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**From Global
Health to
Planetary
Health**

Page 7-9

**Cardiovascular
risk
stratification
of Sri Lankans**

Page 11-14

**Parenting
during the
pandemic**

Page 15-16

**Radiology
Quiz**

Page 17-19



Cover Story

**From global health to planetary health:
How could we chart a path for Sri Lanka?**



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Sri Lanka Medical Association

Call for Applications

Deshabandu Dr C. G. Urugoda Memorial Oration on the History of Medicine - 2023

This Lecture was established in the year 2012, the 125th Anniversary Year of the Sri Lanka Medical Association (SLMA), to mark the meeting attended by a group of doctors at the Colonial Medical Library in Colombo on 26th February 1887 to discuss the formation of the Ceylon Branch of the British Medical Association. The Ceylon Branch later became the Sri Lanka Medical Association.

The lecture was renamed the Dr. C. G. Urugoda Lecture on the History of Medicine in the year 2017 to honour the lasting contribution made by Dr. C. G. Urugoda to document the History of Medicine in Sri Lanka. In 2020, on the demise of Dr. Urugoda, the Council decided to elevate the lecture to that of a Memorial Oration and also to add his national titular honour Deshabandu to the title of the Oration.

The event takes place on the 26th day of February every year.

Applications are called for the oration to be delivered on 26th February 2023. Applicants should

submit a short abstract of the proposed lecture (no more than 500 words, font size 12 in Times New Roman with single spacing and margins set at 0.6 inches right round) and a brief curriculum vitae (no more than 3 pages of identical settings as above).

The applicant should have been significantly associated with and contributed to the field of medicine in his/her chosen topic.

The SLMA wishes to encourage orations in areas of medicine that have not been covered in previous years. A list of past lectures can be found on the SLMA website - <http://www.slma.lk>. Applicants should bear in mind that they must make themselves available to deliver the lecture on 26 February 2023 at the SLMA Auditorium as this is an oration scheduled to mark the founding of the SLMA.

Applications should be submitted to the Honorary Secretary, SLMA, ***on or before 31st May 2022.***



135th Anniversary International Medical Congress 'Planetary Health and Global Health Security'

28th September - 01st October 2022
Cinnamon Grand, Colombo

Apply for the following:

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CONTENTS

President's Message

2

Brief Description of Activities

3-5

Cover Story

From Global Health to Planetary Health: How could we chart a path for Sri Lanka?

7

Feature Articles

Cardiovascular risk stratification of Sri Lankans; what tool to use?

11-14

Parenting during the pandemic

15-16

Radiology Quiz - Chest X-ray

17-19

Miscellany

Beyond Medicine: Doctors as Entrepreneurs -
Dr. Lasantha Malavige

21-22



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President's Message



Dear SLMA Members,

Planetary health is a nascent concept focused on the interdependence of human health, animal health, and the health of the environment. Defined as "the health of human civilization and the state of the natural systems on which it depends," planetary health calls urgent attention to the extensive degradation of our planet for human advancement. The concept focuses on reversing this trend by better balancing of human needs with the preservation of the earth to sustain the health and well-being of future generations. To accomplish planetary health, multi-disciplinary, cross-sector, and trans-border approaches are required.

Biological threats; natural, intentional, or accidental, in any country, can pose risks to global health, international security, and the worldwide economy, threatening global health security. Infectious diseases know no borders, and all countries must prioritize and exercise the capabilities required to prevent, detect and rapidly respond to public health emergencies. In such a context, global leaders and international organizations bear a collective responsibility for developing and maintaining robust global capability to counter infectious disease threats.

Threats to planetary health and global health security include exploitation of biological resources, dealing with plastic waste, reducing air pollution, thereby mitigating against consequent global warming and climate change, disproportionately affecting developing countries like Sri Lanka.

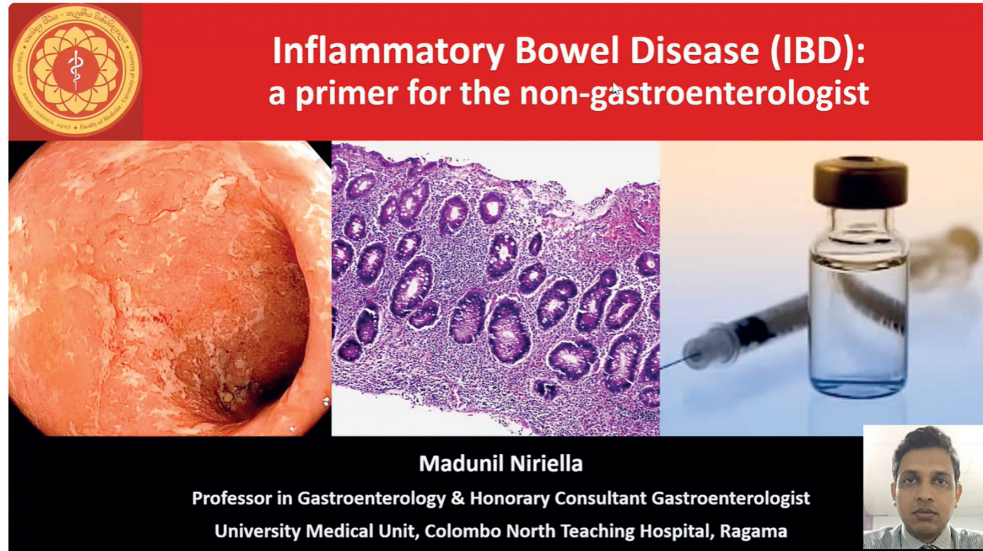
It is time that we as medical professionals and as responsible citizens of this country, take these threats into account and support all the efforts to safeguard our country and the whole world.

With Best Wishes

Professor Samath Dhamminda Dharmaratne
President - SLMA

Brief description of activities (22nd January - 15th February)

22nd January



The SLMA Saturday Talk on 'Inflammatory Bowel Disease: A Primer for the Non-Gastroenterologist' was done by Professor Madunil Niriella, Professor in Gastroenterology, Faculty of Medicine, University of Kelaniya.

23rd January

The SLMA Expert Committee on COVID-19 met to discuss the following topics;

- Current situation of COVID-19 in Sri Lanka
- Steps that should be taken by SLMA in relation to COVID-19

It was decided to send a letter addressed to the DGHS regarding the concerns on the rising number of COVID cases and its impact on the health system and to conduct a media seminar to educate the public on adhering to MOH health regulations and to advocate for the booster dose of Pfizer vaccine.

25th January

The first clinical meeting for the year 2022 was conducted with the collaboration of the Sri Lanka College of Paediatrics on 'Complicated Dengue in children at the midst of the COVID-19 pandemic'.

Dr. Chanaka Rathnayake, Registrar in Paediatrics did a case presentation, Dr. Kosala Karunaratne, Consultant Paediatrician a review lecture and Dr. KGM Abeyrathne, Registrar in Paediatrics did a discussion of MCQs. All resource persons were from Lady Ridgeway Hospital for Children, Colombo.



27th January

A media seminar was held to educate the public on the current COVID-19 situation, importance of adhering to health guidelines and taking the booster dose of the vaccine.

The resource persons were Dr. Upul Dissanayake, Consultant Physician, NHSL and Dr. Surantha Perera, Consultant Paediatrician & Vice President, SLMA.



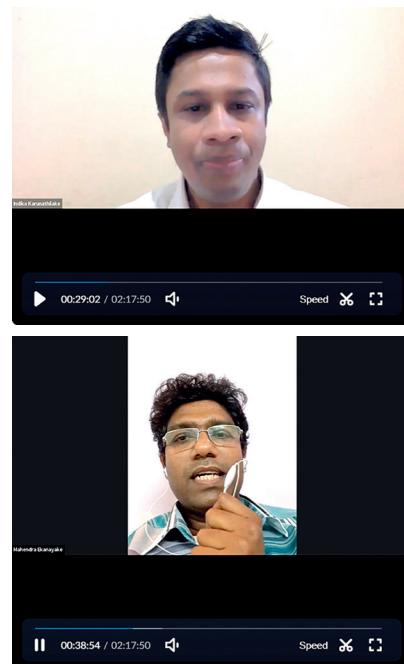
28th January

A webinar titled 'COVID-19 Update' was organized by the SLMA Doc Call 247 Team. The following topics were discussed;

Need for booster vaccination, common symptoms and red flags, what to do when symptoms occur, what not to do, quarantine, isolation process, home management basics.

