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135th Anniversary International Medical Congress 2022

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Call for Nominations for Election to the SLMA Council 2023

Dear members,

I hereby call for nominations for the posts of Council Members (28 positions) of the Sri Lanka Medical Association. **Nomination Form** for Election to the SLMA Council – 2023 and **Eligibility Criteria** for nominations can be obtained from the SLMA office or downloaded from the SLMA web site (https://slma.lk/).

For any further details, please contact the SLMA office on 011 2 69 33 24.

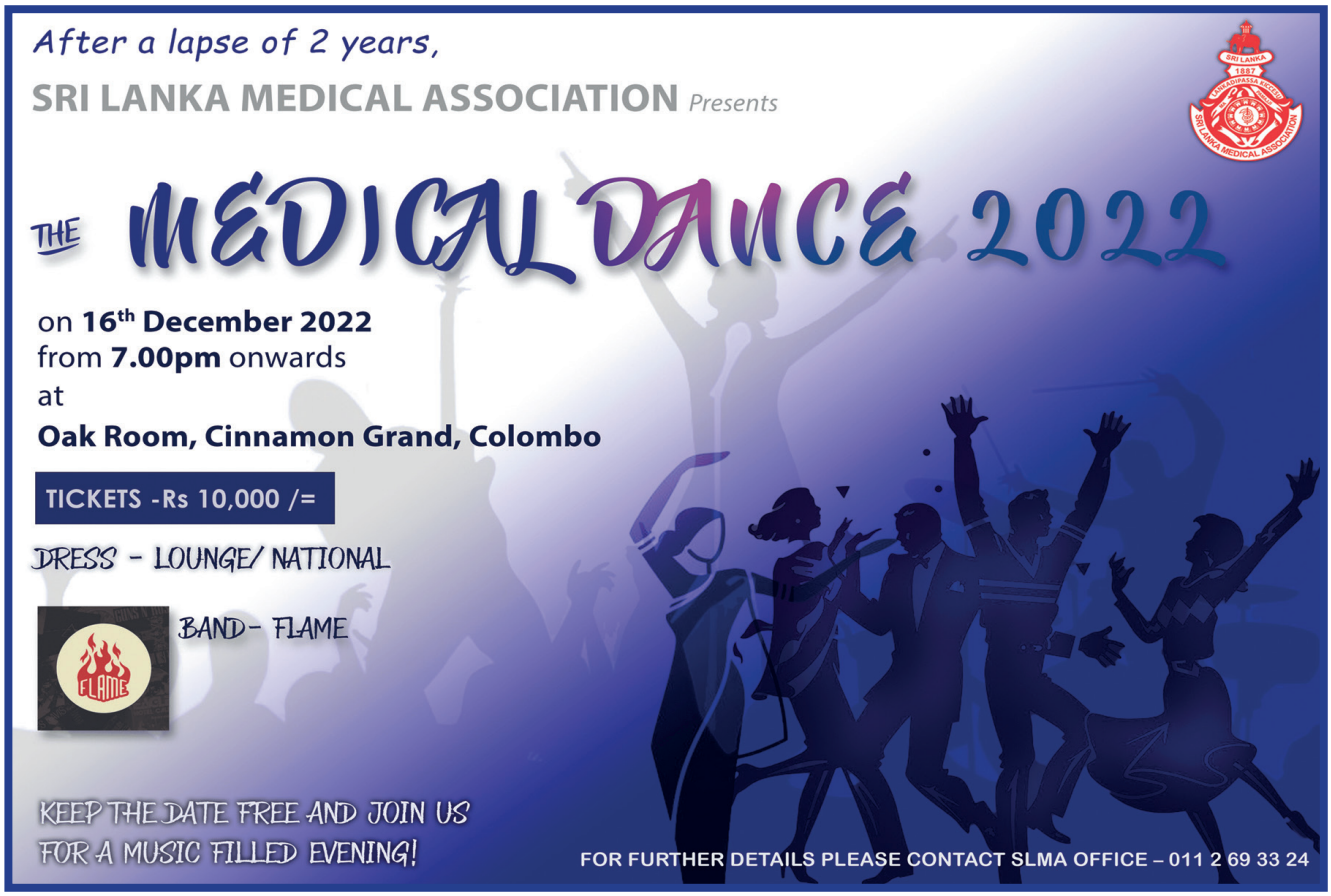
Thank you,

Sincerely,

Prof. Ishan De Zoysa
Honorary Secretary
Sri Lanka Medical Association

The duly completed Application Form should reach Prof. Ishan De Zoysa, Honorary Secretary, No.06, Wijerama Mawatha, Colombo 07 by post or delivered by hand on or **before 30th November 2022 4.00 pm.**

The AGM will be held on ***23rd December 2022 at 7.00 pm*** *in the Professor N. D. W. Lionel Memorial Auditorium of the Sri Lanka Medical Association.*



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SLMA President

Prof. Samath D. Dharmaratne
MBBS (Colombo)
MSc (Community Medicine)
MD (Community Medicine)
President
Sri Lanka Medical Association

President's Message

135th Anniversary International Medical Congress 2022 – Post Congress
Planetary Health and Global Health Security

Dear SLMA Members,

My message for this newsletter, (October 2022) is a follow-up to my message published in the September Newsletter, which introduced the SLMA 135th Anniversary International Medical Congress 2022. This message will describe to you the sessions in some further detail.

The 135th Anniversary International Medical Congress 2022 was a very successful, colourful and satisfying congress, and started on September 28th with the Inauguration and concluded on October 1st with the Doctor's concert. It all took place at the BMICH. The Academic Committee Co-chairs Senior Professor Anuja Abhayadeera and Dr Surantha Perer, ably supported by the Honorary Of the SLMA, Senior Professor Ishan De Zoysa, Dr Harini Fernando, Dr Sumithra Tissera and Ms Nirmala Wijekoon, with the support of our ever-working office staff, Nadeesha, Nadeera, Jayarani, Samararatne, Justin and Raja, completed a successful congress. They were there from about 6.30 am till after 7.00 pm to support us.

The Inauguration Ceremony on the 28th of September, was attended by more than 200 people and the dinner was a happy, lively and lengthy affair and continued to the next day. The 6 orations, 5 plenary lectures, 14 symposia, and 4 panel

discussions were attended by many participants and were praised by many for their technical value and comprehensiveness. The Keynote Address on, 'Planetary Health and Global Health Security'' was well received and the Plenary lectures were well organized and presented important and timely topics addressing the current situation in Sri Lanka. Panel discussions addressed strategic funding measures, road traffic injuries, medical tourism, and concluded with a meeting of the Intercollegiate Committee Members with the participation of Dr Alaka Singh, the Country Representative of the World Health Organization (WHO), where a discussion on the development of the strategic plan for the health sector was discussed. Nearly one-hundred, free papers were presented as oral and poster presentations. Interestingly and importantly no orator, resource person, Chairperson, free paper presenter or judge was absent, highlighting the work of the Academic Committee, especially the two Chairpersons. Then came the Doctor's Concert, which went from 7.00 pm till past midnight, thoroughly and completely enjoyed by all, and thank you, Dr Christo Fernando, for all your efforts and commitment.

I thank all participants, resource persons, chairpersons, judges, orators, well-wishers, sponsors and especially the Academic Committee, together with the Office Staff of the SLMA for their continuing support, encouragement, and motivation. Special thanks are hereby presented to the Executive Committee of the SLMA and the Members of the Council, especially, Senior Professor Anuja Abhayadeera, Dr Surantha Perera and Senior Professor Ishan De Zoysa.

Hope to see you all at the SLMA Foundation Sessions, scheduled from November 11-12, at the SLMA.

With Best Wishes

Professor Samath D. Dharmaratne
President - SLMA

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Activities in Brief (16th September - 15th October)

SLMA Saturday Talks

17th September

'Chronic Venous Diseases' by Dr Joel Arudchelvam, Senior Lecturer in Surgery/ Consultant Vascular & Transplant Surgeon, Faculty of Medicine, University of Colombo.

24th September

'Gastro Oesophageal Reflux Disease and the role of Gastrointestinal Physiology in the Diagnosis' by Dr Nilanka Anjalee Wickraasinghe, Lecturer, Department of Physiology, Faculty of Medicine, University of Colombo.

15th October

'Oesophageal Cancer' by Dr Sumudu Kumarage, Head Department of Surgery, Senior Lecturer (Grade 11), Faculty of Medicine, University of Kelaniya.

