TB “THE PROBLEM” EVEN IN THE 21ST CENTURY

In 1993 W.H.O. declared Tuberculosis a Global Emergency. Today in 2010 at least 1/3rd of the world’s population is infected with TB bacillus which is close to 2 billion people. Observe the following facts on the magnitude of the problem.

• Eight million people develop TB every year and 95% of them live in developing countries
• Close to 2 million people die every year of TB
• TB is the most devastating killer in the infectious diseases category in adults
• 26% of all avoidable deaths in developing countries are due to TB
• More women die of TB than all causes of maternal mortality combined.
• Every year 100,000 children die of TB
• 75% of cases developing TB in developing countries are in the economically productive age group (15 -50). Nearly 50% of them are smear positive and infectious
• More than 50 Million people are infected with MDR (multiple drug resistant) TB
• More than half the diagnosed patients do not complete the full course of treatment resulting in one infectious case on an average, infecting 10 to 15 people in one year
• MDR TB is more difficult and more expensive to treat. MDR TB has a significant mortality even with the best medical care
• TB is the biggest killer of people with HIV. HIV positive patients are 30 times more likely to develop TB once infected
• Increased travel and migration facilitates spread of TB
• Poor socio-economic conditions, overcrowding, poor nutrition, refugee status and poor hygiene are some salient factors which contribute to the ever increasing rate of TB in poor countries

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Many developing countries spend on expensive medical services that benefit only a privileged few but very low priority is given for TB due to politics involved in the respective Ministries of Health. 

- Every 4 seconds someone in the world develops TB.
- Every 15 seconds someone in the world die of TB every year.


Nalin Ashubodha – Editor

Council & Committee News

Pre-Congress – 16th October 2011

Consultative Meeting – 18th October 2011

Desmond responds to December Print CPD Programme: Assessing Chest Pain in General Practice

To the authors: You have left out

1. Tietze’s syndrome  
2. Rib Tip syndrome  
3. Costochondritis of lower ribs  
4. Fibromyalgia syndrome

All 4 can be diagnosed by seeking tender spots on the anterior chest wall - Desmond Fernando

Percy, Abey, JT, Prasadth, Erandie, Asela – please respond – Ed
UNQUALIFIED FAMILY DOCTORS

With excerpts from the welcome address by the President at inauguration ceremony of the sessions 2011

WISHING WELL

Ladies and Gentleman, I wish I could tell you more about the phenomenally successful MCGP programme and about the training programmes of the Faculty of Teachers in developing the pool of examiners. I could have talked at length about the research projects carried out by the Elderly Medicine Committee. It would have been good if I could have talked about the patient safety programme which is now reaching the very corners of our island in the Sinhala, Tamil and English radio broadcasts as a result of generous support from Baur's Health Care.

It would also have been good if I could have elaborated on our efforts in completing an international diploma level curriculum in hypnosis. I would have liked to tell you about the additional academic sessions devoted to wellbeing in the past year, even about our successful collaboration with the Nirogi Lanka project in training a second batch of doctors. Our efforts in collaboration with the Sri Lanka College of Gynaecologists and Family Planning Association of Sri Lanka would have intently you. Our work with the Ministry of Health in carrying forward the Ministry’s initiative in introducing the Family Medicine approach to NCD would have been really worth telling.

The role played by three College Council Members in a WHO SEARO and Wonca initiative to chart the course of Family Medicine in the region should have been highlighted today. The collaboration with the RCGP in the MRCGP [Int] South Asia exam too is what I should have spoken more about. All of this and more in one year mind you.

RAISING THE ALARM

But, my urgent concern today is about the state of postgraduate training in Family Medicine in Sri Lanka. I am raising the alarm that despite our good intentions, all is not right in this regard. A review of formal PG training is the need of the hour.

The gold standard of achievement for a professional body such as ours must surely be to achieve a higher quality of care to our people.

Family Medicine as a discipline is well recognized. In fact recognition of medical schools is often dependant upon their curricula including a robust training in Family Medicine. In UK the successful completion of a five year postgraduate training programme topped up by the MRCGP qualification is required before doctors can set up in GP. We may feel that such rigorous training is not a requirement for our situation.

UNIQUE

But what is terribly unique about Sri Lanka and some other countries in the region is that no training is required in the field of Family Medicine for doctors to set up in GP.

