IMPA NEWS

THE OFFICIAL NEWS LETTER OF THE INDEPENDENT MEDICAL PRACTITIONERS ASSOCIATION

www.impa-sl.com

ISSUE 02 | VOLUME - 29 | FEBRUARY 2025

FROM THE **PRESIDENT'S PEN. . .**

It is with great pleasure that I present the February edition of the Independent Medical Practitioners Association newsletter.

I take this opportunity to extend my sincere gratitude to all council members who attended the council meeting and dinner on January 26th. Your participation and contributions are greatly appreciated.

As you may know, I am currently in Australia on an academic, business, and leisure tour. During my visit, I had the privilege of meeting an experienced family physician and board member of the Melbourne Medical Board of Australia. Our discussions provided valuable insights into their operational practices, some of which could be beneficially adapted for Sri Lanka.

I would also like to extend my appreciation to the organizing team for successfully conducting the Medical Update Program on February 9th. Your dedication and effort in making this event a success are truly commendable.

Best regards,

Thank you,
Yours Sincerely,

Dr. Sanath Hettige MBBS, DFM, MD, FCGP
President, Independent Medical Practitioners Association of Sri Lanka
Board Certified Specialist in Family Medicine
Honorary Senior Lecturer, Faculty of Medicine, University of Colombo
Chief Scientist, Oil of Dermae Laboratories & Dermae Research Medical Center
Chairman, Health & Nutrition Committee, Organization of Professional Association of Sri Lanka

Inside the Issue

IMPA Monthly CPD Programme

The Independent Medical Practitioners Association had a CPD program on the 9th of February at the OPA.

Two eminent speakers made the following presentations.

The first one by *Vidya Jyothi Prof Prasad Katulanda* MBBS, MD, FRCP (Lon), FCCP, FACE, DPhil (Oxon) Professor in Medicine, Faculty of Medicine, University of Colombo, Sri Lanka, Consultant Physician and Endocrinologist of the National Hospital Sri Lanka, on **"Male & Female Sexual Dysfunction in Diabetics"**

The second by, *Prof Rezni Cassim* MBBS(Col), MS(Col), MRCS(UK), Honorary Consultant Vascular and Transplant Surgeon, Professor in Surgery, Department of Surgery, Faculty of Medicine, University of Colombo, Sri Lanka, on **"How to protect your feet in Diabetics?"**

This program was sponsored by **Center for Diabetes Endocrinology and Cardio-Metabolism (CDEM)**

IMPA January Council Meeting

The Council Meeting was held on Sunday 26th January 2025 at 6.30 p.m. at the Office of IMPA under the Chairmanship of Dr Sanath Hettige. The following main points were discussed:

1. Registering IMPA as an organization for CPD points: Issuing an e-certificate and getting CPD points will be an attractive initiation for the benefit of existing members and as an incentive for the membership drive.

2. Conducting a Presidential Induction Ceremony(most probably in April): This will be the first Induction Ceremony that the IMPA will be conducting.

Journal and E-Newsletter Committee

Editor	-	Dr Neelamani Rajapaksa Hewageegana	
Editorial board	-	Dr Palitha Abeykoon	Dr S M Samarage
		Dr S A P Gnanissara	Dr A L P de S Seneviratne
		Dr A H A Hazari	Dr Sanath Hettige
		Dr S M Goonesekera	Prof Sanath Lamabadusuriya
		Dr Iyanthi Abeyewickreme	Dr Kanthi Ariyarathne

IMPA Website / Information Technology and Media Committee:

Co-ordinator	-	Dr A H A Hazari	Dr Sanath Hettige
		Dr Sabith Salieh	Dr Eranthee Walgampaya
		Dr Radhik Wijesooriya	Mr Nilupul Gunarathne

Presidential Induction Ceremony Organizing Committee

Dr Sanath Hettige	Dr A H A Hazari
Dr Sabith Salieh	Dr Sarath Samarage
Dr Sujatha Samarakoon	Dr Kanthi Ariyarathne

Continuous Professional Development / Medical Update Committee

Dr Sanath Hettige	Dr A H A Hazari
Dr Sabith Salieh	Dr Sarath Samarage
Dr Radhik Wijesooriya	Dr Eranthee Walgampaya
Dr Kanthi Ariyarathne	

Cont. on page 04

Organization of Professional Associations of Sri Lanka (OPA)

Dr Sanath Hettige	-	Exco
Dr S M Goonasekera	-	Forum
Prof Sanath Lamabadusuriya	-	Forum

Private Health Sector Regulatory Council (PHSRC)

Dr D K D Mathew

Antibiotic Microbial Resistance (AMR) - Technical Advisory Committee (TAC) - National Action Plan (NAP) National Advisory Committee (NAC)

Dr A H A Hazari
Dr Iyanthi Abeyewickreme
Dr Sujatha Samarakoon
Dr Kayathri Periasamy

Country Coordinating Mechanism (CCM) -

Dr Sarath Samarage	-	Member
Dr Priyadarshani Samarasinghe	-	Alternate Member

National Programme for Tuberculosis Control and Chest Diseases (NPTCCD)

Dr Eranthee Walgampaya	-	Public Private Mix (PPM)
Dr Priyadarshani Samarasinghe	-	Steering Committee Paediatric TB
Prof Jennifer Perera	-	TB Advisory Committee

National STD/AIDS Control Programme

Dr Sanath Hettige	-	National Advisory Committee on HIV/AIDS

The Gut-Immune Connection: Implications for Primary Care

Dr Visula Abeysuriya
Senior Lecturer in Immunology, Institute of Biochemistry, Molecular Biology and Biotechnology, University of Colombo

The gastrointestinal system functions as an important regulatory centre of immune functions beyond its digestive capabilities. Medical practitioners need to understand the gut-immune linkage (GALT=Gut-associated lymphoid tissue (GALT)) since GALT contains approximately 70% of the total immune system components. Science indicates that gut microbiota functions as a key regulatory element which affects the immune system function. The breakdown of normal gut microbiome function produces immune system disturbances which raises the probability of a range of infectious and allergic diseases together with autoimmune disorders alongside diabetes and heart disease.

How Gut Microbiota Influences Immunity

The human body enables the gut microbiome to communicate with immune cells using multiple distinct mechanisms. Anti-inflammatory cytokine production together with regulatory pathway balance constitutes the immunoregulatory action of beneficial bacteria. The intestinal barrier receives additional strength when there is a healthy microbiome which blocks harmful pathogens from entering the body. Research shows that conditions like inflammatory bowel disease, allergies and neuroimmune disorders develop when a person has dysbiosis which describes an imbalance in gut microbiota.

Probiotics and Their Role in Immune Health

The health benefits of live microorganisms rely on proper dosage when these beneficial microorganisms are eaten. The scientific research shows probiotics drive immune system strength through inflammatory control and protective immune response activation and digestive membrane strengthening. Numerous tests have shown strains of Lactobacillus and Bifidobacterium effectively prevent respiratory infections and decrease the risk of antibiotic-associated diarrhoea while providing relief for allergic disorder symptoms.

Practical Applications in Primary Care

Doctors teach essential information to patients regarding gut health together with its connection to immune strength. To maintain a proper microbiome people need to eat foods containing fiber and fermented items and prebiotics. Strategic administration of probiotics proves helpful when patients experience regular infections or experience gastrointestinal disturbances from antibiotic use and immune system-related medical issues. The complete improvement of gut and immune well-being requires medical focus on lifestyle elements which include stress reduction, adequate sleep and exercise. The knowledge on gut health and immune function enables doctors to conduct patient care using an encompassing strategy which combines nutritional changes with lifestyle modifications for immunity enhancement.

Respire 2025 . . .

Forging the future of Respiratory Medicine in Sri Lanka

In alignment with the theme "Equity in Respiratory Health: The Right to Breathe Free," the Sri Lanka College of Pulmonologists proudly convened the 15th edition of Respire the Annual Academic Sessions of the College.

This important international conference highlighted the latest advancements in respiratory medicine. Held from February 9th to 11th, this notable event was presided over by Dr. Neranjan Dissanayake, President of the College.

Respire 2025 brought together a distinguished gathering of global experts, researchers, and clinicians, reinforcing the critical need for accessible, high-quality respiratory care for all.

The conference served as a catalyst for addressing disparities in pulmonary healthcare while advocating for innovation and inclusivity in treatment approaches. Featuring an illustrious panel of over 15 internationally renowned speakers, including Chief Guest Dr. Anil Jasinghe, Secretary to the Ministry of Health and Media, and Guests of Honour Dr. Asela Gunawardena, Director General of Health Services, and Prof. Anita Simonds, Emeritus Professor of Respiratory and Sleep Medicine at Imperial College London, the event showcased groundbreaking insights on emerging trends, transformative therapies, and the future of respiratory medicine. These thought-provoking sessions enriched participants with invaluable knowledge while fostering high-level discourse on global respiratory health challenges.

With an attendance of over 400 delegates, Respire 2025 provided a dynamic platform for medical professionals to engage in meaningful dialogue, exchange expertise, and explore collaborative opportunities.

The meticulously curated program included keynote addresses, interactive workshops, and expert-led panel discussions, ensuring a truly immersive and educational experience.

The overwhelming success of Respire 2025 reaffirmed its reputation as a cornerstone event in the field, reinforcing the Sri Lanka College of Pulmonology's unwavering commitment to advancing respiratory medicine.The conference concluded on a high note, leaving an indelible mark on the global pulmonology community, inspiring future innovations and shaping the trajectory of respiratory healthcare.

Links to Interesting Articles

Chikungunya

Link : https://www.epid.gov.lk/storage/post/pdfs/en_6798b863abfb0_Chikungunya.pdf

Countries and territories certified malaria-free by WHO

Link : https://www.who.int/teams/global-malaria-programme/elimination/countries-and-territories-certified-malaria-free-by-who

Designing Nutrient Clinical Trials for Disease Prevention-A Focus on Vitamin D-SR

Link : https://academic.oup.com/nutritionreviews/advance-article/doi/10.1093/nutrit/nuae164/8006544?utm_source=authortollfreelink&utm_campaign=nutritionreviews&utm_medium=email&guestAccessKey=23933643-621e-4c2e-904b-56c97ed389ff

Vitamin D Fulfils Hill's Criteria-Mechanisms & Insights (Vitamin D suppresses Inflammation and acute-phase reactions):

Link : https://www.mdpi.com/2072-6643/17/3/599

Minerals and Human Health: From Deficiency to Toxicity*

Link : https://doi.org/10.3390/nu17030454

Vitamin D: Evidence-Based Health Benefits and Recommendations for Population Guidelines by William B. Grant, Sunil J. Wimalawansa, et al,

Link : https://www.mdpi.com/2072-6643/17/2/277

Integrating Endocrine, Genomic, and Extra-Skeletal Benefits of Vitamin D into National and Regional Clinical Guidelines by Sunil J. Wimalawansa et.al,

Link : https://www.mdpi.com/2072-6643/16/22/3969

Vitamin D doses:

Link : https://www.mdpi.com/2072-6643/14/14/2997
https://www.mdpi.com/2072-6643/15/17/3842#B219-nutrients-15-03842

Epidemiology Unit
Ministry of Health and Mass Media
231, De Saram Place, Colombo 10
Tel: (011) 2695112, Fax: (011) 2696583

Chikungunya

History

Chikungunya is an arboviral disease transmitted by mosquitoes. It was first identified during an outbreak in southern Tanzania in 1953 and was later described by Marion Robinson and Lumsden in 1955, following an outbreak on the Makonde Plateau near the border of Tanganyika and Mozambique. The term "chikungunya," derived from East African languages, refers to the "bent-over" posture caused by the severe joint pain characteristic of the disease.

In Sri Lanka, the first chikungunya epidemic was reported in the early 1960s, followed by decades of quiescence. The virus re-emerged in November 2006 after a 40-year absence, across various parts of the island. Between 2006 and 2007, an estimated 40,000 individuals were affected, with a similar number of cases recorded in 2008.

Transmission

Chikungunya spreads to humans through bites from infected female mosquitoes, primarily *Aedes aegypti* and *Aedes albopictus*. These mosquitoes are also vectors for other mosquito-borne illnesses, such as dengue. While they bite throughout the day, activity peaks in the early morning and late afternoon. Symptoms of chikungunya typically appear 4–8 days after being bitten by an infected mosquito, though the incubation period can range from 2 to 12 days. Mother-to-fetus transmission is possible between 3 and 4.5 months of pregnancy, as well as vertical transmission during near-term deliveries with intrapartum viremia.

Disease vectors

The mosquitoes *Aedes aegypti* and *Aedes albopictus* are key vectors for chikungunya involving in larger outbreaks.

- **Aedes aegypti**: Found in tropical and subtropical areas, this species thrives near human settlements and prefers indoor breeding sites like flower vases, water storage containers, and concrete tanks.
- **Aedes albopictus**: Found not only in tropical and subtropical areas but adaptable to a broader range of habitats, including temperate and cold temperate regions. In recent decades it has spread from Asia to parts of Africa, Europe, and the Americas. This species breeds in many natural and artificial water-filled habitats such as tree holes, coconut husks, bamboo stumps, cocoa pods, rock pools, and discarded tires. It is commonly found in rural and peri-urban areas, as well as shaded urban parks.

Other mosquito species, including the *A. furcifer-taylori* group and *A. luteocephalus*, have also been linked to chikungunya transmission in Africa.

Reservoir

Humans act as reservoirs for the chikungunya virus during outbreaks. Outside of epidemics, other vertebrates, such as monkeys, rodents, birds, and small mammals, serve as reservoirs. Outbreaks have been reported among monkeys when herd immunity is lower.

Infectious Agent

Virus causing chikungunya is an RNA virus belonging to the *alphavirus* genus of the *Togaviridae* family.

Symptoms

The disease is characterized by:

- A sudden onset of fever, often reaching 39°C, sometimes accompanied by chills or tremors.
- Joint pain (arthralgia) or swelling (arthritis), especially in small joints like the wrists, hands, ankles, and feet, though larger joints may also be affected.
- A petechial or maculopapular rash, typically on the trunk and limbs but sometimes affecting the face, palms, and soles.
- Additional symptoms include muscle pain, headache, fatigue, and nausea.

While most patients recover fully, some experience persistent joint pain lasting months or even years. Rarely, complications involving the eyes, nervous system, gastrointestinal tract, or heart occur. Deaths are uncommon but may occur in infants and children particularly with high fever, prolong convulsions and neurologic defects suggesting a primary encephalitis.

Diagnosis of Chikungunya

Laboratory findings commonly observed in Chikungunya infection include:

1. **Mild leukopenia** with relative lymphocytosis.
2. **Elevated ESR**, typically between 20–50 mm/h.
3. **Positive C-Reactive Protein** levels.
4. **Decreased platelet count**, often accompanied by hemorrhagic manifestations.
5. **ECG changes** indicative of myocarditis.

Differential diagnosis should consider conditions that may present similarly to Chikungunya, such as Parvovirus infection, Hepatitis B prodrome, Juvenile Rheumatoid Arthritis, Dengue and Rubella.

Specific Diagnostic Tests

Chikungunya patients are typically viremic for the first 48 hours, during which the virus can be isolated using both in vivo and in vitro methods. Viraemia levels can be measured using **Hemagglutination** or **ELISA** (serum). As viraemia declines, titers of **hemagglutination inhibition (HI)** and **neutralizing antibodies** rise.

1. **Virus isolation** from serum 1 to 2 days after illness onset.
2. **Antigen detection** via ELISA (less sensitive than serology).
3. **Antibody detection** from serum, typically detectable 5 days after onset

Chikungunya-specific IgM antibody testing is available at the Medical Research Institute (MRI), Colombo. Medical and field staff should send blood samples from all suspected cases. During an epidemic, confirmatory tests may not be required if an epidemiological link is established.

Treatment

There is no specific antiviral treatment for chikungunya. Management focuses on relieving symptoms:

- Antipyretics and analgesics for fever and pain relief.
- Paracetamol or acetaminophen is preferred until dengue is ruled out, as NSAIDs may increase bleeding risks.
- Adequate hydration through sufficient fluid intake.
- Rest and mild exercises to alleviate joint stiffness.
- There is no specific antiviral drug treatment for chikungunya virus infections.

Chikungunya outbreak management: Surveillance, Preparedness and Response

Case Definitions

Healthcare staff should be familiar with standardized case definitions for Chikungunya:

Suspected Case: A patient presenting with acute onset fever (lasting 3–5 days), often with chills/rigors, and accompanied by multiple joint pains or extremity swelling, which may persist for weeks to months.

Probable Case: A suspected case with any of the following:
a) History of travel to or residence in areas with reported Chikungunya outbreaks.
b) Exclusion of malaria, dengue, or other known causes of fever with joint pains.
c) Presence of post-infection hyperpigmented rash.

Confirmed Case: A patient with one or more of the following findings, regardless of clinical presentation:
a) Virus isolation in cell culture or animal inoculations from acute-phase serum.
b) Detection of viral RNA in acute-phase serum.
c) Seroconversion to virus-specific antibodies in paired samples collected 1–3 weeks apart.
d) Detection of virus-specific IgM antibodies in a single serum sample collected after 5 days of illness onset.

Hospital-Based Surveillance and Notification

Chikungunya is not routinely notifiable; however, clustering of suspected cases should trigger immediate notification. Once an outbreak is identified.

- Fever surveillance should be initiated in the hospital OPD.
- Consultant Physicians and Consultant Pediatricians should ensure case reporting.
- Medical staff in the OPD and wards should notify suspected Chikungunya cases using the standardized notification form (H-544) to the relevant Medical Officer of Health (MOH) until further notice.
- Laboratories are required to report positive test results.
- A special case investigation form for Chikungunya must be completed for all clinically diagnosed and/or serologically confirmed cases and sent to the Epidemiology Unit. The Infection Control Nursing Officer in the hospital should assist with this activity.

Field-Based Preventive Measures

Pre-Outbreak Preparedness

Preventive health sectors should begin preparedness activities 2–3 months before the rainy season, focusing on:

- Convening District Health Committees to plan response strategies.
- Strengthening entomological surveillance to monitor vector density as an early warning.
- Establishing rapid response teams for outbreak investigations.
- Engaging community leaders, representatives, and NGOs to promote social mobilization.
- Assessing hospital disaster preparedness, including resources for manpower, insecticides, and fogging equipment.
- Preparing and distributing educational materials (IEC) to raise public awareness**.**

Actions During an Outbreak

- The MOH must initiate preventive measures and supervise field investigations and preventive actions by the Public Health Inspector (PHI).
- The PHI should conduct field investigations for notified cases, identify potential mosquito breeding sites, and implement mosquito population control measures.
- Effective outbreak response includes daily case reporting, investigation of deaths, regular media briefings, and mobilizing resources to match epidemic trends.

Community Role in Outbreak Control

Community involvement is critical for Chikungunya control and prevention:

- **Household level:** Eliminate mosquito breeding sites, use mosquito repellents, wear protective clothing, use bed nets, apply pyrethroid-based aerosols during peak mosquito activity, equip accommodations with screens or nets to block mosquitoes, and avoid mosquito bites during the first week of illness to prevent virus spread
- **Institutional level:** Schools, hospitals, and workplaces should educate on prevention, adopt household-level measures, and ensure compliance
- **Community level:** Mobilize groups for sanitation drives, conduct house-to-house inspections, and advocate for civic authority action on environmental management

Key Interventions

- **Vector Control:** