



IF YOU BLEED, THEY WILL FEED

the ugly side of political medicine

Part One Feeding Frenzy

Internationally renowned legendary Sri Lankan journalist Tarzie Vittachchi was fond of relating the following story of an interaction with an African colleague from his UN days. His colleague had wanted Tarzie to advise him about launching a publicity campaign in the USA for a great and good countryman of his. Tarzie had given him a tongue in cheek response - "shoot him!"

Violence, death and gory incidents sell newspapers. You too dear reader would have noticed how such stories become the leading reports in the newspapers. Hence the somewhat unfair maxim about the media which is often quoted - "If it bleeds, it leads". That was why the late great Vittachchi had humorously advised his colleague to shoot his client to get maximum publicity!

Last month there was a tragic incident in which a medical colleague suffered an untimely death. A media circus followed. Every detail about the deceased doctor that could be sensationalized was published in the media & social media. Not surprisingly, the doctor who had attended on her came across as heinous villain in the press. All this was sad and degrading but to be expected. The media unfortunately has to carry out this "duty" in order to remain relevant.

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However I was surprised and saddened at the spectacle of a few medical colleagues, jumping on the band wagon with their pet theories and preformed notions about what had gone wrong.

Mind you this was even before a cause of death had been determined. Some even had indicated their unhappiness to the press about not being consulted by the poor doctor who had died.

The press also generously reported the frenetic activities of a few medical specialists all eager to analyze and dissect the seemingly inappropriate behaviour of the doctor in custody. They did not fail in their duty to tell the public about the importance of consulting proper doctors (which all of them undoubtedly were) for similar problems. A few fair doctors in a media conference even advanced the medical benefits of having dark skin!

The press quoted minor trade union officials who gave their considered opinion and made recommendations for a presidential commission on doctors. The icing on the cake was when the prosecuting police officer objected to the “offending” doctor being granted bail on the grounds that it would cause a halabaloo among doctors! Bail was disallowed on that occasion.

A similar feeding frenzy of doctor eating doctor was also reported in the press with great relish about a month prior to this tragic incident. On that occasion, some doctors in a press conference had alleged fraudulent activity and subterfuge on the part of their colleagues. Subsequently some docs had barked at other docs and even become physical with each other in a hospital canteen. These of course were properly certified highly qualified doctors acting in surroundings which no doubt exemplified the highest standards of excellence in the country. Proper doctors. Proper places. Exactly what the doctor ordered for the members of the press.

In my opinion this kind of self serving and damaging (to the medical profession) use of the media by doctors is a classic example of the practice of opportunistic Political Medicine. Such activity seems to be particularly vicious when individual private practitioners are involved. So dear colleagues please be advised that when you bleed, they will feed. The press of course will have to lead.

eugene corea

Editor- Views expressed here are those of the writer and do not necessarily represent those of



If You Bleed, They Will Feed, Part 2 Patient safety will be continued in the next issue

***WRITE TO US. KEEP IN TOUCH. SHARE YOUR VIEWS. GIVE US YOUR ADVICE.
BUT FOR GOD'S SAKE DON'T KEEP QUIET!***

BEING MINDFUL IN COMMUNICATION

Communication between persons through power of word takes place by several modes, face-to-face speaking, telephone conversation, writing and emailing. However, we sometimes find that the message received is not quite the same that was intended.

Speech is a valuable human asset for communication, but at times becomes difficult to control, especially when charged with emotion. Therefore, adequate thought is very necessary before we say what we want to say. “Think before you speak” would be a useful motto.

Writing is a mode of communication where we could wisely use restraint. It has been said that a former US President Harry Truman had a rule. Any letter written in anger had to sit on his desk for 24 hours before it could be mailed. By the end of his life Truman’s un-mailed letters filled a large desk drawer. This is a good example.

In this age of advancement in facilities for communication, our tongues, our pens and our keyboards if used with wise restraint will spare us much embarrassment, and not spoil relationships.

In writing this, I have been inspired by a publication, by RBC Ministries Lanka, “Our Daily Bread”

Leela de A. Karunaratne

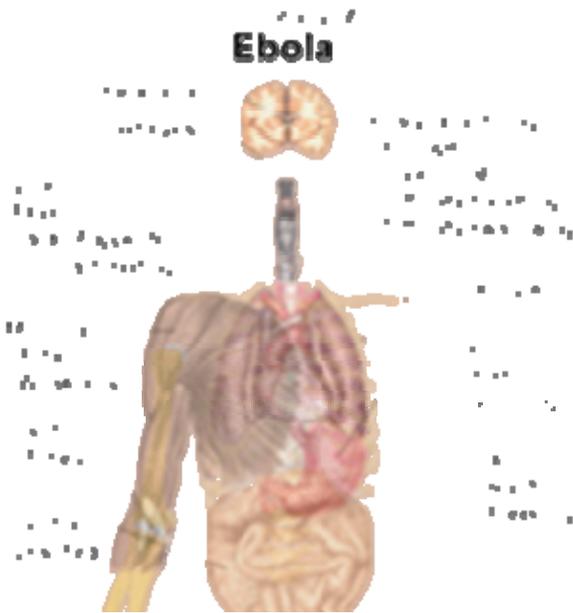
ALL EBOLA**FROM THIVANKA**



The Ebola virus disease was first identified in 1976 in a small rural village in Democratic Republic of Congo. The first known victim was a village school headmaster who had toured an area along the Ebola river, with a small group of people. Later after an outbreak of the virus in the Congo and Sudan, it was identified as a new type and named after the river.

It is one of many viral haemorrhagic fevers which cause a severe acute illness, often a fatal disease for those who contact it (mortality rate 50% - 90%) The fruit bat is the initial reservoir of the virus. It is transmitted through the bats’ faeces to the other wild animals. Then from the infected wild animals, the virus gets transmitted to human via direct contact.

The Ebola virus is a RNA virus. It arises from the genus Ebolavirus which is from the family Filoviridae (filovirus).

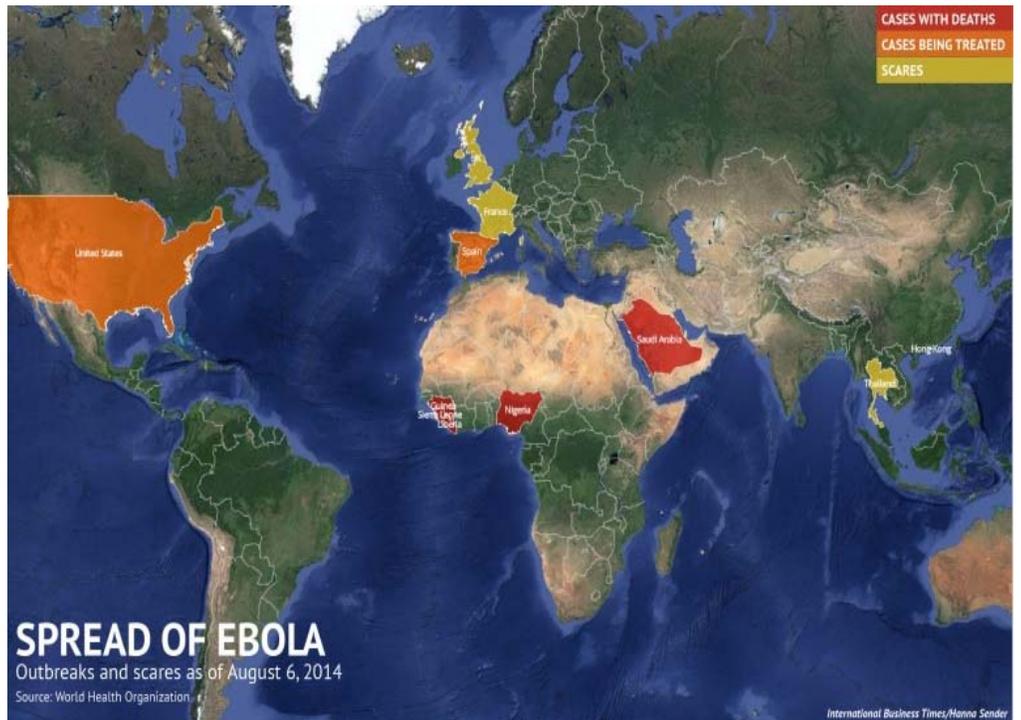


Symptoms & Signs

- Flu-like sudden onset of fever
- Intense weakness
- Muscle pain
- Headache
- Sore throat
- Vomiting
- Diarrhoea
- Loss of appetite
- Maculo-papular rash (in about 50% of cases)
- Impaired kidney and Liver function
- Both internal and external bleeding

The average time between contracting the infection and the start of symptoms is 8 to 10 days, but it can vary between 2 and 21 days.

Early symptoms of Ebola virus disease may be similar to those of malaria, dengue fever or other tropical fevers, before the disease progresses to the bleeding phase. In 40–50% of cases, bleeding from puncture sites and mucous membranes (e.g. gastrointestinal tract, nose, vagina, and gums) has been reported. In the bleeding phase, which typically starts 5 to 7 days after first symptoms internal and subcutaneous bleeding may present itself through reddening of the eyes and bloody vomit. Bleeding into the skin may create petechiae, purpura, ecchymoses, and hematomas (especially around needle injection sites). Types of bleeding known to occur with Ebola virus disease include vomiting blood, coughing it up or blood in the stool. Heavy bleeding is rare and is usually confined to the gastrointestinal tract. In general, the development of bleeding symptoms often indicates a worse prognosis and this blood loss can result in death. All people infected show some symptoms of circulatory system involvement, including impaired blood clotting. If the infected person does not recover, death due to multiple organ dysfunction syndromes occurs within 7 to 16 days (usually between days 8 and 9) after first symptoms.



Diagnosis

- Proper history, especially travel and work history along with exposure to wildlife.
- Low white blood cell count.
- Enzyme linked immunosorbent assay (ELISA).
- Antibody detection tests.
- Serum neutralization test.
- Reverse transcriptase polymerase chain reaction (rt-pcr) assay.
- Electron microscopy.
- Virus isolation by cell culture.

Treatment

There is no treatment that is specific to the virus as of yet. Treatment that is rendered is generally supportive and symptomatic like the administration of electrolytes to reduce dehydration, anticoagulants to prevent disseminated intravascular coagulation, maintain oxygen levels, pain management and drugs against bacterial or fungal infections.

Since the disease has a high mortality rate (50% - 90%), the precautionary level given to the infected according to the World Health Organization is a risk 4 group pathogen. This is isolation and handling of the infected individuals within a closed facility.

Prevention

- Reduce wildlife to human transmission. (fruit bats, monkeys/apes and etc.)
- Animals should be handled with gloves and other appropriate clothing.
- Animal meat should be thoroughly cooked before consumption.

Reduce human to human transmission

- Avoid direct or close contact with infected (or suspected) patients, particularly with their bodily fluids.
- Healthcare workers should take special measures and use appropriate personal protective equipment as they are more at risk (face mask, goggles, clean non-sterile long sleeved gowns and gloves).
- Regular hand washing is required after visiting patients and also should maintain respiratory hygiene, safe injection practices and safe burial practices.
- Educate the community about the nature of the disease and about outbreak containment measures.

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- <http://www.nlm.nih.gov/medlineplus/ency/article/001339.htm>

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THE MYSTERIOUS SINGER OF BATTICALOA

It is a well-known fact that a song is heard in the Batticaloa lagoon by night, especially on full moon days. There are various opinions given as to the singer of this song. Singing fish is a fascinating phenomenon thought to be related to this song. Exactly who does sing this melodious song? Prince G. Casinader, a well-respected senior citizen, former Principal, Methodist Central College, Batticaloa and former member of parliament was interviewed to obtain his views regarding this.



Mr. Casinader said that this music was not confined to a particular season and was best heard, on a quiet full moon night. He said that in order to hear this music you would have to go by boat near the Elephant rock and plunge an oar into the water while keeping the other end to the ear. Mr. Casinader recalled that there were several people, who had heard the musical sounds at first hand. Among them was Sir Emerson Tennent, a former colonial secretary of Ceylon, and a member of the British Parliament. Mr. Casinader kindly requested the younger generation, without being engrossed, only in the restrictive school syllabi, to include topics of local interest like singing fish in their inquiries. He said “definitely there is music, you must go there and listen”. He concluded by saying that to date, it has not been established that it was the fish that provided the musical sounds.

In fact many papers have been published by enthusiastic nature loving investigators in the past. Their ultimate quest was to find out the singer in the Batticaloa lagoon.

Shell as the singer

The documented information regarding the singing fish can be traced to the 19th century. Sir J. Emerson had mentioned in his book that, during his visit to Batticaloa in 1848 he was told by the local fishermen that the music was due to the sound produced by shells. This is known by the Tamil name of *oorie cooleeroo cradoo*, or the "crying shell" [1]. *Cerithium lividulum* is the scientific name for this shell (Figure 1).

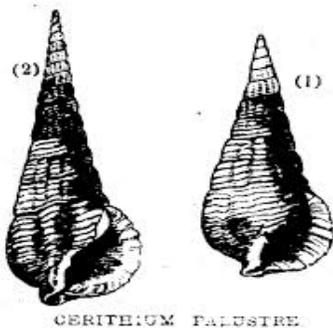


Figure 1. *Cerithium lividulum*

Sir J.Emerson described his experience thus; “In the evening when the moon rose, I took a boat and accompanied the fishermen to the spot. We rowed about two hundred yards north-east of the jetty by the fort gate; there was not a breath of wind, nor a ripple except those caused by the dip of our oars when I distinctly heard the sounds in question. They came up from the water like the gentle thrills of a musical chord, or the faint vibrations of a wine-glass when its rim is rubbed by a moistened finger. It was not one sustained note, but a multitude of tiny, sounds, each clear and distinct in itself; the sweetest treble mingling with the lowest bass.

On applying the ear to the woodwork of the boat, the vibration was greatly increased in volume. The sounds varied considerably at different points, as we moved across the lake, as if the number of the animals from which they proceeded was greatest in particular spots; and occasionally we rowed out of hearing of them altogether, until on returning to the original locality the sounds were at once renewed.

This fact seems to indicate that the cause of the sounds, whatever they may be, is stationary at several points; and this agrees with the statement of the natives, that they are produced by shells and not by fish.

However subsequent investigators who had studied this mysterious music were of a different opinion.

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The Mysterious Singer of Batticaloa, will *be continued in the next issue*



THE INVESTIGATIONS CONTINUE

FROM PUSHPA

IMMUNOGLOBULIN E AND ALLERGY

Immunoglobulin E (Ig E) antibody plays an essential role in type 1 hypersensitivity, which manifests as various allergic diseases, such as allergic asthma, allergic rhinitis, most types of sinusitis, food allergy, atopic dermatitis, and some types of urticaria. It plays a pivotal role in anaphylactic reactions to certain drugs, bee stings and antigen preparations used in specific desensitization immunotherapy.

Though IgE is present in minute amounts, it is capable of triggering the most powerful inflammatory reactions. Blood IgE level in a non-atopic individual is only 0.05% of the Ig antibody concentration. Ig E antibodies are also found in the lungs, skin and mucus membranes.

Atopic individuals can have up to 10 times the normal level of IgE in the blood. However this may not be a requirement for symptoms to occur. Asthmatics with normal IgE levels in their blood can also have symptoms since IgE production can occur locally in the nasal mucosa.

The allergic cascade

- 1. Sensitization to an allergen: being exposed for the first time**

Initially exposed to an allergen by inhalation, ingestion, touch and injection

The body then produces IgE designed specifically for that particular allergen, but experiences no reaction.

- 2. Early- phase response to an allergen upon re-exposure to an allergen.**

This occurs within an hour after initial exposure.

- 3. Late-phase response to an allergen**

The late-phase response actually begins at the same time as the early-phase response, but takes longer to manifest (about 3-10 hours later). Often the late-phase response involves eosinophils and can last for 24 hours before subsiding. During the late-phase response symptoms can be more severe than those seen during the initial response.

Investigations

Diagnosis of allergy is often done by reviewing the patient's history and finding a positive result for the presence of specific IgE by conducting a skin or a blood test. Because IgE antibodies are unique to each allergen, checking for specific variants can help to determine whether an allergy is present.

Skin tests include skin prick or scratch tests and patch tests. These tests should be carried out under medical supervision, as severe reactions including life threatening anaphylaxis may occur. The usefulness of these tests can be affected by skin conditions such as dermatitis, eczema and medications such as anti histamines and some anti depressants.

Skin prick tests are done for

- Food allergens: IgE mediated food allergy eg: cow's milk, egg, pork, beef
- Moulds
- House dust mite/ Cockroach
- Weed
- Grass

Allergen specific IgE antibody test is a blood test and is a safe method as it does not have an effect on the person being tested. It helps to diagnose an allergy to a specific substance or substances. Also to monitor immunotherapy (desensitization) or to check whether the patient has out grown an allergy.

Comprehensive allergy tests are carried out for groups of allergens.

These tests include:

Allergy test panel – Basic: includes grasses, trees, weeds, moulds, dusts, nuts, cereals, fruits, cypress, milk, eggs

Allergy test panel-Food: in this panel rare allergens like apple, rice, wheat flour, grape, potato, spinach, cucumber, onion, coffee, ginger, mustard are also included in addition to the common allergic foods.

Allergy test panel- Inhalation: Aspergillus-fumigatus, cockroach, cat, dog, pigeon feathers, chicken feathers, cotton yarn and fabric, straw dust, sheep wool etc.

Allergy test panel-Respiratory: cat epithelium dog squamous, cypress pollen etc.

IgE antibody test can also be done for individual allergens.

These include

Foods – banana/mango/papaya/coconut/lentil in addition to the common allergens.

Mites- house dust mite

Weed Pollens

Moulds

Microorganisms- eg: Candida Albicans

Epidermal and Animal Proteins – rat epithelium, rat urine proteins

Insects– cockroach/ mosquito

Occupational- wood dust/latex/cotton seed

Drugs- Gelatin Bovine/ Penicillin G/ Penicillin V

Since IgE testing is an expensive affair you should know what IgE tests are available in the country.

You could order the following tests.

1. Total IgE Test
 2. Comprehensive Allergy Test – Here you would have to request the panel that you require. Ex: Basic Allergy Panel, Food Allergy Panel
 3. Individual Allergy Test – Here you have to specify the type and the allergen ex: food- tuna
- It may be advisable to obtain further information from the laboratory prior to requesting the test.

Acknowledgements

I thank Roshan Palihawadana and Niluka Sarangani for the support given in compiling this article.

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Pushpa Weerasinghe

Up Coming Events

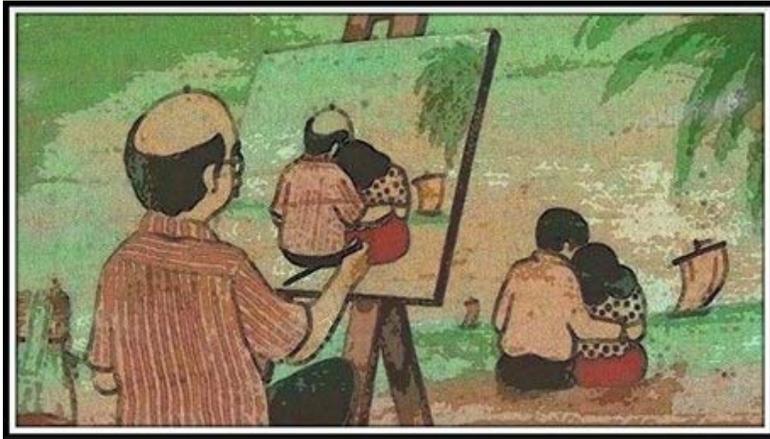
- 28th September 2014 : Pre-congress
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Empathy



An intelligent wife is the one who makes sure, she spends so much that her husband can't afford another one...

-- Fun for Lungs

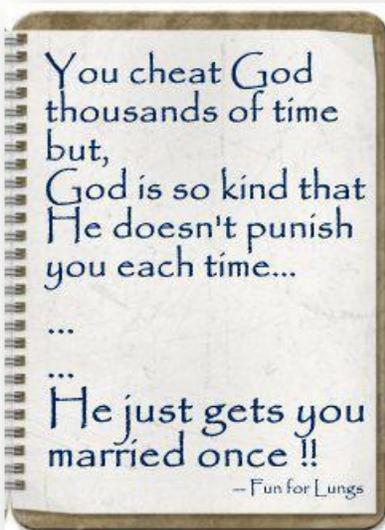


Three Dreams of a Man

To be as handsome as his mother thinks..

To be as rich as his child believes..

To have as many women as his wife suspects !!



NEW TYPE OF "UPVAS"
 LIVING 1 DAY WITHOUT
 1.MOBILE.
 2.VEHICLE.
 3.FACEBOOK.
 4.INTERNET...
 5.PC/LAPTOP
 TRY DIS 2 GET REAL PEACE OF MIND. ---

ANAPHYLAXIS

Update from the Australian Family Physician

Anaphylaxis is reported frequently in the press and in medical circles nowadays. Given below are extracts from an article in the Australian Family Physician Volume 42, No.1, January/February 2013 Pages 38-42 authored by Ingrid Laemmle-Ruff, Robyn O’Hehir, Michael Ackland, Mimi LK Tang. For want of space this will be carried over to the next issue.

Anaphylaxis is a severe allergic reaction that can cause death.

It involves the respiratory and/or cardiovascular system(s), usually with additional cutaneous and/or gastrointestinal features (*Table 1*). It usually occurs within half an hour of allergen exposure, but may take up to 2 hours to develop. Some studies suggest that in children, respiratory features predominate, compared with cardiovascular features in adults.

Anaphylaxis is primarily a clinical diagnosis. Recognising anaphylaxis can sometimes be problematic, for example, in the absence of an obvious trigger. In addition, skin and mucosal features can be absent in up to 10–20% of episodes. Serial serum tryptase levels can sometimes assist in confirming anaphylaxis in unclear cases. **Anaphylaxis should be considered in any patient with acute respiratory distress (ARD), bronchospasm, hypotension and/or cardiac arrest (*Table 1*).**

Table 1. Common features of anaphylaxis

Respiratory/airway	Cardiovascular	Skin	Gastrointestinal
Stridor/wheeze			
Difficulty swallowing	Tachycardia/bradycardia	Urticaria (hives, wheals)	Nausea
Persistent cough	Collapse/loss of consciousness	Angioedema	Vomiting
Dyspnoea	Hypotension	Flushing	Abdominal pain
Hoarse voice	Pale and floppy (in infants)	Generalised itch	Diarrhoea
Throat/chest tightness			

Causes

Medications, food and insect venom are the most common triggers for anaphylaxis.

Medications are a common trigger for anaphylaxis hospitalisation in older adults. Medications that most commonly trigger anaphylaxis are **antibiotics** (especially penicillins), **anaesthetic drugs**, **non-steroidal anti-inflammatory drugs (NSAIDs)** and **opiates**.

The foods that most commonly trigger anaphylaxis are peanuts, tree nuts, hen’s eggs, cow’s milk, wheat, shellfish, fish and seeds (eg. sesame). Nut allergies carry the highest risk of anaphylaxis and death.

The venom of bees, wasps, and certain types of ants can trigger anaphylaxis. **Note that exercise-induced anaphylaxis can occur in isolation or in association with a food trigger.** Other less common triggers of anaphylaxis such as latex, radiocontrast media and idiopathic anaphylaxis will not be specifically addressed here.

Risk factors

1. Risk factors for developing anaphylaxis

Some features in a patient's medical history may indicate an increased risk of anaphylaxis, including previous anaphylaxis, multiple drug allergies, nut allergy and a history of asthma (especially if poorly controlled).

In addition, certain factors present around the time of allergen exposure can increase the risk of anaphylaxis. These include alcohol, exercise, NSAIDs and intercurrent infection.

There are currently no tests that predict anaphylaxis risk. While predictive for clinical allergy, the level of allergen specific IgE or size of the skin prick testing (SPT) reaction do not correlate with risk of anaphylaxis.

2. Risk factors for increased severity or fatality

A number of factors influence the risk of fatal anaphylaxis, including the severity of underlying allergy, allergen dose, age, medical comorbidities and concurrent medication use. Asthma and cardiovascular disease in particular are associated with an increased risk of severe or fatal anaphylaxis. The use of concurrent medications, such as beta-blockers and angiotensin converting enzyme inhibitors (ACEIs), can also increase the severity of anaphylaxis and/or render anaphylaxis more refractory to treatment. Risk factors for fatality vary according to the cause of anaphylaxis.

Management

1. Acute management

Adrenaline is first line treatment for anaphylaxis. Intramuscular (IM) injection into the anterolateral thigh is the preferred route for the initial administration of adrenaline.

Additional supportive therapy with nebulised beta-2 agonists (for bronchospasm), H1 antihistamines (for cutaneous symptoms), and/or glucocorticoids (may reduce the risk of biphasic reactions) is often utilized in clinical practice, but plays a less important role and is considered second line. **These medications should never be used as an alternative to, or before, adrenaline for anaphylaxis.**

Emergency management of anaphylaxis

1. Stop exposure to causative agent (if possible), assess reaction severity and treat accordingly

- Call for assistance
- Give adrenaline IM (lateral thigh) 0.01 mg/kg (maximum adult dose 0.5 mg)
- Lay patient flat (elevate legs if tolerated)
- Set up IV access
- Give high flow oxygen + airway/ventilation support if needed
- If hypotensive, also:
 - set up additional wide bore IV access (14 G or 16 G in adults) for normal saline infusion
 - give IV normal saline bolus 20 mL/kg stat

2. If there is inadequate response, an immediate life threatening situation or deterioration:

- Repeat IM adrenaline injection every 3–5 minutes, as needed, or
- Start an IV adrenaline infusion, as per hospital guidelines/protocol*

* IV adrenaline infusion usually requires intensive care expertise for administration. Intravenous bolus administration of adrenaline is best avoided

Adapted from Brown SG, Mullins RJ, Gold MS. Anaphylaxis: diagnosis and management. Med J Aust 2006;185:283–9

Key points

- Presentations and hospital admissions for anaphylaxis are increasing, however, death from anaphylaxis is rare.
- Anaphylaxis is a medical emergency requiring immediate treatment with adrenaline.
- The most common causes of anaphylaxis are medications, food and insect venom
- Exercise induced anaphylaxis can occur in isolation or with a food trigger.
- Anaphylaxis should be considered in patients with acute respiratory distress, bronchospasm, hypotension and cardiac arrest.
- There are currently no tests that predict anaphylaxis risk.
- Beta 2 agonists, H1 anti histamines and glucocorticoids should never be used as an alternative tool or before adrenaline.

Courtesy B. Karunaratne

Reference

Anaphylaxis, Identification, management and prevention, Ingrid Laemmle-Ruff, Robyn O’Hehir, Michael Ackland, Mimi LK Tang, Australian Family Physician, Volume 42, No.1, January/February 2013 Pages 38-42,

Anaphylaxis will be continued in the next issue



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