Frail patients with a high risk for falls may need help of a physiotherapist to develop a safe program of exercise.

Tobacco and alcohol use - Both tobacco and alcohol are detrimental to bone health and should be avoided.

Reducing falls - Reducing falls is of utmost importance as most osteoporotic fractures occur following a fall. Simple measures can go a long way to prevent a catastrophic fracture. Adequate lighting in the living environment and bathroom, keeping the floor non slippery, removing obstacles in the walking pathways and fixing hand rails in the bathroom can prevent a lot of falls. Improving poor vision (eg: cataract surgery) and treatment of urge incontinence (eg: prostatectomy) are some of the medical conditions that should be attended to. Use of medications that can cause postural hypotension and sedation should be minimized.

Calcium - Inadequate dietary calcium intake is a risk factor for osteoporosis. If dietary calcium intake is inadequate, bone tissue is resorbed to maintain normal serum calcium level. Recommended daily calcium intake is 1200mg. Supplements should be given if diet is inadequate in calcium.

Vitamin D - Vitamin D is important for bone mineralization and muscle strength. Even though vitamin D is synthesized naturally when skin is exposed to sunlight; elderly usually do not get adequate sun exposure. 800 to 1000 IU of vitamin D to keep serum 25(OH) D more than 30ng/ml is the recommended daily requirement.

Pharmacological treatment of osteoporosis

There are two main groups of drugs that are used in osteoporosis.

Antiresorptive therapy inhibits osteoclastic activity thereby reducing bone turnover. Bisphosphonates are the most commonly used antiresorptive agents. Calcitonin, Raloxifen and Denosumab are the other agents that belong to this group.

Anabolic therapy; on the other hand increase osteoblastic activity directly. Parathyroid hormone (teriparatide) is the currently available anabolic agent.

Bisphosphonates

Alendronate; which became available in mid 1990s; is the first bisphosphonate used in osteoporosis. Continuous improvement of BMD over a period of 10 years was seen with use of alendronate. Other bisphosphonates include Ibandronate and Risedronate. Zoledronic acid is an intravenous injection that can be given once a year.

Painful oesophagitis and gastric ulcers are side effects associated with bisphosphonate use. Recent issues on long term safety of bisphosphonate are dealt with below.

Raloxifen

Raloxifen is a selective estrogen receptor modulator. It is used in post menopausal osteoporosis.

Calcitonin

Calcitonin is a weak antiresorptive agent and approved for use as a second line agent for post menopausal osteoporosis.

Denosumab

Denosumab is given as a six monthly sub cutaneous injection. It can be given in renal impairment unlike bisphosponates.

Parathryroid Hormone (teriparatide)

Teriparatide is the only anabolic agent approved for use in osteoporosis. It is given as a daily sub cutaneous injection.

Whom to treat

Decision to start pharmacological treatment is based on both BMD and calculated fracture risk using FRAX algorithm. Drug treatment is considered in post menopausal women and men older than 50 years with primary osteoporosis (T-score < -2) or with hip or vertebral fracture. When T score is between -1 and -2 (low bone mass) drug treatment is recommended if 10 year fracture probability is more than 3%.

How long to treat; long term safety of drug treatment.

Long term safety of antiresorptive therapy was questioned when some uncommon adverse effects were seen with their prolonged use. Long term bisphosphonate therapy has an association with atypical subtrocanteric femur fractures of and osteonecrosis of jaw(ONJ - defined as exposure and loss of bone

in the maxillofacial complex). It has been argued that since osteoclastic activity is necessary for repair of microdamage to the skeleton (bone remodeling); suppression of osteoclasts leads to accumulation of microdamage and thus paradoxical increase of fractures.

Atypical subtrocanteric fracture associated with bisphosphonate therapy is very rare. A recent study has shown that the absolute risk of atypical femur fractures associated with the use of bisphosphonate is too small change current indications for their use5. Benefit achieved by prevention of intertrocanteric fracture outweighs the risk of atypical subtrocanteric fracture. However this safety issue has led the FDA to change labeling of oral bishosphonate; mentioning the possible risk of atypical fracture in the side effect profile.

ONJ which is even rarer is associated with the use of IV bisphosphonates and Denusomab.

Use of Raloxifene, Calcitonin or Teriparatide has no association with these rare adverse events.

There is no agreement about the ideal duration of treatment. Most physicians do not give bisphosphonates for more than five years. Given the possibility of long term adverse events; yearly evaluation of fracture risk with consideration of drug holidays when risk is low is advisable. It should be noted that action of bisphosphonates persists after discontinuation of therapy.