Unlike the disciplines of Surgery, Medicine, Obs & Gyn and Paediatrics where practitioners have to go through a mandatory period of training with certifications before practice, the majority of doctors in general practice have had no training. This is astonishing when one considers the fact that the private sector alone accounts for over 50% of primary care that is provided to the people. These doctors provide both preventive and curative care. That is Family / General practice.

If we intend to improve the quality of care across the board it would be necessary to take into consideration the peculiarities of Family Medicine and General Practice as they exist in Sri Lanka.

In Sri Lanka you find GPs almost exclusively in the private sector. Almost all the training in Family Medicine is carried out in the private sector (with the exception of two university units). Clearly neither the state sector nor the university system have the capacity to deal with training. In fact neither does the College.

HARMONY IN THE PAST

The College and the university system in the past have worked synergistically to provide training. The College teams have whole heartedly and selflessly worked in the DFM and MD programmes. Realizing the special needs of the people and understanding the characteristics of the discipline the many Directors and Boards of Management / PGIM have permitted the Board of Study in Family Medicine to steer the development of training programmes. The results have been extraordinary and they are there for all to see.
The College also developed its own MCGP diploma thereby increasing access to training for doctors wishing to take up GP as a career. The ever increasing popularity of the MCGP even among those who already hold postgraduate qualifications in FM is noteworthy.

**WINDS OF CHANGE**

Unfortunately in recent times winds of change in the body which has a monopoly over postgraduate education in medicine in the state sector have begun to buffet the Family Medicine programme. The need for uniformity and conformity seems to be overriding all other concerns. The epitome of development seems to be the production of board certified specialists. Sadly the board certified specialist in Family Medicine is neither fish nor fowl and has no perch or niche in neither the private nor the state sector. This once again is due to a failure on our part to realize that a specialist in Family Medicine as defined by parameters of other disciplines cannot exist in a primary care setting.

**SPECIALIZED TRAINING**

This is my plea today. Let all stakeholders come together to focus on the development of better quality care for patients who seek help in family practice. We do need specialized training in Family Medicine for doctors. A review of formal postgraduate training in Family Medicine is the need of the hour. Let us do it.

*Eugene Corea*

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**Chennai Conference**

**IMA – CGP**

Annual National Conference in Chennai

I attended the Annual National conference of the Indian Medical Association –College of General practitioners Chennai (IMA-CGP) on the 29th and 30th of October 2011. College of General practitioners Chennai has a membership of over 40000 at present. The theme for the conference was “Family Doctor-Specialist Synergy”. The conference was attended by many delegates from many states in India and Sri Lanka.

The high lights of the conference from the Sri Lankan perspective are as follows:

a) Signing of MOU between the CGPSL and the IMA-CGP  
b) Prof. Antoinette Perera delivering the Dr. Arulraj oration on “Family practice Approach-Way forward for better quality primary care”  
c) Dr. Leela De A Karunaratne making a presentation on Family physician- Specialist synergy  
d) Dr. Dennis Aloysius making a presentation on General Practice in Sri Lanka.  
e) Dr. Leela De A Karunaratne and Dr. Dennis Aloysius received Honorary Fellowships  
f) Release of a book on Family Medicine in which many chapters were written by many College members  
g) Many Sri Lankan MD trainees in Family Medicine presented papers.  
h) Sri Lankan delegates chaired various sessions  
i) A frank and cordial discussion was held with the important office bearers of the IMA-CGP on matters of mutual interest.

It is my sincere hope that the relationship between the College and the IMA-CGP need to be developed carefully so that the College and the discipline of Family Medicine in our country benefits from such endeavours.

*K Chandrasekher*
RISK FACTORS FOR CANCER IN OUR SOCIETY

1. Tobacco smoke (passive&/or active smoking)
2. Increasing weight or obesity
3. Low fiber use (fruits and vegetables)
4. Physical inactivity
5. Excessive alcohol use (see consumption below)

6. Sexually transmitted Human papiloma virus (HPV)
7. Helicobacter Pylori infection, a risk factor for stomach cancer
8. Air pollution (very high in urban areas)
9. Indoor smoke (specially from household use of solid fuels). It has been established that that one mosquito coil is equivalent to 20 cigarettes smoked. It would be good if a study on mosquito coil smoke and it’s effects ranging from lung disease to cancer could be carried out.