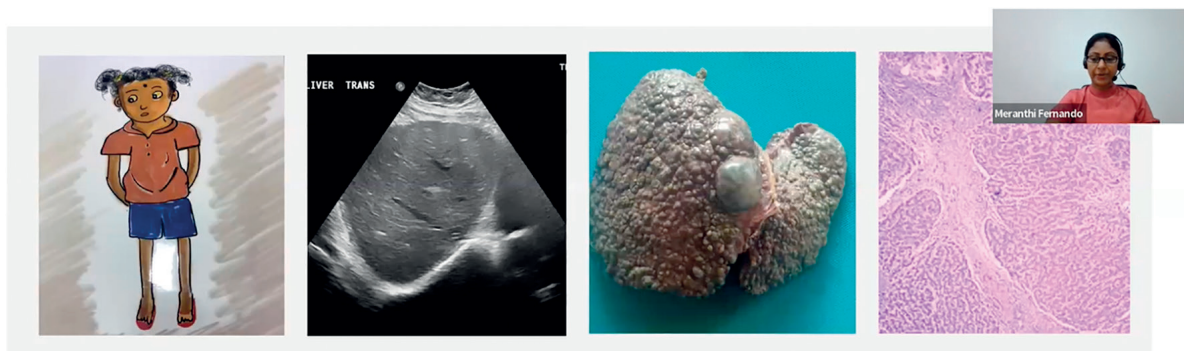
The resource persons at the webinar were Professor Neelika Malavige, Professor in Microbiology, University of Sri Jayewardenepura, Dr. BJC Perera, Consultant Paediatrician, Dr. Shirani Chandrasena, Consultant Microbiologist, Colombo South Teaching Hospital, Dr. Mahendra Ekanayake, Consultant Physician and Dr. Ranmalee Samaranayake, Consultant Respiratory Physician, NHSL.

The session was moderated by Professor Samath Dharmaratne, President SLMA, Professor Indika Karunathilake, Past President, SLMA and Dr. Sajith Edirisinghe, Assistant Secretary, SLMA.



29th January

The SLMA Saturday Talk on 'Chronic Liver Disease in Children' was done by Dr. Meranthi Fernando, Senior Lecturer in Paediatrics, Faculty of Medicine, University of Kelaniya.



Case based discussion on chronic liver disease in children



Meranthi Fernando

Senior Lecturer & Consultant Paediatrician
Faculty of Medicine, University of Kelaniya
Colombo North Teaching Hospital, Ragama
29.01.2022

3rd February

A media seminar was organized to update the current status of COVID-19 in Sri Lanka with the participation of Professor Samath Dharmaratne, President, SLMA, Dr. Harsha Sathischandra, Consultant Physician, NHSL and Dr. Rajiva de Silva, Consultant Immunologist, MRI. Dr. Surantha Perera, Vice President, SLMA moderated the session.




5th February

The SLMA Saturday Talk on 'Ethics in Clinical Practice' was done by Professor Anoja Fernando, Emeritus Professor of Pharmacology, Faculty of Medicine, University of Ruhuna.


Who can see your viewing activity? X

Ethics in Clinical Practice



Anoja Fernando

SLMA Saturday Talks
5 February 2022



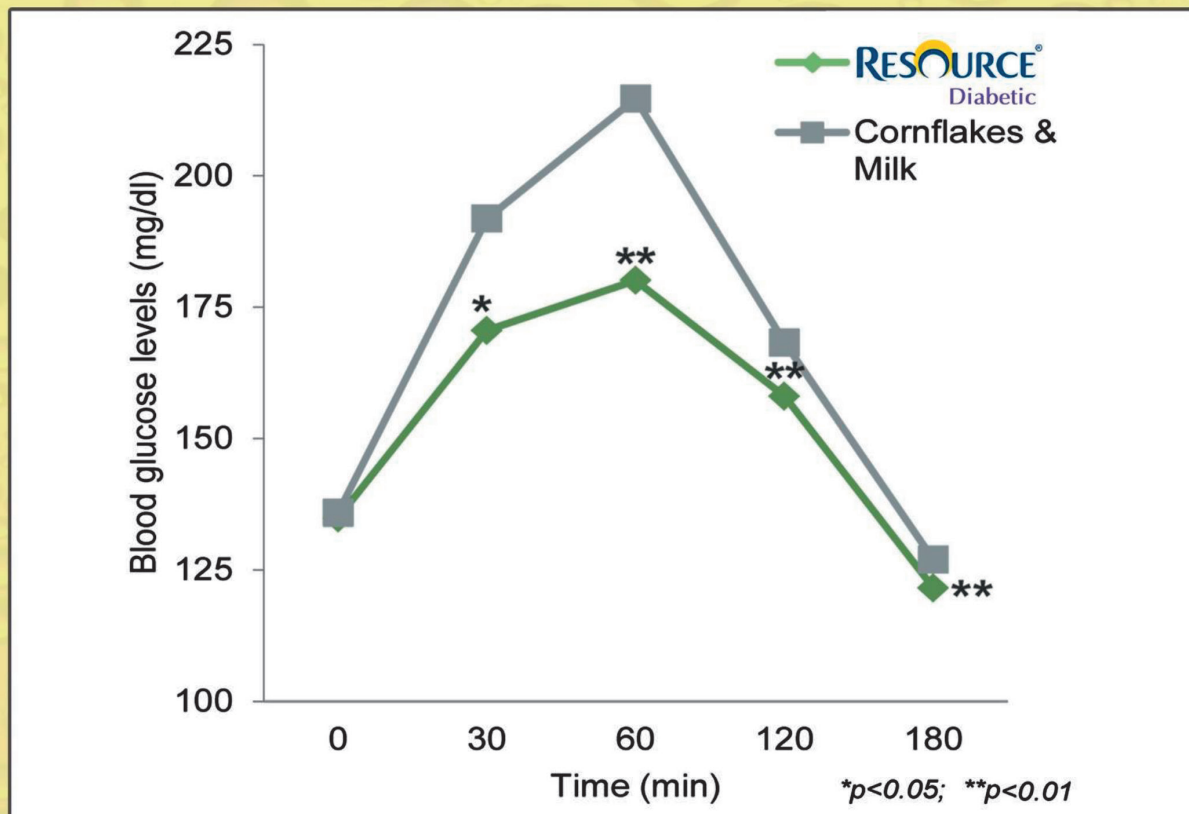
11th February

A General Meeting of the SLMA was held to discuss the Resolutions forwarded and confirmed at the AGM held on 21st December 2021, before forwarding to the Registrar of Companies.

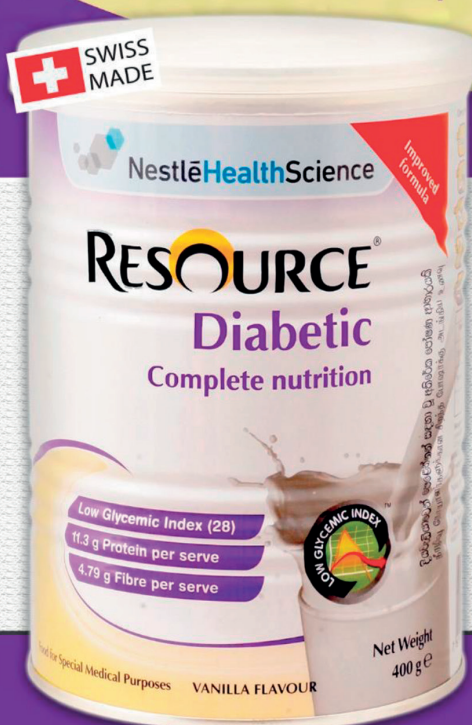
12th February

The SLMA Saturday Talk on 'Why Research and Statistics?' was done by Professor Samath Dharmaratne, Chair Professor in Community Medicine, Faculty of Medicine, University of Peradeniya.

Average blood glucose levels after consumption of **RESOURCE DIABETIC** vs isocaloric breakfast



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From Global Health to Planetary Health: How could we chart a path for Sri Lanka?

Saroj Jayasinghe

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Evolution of concepts

Terms such as Global Health are frequently used in discussions and forums and have reached

the standard of a discipline. The development of disciplines or descriptions of illnesses in medicine illustrates how medical knowledge tends to be socially constructed. This contrasts with our understanding of progress in knowledge. For the medical profession, a disease or disorder is a biological condition that is universal and unchanging (e.g. face-arm-leg hemiparesis) while to a sociologist, it is a disability that has social meaning and impairs activities of living and social interactions. Similarly, concepts such as global health have evolved based on certain disease groups (ie a 'medical' view) or based on social needs and experiences (ie socially constructed). These are not mutually exclusive and, social scientists try to understand why such concepts have emerged in society, rather than explaining them as simple labels or a collection of disease categories.

Social science researchers trace the origins of the concept of global health to predecessors such as "colonial medicine" of the 19th and early 20th centuries, "Tropical Medicine" and later to "International Health" (1).