22nd September

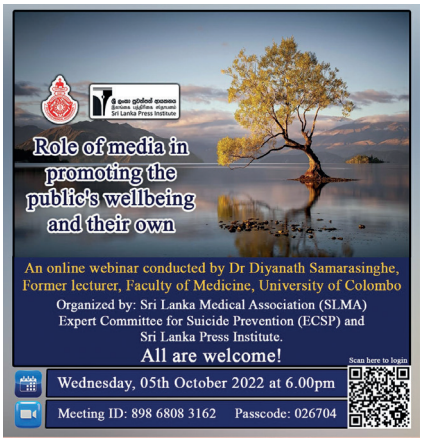
The SLMA Expert Committee on Rehabilitation organized a symposium on 'Outcome Measures on Prosthetics & Orthotics and its Application'.

The topics of discussion and resource persons for the conference are given below.

'Introduction to Sirindhorn School of Prosthetics & Orthotics', Mahidol University, Thailand, by Ms Sirirat Seng-iad, Lecturer, 'Outcome Measures in P & O', by Mr Tullathorn Tulatharn, Lecturer, 'Application of Outcome Measures in P & O' by Ms Sirirat Seng-iad, Lecturer and 'Thai Prosthetics & Orthotics Data Base' by Ms Conthicha Chaemkhuntod, Assistant Lecturer.

All resource persons were from The Department of Prosthetics & Orthotics' Mahidol University, Thailand.

5th October



A webinar was organized by the SLMA Expert Committee for Suicide Prevention on 'Role of Media in Promoting the Public's Wellbeing and their Own' by Professor Diyanath Samarasinghe, Senior Lecturer in Psychiatry (Retired), Faculty of Medicine, University of Colombo.

Inauguration and the SLMA Oration 2022

The Inauguration of the 135th Anniversary International Medical Congress and the SLMA Oration 2022 was held on 28th September 2022 at the Lotus Hall, BMICH, Colombo. The Chief Guest at the occasion was Dr Alaka Singh, Country Representative of the World Health Organization, Sri Lanka.

Dr Asela Gunawardena, Director General of Health Services, Ministry of Health, Sri Lanka, who was invited as the Guest of Honour, was unable to attend due to a work commitment and a message sent by him was read by the President, SLMA.

The much-revered SLMA Oration 2022 was delivered by Professor Eranga Wijewickrama, Professor in the Department of Clinical Medicine, Faculty of Medicine, University of Colombo, Sri Lanka as well as Honorary Consultant Nephrologist, National Hospital Sri Lanka and National Institute of Nephrology Dialysis & Transplantation, Colombo, on 'Deciphering acute kidney injury in Sri Lankan viper bites: Is thrombotic microangiopathy the key?'.

The Inauguration Ceremony concluded with a musical interlude and the traditional reception.

135th Anniversary International Medical Congress

Professor Anuja Abayadeera & Dr Surantha Perera - Co-Chairpersons of the Academic Committee

Dr Harini Fernando -
Secretary, Academic Committee

Reflections On The Congress

The Sri Lanka Medical Association (SLMA) conducted its 135th Annual Academic Congress from 28th September to 01st October 2022 at the BMICH, Colombo. The theme of the congress was in keeping with the SLMA theme for the year, *'Planetary Health & Global Health Security'*. The event was very successful with high calibre presentations although the participation was poor. The Organizing Committee for the Annual Academic Congress was headed by the two Vice Presidents of the SLMA, Professor Anuja Abayadeera and Dr Surantha Perera.

The academic sessions comprised a total of 4 Orations, 5 Plenary Lectures, 14 Symposia and 4 Panel Discussions. The Keynote Address titled *'Global Security through One Health Approach'* was delivered by Dr Shiyong Wang, Senior Health Specialist of the World Bank. The Plenary Lectures were delivered by Professor Prasad Katulanda on *'Prevention & Reversal of Type 2 Diabetes - A Paradigm shift in facing the pandemic'*, Professor Vajira Dissanayake on *'Insights into the Spectrum of Genetic Disorders in the Sri Lankan Population from four Decades of Research in Sri Lanka'*, Professor Tissa Wijeratne on *'Challenges ahead with Post Covid-19 Neurological Syndrome and long-term complications'*, Dr Alaka Singh on *'Lessons learnt from the pandemic for strengthening Primary Health Care'* and Professor Suranjith L. Seneviratne on *'Precision Medicine'*, respectively.

The Symposia were on Cardiology, Endocrinology, Reproductive Health of Adolescents, Nutrition & Food Security, Current National Crisis, Lifestyle Medicine, Neonatology, Pulmonology, Screening for Common Malignancies, Solid Organ Transplantations, Neurology and Obesity.

Following tradition, three erudite orations were delivered during the academic sessions. These were delivered by the following orators: Dr S. C. Paul Mmorial Oration by Dr Dulika Sumathipala on *'Using high throughput sequencing technologies to study genetic causes of ultra-rare neurological diseases'*, Professor N. D. W. Lionel Memorial Oration by Professor Sachith Mettananda on *'Fetal Haemoglobin induction as a treatment for Thalassaemia: Evidence from bench and bedside'* and Dr. S. Ramachandran Memorial Oration by Professor Chamila Mettananda on *'Cardiovascular risk prediction of Sri Lankans'*.

There were 4 Panel Discussions on *'Funding to financing and reorienting our approach to current crisis in Sri Lanka'*, *'Legal and Economic implications of Road Traffic Crashes'*, *'Medical Tourism: A solution to foreign currency crises'* and *'Strategies for health sector recovery in the current socio-economic crisis in Sri Lanka'*, all of which were well received by the audience in attendance.

A total of 89 posters and 29 free papers were presented throughout the congress.

Day 01

Day 01


29th-30th SEPTEMBER 2022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Professor Tissa Wijer
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Day 02


29th-30th SEPTEMBER 2022


29th-30th SEPTEMBER 2022


procedures
Source: Gopal

Day 03


SRI LANKA MEDICAL ASSOCIATION
135th ANNIVERSARY INTERNATIONAL MEDICAL CONGRESS 2022
"Planetary Health & Global Health Security"
1st OCTOBER 2022


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The SLMA Doctors Concert - 2022

The SLMA Doctors' Concert which is traditionally scheduled for the last day of the Annual Congress, was held this year on 1st October 2022, at the Lotus Hall, BMICH, Colombo.

Over many a year, it has been an event where the doctors and the families of doctors get an opportunity to showcase a multitude of artistic talents in singing, instrumental music, drama and dancing, in an extravaganza of performing arts. It has been a much looked-forward to event in the calendar of activities of the SLMA.

This year's concert was also the ultimate end-result of the untiring efforts and enthusiasm of none other than the much talented musical virtuoso, Dr Christo Fernando, the Social Secretary of SLMA, who is an ardent music lover and a superb drummer himself.

He was ably supported by Dr Pramilla Senanayake, the Co-Social Secretary and the members of the SLMA Concert Organizing Committee.

This was the 7th and the last time that Dr Christo Fernando was organizing this event. It was indeed a very emotional time for all who have been associated with the concert, as well as Dr Christo himself and all present at the event. Following a beautiful vocal accolade by Dr Pramilla Senanayake on the contributions made by Dr Christo Fernando to the SLMA in general and the Doctors' Concert in particular, a superlatively crafted token of appreciation was presented to Dr Christo by the President, Professor Samath Dharmaratne. It was in recognition of all that Dr Christo had done, over many years to bring up the concert to one of absolute class and artistic splendour.

This component of the felicitation to Dr Christo Fernando concluded with Dr BJC Perera presenting a powerful and titillating version of "His Way", set to the original classic "My Way" sung by that fantastic singer of yore, Ole Blue Eyes, Frank Sinatra. That was a very special rendering, superbly backed by the fabulous Dr Farzad Nazeem on the keyboard, Upali Fernando on the Lead Guitar, Prashan Fernando on the Bass Guitar and of course, Dr Christo Fernando himself on the drums. It is noteworthy that BJC had sung this version of the song many a time before but always as a tribute to ladies. This is the very first time that he did it for a gentleman. It was followed by three cheers for Dr Christo Fernando and the traditional "He's a Jolly Good Fellow" recital by all present.

The following persons performed at the concert:

Hopalu Wana Petha Kampitha (Dance) - Visharada Dr Udumbara Sevwandi Kumari, *Obai Ramya Sanda Kirana* - Dr Kaushika Premasiri, *Mala Gira* - Dr Jaliya Jayasekera, *An Indian Classical* - Visharad Dr Sakthilandran Muthurajanathan and Sangeetha Kala Vithagar Sailakshmi Logeeswaran (Final year Student FOM, UOC), *Kothanaka Sitiyath* - Dr Ranjith Perera, *Welcome Rain* - Dr Manella Joseph, *Latin Ballroom Dance* - Dr Kaushika Premasiri, Mr Rajeev Fernando, Mr Nirosh Muthukuda & Dr Anusha Muthukudaarachchi, *But I can't help falling in love with you* - Dr B J C Perera with his daughter Maneesha, granddaughter Malaika and grandson Jaydon, *Gammanaye Hadakariye* - Dr Thusitha Sudarshana, *Africa* - Drs Isha Prematilleke & Kalani Kulatilleke, *You raise me up* - Savin Rajapakse, *Master Sir* - Dr Savinki Rambadagalle, *Duleeka* - Dr Dinithi Upeksha Ranaweera, *Wassanayata Atha Wanala* - Dr Uditha Kodituwakku, *You belong with me* - Nishalee Weeraratne, *A medley of songs by Elvis* - Dr Lanka Wijesena, *Save the last dance for me* - Dr Farzad and Khazaan Nazeem, *Last ride of the day* - Dr Yamuna, Manuka and Minara Rajapakse, *Ganga addara pipuna malaka* - Dr Disna Amaratunge, *A medley of songs by Clarence* - Upali Fernando & Prashan Fernando, *Amma* - Dr Nilanka Munasinghe, *Achy Breaky Heart, Ten Guitars, Crazy little thing called love* - Seneka Pereira and finishing with the presentation by the entire Council; a two song seamlessly amalgamated medley of 'පැලේ වසන රන් මලී' and 'යමුනා, යමුනා, සෝහන ගංගා'.

They were ably supported by the Band consisting of Dr. Christo Fernando - Drums, Dr. Farzad Nazeem - Keyboards / Vocals, Upali Fernando - Lead Guitar / Vocals, Prashan Fernando - Bass Guitar / Vocals, Raju Jayakody - Keyboards / Vocals and Seneka Pereira - Drums / Vocals.

Drs. Rizka Ihsan and Pramitha Mahanama did a wonderful job as the comperes of the concert this year as well. They kept the place going with witty announcements,

catchy repartees and classy verbal duels, in the best traditions of fantastic compeering.

All in all, it was an event to remember. The fare served was of the highest quality, with the artistic variety of sheer class that the SLMA Doctors' Concert is now well known for. It was a multi-faceted presentation designed to tickle the artistic palate of even the most discerning enthusiast. The fabulous audience showed their appreciation with thunderous applause and also by joining in the singing as well.

Long live the SLMA Doctors Concert; an event like no other, presented by a unique set of entertainers.













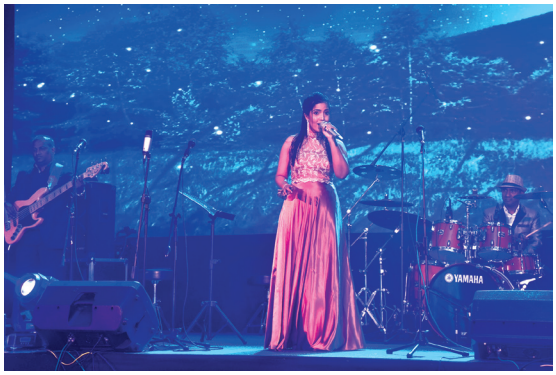





DOCTORS' CONCE
DR. RIZKA IHSAN
DR. PRAMITHA MA




Chief Guest's Speech

An excerpt from the Address by the Chief Guest, Dr Alaka Singh, World Health Organisation (WHO) representative to Sri Lanka at the Inauguration Ceremony of the International Medical Congress 2022 of SLMA.

The chosen theme for this congress, ***Planetary Health and Global Health Security*** is particularly relevant at this juncture in Global Health. Please allow me to use this opportunity today to discuss the significance of Planetary Health for Global Health Security and also to reflect on health security in the broader context of COVID-19 recovery and the economic crisis in Sri Lanka.

The World Health Organization (WHO) for the last two decades, through its member states including Sri Lanka, with a significant global voice has drawn attention to global health security through several World Health Assembly resolutions which have been reinforced at the Regional Level through the Regional Committee, the highest governing body in the region. These have brought into focus the need for urgent action to minimize the danger and impact of acute public health events. Given the high mobility, these are now very difficult to contain within geographical regions and indeed even within national boundaries. As emphatically underscored by COVID-19, these also now pose a threat and and the greatest risk to the global economy. *'Our planet Our Health'* was in fact the theme for World Health Day in April this year. The purpose was really to bring to the attention of the world the estimated 13 million deaths annually due to avoidable causes linked to planetary health.

The Lancet commission in 2015 - Commission on Planetary Health; suggests that we are actually mortgaging the health of future generations to realize economic gains and development today. The evidence on health security and the impact of the triple planetary crisis; climate change, biodiversity loss and air pollution is very clear. Just a few examples: the number of dengue cases reported to WHO increased over 8-fold in the last two decades. The WHO Director General, Dr Adhanom Ghebreyesus Tedros, just last week flagged that COVID-19 is strongly suspected to be of zoonotic origin which now highlights how closely environmental health relates to human and animal health.

Seven million global premature deaths have been attributed to pollution with one-third of these being in our region - the WHO Southeast Asia region. Importantly of the 7 million deaths globally, half of them are caused by indoor air pollution which disproportionately impacts women. Also, air pollution alone costs over 8 trillion dollars in healthcare expenses which is about 6% of global GDP.

WHO has taken important steps on Planetary Health. If I may just highlight a few here: again Sri Lanka has been a very important contributor both at a global level as well as the regional level. More significantly last year at the World Health Assembly, the WHO established with its member states and intergovernmental negotiation body -INB- to draft a negotiator compact or treaty, the second treaty the WHO is sponsoring to strengthen pandemic prevention, preparedness and response. WHO has also brought together international organisations to launch a 'one-health' high-level expert panel backed by a road map for aligning the WHO and partner contributions. With respect to technical and implementation support, in partnership with the World Organization for Animal Health and United Nations Environment Programme. The WHO does a joint programme for action on one-health which is really a multi-sectoral response to planetary health. We also have with UNDP, UNEP and UNICEF a compendium of actions to reduce diseases caused by environmental factors. WHO has developed a manifesto for healthy and green recovery from COVID-19 which includes a call to stop using taxpayer money to fund the pollution that we are suffering globally.

Let's now consider the wider implications of the pandemic and the economic crisis and what really needs to be done to make public health more resilient for health security. In that context, let us now focus on Sri Lanka. First and foremost, from the WHO perspective, we emphasize that public investment in public health in Sri Lanka is the most effective social protection effort in the country. For WHO, we always emphasize the Sri Lanka experience in terms of what can be done for equitable access to quality care even in developing countries. Sri Lanka has performed consistently well on all key health indicators within its own income group and even in higher-income group. These relate to life expectancy, and maternal and child health but importantly, even to reducing impoverishment due to the cost of accessing care.

During the Pre-COVID situation in Sri Lanka, the focus was really on NCDs, in terms of the rising and increasing challenges from non-communicable diseases. NCD experience highlights the complexity of the influences on health including and especially highlighting the factors outside the sector and the need for an inter-sectoral response. In addition, the

consequences of NCDs are also beyond the health sector. Productivity losses with NCDs have been identified by the World Economic Forum as a key global macroeconomic risk. Notably, half of the seven million who die within the productive age is from low-and-middle-income countries. This is something of particular consequence to our countries.

COVID-19 stretched the health system in every country, and as we know it, Sri Lanka was not an exception. From the WHO PULSE survey, during the pandemic, we had three rounds of this, to look at the disruption of services, Sri Lanka reported about a 50% disruption of essential health services during the two years. This is against a global estimate of 90% which really again focuses on the sound primary healthcare foundation in Sri Lanka for resilience. However, Sri Lanka has learned important lessons on health security during COVID-19; first and foremost, the critical importance of health worker security. Additionally, we need to focus on mental health as a key component of NCDs. The use of alternative service delivery models that the SLMA is familiar, as well as the healthcare management that was implemented during COVID-19. The critical engagement of communities and the whole of society approach, right from contact tracing to addressing reluctance and hesitancy on vaccines and vaccination. In potential technology for health system resilience, Sri Lanka had again shown up as a model for vaccine tracking, which the WHO, along with the Ministry of Health, was even able to export to other countries. We have countries in the region that followed Sri Lanka's example with support from Sri Lanka on this.

As a direct consequence of the pandemic, global growth is expected to decelerate significantly from about over 5% just before the pandemic to below 3% this year. This is a very difficult environment for a country to pick up its economic growth. Recovery is predicted to be slow. Superimposed on this, Sri Lanka's country-specific economic crisis. the worse since independence, progressed with the threat of potentially pushing people below the poverty line. As an immediate response, WHO has been looking at access to medicines along with partners and donors in collaboration with the Ministry of Health. WHO has also directly funded the importation of medicines. But what we really need to focus on are the long-term considerations to adjust and adapt to what is needed to sustain and accelerate Sri Lanka's remarkable health achievements.

