To begin with it is noteworthy to mention that the new legislation has been formulated in line with the proposals made by Prof. Senaka Bibile in 1971. However, it is disheartening that most of the authorities have forgotten the legendary general practitioner, Dr. S. A. Wickramasinghe, who served in the southern part of the island and took part in formulating proposals for the management of pharmaceuticals in Sri Lanka along with Prof. Bibile.

The above enactment was passed in the parliament recently repealing the previous Cosmetics, Devices and Drugs Authority (CDDA) Act. Although the Act was subjected to debate and discussions during the recently concluded presidential election, neither the medical fraternity nor the public had an adequate opportunity to have a dialogue on its contents. However, the College of General Practitioners discussed the proposed legislation in the council and has recommended amendments of relevant interest to GPs.
Objective and powers of NMRA
The prime objective of the new enactment is to ensure a supply of efficacious, safe medicines of good quality in an affordable and equitable manner to the public. In line with this objective, more power and functions are assigned to the new authority. The new authority has the power to regulate all aspects of medicinal drugs, devices and borderline products and their manufacture, importation, storage, transportation, distribution, promotion, advertising, dispensing and selling.

In addition the new NMRA has the power to regulate prices of all products, regulate all aspects of clinical trials, regulate and monitor adverse reactions through the pharmaco-vigilence division, disseminate information and conduct educational activities regarding medicines to the prescribers, dispensers and the public. Further, the minister has the power to appoint authorized officers also, those who can raid any place or institution coming under the subject of this enactment and to prosecute. In addition, any person who commits an offence under this enactment may be arrested without a warrant and shall be triable by a magistrate court.

Drug authority
The Drug authority under the previous enactment was the Director General of Health Services, who exercised the power through the Director of Medical Technology and Supplies of the Department of Health Services. The NMRA, under the new enactment, constitutes three ex-officio members and ten members appointed by the minister. Four of them are appointed on recommendation of main professional colleges namely Physicians, Surgeons, Paediatricians and Obstetricians and Gynaecologists. The chairman of the authority is appointed by the minister from among any appointed member. The chairman or any appointed member can be removed by the minister by assigning reasons.

The Technical Advisory Committee and its subcommittees for Drugs, Devices and Advertisements have been replaced with separate divisions under a head with relevant expert committees for the purpose evaluation of products. In addition a National Advisory Committee comprising of twenty three stakeholders will be appointed to advise the minister and the NMRA.

In contrast to previous legislation there are provisions to consider the need and the cost of medicines as criteria to grant registration and entry into market, in addition to the efficacy, quality and the safety.

From the frying pan into the fire?
Prescribing in generic name has been made a law while allowing the medical practitioner to mention a preferred brand of the prescribed generic in addition. Further legislation has been provided for the pharmacist to substitute the prescribed brand with another brand, in case the prescribed brand is not available or not affordable to the customer. However, it is premature and dangerous to have this legal provision in our health system, considering the number of actively registered pharmacists in the state and the private sectors, which is 6565 according to the Sri Lanka Medical Council Sources. The alarming information is the number of legally registered retail pharmacies in the country is only 2548 as per the statistics available at present CDCA, whereas the total number of retail drug outlets mushroomed in every corner of the country may be several times of the registered number. The sad part of this story is that, a legally qualified pharmacist is not available even in most of registered drug outlets.
Although the legal provisions are there in the enactment itself with regard to prescribing in generics, absence of legislation in the enactment to make the presence of a legally qualified pharmacist mandatory to dispense medicines in all the time, and to prohibit dispensing without valid prescriptions is a major drawback.

Further, granting legal status to the Apprentice Pharmacist (AP) is questionable, because any individual with three passes in advanced level including chemistry is the requirement to become an external AP under any registered pharmacist, and there is neither a selection examination to test the eligibility nor at least a preliminary course of theory in the subject of pharmacy as a prerequisite.