References

1. Melton LJ, 3rd, Chrischilles EA, Cooper C, et al. (1992) Perspective. How many women have osteoporosis? J Bone Miner Res 7:1005.
2. Gullberg B, Johnell O, Kanis JA. World-wide projections for hip fracture. Osteoporos Int. 1997;7(5):407-13.
3. http://www.shef.ac.uk/FRAX
4. Application of FRAX model to Sri Lankan postmenopausal women. Lekamwasam S Center for Metabolic Bone Diseases, Faculty of Medicine, Galle, Sri Lanka. sarathlk@sltnet.lk J Clin Densitom. 2010; 13(1):51-5 (ISSN: 1094-6950)
5. Bisphosphonate Use and Atypical Fractures of the Femoral Shaft. Jörg Schilcher, M.D., Karl Michaëlsson, M.D., Ph.D., and Per Aspenberg, M.D., Ph.D. N Engl J Med 2011; 364:1728-1737 May 5, 2011

Dr. Sanjeewa Wijekoon
Consultant Physician and Senior Lecturer in Medicine
Faculty of Medical Sciences
University of Sri Jayawardenapura

FELLOWS

Honorary Fellowship	*Fellowships conferred in Person*	*Fellowships conferred in absentia*
Prof. Andrew Dawson	Dr. P.H. Chandrawansa	Dr. N.D. Guneratne
Dr. Neil Dewhurst	Dr. S.U. Dissanayake	Dr. M.K. Jayatilake
	Dr. Y.K.R. Dissanayake	Dr. J. Sanmugarajah
	Dr. R.S.I.N. De Silva	Dr. T. Rajshankar
	Dr. E.A.C. Fernando	
	Dr. P. Galappatthy	
	Dr. G. Galappatthy	
	Dr. W.W.L.A. Jayananga	
	Dr. S.F. Jayamanne	
	Dr. C.D. Ranasinha	
	Dr. S. Sivapragasam	
	Dr. W.M.G. Weerakoon	

WORLD DIABETES DAY – GLOBAL WALK FOR DIABETES

AN ISLAND WIDE DIABETES WALK HAS BEEN ORGANIZED BY THE SLMA AND THE NCD UNIT OF THE MIISTRY OF HEALTH TO MARK THE WORLD DIABETES DAY ON 13TH NOVEMBER 2011 AT 7.00 A.M.

WALK IN COLOMBO WILL BE FROM EYE HOSPITAL JUNCTION TO THE BMICH FOLLOWED BY A PRESS BREIFING AND A PUBLIC SEMINAR. PARALLEL TO THIS EVENT, THREE OTHER WALKS WILL BE HELD IN KANDY, JAFFNA AND GALLE WITH THE ACTIVE PARTICIPATION OF COLLEGE MEMBERS. THESE WALKS WILL BE HELD AS A PART OF THE GLOBAL WALK FOR DIABETES.

\ALL THE MEMBERS ARE INVITED TO JOIN THE WALK!

Annual General Meeting – Friday 16th December 2011

To all members of the College

14th October 2011

Dear Member,

In terms of the **Section 22, Clause 2** of the Constitution of the Ceylon College of Physicians, nominations are called for the following posts for the year 2012.

1.	President - elect	01 Post
2.	Two Joint Secretaries	02 Posts
3.	Treasurer	01 Post
4.	Ten other Council Members	10 Posts
5.	Two representatives of Fellows	02 Posts
6.	One Member from Sri Lanka College of Pathology	01 Post
7.	One Member from Sri Lanka College of Paediatrics	01 Post
8.	One Member from Sri Lanka College of Psychiatry	01 Post
9.	Three representatives Past Presidents	03 Posts

- A member serving the third consecutive year in any of the above posts is not eligible for nomination for the same post.
- Nominees for Post in 6, 7 and 8 should be Members of the Ceylon College of Physicians
- Nominations should be made in the enclosed form and **posted under registered cover or personally handed over** to the College Office. Nominations will be received up to 3.00 p.m. on **Thursday 25th November 2011.**
- Resolutions (if any) should be submitted at least 21 days before the meeting (i.e. on or before **25th November 2011**).
- The Annual General Meeting will be held **on Friday 16th December 2011, at 12.00 noon at the College Board Room at 341/1, Kotte Road, Rajagiriya**.

Dr. Nirmala Wijekoon
Hony. Jt. Secretary

College News
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