Firstly, we do need more money for health. Together we must continue to advocate to safeguard current government expenditure on health, highlighting this as a key principle of primary health care, and public investment in public health as a flagship social protection effort in Sri Lanka. In the current dialogue, social protection is captured largely and mainly through household income support and nutrition for children. But we must keep emphasising what Sri Lanka has demonstrated as the most significant social protection effort, which is health. Moreover, in the economic discussion, we must keep reminding ourselves that health is, in fact, an investment sector. Just as an example, investment in the 'best-buys' for NCDs, has a potential rate of return of 7 dollars for every single dollar invested. In fact, the health sector is a key employer, particularly in Sri Lanka.

More needs to be done. We need to look at other countries as to how they have raised additional resources to get more money for health. A useful example is the Philippines, where they havee looked at taxation in areas that directly impact public health. We are all familiar with tobacco, alcohol, sugar and salt. Philippines for example, has accelerated and improved universal health coverage; the insurance coverage, through both a larger share of what is collected as well as increased taxation.

Secondly, along with more money for health, we also need more health for the money that we have. Here, WHO has highlighted key areas of efficiency that result in savings so that we essentially have more resources even within our current budget and below. WHO has identified key areas of efficiency gains as a structure and organisation of services. We need to focus on prevention, and we need to look at cross-programmatic efficiency gains. A study that WHO did, looked at the potential gains. These are quite significant in Sri Lanka. For example, through connecting more efficient laboratory services, it becomes much more efficient and effective across programmes in using laboratory services. Together with all this, the usage if Information Technology, which has huge potential to look at digital health. The related health workforce efficiency gains, including skill-mix, engagement of the private sector including community health workers, and in fact, looking at service delivery and the human resources, we really need to now engage the communities and community-based organizations more systematically and formally.

The third area for efficiency improvement is medicines. These include prescribing behaviour, irrational use of medicines and the better use of generics. The efficiency study in Sri Lanka pointed out potential gains by reviewing the supply chain management as well.

Finally, how do we effectively manage our resources? In Sri Lanka, out-of-pocket spending now is about 50% of total health spending. It's one of the few countries where this is not regressive. About 75% of out-of-pocket expenses is coming from the richer income group. However, there are different ways of pooling this money that can be more effective for cross-subsidies from the rich to the poor, from the young to the old and from the healthy to the sick. We need to look at how well we can improve the available finances through pooling, but also when we pool resources, it allows the management of these resources through strategic purchasing. The government can become a strategic purchaser and be able to look at what is being purchased and of course the price that it is being purchased at.

Update on the Management of Hypertensive Emergencies

Dr Ushani M Wariyapperuma

MBBS (Col) MD (Medicine) MRCP (UK)
Specialist in Internal Medicine
Head/Department of Physiology
Faculty of Medicine
University of Moratuwa

Overview

Hypertensive emergencies are a group of disorders where very high blood pressure (BP) values are associated with acute hypertension-mediated organ damage, necessitating immediate or urgent blood pressure reduction to limit extension or promote regression of target organ damage. The primary target organs of acute hypertension-mediated damage are the heart, retina, brain, kidneys, and large arteries. It should be noted that there is no threshold blood pressure value for diagnosis of hypertensive emergencies. Very high blood pressure with stroke, myocardial infarction and heart failure accounts for majority of the presentations. (1) The type of target organ damage is the key element guiding the choice of treatment, blood pressure goal, and timeframe by which the blood pressure should be lowered (2).

The term "Hypertensive Urgencies" which has traditionally been used to define conditions with elevated blood pressure where target organ damage is not present, is no longer encouraged. In contrast, "Uncontrolled Hypertension" is the preferred definition. This is based on the observations that cardiovascular risk of such patients was not particularly high and their referral to emergency departments has not proven to be beneficial in terms of cardiovascular outcome or blood pressure control at six months. As such, the term "hypertensive crisis", an umbrella term used to define both hypertensive emergencies and urgencies, has now become obsolete (2).

Epidemiology

Over the past two decades, approximately 1 in every 200 patients who presented to emergency departments was suspected of having a hypertensive emergencies (3), a figure which has been observed across continents (4,5). According to the Hypertension Sri Lanka 2020 country profile by the World Health Organization, among 3.6 million people with hypertension in Sri Lanka, 3.2 million do not have it under control (6). Considering the impact of current socioeconomic status of the country on the management of noncommunicable diseases, it is very much likely that we will encounter an increasing number of hypertensive emergencies in future.

Pathophysiology

Although the initiating events for the acute elevation of BP are poorly understood, the final common pathway of all hypertensive emergencies is intense peripheral vasoconstriction, leading to rapid rise in blood pressure setting up a vicious cycle of events, resulting in ischaemia of the brain and peripheral organs. This ischaemia stimulates neurohormone and cytokine release, worsening vasoconstriction and ischaemia. Renal ischaemia also activates the renin-angiotensin system which further elevates the blood pressure. This in turn leads to failure of auto regulation of blood flow and aggravates the microvascular damage with excessive endothelial injury leading to thrombotic microangiopathy (TMA) (7).

Stratification

Hypertensive emergencies are classified in to five broad entities based on the condition/target organ involved as below.

- Malignant hypertension with or without TMA or acute renal failure
- Coronary ischemia or acute cardiogenic pulmonary oedema
- Acute stroke or hypertensive encephalopathy
- Acute aortic disease (Aneurysm or dissection)
- Eclampsia/severe eclampsia/ HELLP syndrome

Evaluation

The history should focus on evaluating emergency symptoms like headache, visual disturbances, focal/ general neurological symptoms, chest pain, dyspnoea accompanied by details of treatment including current antihypertensive treatment, treatment withdrawal, disease duration, previous BP control and inquiry in to possible aetiology.

Examination is mainly targeted on cardiovascular and neurological assessment including fundoscopy.

Investigations should be guided by the initial assessment and are outlined below.

Laboratory Analysis
Haemoglobin, platelet count
Creatinine, sodium, potassium, lactic dehydrogenase (LDH), haptoglobin
Quantitative urinalysis for protein, urine sediment for erythrocytes, leucocytes, cylinders and casts
Diagnostic Examination
ECG (ischemia, arrhythmia, left ventricular hypertrophy)
Fundoscopy
On Indication
Troponin-T, CK, CK-MB
Peripheral blood smear (for assessment of schistocytes)
Chest X-ray (Fluid overload)
Transthoracic echocardiography (Cardiac structure and function) or point of care cardiac and lung ultrasound (Cardiac pulmonary edema)
CT (or MRI) - Brain (Intracranial haemorrhage)
CT-angiography of thorax and abdomen (Acute aortic disease)
Renal ultrasound (postrenal obstruction, kidney size, left and right difference)

Table 1 - Diagnostic investigations for a patient suspected of having a hypertensive emergency

Acute Management

Since there have not been randomized controlled trials evaluating different treatment regimens except in the case of patients with stroke, the treatment strategies are mainly derived from consensus from clinical experience, observations and comparisons of intermediate outcomes (2). The basic principles of treatment are

- The type of target organ damage is the key element guiding the choice of treatment, target BP, and timeframe by which BP should be lowered.
- The aim is to prevent or minimize further damage to target organs by a controlled BP reduction.
- Immediate BP reduction unless indicated, is not recommended as it can lead to compromised blood supply to target organs.
- In most instances, the treatment goals are best achieved by intravenous medication under close haemodynamic monitoring.
- The rapidity and level of BP reduction is mainly driven by the clinical context.
- Most of these emergencies can successfully be treated with labetalol or nicardipine

A summary of acute management depending on clinical context, the expected time line and target blood pressure reduction and preferential pharmacological agents are outline in table 2. Relevant pharmacological properties of the recommended drugs are detailed in Table 3

Clinical presentation	Time line and target BP	1st line treatment	Alternative
Malignant hypertension with or without TMA or acute renal failure	Several hours, MAP -20% to 25%	Labetalol Nicardipine	Nitroprusside Urapidil
Hypertensive encephalopathy	Immediate, MAP -20% to 25%	Labetalol Nicardipine	Nitroprusside
Acute ischaemic stroke and BP> 220 mmHg systolic or > 120 mmHg diastolic	1 h, MAP -15%	Labetalol Nicardipine	Nitroprusside
Acute ischaemic stroke with indication for thrombolytic therapy and BP>185 mmHg systolic or >110 mmHg diastolic	1 h, MAP -15%	Labetalol Nicardipine	Nitroprusside

Acute haemorrhagic stroke and systolic BP> 180 mmHg	Immediate, systolic 130 < BP < 140 mmHg	Labetalol Nicardipine	Urapidil
Acute coronary event	Immediate, systolic BP < 140 mmHg	Nitroglycerine Labetalol	Urapidil
Acute cardiogenic pulmonary oedema	Immediate, systolic BP < 140 mmHg	Nitroprusside or Nitroglycerine (with loop diuretic)	Urapidil (with loop diuretic)
Acute aortic disease	Immediate, systolic BP < 120 mmHg and heart rate < 60 b.p.m.	Esmolol and Nitroprusside or Nitroglycerine or Nicardipine	Labetalol or Metoprolol
Eclampsia and severe pre-eclampsia/HELLP	Immediate, systolic BP < 160 mmHg and diastolic BP < 105 mmHg	Labetalol or Nicardipine and Magnesium sulphate	

Table 2 - A summary of the treatment of hypertensive emergencies according to affected target organs.

Drug	Onset of action	Duration of action	Dose	Contraindications	Adverse effects
Esmolol	1-2 min	10-30 min	0.5-1 mg/kg i.v. bolus; 50-300 micro g/kg/min as continuous i.v. infusion	History of 2nd or 3rd degree AV block (and in the absence of rhythm support), systolic heart failure, asthma, and bradycardia	Bradycardia
Metoprolol	1-2 min	5-8 h	2.5-5 mg i.v. bolus over 2 minutes; may repeat every 5 minutes to a maximum dose of 15 mg	History of 2nd or 3rd degree AV block, systolic heart failure, asthma, and bradycardia	Bradycardia
Labetalol	5-10 min	3-6 h	0.25-0.5 mg/kg i.v. bolus; 2-4 mg/min continuous infusion until goal BP is reached, thereafter 5-20 mg/h	History of 2nd or 3rd degree AV block, systolic heart failure, asthma, and bradycardia	Bronchoconstriction and foetal bradycardia
Fenoldopam	5-15 min	30-60 min	0.1 micro g/kg/min i.v. infusion, increase every 15 min until goal BP is reached with 0.05 to 0.1 micro g/kg/min increments		
Clevidipine	2-3 min	5-15 min	2 mg/h i.v. infusion, increase every 2 min with 2 mg/h until goal BP		Headache and reflex-tachycardia
Nicardipine	5-15 min	30-40 min	5-15 mg/h as continuous i.v. infusion, starting dose 5 mg/h, increase every 15-30 min with 2.5 mg until goal BP, thereafter decrease to 3 mg/h	Liver failure	Headache and reflex-tachycardia

Nitroglycerine	1-5 min	3-5 min	5-200 micro g/min, 5 micro g/min increase every 5 min		Headache and reflex-tachycardia
Nitroprusside	immediate	1-2 min	0.3-10 micro g/kg/min, increase by 0.5 micro g/kg/min every 5 min until goal BP	Liver/kidney failure(relative)	Cyanide intoxication
Enalaprilat	5-15 min	4-6 h	0.625-1.25 mg i.v.	History of angioedema	
Urapidil	3-5 min	4-6 h	12.5-25 mg i.v. bolus, 5-40 mg/h as continuous infusion		
Clonidine	30 min	4-6 h	150-300 micro g i.v. bolus in 5-10 min		Sedation and rebound hypertension
Phentolamine	1-2 min	10-30 min	0.5-1 mg/kg i.v. bolus OR 50-300 micro g/kg/min as continuous i.v. infusion		Tachyarrhythmias and chest pain

Table 3 An overview of recommended drugs

Following acute management and blood pressure at target for a period of about 8 to 24 hours, intravenous therapy tapered and discontinued while commencing oral medication.

Prognosis and follow up

Although the overall survival has increased over past decades (8), people who have presented with a hypertensive emergency are comparatively at increased risk of cardiovascular and renal disease (9). The recommendation is for initial frequent follow up until target BP is reached followed by a protracted follow up until evidence of target organ damage has resolved (2). Regular assessments, counselling and motivational interviewing should be scheduled for patients who do not achieve target BP control to address noncompliance.

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Gynaecological Cancers: The Family Physician's Role

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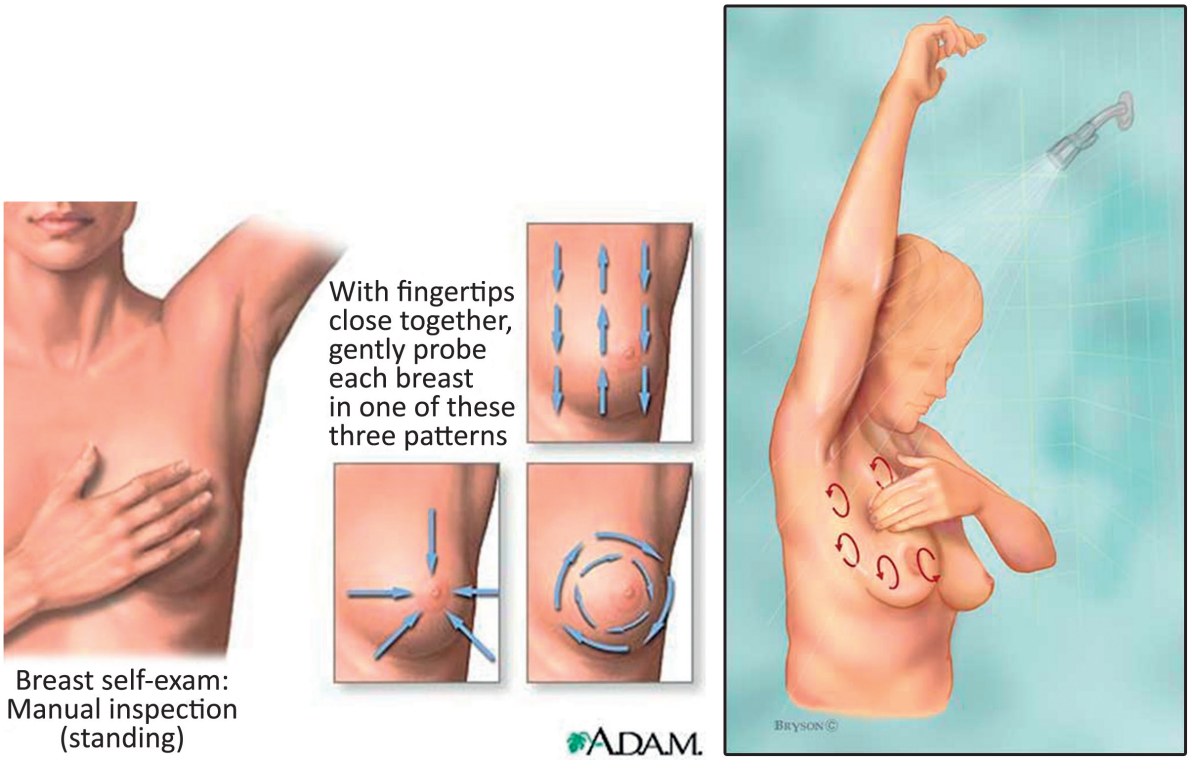
Introduction

Family Physicians (FPs) play a key role in the provision of healthcare in a primary care setting. They see more patients and each patient more often than any specialist doctor. The general public trusts their regular family doctor and tends to follow their advice. Most FPs know many aspects of the patient, as they have provided care for a long time at different ages of the same patient. This places FPs in a unique position in the prevention and early detection of many non-communicable diseases including cancers. This brief communication will discuss the role of FPs in the prevention and early detection of gynaecological cancers.

Breast Cancer

Breast carcinoma is the commonest cancer in women. Worldwide, the lifetime risk of breast cancer in women is one in eight before the age of 70 years. However, it is estimated that the risk is one in thirty and rising in Sri Lanka. Many of these patients present with advanced stages of the disease.

During consultations, it is important to inquire about family history of breast, uterine, ovarian and bowel cancers in immediate family members. Sometimes the FP may be aware of family members who have been diagnosed with cancer earlier. In this instance breast examinations annually may be helpful. Encouraging breast self-examination (BSE) is very important to detect breast cancer early. Women considered to be in high risk categories should be encouraged for screening with mammograms after 40 years of age, while others require a mammogram only after 50 years, as recommended by the Ministry of Health. Refer all women with suspicious lumps for further imaging and ultrasound guided biopsy. Genetic screening for BRCA (**BR**east **CA**ncer Gene) 1 and 2 is available in Sri Lanka and referring patients with a strong family history will help to categorize risk and undertake closer follow-up.



Breast self-exam: Manual inspection (standing)

Cervical Cancer

Cervical cancer is the second commonest gynaecological cancer of women in Sri Lanka. Unfortunately, despite the long pre-cancerous stage, many women present at an advanced stage of the disease. Human Papilloma virus (HPV) infection of the cervix is the causative factor in most cases and is transmitted by sexual intercourse. There is a preventive vaccine available which should be given before commencing sexual intercourse. Since 2017, the National Immunisation Programme has included the HPV vaccine to be given to females at the age of 10 to 14 years. Many parents are concerned about the vaccination of young girls. Encouraging them to get their children vaccinated and addressing the concerns that they have, will immensely help to prevent cervical cancer in future generations. Any woman who has not been sexually active could get vaccinated at any age.

There is an established screening programme for cervical cancer with the Papanicolau (Pap) periodical smear test. This is considered to be one of the most effective ways of early detection of cervical cancer. However, it is under-utilised in Sri Lanka. It is recommended that all women from the age of 30 years should be screened every 5 years until the age of 65 despite being vaccinated. The starting age can be early if sexual intercourse has been initiated at an early age. As FPs during consultation should ask about the results of the last Pap smear and encourage them to attend the screening, if it's due. It will play a key role in the early detection of the disease. HPV swab test (usually done as a self-test) is being piloted at the Medical Research Institute (MRI). It is considered culturally more acceptable as many women are uncomfortable with a speculum examination. This test is also available in the private sector.

Refer patients presenting with postcoital bleeding, inter-menstrual bleeding, purulent vaginal discharge, and post-menopausal bleeding to a Gynaecological Unit for further investigations without delay as these are possible symptoms of cervical cancer.

Endometrial Cancer

This is the third commonest gynaecological cancer in women in Sri Lanka. Stage by stage endometrial cancer has a poor prognosis compared to cervical cancer. However, more than ninety percent of patients with endometrial cancer present at an early stage, and therefore have a better outcome. Majority of patients (more than 90%) present with post-menopausal bleeding (PMB). Ten percent of all women with PMB have endometrial cancer. Peri-menopausal women are also at an estimated one percent risk of endometrial cancer when presenting with abnormal uterine bleeding after the age of 45 years.

Women presenting with post-menopausal bleeding should be thoroughly evaluated, regardless of the severity of bleeding. Empirical treatment especially with hormones should **NOT** be prescribed without proper assessment of patients presenting with PMB or peri-menopausal bleeding after the age of 45 years. Family history of endometrial, breast, ovarian and bowel carcinomas are risk factors for developing endometrial cancer due to gene mutations. Nulliparity, polycystic ovarian syndrome, early menarche, late menopause, obesity, and diabetes are also risk factors for endometrial carcinoma. Women with any one of these risk factors presenting with PMB or peri-menopausal bleeding should be considered as high risk and should be referred for endometrial evaluation by a Gynaecological Team without delay. Trans-vaginal ultrasound scan with or without endometrial biopsy is used for endometrial assessment. Hysteroscopy and endometrial biopsy are considered as the gold standard for endometrial assessment. However, endometrial Pipelle aspiration, which is an outpatient procedure has 99% sensitivity of detecting endometrial cancer and is commonly used in modern gynaecology practice.

Ovarian Cancer

Many patients with ovarian cancers present in an advance stage with poor prognosis. There is no effective screening method available. Refer the woman urgently if physical examination identifies ascites and pelvic or an abdominal mass (which is not due to obvious uterine fibroids) for further investigations. Most patient initially presents with vague symptoms. In the primary care setting, if a woman, especially if 50 years or over, reports having any of the following symptoms on a persistent or frequent basis; particularly more than 12 times per month, refer to a gynaecologist with CA-125 level and if possible, ultrasound scan of the abdomen and pelvis.

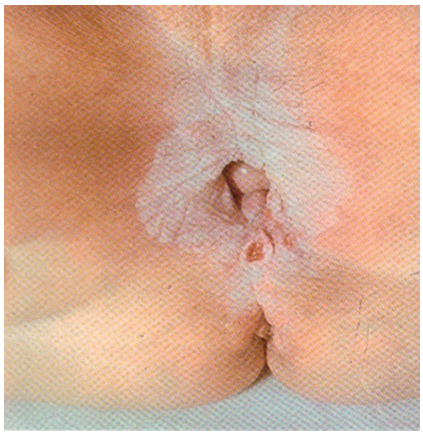
- persistent abdominal distention (women often refer to this as 'bloating')
- feeling full (early satiety) and/or loss of appetite
- pelvic or abdominal pain
- increased urinary urgency and/or frequency.
- unexplained weight loss and fatigue
- changes in bowel habit.

Advise any woman who is not suspected of having ovarian cancer to return to her GP if her symptoms become more frequent

or persistent, especially women who have a family history of breast, ovarian and endometrial cancer, as this will help to detect cancer at an early stage.

Vulval Cancer

Vulval cancer is rare and usually develops in the older age group. Unfortunately, two-thirds of patients present at an advanced stage of the disease. Vulval pruritus (itching) and soreness in older age patients should be investigated. History of lichen sclerosis and lichen planus have a higher risk of developing vulval cancer and follow-up is indicated in the primary care setting. Vulval examination with a good light will help to identify lesions at an early stage. These patients should be referred to a gynae-oncology unit at the earliest.



Role of Family Physicians

The population scenario in Sri Lanka is changing and many females will be in the post-menopausal age group with increased risk of developing gynaecological cancers. Most patients when symptomatic, will consult their FPs first. They will be more open to suggestions and will be more likely to follow FPs advice. This position the FPs are in, is a challenging but unique place in providing care for these patients. Therefore, it is very important to educate patients regarding the screening methods available and to encourage them to utilise these facilities. Taking a proper history, assessing for risk factors and proper examination, remain as the corner stone of detecting cancers at an early stage. Avoiding empirical treatment in high-risk patients and referring these patients for gynaecological input early, will definitely help many women. Thinking beyond symptoms and being suspicious of a possible carcinoma when being consulted will help to detect cancers early. FPs also play a key role when patients are detected and treated for cancers. These patients need to be encouraged to be compliant with treatment and follow-up regularly, as many women default their treatment regimes. Providing symptomatic treatment for side-effects of cancer treatment can be prescribed by the FPs. They can liaise with palliative care teams for patients with advanced disease, which will help to improve the quality of life in their final stages.

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Beyond Medicine: The Aquatic Adventures of a Diving Medic

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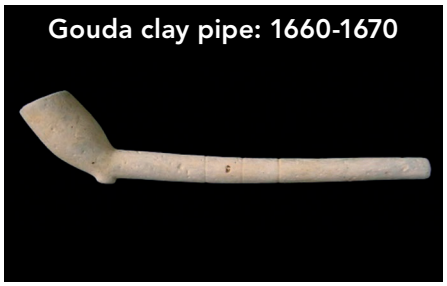
Alcohol and tobacco are both frowned upon by doctors - but enjoyed by many, particularly the former. It was therefore quite by happy chance that I stumbled upon ancient artefacts related to both these practices way back in the nineteen-eighties. The result was the start of a passion that kept me enthralled for many years—not drinking and smoking, I might add, but seeking and studying more artefacts from ancient times lying on the seabed of the Galle Harbour—a study that contributed to the establishment of the discipline of Maritime Archaeology in Sri Lanka.

The year was 1986—we had just formed the Sri Lanka Sub-Aqua Club, a recreational SCUBA (Self Contained Underwater Breathing Apparatus) diving club. This was the brainchild of a marine biologist, who wished to train other scientists and interested people to dive, free of charge, using our own spare equipment. I was one of a small group with a diving qualification from a UK club who joined him in establishing the club; and later, I went on to run the club for many years, training many aspiring divers, including another doctor and a medical student. The Galle Harbour was not under a security blanket in those days and was an interesting place to practice our sport. On one of our first expeditions, when we were diving on an old steel-hulled shipwreck, I came across an interesting little object inside the hull, that turned out to be a bowl fragment of a clay tobacco smoking pipe of the Dutch era—later established to date from the second quarter of the 18th century. The pointer to its identity came only in April of 1988, when one of my colleagues found a pipe-stem fragment on which were decipherable the letters '..OUDA'—that later turned out to be 'GOUDA', a Dutch town famed as a centre of the pipe industry as well as for its cheese. By this time, we had built up a sizeable collection of pipe bowls and stem fragments of a bewildering assortment of shapes and sizes.

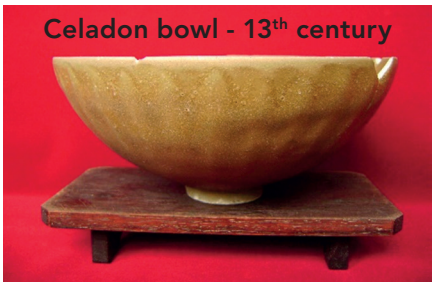
April 1988 turned out to be a good month. On the same day as the finding of the marked pipe-stem fragment, I came across an odd-looking glass bottle sitting on the sand bottom 20 feet down. I was searching for more pipe fragments, that were quite plentiful, and was inclined to ignore the bottle; but picked it up anyway. It turned out to be a Dutch period wine bottle dating from the late 17th century, described as an onion bottle on account of its squat, bulbous shape with a moderately long, cylindrical neck. Another jaw-dropping find on the same dive, also sitting on the sand bottom, was a ceramic bowl with a lotus design in relief on the outside. This was identified by my colleague, late Cedric Martenstyn, as being a Chinese Celadon bowl, a type of old Chinese ceramic ware, later dated to the 13th century; he also told me, with much excitement, about the onion bottle. These items were later identified and dated by experts at the British Museum and the Scheepvaart Museum in Amsterdam, on the side lines of a visit to the UK to celebrate the 25th Anniversary of graduation from the University of Bristol in 1998; that was after a pilgrimage to Gouda, where I learned about clay pipes, and how they were made, at the Pipe Museum.

Bristol turned out to have been a pipe making centre in England and I learnt with glee that some of the pipe bowls that were not identified in Amsterdam were in fact of English and Irish manufacture. But there was one still unidentified—this was of a Mediterranean design. Following up on this took many years, consulting people in Liverpool and Calgary Universities. Yes, it was a bowl from the Ottoman Empire, not accurately dated, but likely to have been from the 18th century. The smoking pipes of the Turkish people were of a completely different design to those of Britain and Holland. This second stage of chasing after identities was during a visit to the UK to attend the BMI Annual Representatives Meeting (ARM) in 1992 when I was President of the SLMA.

The efforts of our diving club did not go unnoticed by the authorities, eventually, with a lot of pushing by interested non-Government amateur archaeologists with an interest in maritime archaeology—like Lt. Commander Somasiri Devendra. The Joint Australia-Netherlands - Sri Lanka Maritime Archaeology Project, with which we were associated eventually led to the establishment of the Maritime Archaeology Unit by the Central Cultural Fund. One of the factors that tipped the scales in its favour were the three presentations that I and two colleagues made at the National Archaeological Congress in 1990. Prof. Vini Vitharana, who was chairing the session, remarked


Gouda clay pipe: 1660-1670


Onion bottles: Galle Harbour


Celadon bowl - 13th century

that he couldn't believe that such a lot of interesting stuff lay in the mud of the Galle Harbour. Sri Lanka archaeologists had hitherto only concentrated on the ruined cities in the more northern parts of the country—we helped in directing their gaze to the Galle Harbour by our diving activities. Unfortunately, with the situation in the country deteriorating, the harbour was put out of bounds for divers; but that did not deter the local divers, who scoured the harbour bottom using the breath-hold technique, picking up bits of coal which they sold to local blacksmiths, for their furnaces. In the process, they found more old bottles and the occasional clay pipe fragment that made their way to small antique shops and thence to my cupboards.

Soon after 1992, my diving with the Galle Harbour Project tapered off, and I spent more time on marine biology. We initiated the Mount Lavinia Marine Biodiversity Mapping Project in 1995 as a joint exercise with the S. Thomas' College diving club that had been formed as an associated club by the SLSAC. I was responsible for the final training and signing off of the schoolboy divers in the pool; and then in the sea. Unfortunately, we had bitten off more than we could chew, and the project petered out to a sad ending in 1997. But not without its high points. The one that comes to mind is the "low visibility" dive training that we did in the Kelani Ganga. Yes, in the Kelani, at Mulleriyawa; with cattle being bathed upstream of our dive site, that was also below an abattoir, with polybags of animal innards floating by on the surface. But it was quiet and peaceful on the river bottom 10 m down: squelchy mud, no obvious current, and pitch dark. We had to feel our way around, probing the mud for hard objects with our fingers.

This dive site was explored in the expectation that it might contain relics from the Battle of Mulleriyawa (1559) and subsequent wars between the Kingdoms of Sitawaka and Kotte, with the involvement of the Dutch and the Portuguese. The exact location was based on "convenience sampling" as it were, as the dive organiser had property on the riverbank and gave us lunch—traditional thalapé, not to everyone's taste! The final tally after a few dives showed evidence of Dutch and British presence in the area: two fragments of a Dutch gin bottle (circa 1700), a beautiful squat wine bottle (British, circa 1710-1790), and a cannonball that was found on the first dive at this site on 1st March 1993; it weighs 1550 gm and is 10.2 cm in diameter.

One might wonder at the possible perils of diving in these dark waters. In fact, many of our adult divers would not join us, but the teenagers from STC loved it. This was an adventure that they could be proud of. I was always the first into the water, to check the area for snags that might have washed downriver, such a tree branches, following which I laid a white, weighted line from shore to shore on the bottom. The divers followed this line singly, with me on the surface in full dive gear monitoring the bubbles. Once they settled down, they were allowed to roam free. But I was always at hand, on the surface. We had no mishaps. Although Kelani diving has not survived, another adventurous activity that I pioneered and introduced to the dive club persists, among the STC club divers. That involves swimming out to the reef off Mount Lavinia during the S-W monsoon, using flippers only, no mask. It teaches self-reliance, a healthy respect for the sea, and how to monitor currents and take appropriate action to be able to return to the starting point. As well as concern for others in the group.

Getting back to Dutch gin bottles; these belong to a group with the generic name of case bottles. They have square bases and rectangular sides with short necks, designed to fit into wooden cases. Made in Germany, Spain, and Holland, this was a traditional bottle shape from the 17th century onwards. Gin was a beverage developed in Holland, called genever at the time. It was sold as a remedy for kidney stones, flavoured with juniper berries, having been developed as a diuretic by apothecaries. It was popular more for its alcohol content than for any effect it might have had on the kidneys. Exported to neighbouring countries it became very popular in Britain. Old gin bottles make beautiful collectors' items as they come in a variety of shapes and sizes. With the passage of time the bottle changed shape—the earliest ones had the shoulders and bases equal in width; later ones were made with progressively increasing downward tapers.

[More information about old bottles, clay pipes, seashells and seaweeds, including images, can be found at <www.docmalikfern.com>]

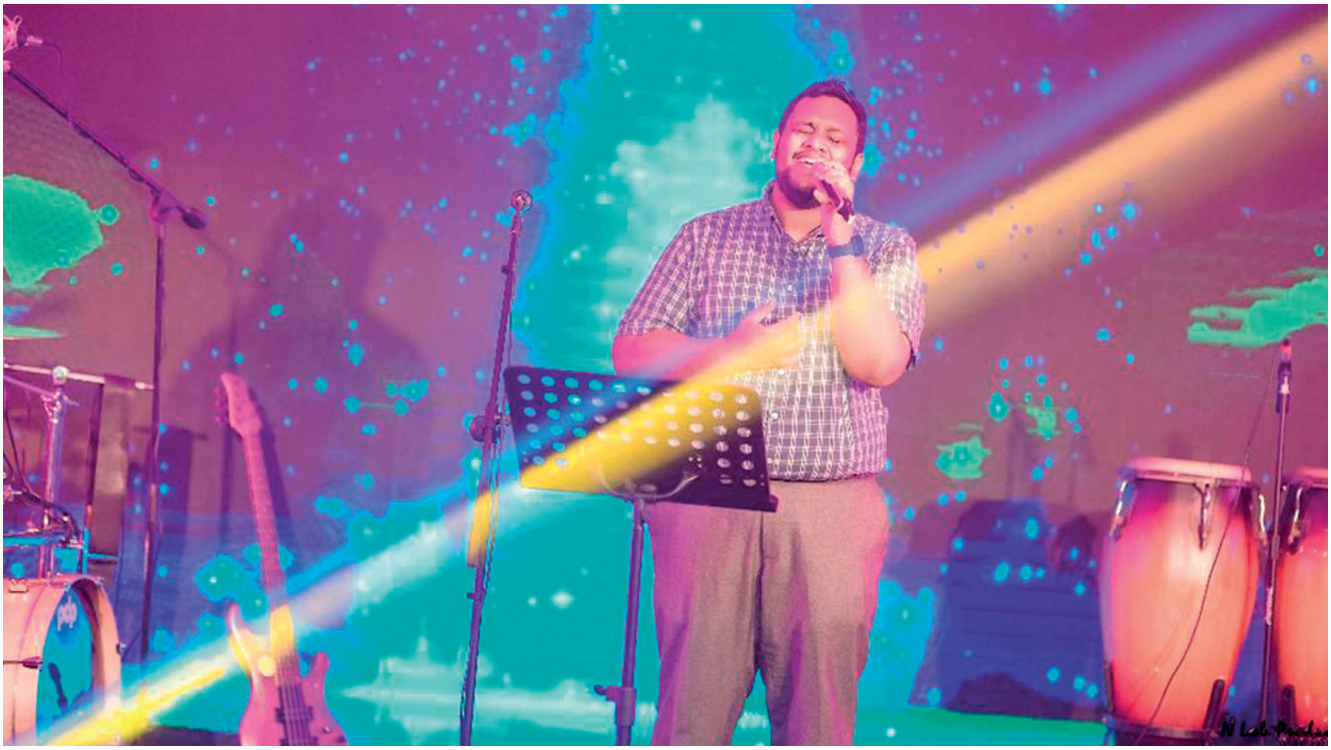
Appreciation - Dr Sachin Kalhara Colambage

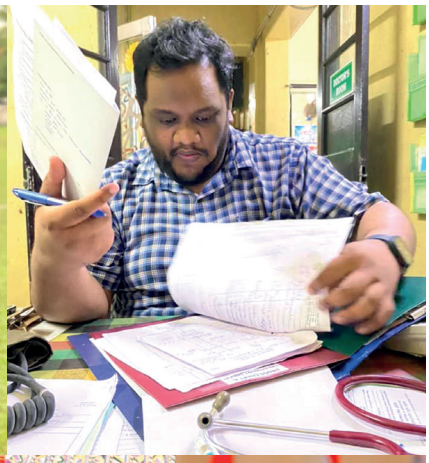
As a former President of the Sri Lanka Medical Association (SLMA), I am writing this heartfelt tribute to late Doctor Sachin Kalhara Colambage, who worked as a Pre-intern doctor at the office of the Sri Lanka Medical Association in 2021. This is an eulogy to an enormously talented young doctor, a wonderful human being; one so exceptional that my professional colleagues will wholeheartedly agree with me in honouring his precious life. In that spirit, he is one of the most exceptionally gifted individuals that I have ever met during my entire medical career spanning over 40 years.

My very first encounter with Sachin was when he presented himself for the interview to be recruited as a Pre-intern to the SLMA. Owing to the pandemic of COVID-19 related issues, being the leading Medical Association of the country, SLMA was overwhelmed with challenging tasks to be undertaken including the Anniversary International Medical Congress. As the need for an adequately skilled extra hand was intensely felt, the interviews were called from the Pre-intern batch of Medical Students. Among many applicants with high academic achievements, chubby but tall and bubbly Sachin stood out, literally and metaphorically, displaying multiple talents. He was considered the best; a unanimous choice for us. Once appointed and most surely, he lived up to our highest expectations.

Dr. Sachin Colambage was an exceptional student of Richmond College, Galle, and entered the Faculty of Medicine, Colombo, in 2014; having earned "A"s for all subjects both in ordinary and advanced levels. He qualified with the MBBS degree in 2021, having secured second class upper division passes for both Community Medicine and Behavioural Sciences Streams during his academic career.

In addition to academic achievements, he excelled in a multiplicity of other fields. He displayed his leadership skills by captaining the University Chess Team (2019) with colours of Medical Faculty and University Chess, consecutively from 2015 - 2019 and captaining the Chess Team while at Richmond College, Galle (2011), with school colours for Chess





(2012), and by being Vice Captain, Cricket Team of the Faculty of Medicine, Colombo (2019) with colours for University Cricket consecutively from 2015 - 2018. He was proficient in both Sinhala and English and had received "W. J. T. Small - Medal" for Proficiency in English at Richmond College in 2012. His bilingual skills in effective compering were an additional advantage for a professional association such as SLMA that conducted many activities for the profession and the public. He was well experienced in computer software; an essential element for the association's activities, particularly Microsoft packages and multimedia, and had a degree in JAVA - CMJD. Most of all, his extraordinary talents in performing on the music keyboards and the guitar, along with his melodious prowess at singing were intriguing to many of us on the organizing committee of the conference.

Since Dr Sachin was recruited, his contributions to the SLMA were quite substantial as a young doctor. We were most fortunate to note how talented he was, how well he worked with others, and how much he managed to accomplish. He was an intelligent, responsible and creative thinker, all of which benefited our professional association.

As the icing on the cake, he was a wonderful human being with humility and happily associated with all staff of varying social levels and from a wide age range which was rather unusual for a young doctor of his age. He was instrumental in contributing to some of our major activities; organizing the Anniversary International Medical Congress 2021, the SLMA Doc Call 247 Telephone Helpline initiative and the COVID Sahana, the fund raiser for the benefit of COVID-19-affected people and for the health care professionals. His organizational skills assisted many COVID 19 affected patients in the community via Doc Call 247 and COVID Sahana programmes. His charming character with admirable work ethics remain as a memorable beacon to all of those who worked at the SLMA. His singing at the closing up ceremony of the 134th Anniversary International Medical Congress echoes at the SLMA auditorium, even now.

While our hearts ache uncontrollably with his sudden and most unfortunate demise, our minds are filled with gratitude for the privilege to have associated with him even for a few months. He will be dearly missed by all of us at the SLMA, as well as his colleagues and friends. Even to talk about him in the past tense is totally unbearable. Sachin is survived by his loving brother and parents who are doctors, all of whom have contributed immensely to the development and upliftment of the health of the people of Galle. Sachin's untimely passing reminds us of the message of the uncertainty of every life, as preached by Lord Gautama Buddha.

I am quite sure that the Council of the SLMA, together with its entire membership, would earnestly agree with me that, though he left us too early, the distinctive and beautiful memories of the way he lived and contributed to the society in general, will remain with all of us forever.

May he attain the supreme bliss of Nirvana.

Dr. Padma S. Gunaratne

MBBS(SL), MD (SL), FRCP(Edinburgh, Glasgow, London), FCCP, Hony. FRACP, FAAN, FWSO
President, Sri Lanka Medical Association in 2021

Recognition of Services

Asia Sports Medicine and Science Award 2022: Dr Chathuranga Ranasinghe

Former Convener - NCD Subcommittee/SLMA | Chairperson - NIROGI Lanka /SLMA

Dr. Chathuranga Ranasinghe, a specialist in Sport and Exercise Medicine, was awarded the 7th Sheikh Fahad Hiroshima-Asia Sports Medicine and Science Award in line with the Asian Games 2022, by the Hiroshima City Sports Association, Hiroshima, Japan. The award was made at the General Assembly of the Olympic Council of Asia (OCA) (mother organization of all 45 National Olympic Committees (NOC)/countries in Asia) on the 4th October 2022 in Phnom Penh, Cambodia (https://olympic.lk/nocnews/394).

This is a prestigious award given to one scientist/ doctor from Asia once in 4 years in recognition of the scientific/ medical contribution to sports and achievements in the Asian region. It's a competitive award where individuals are nominated from NOCs of member countries and selected by an independent expert panel.

This is the first time a Sri Lankan has received this award giving international recognition to the country. It further establishes Sri Lankan contribution to the sport and exercise medicine discipline. Dr Chathuranga is working in the promotion of physical activity and wellbeing with the NCD subcommittee and NIROGI Lanka project SLMA. He is a main stakeholder in policy development at national and international level.

This award was recognized by the government of Sri Lanka.

Global Preparedness Monitoring Board (GPMB) WHO: Dr Palitha Abeykoon

Past President - SLMA

Dr Palitha Abeykoon, Senior Advisor to the Health Ministry & Former WHO Special Envoy for COVID-19 Preparedness and Response has been appointed to the new board membership on 30th September 2022.

The GPMB is charged with providing a comprehensive appraisal of global preparedness for health emergencies. This is in view of the COVID-19 pandemic revealing gaps in how the world understands and monitors preparedness with human elements such as leadership, trust and the performance of multiple sectors found to be crucial to the response, and therefore, to the evaluation of overall preparedness.

The GPMB's 16 board members include former policymakers, diplomats, and other leading professionals with expertise including human rights, economics, law, veterinary epidemiology, environment, gender, global health and development. The member-selection has been based on their leadership, reputation and independence, with a view to ensuring diversity and balance in gender, geography and sectoral experience.

With negotiations underway to create new global health emergency governance structures, including the Pandemic Treaty and newly established Financial Intermediary Fund, the GPMB has emphasized the need for a robust independent monitoring mechanism to shine a light on key gaps in preparedness within the global health architecture, ensuring that actions taken are as effective as possible.

(An extract from the notice published in the Sunday Times of 2022.10.16)

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