It has to be mentioned that any pharmacist can have six APs at any given time and approximately 32500 indentures have been issued by Sri Lanka Medical Council up to now for the purpose of apprentices. undoubtably, most of retail drug outlets without valid registration may have been run by these APs. Hence, the selection and training of APs should be regulated and organized in the future to prevent hazards in dispensing medicines to the public.

Need for GP representation
If the main objective of the new legislation is to make good quality, safe medicines, more affordable to the general public, the role of the General Practitioner is very important. A well organized system of general practice can play a pivotal role in reducing the out of pocket health expenditure of the citizens of Sri Lanka. The available statistics substantiate this matter, as 51% of total number of doctor patient encounters, in both state and private sector, which amounts to 13.5 million doctor patient interactions per annum, done by the GPs. Further, GPs are end users of medicines at the first contact level as family practitioners and they do both prescribing and dispensing on their own. Hence, the practical experience of GPs may play a vital role at the level of registration and evaluation of medicines in the new NMRA. Therefore the health authorities should consider the inclusion of GP representatives in the NMRA itself and the medicine evaluation committee and the boarderline product evaluation committee.

Act does not allow gps to maintain dispensing units
Moreover, the medical practitioners registered under the Medical Ordinance had the legal provision to store, dispense or sell medicines on their own prescriptions according to regulations issued under the previous enactment and it should be ensured that the same provisions prevail in the future regulations too. The new act does not allow it.

In conclusion the full credit should be given to the Minister of Health for bringing in necessary legislative amendments to regulate the pharmaceuticals used by the taxpaying citizens of the country and provide them a better health care service in the future.

Chandana Atapattu
BUY A BRICK PROJECT

“Dream! It will transform into thoughts and that in turn would result in action”.

Dear Colleagues,

This will be my last message to our members as the President of the College of General Practitioners of Sri Lanka. The Council, as proposed by me, has unanimously decided to conduct the AGM on the 26th of April, 2015.

I consider it a great privilege to have led the College for the last two years. I look back with great satisfaction at what we have, as a team, managed to accomplish. I applaud the considerable work that has been carried out by our Council in the last two years. I have been overwhelmed by their courage, commitment, and determination to work on complex projects that would have long-term benefits for our members and the community at large, even if it meant moving into uncharted territory. I am convinced that all our achievements would not have been possible if not for the dedication, team spirit, and “can-do” attitude of each and every Council member, and the spontaneous support and goodwill extended by our membership. Since I do not wish to make this message lengthy I will be sharing my views further, with regard to our activities over the past two years, during the upcoming AGM.

I am sure that those who were present during my induction would recall one of the fond dreams that I have for the College –to have its own building. I quoted, Dr. Abdul Kalam, the former President of India who once said, “Dream! It will transform into thoughts and that in turn would result in action”.

I am happy to inform you that we have made great strides in this regard with the support of my colleagues in the Council and our members. We have thus far collected rupees ten million. The break-up of the sources for this amount are as follows.

From College funds Rs. 1.5 million
Profits from the Desk Top Directory project (2013 - 2014) Rs. 3.3 million
Profits from the MCGP programme (2012 - 2014) Rs. 3.8 million
Part of the profits from the College academic sessions (2013-2014) Rs. 1.4 million
Total Rs. 10 million

The confidence exhibited and the support I received from the Council, my predecessors, our members and the great minds that adorn our College in launching this initiative has been very heartening.
Judging by present trends it is clear that the volume and pace of College activities will increase substantially in the coming years. It is imperative that our staff (who are five in number at present) and our members, who are involved in various activities of the College, need a more welcoming and comfortable ambience to do their work.

The activities that we are involved in are many. The Newsletter, CPD DE, the very important MCGP programme, the various other subcommittee activities not forgetting the Palliative Care Association of Sri Lanka (PCASL) which has been the latest addition, are just a few of our activities. The PCASL was registered in the month of September 2014 under the patronage, guidance and auspices of the College of General Practitioners of Sri Lanka.

At present we are paying a rent of almost Rs. 55,000/= per month to the SLMA (Sri Lanka Medical Association). This could increase further over the coming years.

To be effective and confident, our College needs a building of its own. A building of our own will lend not just stability but also prestige and credibility.

Although it might take some years to achieve this dream, the main idea behind the building fund and related activities is to ensure that enthusiasm for this project is sustained through the development of creative initiatives and plans to move forward.

We need to find a way to make our members take ownership of the building fund project since it can never succeed without active member participation. The “Buy a Brick “project is an initiative in this context. Each brick is priced at Rs. 1000/= (please see the picture). You can collect “bricks” from the office which can then be sold to your circle of friends, professional contacts, and relations. The brick has been designed in such a way that it could also be used as a paper weight that could come in handy in your working area.

The idea behind this approach is to empower each member of the College to contribute and run a mini-project of his/her own to contribute towards the building fund of “OUR COLLEGE.” Needless to say all transactions will need to be properly recorded and receipts issued.

I earnestly request all of you to take part in this project and make it a success. It is your project to help your College to move forward with greater vigour in the coming years. The success of this project will give the incoming Council the courage to move forward towards making our dream a reality.

I wish to extend my sincere gratitude for the confidence you had placed in me by electing me unanimously as President of the College for the last two years.

I would like to end this message by quoting my concluding remarks at my induction.

“It is my fond hope that my term should be remembered with warmth and appreciation for delivering more than what has been promised and makes us all proud to say that, “We are GPs.”

I hope I have made you proud and justified the faith you placed in me.

K. Chandrasekher
President
CGPSL
THE FAMILY DOCTOR IS AN ORPHAN!
All family doctors are primary care doctors but not all primary care doctors are family doctors

A family doctor in the Sri Lankan context is a fulltime practitioner dispensing most of the drugs he prescribes from his establishment. He works long hours without a proper arrangement to have days off or leave. Company doctors, medical examiners of recruitment companies, nursing home owners, state service doctors or university academics seeing patients during the off hours and doctors attached to NGOs too call themselves family doctors. Sometimes they make matters worse by lobbying on behalf of family doctors. Many of these categories do not engage in night work, do not undertake home visits and are not contactable by the patients after duty hours. The doctors who own nursing homes share some problems with family doctors. It must be realized though that while all family doctors are primary care doctors all primary care doctors are not family doctors.

A family doctors problems are to maintain the infrastructure of the practice, finding staff to work the awkward hours, training the staff, purchase of pharmaceuticals and equipment at a reasonable cost, dealing with the Labour Department and the Department of Inland Revenue, and updating knowledge and skills. Whenever the family doctor takes time off for CPD activities the practice gets neglected. The PGIM charges about fifty percent more for examination and course fees from doctors in the private sector. Some of those who lobby on behalf of family doctors are not aware that these problems exist! These can be broadly classified into professional self improvement and practice management. The writer has faced most of these problems in various stages of his career.

Two recent problems were banning of frequently prescribed cough syrups and banning of bulk packs (750 ml bottle) of paracetamol syrup. The knee jerk response to the cough syrup issue may be to say prescribing cough syrups is against evidence based medicine! Adrenaline injection was not available for purchase for about one year. A prefilled syringe designed for self administration is now available at a cost of Rs 11000/+ a dose!

Private Health Services Regulatory Council registers the family doctors and charges Rs 10000/= per annum. We do not get anything in return. They can at least send us copies of circulars, things like changes in immunisation schedule and management of dengue fever. I have not heard of any powerful lobbying on the above issues.

The family doctor has no recognised place in the healthcare system of Sri Lanka .The British GP is highly recognized by the National Health Service (NHS). What has been done and what is being done by the Independent Medical Practitioners Association and College of General Practitioners is much appreciated. These are areas that should receive the attention of these two professional bodies.

Duncan Bujawansa

FROM UNITY IN ADVERSITY TO DIVERSITY IN UNITY
The College - GPs, FPs, Academics, Specialists, Company MOs, UMOs, Full Time, Part Time etc.

Duncan Bujewansa is a past president of the IMPA, past secretary of the College and a senior GP. He is also probably the only contemporary GP whose life and wellbeing of his family was threatened for exposing illegal activities of business interests that were harmful to patients. Buje is a senior and long standing member of the values committee. Therefore when Buje talks we need to pay heed.
He has left out a key characteristic of general practice. We have to fund ourselves! Only gps will know how things get tough when the practice attendance dwindles. This is a time when all of us begin to worry how to make ends meet.

**Who is a GP and what is the College?**

There is lack of clarity in our minds regarding the definition of the term general practitioner. Personally I prefer to be known as a GP rather than Family Physician. The College is a sleeping giant. Many of the categories mentioned by Dr. Bujewansa are entitled to apply for membership of the College. This should be so. In terms of potential membership we are far larger than most Colleges and Associations. We are a diverse bunch but unity must remain our strength. The CGPSL is not only a professional organization. It is also an academic body. College therefore has a duty to advance the cause of academic general practice or family medicine. In this regard it becomes necessary for us to make certain concessions for academic GPs who wish to become members of the College. This has been done.

**MCGP**

It was over twenty years ago that our founder G. M. Heenilame initiated the setting up of the MCGP. Full time general practitioners and academic GPs have to pay only one fourth the course and examination fees for the MCGP. Today the MCGP is an SLMC registrable GP friendly course.

**College activities that benefit the membership**

Coming to the present, the College spends four lakhs of rupees annually to provide information, guidance and CPD to the membership. This is now a monthly feature with either the CPD print or newsletter reaching the membership regularly. The academic sessions, website, face book etc too are maintained for benefit of members and associates of the College.

The intervention by College to prevent the harassment of our members and associates by the PHSRC in which the IMPA, GMOA and College acted in unison is another example of what College has done to protect practitioners.

College has also made representations to the authorities to amend certain harmful clauses in the National Medicine Regulatory Authority act which was presented in parliament a few days ago.

Mid term and annual Secretary’s reports, Treasurer’s report, audited accounts, consultations by the Council and the Committees of the College, all of these reach the members and associates to ensure accountability.

Has the College done enough for GPs? That is a question that I would leave to the membership to answer. Have our members and associates done enough to support the work of the College? That too is a question that I must respectfully request my peers the members and associates of the CGPSL to answer.

*eugene corea*
CARING FOR CARERS

Introduction
Even in a country like Australia up to 90% of terminally ill patients spend the majority of their last year of life at home. In Sri Lanka this would probably be more.

Urbanization, economic developments and the need for increasing family income have resulted in disruption of the traditional extended Sri Lankan family. Mothers and wives seeking jobs abroad have disrupted even the nuclear family. With migration of children to big towns and other countries, old people are left alone to themselves without help. When they become victims of a terminal illness only the spouse or one sibling is available to take care of the patient. If the care giver is the spouse he/she also has morbidities to take care of. If the care giver is a sibling he/she might be studying, employed or has his/her own family to look after which creates a higher strain on the care giver.

Sri Lanka is a multi-religious country in which the four great religions uphold the value of caring for the sick. This should make the setting up of a network of care givers even at village level a little easier.

Home palliative care would be impossible without the support of care givers. This care may last for weeks, months or years.

Care givers are of two categories:
Professional carers - Health care professionals who are doctors, nurses, counselors, nutritionists and physiotherapists among others.

Volunteers-Either family members, relatives or friends. They are the key partners in the palliative care team. A volunteer care giver is an unpaid person who helps an ill patient with physical care and management of a disease. Being a care giver of a family member /a relative/ friend in most instances is not what people have planned for, but find themselves in situations where they are required to provide much needed palliative care. It has been described as one of the toughest undertakings which at the same time can be a most rewarding experience when they know that they have done the best for their loved one. No two caring situations are the same even in similar terminal illnesses. Due to multiple complex symptoms, such as pain, increased weakness, altered breathing patterns, gastrointestinal problems, and decreased levels of consciousness, experience by the patient it can be confusing and frustrating to the care giver because each experience is different. The task of care giving results in additional responsibilities and occupies the caregiver’s time, energy and attention.

Voluntary care givers burden:
Care giving when prolonged may affect the physical health of the voluntary carer by insufficient rest and sleep. Limited finances, limited knowledge, lack of support and anticipating death of the patient may cause symptoms such as anxiety and depression. This often leads to a negative impact on the capacity for social engagement.

Other factors that can affect voluntary care giver are
- Gender – Females experience greater burden than males.
- Age – Younger carers have higher strain.
- Race – One study had found Caucasians had a higher spiritual strain than other races.
- Financial status – Lower income families report higher economic strain.
- Education level – One study had found lower levels experienced higher strain. However another study found no relationship between education level and strain.
- Employment – Carers who are employed report a higher strain having to balance work and caring duties.
• Health status – Carers with poor health report higher level of physical, spiritual and economic strain.
• A study had found that longer duration of care giving was related to lower care giver stress.
• Care givers who developed personal protective resources such as intrapsychic resources (sense of confidence and inner strengths), self-efficacy and reframing were found to have lower perceived burden.

**Patients who add to care giver stress**
• Patients with more physical symptoms and distress
• Patient’s psychological stress
• Patients with more activities of daily living
• Patients with more frequent hospitalization
• Diagnosis of a terminally illness itself

**Ways of helping care givers**
• Offer physical tangible support – Discussing and obtaining permission on the best way they would like.
  Examples: Assist in meal preparation or providing ready made meals, assisting with house work, caring for their children and giving assistance in the caring process to enable the carer get time off for their own self-care.
• Emotional support – such as conveying acceptance, responsiveness, listening to concerns, demonstrating understanding and showing of concern to the welfare of the family.
• Informal support – giving information regarding the cause and course of the illness, management of symptoms, how to care for the patient, likely prognosis, how to respond to sudden changes in the patient’s condition, the services available to assist them.

**Burden on professional caregivers:**
• Not being able to cope with the care demands or expectations from patients, their relatives or friends
• Patients in many instances are deteriorating
• Emotional stress of the family after the death of the patient
• Having to handle their own morbities and mortalities
• Patient’s cultural diversities

**Possible ways of addressing the above challenges:**
• Training professional carers in palliative care alongside their formal training
• Offer updates in new developments in palliative care
• Allow to work in shift basis in order to prevent burn out
• Counseling sessions – opportunities to allow sharing personal experiences which serves as a learning forum as well as therapeutic sessions

To provide this type of support we need a good network of social care volunteers. The Palliative Care Association of Sri Lanka will have a big task ahead and a challenge to address these issues affecting volunteer and professional care givers.

In conclusion carers are key in the provision of palliative care whether they are professionals or volunteers. Carers must therefore be supported so that they can cope in with their caring roles.
Acknowledgements
I thank Dr. Chaminda Namaratne for the two photographs of the family carers.

References
International Journal of Humanities and Social Science, Vol.3 No11; June 2013
JBI “Caregiver burden of terminally ill adults in the home setting” Best Practice 15(6) 2011

Pushpa Weerasinghe

STRESS BUSTERS

POTATOES AND SUCKERS

*An old farmer wrote a letter 2 his innocent son in prison:

“This year I’m unable to plant potatoes because I can’t dig the ground. I know if you were here you would have helped me”

Son replied: “U idiot, don’t dig the ground, I have hidden the guns there”

Police read the letter, next day the ground was dug by the police, searched for guns, but nothing was found.

Son wrote again: “Now plant your potatoes dad, it’s the best I could do from here”*
REQUEST FORM FOR BLOOD PICTURE

Blood picture is a useful investigation even in primary care when patients presenting with unexplained fever, lymphadenopathy, hepato-splenomegaly and when patients are found to have abnormalities in blood counts. It is not a frequent investigation ordered by general practitioners (GPs). Therefore GPs may forget to send the necessary information to the haematologist to correctly interpret the blood picture. Time constraint is also another factor which may prevent doctors from mentioning required details. As a solution the following request form was designed after consulting haematologists. Such a printed form saves time as well as recalls information that should be included when ordering a blood picture.

---

**Letter head**

**Request For Blood Picture**

Date: ........................................

Dr. ..................................................

Con. Haematologist

Pt’s name: .......................................................... Age: ........................................

Gender: Female/Male

Reason for request: ........................................................................................................

Symptoms: ..............................................................................................................................

Pallor: Yes/No  Icterus: Yes/No

Lymphadenopathy: Yes/No

Hepatomegaly: Yes/No

Splenomegaly: Yes/No

Other: ...........................................................

Investigations: HB  Mg/dl, WBC: T- N- %, L- %, E- %

PL - Other: ............................................................

Comorbidities: ..............................................................................................................................

Medications: .................................................................................................................................

Thank you,

Dr. ..................................................

---

*R. P. J. C. Ramanayake*
# THESE SHOES ARE MEANT FOR WALKING

**DSI Diabetes Shoes - Available Locations**

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<th>No</th>
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<th>Tel. No.</th>
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<td>Dambulla</td>
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<td>Embilipitiya</td>
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<td>Badulla</td>
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<td>Pelawatta</td>
<td>No. 730A, Pannipitiya Rd., Pelawatta, Thalangama South.</td>
<td>011-2177046</td>
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**HEALTH EFFECTS OF 3D**

**FROM THIVANKA**

*continued from the last issue*

**Infections**

Infections are mainly due to hygiene. Movieline's special medical correspondent said the transmission of eye infections can occur in one or both or different parts of the eye due to unsanitized 3D glasses. Commonest eye infection is inflammation of the conjunctiva or conjunctivitis. Other possible inflammations include blepharitis, viral or bacterial keratitis, Dacrocystitis (almost always secondary to obstruction of the lacrimal duct) and ocular herpes.

**Standards in 3D cinemas**

It is necessary that extra care be taken for the cleaning or sterilization of the eyewear once used; A staff member can hand-clean each pair with a cloth & some light soap or the glasses can be collected in trays & cleaned in a dishwasher like machine or hand-out individual disinfecting wipes to each customer or to use one-time-use disposable glasses.
Who's at risk

Prolonged exposure to 3D for kids under 3 years can lead to defective development of vision and increases risk of eye infection from contaminated 3D glasses. Vision is well formed by the age of 3 years. Children and teens seem like the ideal consumers of 3D TV. They are prone to dizziness, nausea and other symptoms. Watching 3D TV is an entirely new experience for the elderly and the novel experience could be so immersive that it leads to dizziness, disorientation and confusion. Several 3-D device companies have issued warnings about children's use of their new products. The original Nintendo (a video-game company) warning, in late 2010, urged parents to prevent children under age 6 years from prolonged viewing of the device's digital images, in order to avoid possible damage to visual development.

At present there are no conclusive studies on the short, and/or long-term effects of 3-D digital products on eye and visual development, health or function in children, nor are there persuasive, conclusive theories on how 3-D digital products could cause damage in children with healthy eyes.

The development of normal 3-D vision in children is stimulated as they use their eyes in day-to-day social and natural environments, and this development is largely completed by the age three years.

Pregnant women may experience motion sickness, perceptual after effects, disorientation, eye strain and decreased postural stability which may cause accidental and unintended harm to both mother and the unborn child.

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Thivanka Munasinghe

Up COMING EVENTS

Up Coming Events

* 20th April 2015: Launch of Palliative Care Association of Sri Lanka
* 26th April 2015: Annual General Meeting

COLLEGE NEWS
TRUTH ABOUT HAND WASHING AND BACTERIA

Better dine in the toilet!

Are you a person who takes care to wash your hands properly? Well, if you are then you are one of a worldwide minority of people who wash their hands. Surveys conducted in the United States suggest that while 2/3 of people do wash their hands, 95 percent of them are washing them wrong. In Britain, one experiment found that while 99 percent of the people tested admitted to washing their hands after using the facilities, a camera revealed that only 32% of the men and 64% of the women actually washed their hands with soap and water.