The objective of colonial medicine was mainly to protect the health of

the colonizers, and the social factors of disease causation especially among the colonized natives, such as poverty, discrimination and structural violence were often ignored (2). With development and increasing influence of the discipline of public health, there was some interest in improving the health of the local population. These events paralleled what happened in Sri Lanka, where health services of the British was under the military until 1859 when the first civil medical department was established (3).

Tropical diseases could be considered an off shoot of colonial medicine. The very first edition of Manson's Tropical Diseases in 1898 describes it as 'diseases of warm climates' which corresponded to geographic areas that were colonized, though Manson appeared to have coined the term more for convenience (4, 5). However, European nations began to have concerns about contracting infections when invading other continents. Thus, the need to protect themselves spurred them to increase cooperation across nations and a process was initiated in 1850s with The International Sanitary Conference. Concepts related to international health

began to emerge thereafter (6). The term International health was popularized in the early 20th century, especially by the Rockefeller Foundation's International Health Commission launched in 1913 (6). Sri Lanka too was a part of the international health program of the Rockefeller Foundation and funding was provided to control of hook worm diseases and malaria. The Foundation helped to establish the current medical officer of health system (MOH), the first of which was commenced in Kalutara in 1926.

International Health evolved to be understood as problems of health in underdeveloped countries and "efforts by industrialised countries and international agencies to address these problems" (6). The term focused on health work abroad in developing countries. The content areas were infectious diseases and diseases prevalent in the tropics, issues related to sanitation, water, and malnutrition (7). After 1945 when World War II ended, the term International Health was still in use but the establishment of the World Health Organization (WHO) and adopting of its constitution in 1948 saw the emergence of the concept of 'world health'. This was, however,

mainly used to describe health of individual nations though the introduction of international health laws increasingly explored health across nations or addressed supra-national issues. These developments probably paralleled increasing travel and the process of globalization.

From around year 2000, the term global health began to gain popularity. It was meant to 'transcend past ideological uses of international health' and to imply 'a shared global susceptibility to, experience of, and responsibility for health' (6). One definition proposed is that Global Health is "an area for study, research, and practice that places a priority on improving health and achieving health equity for all people worldwide" (8). This definition moves the concept towards the whole human species, involving interdisciplinary collaborations to find solutions to issues that cross borders. The latter point is emphasized in another definition from Europe: "health issues that transcend national boundaries and governments and call for actions on the global forces that determine the health of people" (PMID: 17132587)

The focus of global health is health and health equity that transcends national borders, with solutions that require global cooperation and that are often multi-disciplinary in nature (7). A recent systematic review found that the concept global health is complex and diffuse with multiple approaches that aim for worldwide health improvement. It has an ethical orientation towards justice and emphasis on certain modes of governance e.g. influence through political decision-making and allocation of resources across borders (PMID: 34083243). An expert group mostly, from China suggested that a study or project is on global health if it is "framed with a global

perspective, intends to address an issue with global impact, and/or seeks global solutions to an issue" and recognized its conceptual links to international health (PMID: 32289081). Whatever its deficiencies, the concept of global health enables a broader and holistic view of health of the human species and its determinants.

Critical issues related to global health

When we take such a holistic global view of health, we begin to observe several troubling issues. The first is the increasing financial power of large philanthropists and global banks to leverage the global health agenda by using their massive financial resources. An example is the Bill and Melinda Gates Foundation and its emphasis on financing and controlling certain communicable diseases mainly by vaccines or technology-based solutions, rather than by environmental or social changes. The asymmetry of power at a global level are highlighted in several areas (PMID: 33886540). Similarly, the World Bank has displaced the WHO as a key funding organization and is now setting some of the health agendas. One study found that around 85% organizations where major decisions on global health are made, are headquartered in high-income countries such as USA, Canada, Europe, Australia, and Japan). About 80% of the leaders (i.e. CEOs or Board Chairs) of these organizations are also citizens of high-income countries. (<https://globalhealth5050.org/2020report/>)

The second relates to realization that the 'colonial' past seem to influence agendas on global health research. The networks, funding and research teams continue to be in the northern hemisphere and are dominated by their priorities and ideas (PMID: 33165557). Perhaps there is a need for 'decolonization' through formation of 'South-South'

research networks. There are allegations of racism in academic publications which could bias the global publication landscape (PMID: 32723765).

Third, there is a need to be aware how our colonial histories have shaped our thinking with regard to global health and continue to influence our perceptions and practices (PMID: 33886540). In Sri Lanka we have noted how supremacist ideologies of race discrimination during the colonial era may be continuing as language discrimination and colorism in the health sector (PMID: 33968214, <https://doi.org/10.1007/s41649-021-00195-x>). We have also observed professional Colleges in Europe globalizing their examinations (e.g. MRCGP, MRCP PACES) and training programs.

Fourth, the global perspective has given rise to the concept of global public health security defined by the WHO as "the activities required, both proactive and reactive, to minimize the danger and impact of acute public health events that endanger people's health across geographical regions and international boundaries". Some of the greatest risks to the global economy and security include rapid urbanization, environmental degradation, misuse of antimicrobials, emergence of new diseases, environmental health hazards, climate change and air pollution, tainted ingredients in the global food chains, risk of foodborne diseases, pandemics, and health emergencies. Did some of these issues become global priorities after the more powerful states began to be affected? For example, why was the destruction of virgin forests for large plantations supported by the global north from the time of colonization? Weren't the protests by native population groups and local farmers never heard? Were these powers deaf until global warming began to

affect the more affluent nations?

Finally, global health as a concept is anthropocentric (i.e. centered around humans) and does not emphasize the totality of the earth systems and the fact that our health is inextricably linked to that of the planet. As a species, our survival, our health, and continuation of our societies depend on flourishing natural systems and availability of natural resources. These have been degraded to unprecedented levels and both our health and that of the planet are in danger of severe disruptions.

From Global Health to Planetary Health

The anthropocentric view inherent in Global Health ideology has led to a novel concept called Planetary Health defined as "the achievement of the highest attainable standard of health, wellbeing, and equity worldwide through judicious attention to the human systems-political, economic, and social-that shape the future of humanity and the Earth's natural systems that define the safe environmental limits within which humanity can flourish" (PMID: 26188744). In simple terms, planetary health could be views as "health of human civilization and the state of the natural systems on which it depends" (PMID: 26188744). With an emerging climate catastrophe that may threaten our very survival on earth, there is increasing interest on the determinants of planetary health. Critical areas include the status of global forests, global warming economic structures, international politics, and the impacts of past colonization (PMID: 33713610). There are calls for inclusion of Planetary Health in medical curricula (PMID: 34615635).

A role for the SLMA

It is opportune that the SLMA leads the profession and charts our own course aimed at human wellbeing and wellbeing of the planet. Climate change is one area to tackle, but there are other global priorities such as air pollution, deforestation, ubiquitous microplastics, freshwater scarcities, ocean acidification, ozone depletion and the nitrogen cycle. These are known as the planetary boundaries (PMID:19779405). Perhaps, we should form a network on the topic of Planetary Health as proposed during a Symposium in the Colombo Medical Congress-2020. There is interest in using mindfulness as a novel way to promote health of the planet and of humans. Its role in making practitioners develop stronger 'connections with nature' and in dampening our attractions towards consumerism are subjects of intense research (and a topic under investigation in the research program of the Colombo Medical Faculty). Other Sri Lankan initiatives include the 'Mindfulness for Earth' (M4E) (www.mindfulness4earth.org), which is collaborating with the United Nations Environmental Programme - Faith for Earth (<https://www.unep.org/about-un-environment/faith-earth-initiative>). Another area is the role of indigenous agricultural methods and the unique cascade irrigation systems of our past, both of which are more sustainable and nature-friendly towards nature than agrochemical intensive large-scale plantations.