Prevention
1. Avoid above risk factors
2. Vaccination for HPV and Hepatitis B Virus (HBV)
3. Control of occupational hazards
4. Exposure to Sunlight

The Four principle strategies advocated by W.H.O. Are
WHO has identified four pillars in the fight against cancer, namely Prevention, Early detection and diagnosis, Treatment, and Palliative care [2].

References:
1. International Atomic Energy Authority
2. IAEA's role in the global management of cancer-focus on upgrading radiotherapy services
EEVA SALMINEN1, JOANNA IZEWSKA1 & PEDRO ANDREO1
1Division of Human Health, International Atomic Energy Agency, Wagramerstrasse 5, A-1400 Wien, Austria
3. PACT

Editor
JAKARTA CONFERENCE

I was nominated by the president of CGPSL to attend the “Regional Consultation on Strengthening Role of Family/Community Physicians in Primary Health Care” held in Jakarta, Indonesia from the 19-21 August 2011. The meeting was attended by medical (community physicians, academic staff from the Family Medicine departments of various Universities and general practitioners from the private sector) and non medical personnel from the administrative grade of health departments of the countries which participated in this deliberation. The countries that participated were Sri Lanka, Indonesia, India, Bangladesh, Nepal, Maldives, Korea, Thailand, Bhutan and Myanmar. The objectives of this consultation were as follows.

General objective:
To review, strengthen and promote the role of general practitioners, family/community physicians in PHC.

Specific objectives:
• To review and share experiences of general practitioners and family/community physicians in primary health care in the South-East Asia Region.
• To identify issues and challenges in strengthening the role of general practitioners and family/community physicians in the South-East Asia Region.
• To agree on a draft framework of action for strengthening the role of general practitioners and family/community physicians in PHC in the South-East Asia Region.

At the end of the three day consultations the following draft recommendations were agreed upon by the participants which will be finalized shortly.

Member States should:
• Strengthen national health policies to clearly articulate the roles and responsibilities of family physicians as providers of primary care and in supporting PHC activities. Recognize FP/GP as an integral part of national public health system.
• Include development, placement, retention and career development of family physicians through appropriate strengthening of national HRH policies and strategies
• Consider establishing departments of family medicine in medical colleges in consultation with medical councils and work towards including family medicine as a subject in the undergraduate curriculum.
• Consider training courses/diplomas and degree programmes to enhance their capacities for primary care physicians both in the government and private sectors. These could be implemented by universities, professional bodies, national boards etc. as per country needs. Distance education coupled with practical training can be a cost-effective means of training large numbers in a relatively short period of time.
• Standardize existing training programmes for family physicians and establish an accreditation mechanism.
• Implement and institutionalize CME programmes for family physicians/general practitioners.
• Conduct operational research to inform policy-makers for defining roles and responsibilities of family physicians and the number of FP/GP required to meet the gap.

WRITE TO US. KEEP IN TOUCH. SHARE YOUR VIEWS. GIVE US YOUR ADVICE.
BUT FOR GOD’S SAKE DON’T KEEP QUIET!
WHO-SEARO should:

- Assist in advocacy for strengthening the role of family physicians in PHC in Member States.
- Provide technical support to Member States in developing and implementing training programmes for family physicians.
- Assist Member States in generating evidence about effectiveness of family physician.
- Facilitate exchange of information, experiences and evidence regarding family physicians between and among countries.

Personally I was able to exchange details about our College with those who took part in the deliberation especially those from the Maldives, India and Indonesia who showed keen interest in working with the CGPSL towards the common cause.

All details in regard to the conference as well as the details of the various presentations made would be made available shortly in the College office for those interested.

K Chandrasekher

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**Paracetamol Over Dosage**

**FROM JANAKA**

**MEASURES TO AVOID PARACETAMOL OVER DOSE AMONG CHILDREN IN A GENERAL PRACTICE**

1. Educate parents how to calculate appropriate dose according to body weight
2. Create awareness about paracetamol the availability in different trade names(Panadol, calpol, etc)
3. Educate parents about the various dosage forms and strengths
   - PCM adult tab 500mg
   - PCM paediatric tab 80mg
   - PCM syrup 120mg/5ml
   - PCM infant drops 100mg/ml
4. Tell parents not to exceed 4 doses per 24 hours
5. Inform parents when you dispense PCM from your dispensary and that it is not recommended to give PCM in addition at home
6. Label medicinal packets and bottles when you dispense from your practice
7. Write instructions clearly in addition to verbal advice
8. Demonstrate to parents how to measure the correct dose using droppers, spoons and measuring cups
9. PCM should not be kept within reach of children
10. When dispensing from the practice dispense standard colour and shape tablets without using coloured tablets which can mislead parents
11. Refrain PCM from adding to other preparations such as mixtures

R. P. J. C. Ramanayake
Faculty of Medicine, University of Kelaniya
ACTION TAKEN WORLDWIDE ON THE USE OF PIOGLITAZONE

Pioglitazone is one of the drugs used to manage Diabetes Mellitus. Due to safety concerns, Drug Evaluation Sub Committee (DESC) of the Ministry of Health has recommended informing all prescribers regarding bladder cancer risk associated with prolonged use of pioglitazone via SLMA, IMPA and your newsletter.

DESC has recommended that informing vigilance on pioglitazone was essential and decided to request doctors to report any signs of bladder cancer in patients taking pioglitazone.

Cosmetics Devices and Drug Regulatory Authority also decided not to approve registration of any new applications that are submitted.

**Actions taken worldwide on the use of Pioglitazone – summary**

1. **France**
   Pioglitazone has been banned from the market in France.
   
   A government funded study revealed that Pioglitazone can increase the risk of bladder cancer, the French Medicines Agency in France banned the “Actos” which was the innovator of Pioglitazone. The agency has further advised French doctors to refrain from prescribing to patients.

2. **German**
   German health officials have followed the same procedure after reviewing the French report.

3. **US FDA**
   The U.S. Food and Drug Administration (FDA) has not banned the drug yet. But they informed the public that the use of Actos (Pioglitazone) for more than 1 year may be associated with an increased risk of bladder cancer. Information regarding the risk will be added to the warnings and precautions section in the label of pioglitazone medicine.

4. **European Medicines Agency**
   European Medicines Agency agreed that it was not possible to further restrict the current indications of pioglitazone. Instead of that prescribers are advised to select patients carefully for the drug and monitor response to treatments.

5. **Medicines and Healthcare product Regulatory Authority of UK (MHRA)**
   MHRA is advising not to use Pioglitazone for patients with a history of bladder cancer or to patients with uninvestigated visible blood in the urine and this applies to those being considered for Pioglitazone treatment and to those who are already receiving it.

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**JOEL – GUEST OF HONOUR AT THE 11TH PERADENIYA INTERNATIONAL CONGRESS**

‘PAÑÑA PADIPA JALITHO’

The alumni association of the Peradeniya Medical School (PeMSAA) organized the 11th International Congress at Peradeniya which commemorated the 50th Anniversary of the Peradeniya Medical School.

It is with a sense of pride that MY COLLEGE records the honouring of Joel Fernando, GP, teacher, senior Council Member and a Professor of the Faculty of Teachers of the College, by the Alumni Association of Peradeniya which had invited him to be Guest of Honour at the International Congress. Joel was the Founder President of PeMSAA.
CERTIFICATE COURSE IN ESSENTIAL PALLIATIVE CARE

Palliative medicine is the discipline that is concerned with the scientific practice of managing the terminally ill.

In Sri Lanka the professionals who manage terminally ill patients in the community are the general practitioners. Palliative Care is a priority area for the WHO in the South Asian Region.

College will shortly be signing an MOU with the Institute of Palliative Medicine Calicut, Kerala, India (which is a WHO center for Training) for the conduction of a certificate course in Essential Palliative Care. We hope to commence this short, GP friendly, course in March.

Members and Associates who are interested are kindly requested to write to me C/o the College.

Darrel Mathew  
Secretary - Palliative Care Committee  
CGPSL

HANIFFA ACKNOWLEDGED BY OXFORD HANDBOOK OF GENERAL PRACTICE – 3RD EDITION

Ruvaiz Haniffa, Asst. Secretary of the College and Lecturer in Family Medicine at the Faculty of Medicine, Colombo has been acknowledged for his contribution to the 3rd Edition of the Oxford Handbook of General Practice (OHGP).

The acknowledgment appears in on page xxiii of the OHGP. The OHGP is available as a low price edition for the SAARC region and is available in all leading bookshops. It is also available on the web at http://ohgp.oxfordmedicine.com for free download.