You may be wondering why the test subjects lied. It may be that they sincerely believed that their hands weren't dirty enough to spread disease or infection. But after reading about these places that are dirtier than your toilet, you probably will wash your hands thoroughly.

Keyboards: Your computer keyboard, yes the one you are typing on right now, can have up to 200 times more bacteria than a toilet seat. During a test of the equipment in a busy London office, microbiologists found a few keyboards that were so dirty that they were classified as 150 times the acceptable limit for bacteria. The most common bacteria found on the keyboards was Staphylococcus, which lives in our noses, throats, hair and skin. Staph spreads when we touch our faces or sneeze into our hands, and fail to wash them after. Many of the items on this list are here because they are heavily ridden with staph.

Restaurant menus: Of course, with everyone touching, sneezing or coughing on the menu in front of them, it's no wonder that they usually carry 100 time more bacteria than a restaurant toilet seat. In fact, a large percentage of food-borne diseases like E. Coli spread in restaurants when someone has contaminated hands.

Toothbrush: Although it may only enter your mouth, your toothbrush is ridden with bacteria. Research has found that one tooth brush can harbour more than 100 million bacteria, including dangerous E. Coli bacteria, which can cause diarrhoea, and staph. Make sure you change your brush on a regular basis!

Light switch: The light switch can have up to 217 bacteria per square inch, which means that every time you turn the light on and off, you could be exposed to dangerous bacteria that has accumulated there over time. Make sure that you clean the light switches regularly at your home and office with bleach!

Remember, you should wash your hands thoroughly with antibacterial soap for a total of around 40 seconds to a minute. Make sure the soap reaches a rich lathery consistency before washing it off. If everyone washes their hands the way they should, it is predicted that over a million deaths from disease a year could be prevented. So, for your good and the good of all, wash your hands responsibly!

Narne Wickremasinghe

Points to ponder
• If you regularly wash your light switches (leave alone use bleach on them) aren’t you likely to be electrocuted?
• If you use antibacterial soaps regularly on your hands is it likely that the millions of protective comensal bacteria too would be destroyed?
• Isn’t the human skin a wonderful organ?

Editor
Infection Prevention and Control

- Most simple and effective way to prevent hospital acquired infection is hand hygiene
- Adhere to WHO my 5 moments of hand hygiene
- Follow six (06) steps
POOR RESPONSE TO STATINS MAY MEAN CLOGGED ARTERIES

*About 1 in 5 patients taking cholesterol-lowering drugs doesn't benefit, researchers find*

THURSDAY, Feb. 26, 2015 (Health Day News) -- Twenty percent of people with heart disease don't respond to cholesterol-lowering statins and may have dangerously clogged arteries, researchers have found.

A new study found these people experienced little or no reduction in the "bad" cholesterol that contributes to artery-blocking plaque, making heart attack or stroke more likely.

The finding has important implications for statin guidelines, said lead researcher Dr. Stephen Nicholls, deputy director of the South Australian Health & Medical Research Institute in Adelaide. "Cholesterol levels should continue to be monitored to ensure we are moving in the right direction," said Nicholls. "It is simply not good enough to prescribe [a statin] and move on."

The analysis also underscores the need for new medications to target plaque buildup in statin non responders, the study said.

Nicholls said many patients -- responders and non responders alike -- take low doses of statins, which is not supported by the guidelines. Treating high cholesterol more aggressively is essential to lowering the risk of heart attacks and strokes, he said.

Low-density lipoprotein (LDL) cholesterol -- the bad kind -- leads to thick, hard deposits of plaque that can narrow arteries and make them less flexible.

"Statin therapy has been demonstrated to slow or even reverse progression of plaque along with preventing heart attacks and strokes," said Dr. Gregg Fonarow, a professor of cardiology at the University of California, Los Angeles. "However, response to statins may vary among individuals."

Prior studies have shown that clinical benefits of statin therapy are in direct proportion to how much LDL is reduced, said Fonarow, who was not involved with the study.

He agreed that the findings of this study "suggest it may be important for evaluating clinical response to monitor LDL reduction during statin therapy."

For people who don't respond to statins, there may be hope on the horizon. Fonarow said new drugs to lower LDL cholesterol are being tested in large clinical trials.

For the study published Feb. 26 online in the journal *Arteriosclerosis, Thrombosis and Vascular Biology* Nicholls' team analyzed seven studies involving a total of 647 patients with heart disease taking statins.
Ultrasound was used to compare the patients' arteries before and after statin therapy. Patients were followed for 18 to 24 months.

Most patients saw significant decreases in LDL cholesterol. However, for 20 percent of the patients, LDL cholesterol levels either decreased only a little, remained the same or increased.

Moreover, these non responders had faster plaque buildup in their arteries than patients who responded to statin therapy, the researchers found.

Exactly why so many had a poor response isn't clear, they said.

Guidelines from the American Heart Association recommend statin therapy for:

- People without heart disease, 40 to 75 years old, with some risk for having a heart attack or stroke within 10 years.
- People with a history of heart attack, stroke, angina, artery disease, ministroke, or those who've had angioplasty.
- People 21 and older who have LDL cholesterol of 190 mg/dL or more.
- People 40 to 75 with type 1 or type 2 diabetes.
  Others might also benefit from taking statins, but that decision should be made by their doctor.

SOURCES: Stephen Nicholls, M.B.B.S., Ph.D., deputy, South Australian Health & Medical Research Institute, professor, cardiology, University of Adelaide, Australia; Gregg Fonerow, M.D., professor, cardiology, University of California, Los Angeles; Feb. 26, 2015, Arteriosclerosis, Thrombosis and Vascular Biology, online.
## Clinical Indications for HIV Testing

**Test Early to Save Lives**

### Neurological
- Cerebral toxoplasmosis
- Primary cerebral lymphoma
- Cryptococcal meningitis
- Progressive multifocal Leucoencephalopathy
- Aseptic meningitis / encephalitis
- Space occupying lesion of unknown cause
- Guillain - Barré syndrome
- Transverse myelitis
- Peripheral neuropathy
- Dementia
- Cerebral asceps

### Ophthalmological
- Cytomegalovirus retinitis
- Infective retinal diseases including herpesvirus and toxoplasma
- Any unexplained retinopathy

### Dermatological
- Kaposi’s sarcoma
- Papular pruritic eruptions
- Severe or recalcitrant seborrheic dermatitis
- Severe or recalcitrant psoriasis
- Multidermatomal or recurrent herpes zoster

### Respiratory
- Tuberculosis
- Pneumocystis pneumonia
- Recurrent / severe bacterial pneumonia
- Aspergillosis

### Haematological
- Any unexplained blood dyscrasia
- Thrombocytopenia
- Neutropenia
- Lymphopenia
- Unexplained high ESR
- Unexplained anaemia

### Oncological
- Non - Hodgkin’s lymphoma
- Anal cancer or anal intraepithelial dysplasia
- Hodgkin’s lymphoma
- Castelman’s disease

### Gastrointestinal
- Persistent cryptosporidiosis
- Oral candidiasis
- Oral hairy leukoplakia
- Chronic diarrhoea of unknown cause
- Weight loss of unknown cause
- Salmonella, shigella or campylobacter diarrhea
- Hepatitis B infection
- Hepatitis C infection

### Gynaecological
- Cervical cancer
- Vaginal intraepithelial neoplasia
- Cervical intraepithelial neoplasia grade 2 or above

### Other
- Pyrexia of unknown origin
- Recurrent bacterial infections
- (e.g. meningitis, sepsis, osteomyelitis, pneumonia etc.)
- Systemic fungal infections
- Unexplained proteinuria

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For further information contact nearest STD Clinic

Always request an HIV test even in the absence of above indications considering the possible behavioural risk factors of your patient.
SAYONARA

A Big Thank you to our readers for the past two years, for your patient reading!

Editorial Board