"Today we understand that the future of humanity very much depends on our plant and tht the future of the planet very much depends on humanity" His Holiness Dalai Lama

REFERENCES

1. Holst J. Global Health - emergence, hegemonic trends and biomedical reductionism. *Global Health*. 2020 May 6;16(1):42. doi: 10.1186/s12992-020-00573-4. PMID: 32375801; PMCID: PMC7201392.
2. Marks, S. (1997). What is Colonial about Colonial Medicine? And What has Happened to Imperialism and Health?. *Social History of Medicine*, 10(2), 205–219. doi:10.1093/shm/10.2.205
3. Urugoda C (1987). A history of medicine in Sri Lanka. Colombo: Sri Lankan Medical Association.
4. Gibson AD. Miasma revisited - the intellectual history of tropical medicine. *Aust Fam Physician*. 2009 Jan-Feb;38(1-2):57-9 quoting Manson's *Tropical Diseases*, 21st Edition Edited by Gordon C. Cook and Alimuddin I. Zumla Philadelphia: W. B. Saunders, 2003
5. Brown M. Manson's tropical diseases. *Lancet Infect Dis*. 2009 Jul;9(7):407–8.
6. Birn AE. The stages of international (global) health: histories of success or successes of history? *Glob Public Health*. 2009;4(1):50-68
7. Koplan JP, Bond TC, Merson MH, Reddy KS, Rodriguez MH, Sewankambo NK, Wasserheit JN; Consortium of Universities for Global Health Executive Board. Towards a common definition of global health. *Lancet*. 2009 Jun 6;373(9679):1993-5
8. Beaglehole R, Bonita R. What is global health? *Glob Health Action*. 2010 Apr 6;3. doi: 10.3402/gha.v3i0.5142. PMID: 20386617; PMCID: PMC2852240. 12.02.21267198

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Cardiovascular risk stratification of Sri Lankans; what tool to use?

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1. What is the issue in cardiovascular risk prediction of Sri Lankans?

There are no cardiovascular (CV) risk prediction models derived from Sri Lankan cohorts. Therefore, different risk prediction models derived from Western populations like Framingham General Risk Score (FRS), Atherosclerotic Cardiovascular Disease Risk Calculators (ASCVD), Systematic COronary Risk Evaluation (SCORE) etc. are being used in clinical practice to risk stratify Sri Lankans. However, Asians have a different risk factor profile to Western populations. They are at increased risk of developing CV diseases with the same risk factor levels compared to white Caucasians¹. Asians develop CV diseases (CVDs) at younger ages and develop CVDs despite having low serum cholesterol levels and body mass indices (BMIs) compared to Caucasians. They have a distinct genetic make-up, a higher prevalence of hypertension, diabetes mellitus, central obesity, insulin resistance and metabolic syndrome than whites in the UK and America. Asians' absolute CV

risk is higher than the predictions of standard European scores².

Different physicians/specialists adopt different international risk factor management guidelines that they are happy and comfortable with, in risk stratifying Sri Lankans. These international guidelines make recommendations on risk scores specific for the country/region of the origin of the guideline, which are not all that well predictive in Sri Lankans.

There are several other problems of using the risk models meant for Western populations in Asians. The relative importance of risk factors changes with socio-environmental differences. The cut-off values for risk definitions changes with the affordability of the country. Furthermore, different models predict different risks, e.g., FRS and ASCVD scores predict the risk of both fatal and non-fatal CV events, while SCORE charts predict hard CV events (CV deaths) only.

2. What risk prediction model should be used?

Due to the paucity of specific risk prediction models derived from most low and middle-income countries, the World Health Organisation and International Society of Hypertension (WHO/ISH) collaboratively developed a set of 10-year CV risk prediction charts in 2007 for 14 epidemiological sub-regions using large cohort data and

recalibrating them to estimate 10-year risk of a fatal or non-fatal major cardiovascular events of those sub-regions³. WHO lately revised the risk prediction charts in 2019 using individual-participant data from 85 prospective cohort studies and re-calibrated those using age-specific and gender-specific incidence rates and risk-factor values obtained from the Global Burden of Disease (GBD) Study to suit 21 global epidemiological regions to best predict CV risk of the populations who do not have specific risk prediction models⁴.

With that background, it has been shown in a prospective follow-up cohort of Sri Lankans that the WHO/ISH-2007 risk prediction charts showed 81% agreement in the prediction of fatal and non-fatal CV events of Sri Lankans⁵. It was also shown that the agreement in risk stratifications between WHO/ISH charts and FRS was not satisfactory among Sri Lankans⁶.

Therefore, WHO revised CV risk charts, developed in 2019 for the South-East Asia region are the best to be used in risk stratification of Sri Lankans until a specific risk prediction model is developed from a Sri Lankan cohort⁴.

There are two types of WHO risk charts, non-laboratory based and laboratory-based, to be used depending on the available resources. Laboratory-based charts include information on age, sex,

WHO cardiovascular disease risk laboratory-based charts

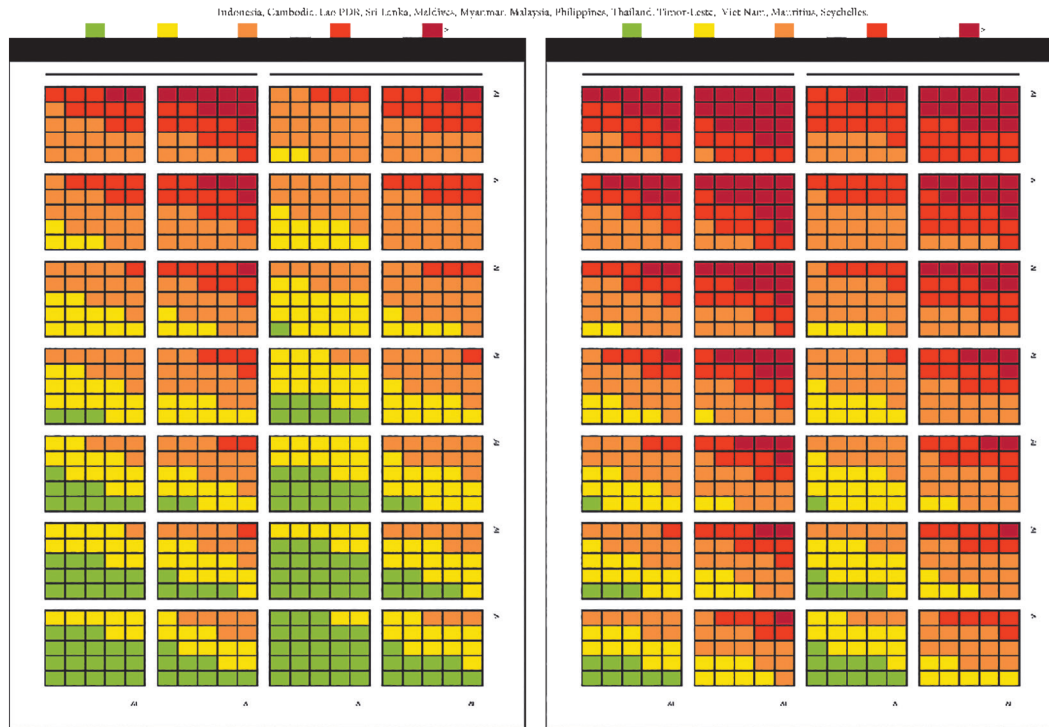


Figure 1 laboratory-based charts for South-East Asia

WHO cardiovascular disease risk non-laboratory-based charts

Southeast Asia

Indonesia, Cambodia, Lao PDR, Sri Lanka, Maldives, Myanmar, Malaysia, Philippines, Thailand, Timor-Leste, Viet Nam, Mauritius, Se

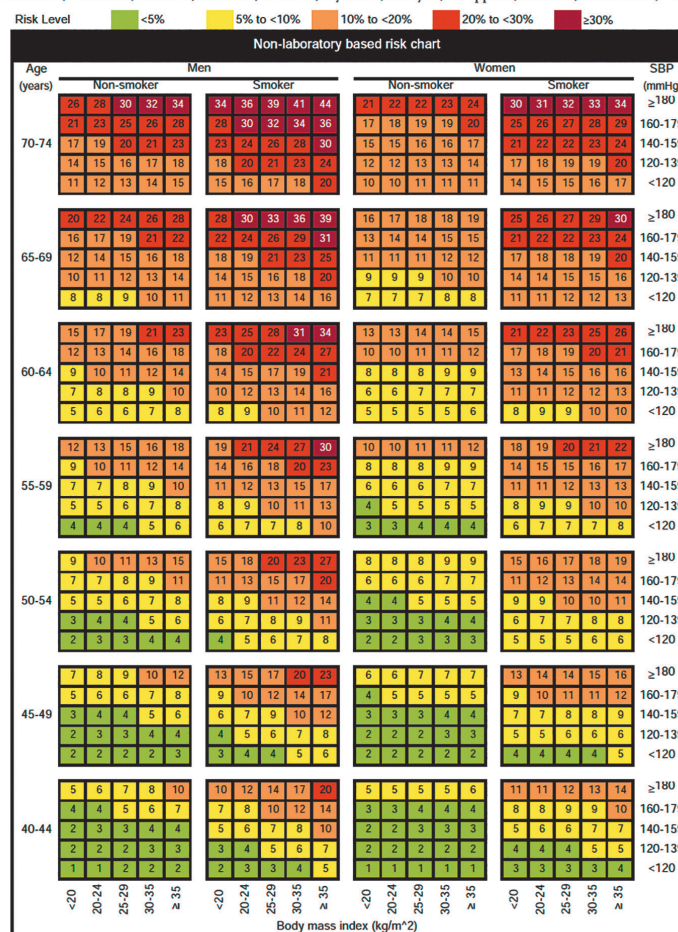


Figure 2 WHO cardiovascular disease risk non-laboratory-based chart for South-East Asia

smoking status, systolic blood pressure, history or evidence of diabetes mellitus, and the total cholesterol value (Figure 1). In the non-laboratory-based chart, body mass index (BMI) is included; information on diabetes mellitus and cholesterol is not necessary for these charts (Figure 2). Figure 1 WHO cardiovascular disease risk. However, these charts also have some limitations. These are meant for the whole Southeast Asian region, i.e., Indonesia, Cambodia, Lao PDR, Sri Lanka, Maldives, Myanmar, Malaysia, Philippines, Thailand, Timor-Leste, Viet Nam, Mauritius, Seychelles and therefore are not perfect for Sri Lankans, but are the most suitable charts out of the available risk prediction models.

3. What important practical issues should we consider in using WHO CV risk prediction charts?

It is important to know who needs to be risk-stratified and when and how to use these charts.

The charts apply to subjects between the ages of 40-75 years without established CVDs as the cohorts that these scores were derived from were between 40-75 years. Individuals with established CVDs need not be risk-stratified as they are anyway at high risk of further CVDs. Patients less than 40 years of age should be risk-stratified

either using a different chart, i.e.: a lifetime risk chart or by CV risk age calculator or by calculating what the person's risk would be at the age 60 years if current risk factor levels were maintained. Elderly, above 85 years are considered at increased risk of CVDs because of age alone, particularly people who smoke or have raised blood pressure^{7,8}. Specifically, type 2 diabetic patients also need to be risk-stratified using CV risk charts but type I diabetics older than 40 years or who have had diabetes for more than 10 years or with established nephropathy or with other cardiovascular disease risk factors are considered as high risk without risk stratification⁸. The charts may underestimate the risk in certain categories of people with a very high single risk factor e.g., persistently raised blood pressure $\geq 160/100$ mm Hg or total cholesterol ≥ 8 mmol/l or diabetes with renal disease and therefore, they need not be risk-stratified with these charts especially in deciding on drug treatment³.

WHO CV risk predictions show moderate agreement between laboratory and non-laboratory-based charts. Of those at $>20\%$ risk using the laboratory-based risk charts, $>97\%$ of men and women were also identified at $>10\%$ risk level by using the non-laboratory-based risk charts. However, when using a 20% cut-off with non-laboratory-based risk charts, only

approximately 65% of men and 35% of women were identified as at the same level of risk when compared to the laboratory-based risk charts⁷. This discrepancy is due to the non-consideration of the presence or absence of diabetes mellitus in non-laboratory-based risk charts. Therefore, when non-laboratory based risk prediction models are used for the identification of high-risk individuals, the cut-off values should be set at $>10\%$, while it should be $\geq 20\%$ when laboratory-based charts are being used⁷.

The appropriate threshold of an individual's total risk at which intensive lifestyle interventions and drug treatment need to be initiated depends on the availability of resources as well as the risk level. Therefore, it is recommended that the WHO laboratory-based risk charts should be used for treatment decisions while the non-laboratory-based risk charts should be used for screening in low-resource communities and office settings for the decisions regarding referral for lab-based risk stratification⁷.

In conclusion, WHO laboratory-based risk charts revised in 2019 is recommended as the best tool available at the present time for CV risk estimation of Sri Lankans and the risk $\geq 20\%$ is the recommended cut-off value for identification of subjects with high-risk needing initiation of drug treatment in addition to lifestyle modification⁷.

TAKE-HOME MESSAGES

- There are no cardiovascular (CV) risk prediction models derived from Sri Lankan cohorts and the risk models derived from white Caucasians are not predicting CV risk of Sri Lankans accurately
- WHO CV risk charts, revised in 2019 for Southeast Asia were developed by re-calibration and validation to predict CV risk of South-East Asians including Sri Lankans and therefore is the best to be used for CV risk stratification of Sri Lankans
- These charts are meant to risk stratify individuals between 40-75 years of age without established CVDs
- WHO laboratory-based risk charts should be used for decisions on drug treatment while non-laboratory-based charts are to be used for screening for high-risk individuals in resource-poor settings
- WHO CV risk $\geq 20\%$, calculated using laboratory-based risk charts is recommended as the cut-off for identification of high-risk individuals needing initiation of drug treatment in addition to lifestyle modification

References

1. Volgman AS, Palaniappan LS, Aggarwal NT, et al. Atherosclerotic Cardiovascular Disease in South Asians in the United States: Epidemiology, Risk Factors, and Treatments: A Scientific Statement From the American Heart Association. *Circulation* 2018; **138**(1): e1-e34.
2. Bhopal R, Fischbacher C, Vartiainen E, Unwin N, White M, Alberti G. Predicted and observed cardiovascular disease in South Asians: application of FINRISK, Framingham and SCORE models to Newcastle Heart Project data. *Journal of public health (Oxford, England)* 2005; **27**(1): 93-100.
3. WHO. World Health organization/International Society of Hypertension risk prediction charts for 14 WHO epidemiological sub-regions. WHO; 2007. p. 40.
4. World Health Organization cardiovascular disease risk charts: revised models to estimate risk in 21 global regions. *Lancet Glob Health* 2019; **7**(10): e1332-e45.
5. Thulani UB, Mettananda KCD, Warnakulasuriya DTD, et al. Validation of the World Health Organization/International Society of Hypertension (WHO/ISH) cardiovascular risk predictions in Sri Lankans based on findings from a prospective cohort study. *PLoS One* 2021; **16**(6): e0252267.
6. Mettananda KCD, Gunasekara N, Thampoe R, Madurangi S, Pathmeswaran A. Place of cardiovascular risk prediction models in South Asians; agreement between Framingham risk score and WHO/ISH risk charts. *Int J Clin Pract* 2021; **75**(7): e14190.
7. WHO. HEARTS technical package for cardiovascular disease management in primary health care: risk based CVD management. 2020. file:///Users/chamilamettananda/Downloads/9789240001367-eng%20(1).pdf (accessed 24.10.2021).
8. NHS. NHS lipid management pathway. 24 January 2022 2022. <https://www.guidelines.co.uk/cardiovascular/nhs-lipid-management-pathway/456226.article> (accessed 16.02.2022).

Parenting during the pandemic

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The pandemic has affected the mental health of populations across the globe. Parents have been identified as a group especially vulnerable to develop mental health consequences during the pandemic, but their mental health needs have often been overlooked. Worldwide, parents have faced economic hardships, job losses and worsening food security. Due to school closure, parents have had to adjust to home schooling of their children with no prior warning or preparation. Many refrained from obtaining free childcare from grandparents, due to the fear of transmitting infection to elderly parents. All of these, together with closure of regular childcare facilities, have needed parents to manage multiple roles with fewer resources. In addition, parents have also been overwhelmed with worries about their children's physical and mental health and have been burdened with the added responsibility of managing infection control within the household. For healthcare workers who are parents, there has been increased demands of both childcare and parental employment during the pandemic, which have added to the stress. All these have caused marked psychological impact on parents during the pandemic.

Psychological impact on parents

Studies have revealed that more than 80% ⁽¹⁾ of parents experienced high levels of psychological distress and more than a quarter

experienced worsening of their mental health during the pandemic. Parents have reported increased levels of parenting stress, burnout, sleep disturbances and increased negative affect compared to the times before the pandemic. Parenting-related exhaustion has been reported in almost 20% ⁽¹⁾. The rates of depression and anxiety among parents during the pandemic has been noted to be as high as 40% ⁽²⁾.

However, all parents are not equally affected by the pandemic. Mothers, single parents, parents having a poor marital relationship, those having younger children, a larger number of children and having children with special needs have been identified as being at higher risk of developing negative mental health consequences ⁽¹⁾. In addition, parents with a history of psychiatric disorders, who felt less competent in educating their children at home, who had fewer social connections and parents with a history of childhood adversity were also identified as having a higher risk of mental health problems ⁽³⁾. Dissatisfaction with the sharing of childcare duties, with having to take care of the children mainly by oneself, also predisposed parents to mental health problems during the pandemic ⁽³⁾.

Effects on parenting behaviour

Parents' negative mental health is known to affect their parenting behaviour. Parents were described to use either too much or too little discipline, use more frequent and more harsh punishments and to shift from authoritative to authoritarian parenting styles during the pandemic ^(4,5). Parents were found to be more hostile and critical and more emotionally

withdrawn from their children. Despite spending more time under the same roof due to the lockdowns, parents were found to be less supportive, less sensitive to their children's emotions and less encouraging to their children. Furthermore, they had lower ability to direct their complete attention to their child's needs, due to the need to balance multiple roles. Parenting stress was also shown to affect the parent-child relationship.

Effects on children

Parental stress and mental health problems invariably effect their children. Parents who are highly distressed may be less available and less responsive to their children's needs, which may result in maladaptive behaviour in their children. Parental stress also contributes to the elevated rates of emotional and behavioural disorders, higher child and anxiety scores and poor emotional regulation in children during the pandemic ⁽²⁾. The rates of child abuse had spiked during the pandemic, which is thought to be, at least in part, due to parental distress. High parental depressive and anxiety symptoms, parental burnout and job loss during the pandemic were shown to be associated with higher child abuse potential ^(6,7). Conversely, greater parental support and perceived control during the pandemic are associated with lower perceived stress and child abuse potential.

Interventions

As healthcare workers, we must consider the possibility of parental burnout when working with parents, children and families. Research shows that non-directive interventions such as active

listening and encouragement can be as effective as directive interventions. Therefore, doctors should acknowledge and validate parental distress where needed. Parental satisfaction with sharing of caregiving has been identified as an important factor for parental coping during the pandemic. Therefore, sharing of caregiving between partners should be encouraged where appropriate ⁽³⁾.

Parents should be directed to freely available educational materials providing tips for parents on how to explain the risks of COVID-19 to their children, on how to manage daily life at home and behavioural strategies for parents to use to manage difficult behaviour. Such resources are freely available on the web through the World Health Organization and UNICEF. Material in the local language developed by local professional organizations such as the Sri Lanka College of Psychiatrists and the Sri Lanka College of Child and Adolescent Psychiatrists are also available.

Healthcare workers should also educate the parents on available psychological and social services. During periods of school closure, parents are unlikely to be able to leave home to attend supportive therapies in person. Therefore, telehealth facilities should be improved so that parents can access such services from home. For parents simply wishing to discuss their concerns or to get advice from a mental health professional, they can be directed to the toll-free mental health help-line 1926 of the National Institute of Mental Health.

Parents should be educated about the system and platforms for remote learning, including the tools and key pedagogical concepts. Schools should allow more options for parents to communicate with the teachers. As different parents will need different levels of support in home schooling of their children, parents should be contacted by teachers and other school personnel to discover what types of support each family needs.

Job support measures, paid leave for caring for children infected with COVID-19 and flexibility of working hours to attend to childcare responsibilities have all been shown to be effective in reducing parental mental health problems ⁽⁸⁾.

The pandemic is likely to continue with possible school closures and social restrictions well into the future. Therefore, methods to support parents need to be developed in order to prevent the long-term psychological impact of this pandemic on children.

References

1. Marchetti, D., Fontanesi, L., Mazza, C., Di Giandomenico, S., Roma, P., & Verrocchio, M. C. (2020). Parenting-related exhaustion during the Italian COVID-19 lockdown. *Journal of pediatric psychology*, 45(10), 1114-1123.
2. Lee, S. J., Ward, K. P., Chang, O. D., & Downing, K. M. (2021). Parenting activities and the transition to home-based education during the COVID-19 pandemic. *Children and Youth*

Services Review, 122, 105585.

3. Clemens, V., Köhler-Dauner, F., Ziegenhain, U., & Fegert, J. M. (2021). Predictors of parental coping during the Covid-19 pandemic: A survey in Germany. *Frontiers in Psychology*, 3830.
4. Chung, G., Lanier, P., & Wong, P. Y. J. (2020). Mediating effects of parental stress on harsh parenting and parent-child relationship during coronavirus (COVID-19) pandemic in Singapore. *Journal of family violence*, 1-12.
5. Fontanesi, L., Marchetti, D., Mazza, C., Di Giandomenico, S., Roma, P., & Verrocchio, M. C. (2020). The effect of the COVID-19 lockdown on parents: A call to adopt urgent measures. *Psychological Trauma: Theory, Research, Practice, and Policy*, 12(S1), S79.
6. Lawson, M., Piel, M. H., & Simon, M. (2020). Child maltreatment during the COVID-19 pandemic: Consequences of parental job loss on psychological and physical abuse towards children. *Child abuse & neglect*, 110, 104709.
7. Griffith, A. K. (2020). Parental burnout and child maltreatment during the COVID-19 pandemic. *Journal of family violence*, 1-7.
8. C. Fong, V., & Iarocci, G. (2020). Child and family outcomes following pandemics: A systematic review and recommendations on COVID-19 policies. *Journal of pediatric psychology*, 45(10), 1124-1143.

Radiology Quiz

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MBBS, MD-Radiology

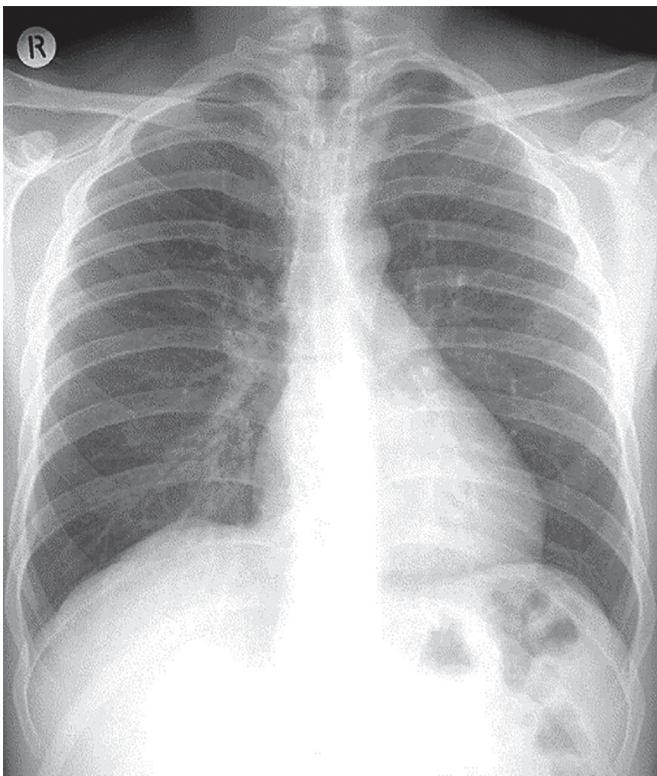
Senior Lecturer and Specialist in
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Faculty of Medicine, University of
Kelaniya

1. A 47-year-old man presents with non-specific chest pain. A routine chest radiograph is performed.
What is the best interpretation of his X-ray?

2. A 15-year-old boy presents with fever and cough.
Which response is correct regarding his chest radiograph?

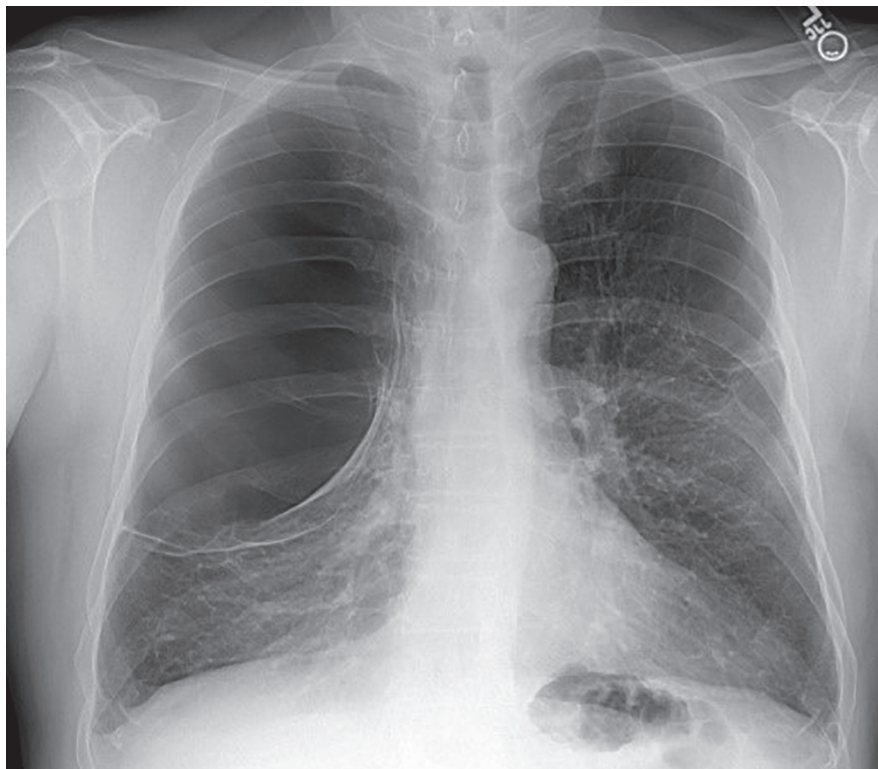


- A. Chronic obstructive airway disease
- B. Free gas under the diaphragm
- C. Normal chest X-ray
- D. Pneumothorax
- E. Cardiomegaly

- A. Heart failure
- B. Left side pneumothorax
- C. Right lower lobe consolidation
- D. Right middle lobe consolidation
- E. Right side lung cancer

3. A 56-year-old heavy smoker presents with progressive shortness of breath.

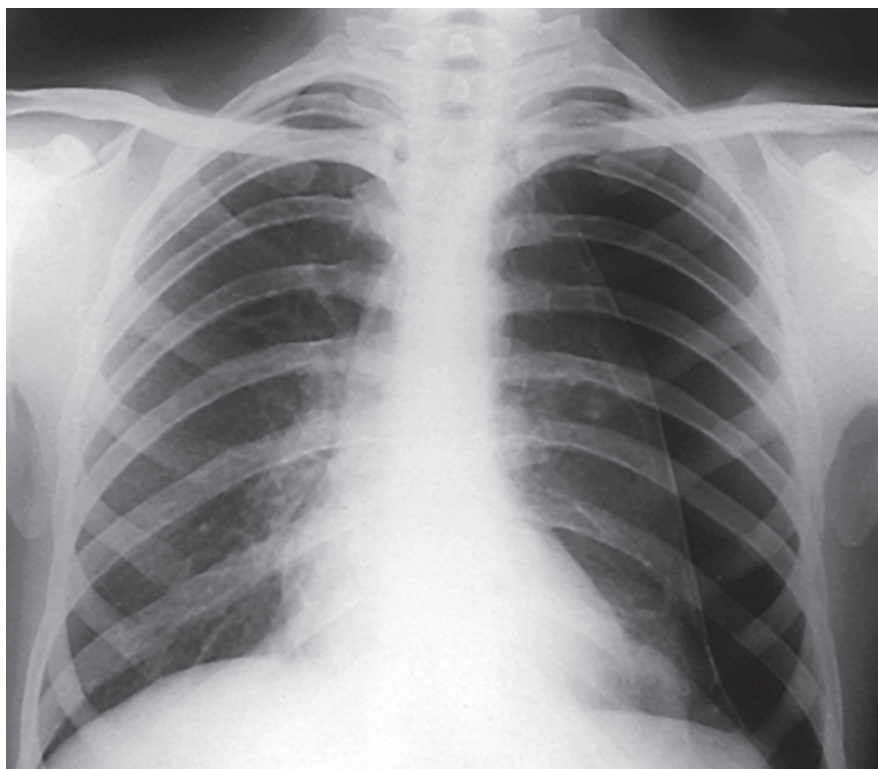
Which response is correct regarding his chest radiograph?



- A. Bullous emphysema
- B. Cardiomegaly
- C. Right middle lobe consolidation
- D. Right side lung abscess
- E. Right side pneumothorax

4. A 37-year-old man presents with shortness of breath and left sided chest pain.

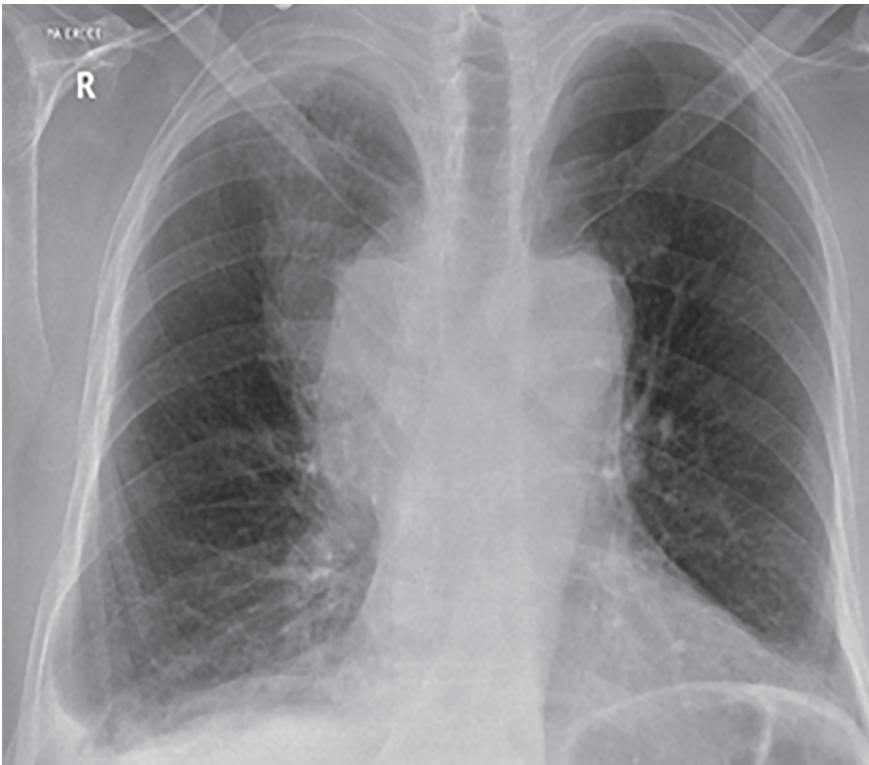
Which radiological finding is present in his chest radiograph?



- A. Chronic obstructive airway disease
- B. Prominent hilar vessels
- C. Left middle lobe consolidation
- D. Left side pneumothorax
- E. Normal chest X-ray

5. A 65-year-old ex-smoker presents with recent weight loss and haemoptysis.

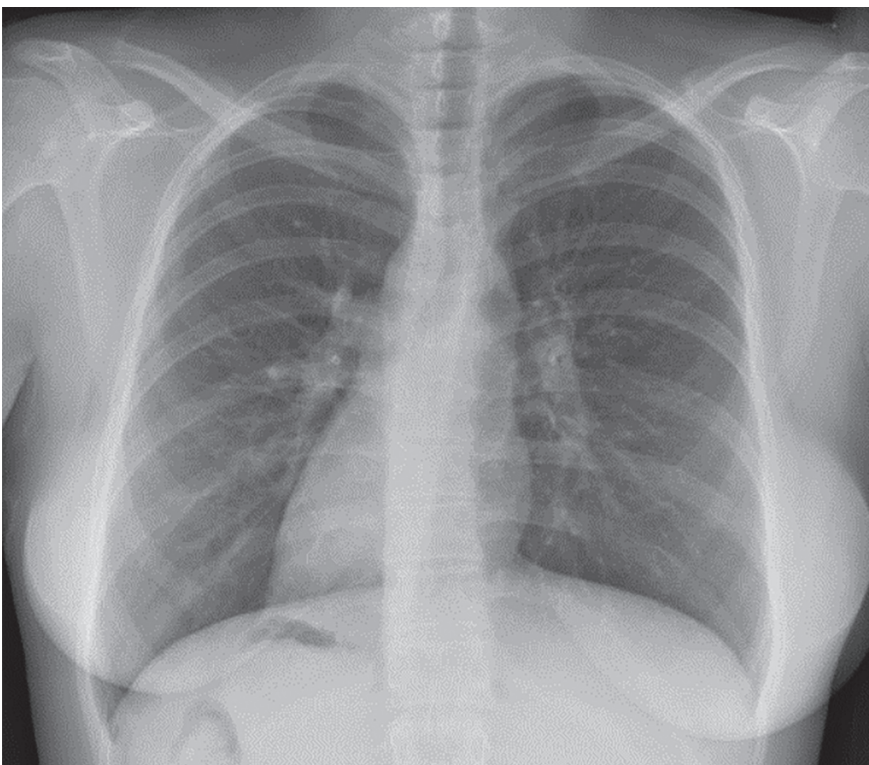
What is the most likely diagnosis?



- A. Bronchial carcinoma
- B. Consolidation
- C. Right lung collapse
- D. Right side pneumothorax
- E. Sarcoidosis

6. A 17-year-old girl presents with gradual onset left iliac fossa pain. Her urine hCG test is negative.

Which statement is true?



- A. Free gas under the diaphragm.
- B. Acute appendicitis should be suspected.
- C. Chest X-ray should be repeated
- D. Cardiomegaly
- E. Intestinal obstruction

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Beyond Medicine : Doctors as Entrepreneurs

Dr. Lasantha Malavige

MBBS (Colombo), PhD

Specialist in Sexual Medicine

Founder /CEO Lassana Flora &

Lassana Group of Companies

a) What made you to start a business while you were a 2nd year medical student?

I had childhood dreams of becoming a doctor and an entrepreneur. While pursuing the quest to become a doctor I wanted to explore the other dream too. The holidays, after the second MBBS examination gave me an opportunity to plan and execute my second dream. I love to create and build things. I think being a good entrepreneur can make a big difference to society. Unfortunately, entrepreneurship is not accepted and recognized in our society, partly because entrepreneurs haven't fulfilled their social responsibilities to the extent expected of them which has led to a vicious cycle where individuals with broader vision not venturing into becoming entrepreneurs.

b) What advice do you have for medical students or doctors with other dreams or for those who want to become entrepreneurs?

I would always tell them to pursue their dreams. Nothing is impossible if you pursue your dreams with focus and determination. I think our education system was designed to address colonial needs and therefore, did not promote creativity, innovation and entrepreneurship. Instead, the smartest and the brightest were kept caged in a professional career. We must break this vicious cycle, more young professionals with broader vision should get into entrepreneurship.

However, entrepreneurship is not for everyone. Certain personality traits are better suited to become entrepreneurs. If you enjoy taking risks, like to create things, enjoy making a difference, are prepared to take on any challenge positively and enjoy traversing



a journey that no one has ever been on before, then you have some of the qualities needed.

c) Did you start the business with a big vision?

Honestly, No! I did not have a big vision at the beginning, I just saw that there is a gap in the wedding floral industry and stepped in to bridge that gap by providing creative floral solutions at affordable prices. However, 9 years ago, while participating in an Executive Training Programme in Japan through a scholarship offered by JESTICA, I realized that I could provide a much bigger difference to society if I took my entrepreneurship to the next level. I tried to figure out what would make me happy in the end. I know that as a person, I derive a huge amount of happiness by contributing to others' happiness. I thought that if I had a vision and a purpose for the business that goes in line with my personal vision, I could be that much happier.

I had realized by then that improving the service standards can significantly improve our happiness and quality of life. Poor service standards make us unhappy all the time.

Since then, I adopted a broader vision of our business setting up standards in service delivery and contributing to improved service standards, thereby improving happiness at a societal level.

d) Wasn't it difficult to build a business while spending five years in medical school and five years in the UK doing your post graduate studies, handling positions like the Secretary of the Sri Lanka Medical Association in 2012, and the president of the South Asian Society for Sexual Medicine 2017 to 2019?

It was hard work and extremely challenging. The journey hasn't been easy at all, especially while I was in the UK for 5 years. I had to travel to many areas in the UK to collect data from GP clinics, get funding within the UK, do the erectile dysfunction and sexual health clinic at the OCDEM, at University of Oxford, all while handling Lassana flora in Sri Lanka. I was attached to the University of Oxford to do my PhD, which was a split PhD and this was one of the most difficult periods of my life, having to do my PhD, get clinical training, while making sure that Lassana flora, which is like my child, thrive.

However, I am so blessed to have been in received all the support from family, staff, friends and colleagues. I am ever so grateful to everyone who supported me over the years. I have vivid memories of a day I had fallen asleep on the floor of a 5-star hotel banquet hall while doing the wedding setup overnight. A person by the name of Reshan woke me up with a nice cup of coffee and a sandwich. My parents, sister, wife, daughter and even my son aged 13 have been a huge strength and all of them supported me unconditionally throughout. My staff, current and former, have done most of the work I have just given them, together with the support and guidance needed. I am eternally grateful to everyone who has helped me and continue to help me. I always find ways to express my gratitude in whatever way I can.

e) What are your plans for the next five years?

We have two specific objectives. Firstly, as I mentioned before, we want to set up

standards in service delivery in Sri Lanka. Secondly, we want to build a global brand that all Sri Lankans can be proud of.

f) Why did you select sexual medicine as your specialization, and do you want to give it up?

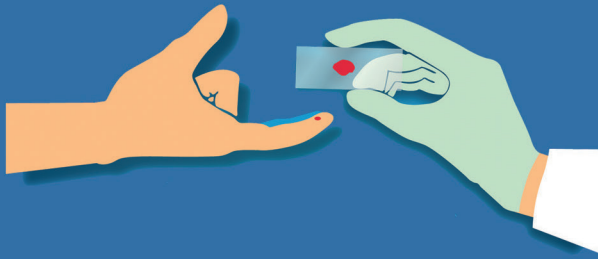
During my internship I came across a patient who attempted to commit suicide for unresolved severe form of premature ejaculation called ante-portal ejaculation. I realized that there were no specialists in the field to refer him to and decided to take it on. I enjoy being a doctor and helping a lot of patients, my creative skill has really helped as I often give a creative solution to the couple or the individual. However, I think it will be hard for me to give much time for medical practice in the future and I am planning to lay more emphasis on my entrepreneur journey over the next couple of years.

g) Does medical training help in your career as an entrepreneur

I think so. As doctors we get more grounded, we are inculcated with good values and attitudes, we understand human suffering and we always try alleviating suffering while trying to help people. We are trained to be concerned about others and the society. Also, my postgraduate training in psycho analytic psychotherapy has helped me to listen, understand, and respect different views, different values and opinions, quite a lot better. I think all these help me in the business to deal with my staff, suppliers, other partners and clients in a more meaningful manner.

h) What are few key take home messages

There is always a place for entrepreneurship amongst professionals. One needs to pursue one's dreams and should not be afraid to take a different route to everyone else. If we can derive happiness by contributing to others happiness consistently in a sustainable manner the world is going to be a happier place.



Reduce the Delay

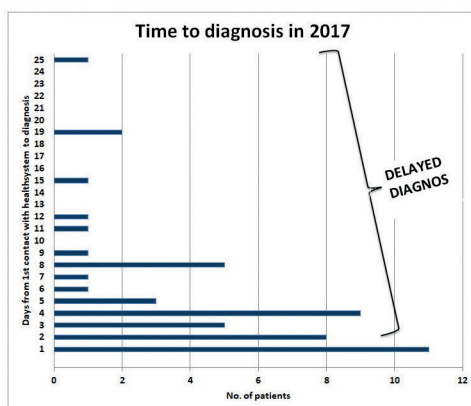
in diagnosing imported **Malaria**

Every single day that a malaria patient is left untreated,

- * His/her chances of survival decreases, &
- * He/she can transmit the disease to others & re-introduce malaria to Sri Lanka



Therefore **malaria should be diagnosed within 24 hours of onset of fever**



Your role:

For all fever patients, always check **travel history** at first interview. If patient has travelled to a malaria endemic country recently, **test for malaria**.

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Radiology Quiz

Answer Key:

1. Answer - C

Well-exposed normal inspiratory film. Diaphragmatic contours are normal. The gastric air bubble is seen under the left hemidiaphragm.

2. Answer - D

Consolidation is seen in the right lower zone. The right hemidiaphragm contour is distinct. Therefore, right lower lobe consolidation is not likely. The right heart border is indistinct, and consolidation is likely to be in the right middle lobe. Consolidation may be due to pneumonia, lung carcinoma, pulmonary oedema, or pulmonary haemorrhage/contusion. Answer E is not likely due to the age of the patient and the presenting complain.

3. Answer - A

Large focal lucency in the upper and middle zones of the right lung causing mild compression and crowding of vascular markings of adjacent lung parenchyma. No lung markings are seen within the lucent area. There is no visible visceral pleural edge lateral to the lucent area to suggest pneumothorax. Both lung fields are hyperexpanded with flattened diaphragms.

There is no evidence of cardiomegaly, and no air-fluid level to suggest lung abscess.

Answer - D

A visceral pleural edge is seen as a thin, sharp white line in the left hemithorax with absence of

lung markings peripheral to the visible pleural edge. This peripheral space is radiolucent compared to the adjacent collapsed left lung. There is no consolidation in the left lung, and no evidence of flattened hemidiaphragm or bullous changes in both hemithoraces. The mediastinum is not shifted.

4. Answer - A

A lobulated soft tissue mass on the right paratracheal region extends up to the lung hilum, narrowing the right lower lobe bronchial air shadow. There is no air bronchogram within the lesion. A segmental ground-glass opacity is seen in the right upper lobe. Obliterated cardiophrenic angle with the meniscal sign is seen on the right side, suggestive of a pleural effusion. There is no evidence of left hilar masses or lymphadenopathy. In sarcoidosis bilateral hilar adenopathy is present in over 95% of cases.

5. Answer - B

Cardiac apex, aortic knuckle and descending aorta are seen in the right hemithorax. The gastric air bubble is also visible just beneath the right hemidiaphragm. This indicates dextrocardia with situs inversus, where chest and abdominal organs are located in a mirror image of the normal. Hence, the appendix is also in the left iliac fossa region. This chest radiograph is properly taken, and the side is correctly marked.





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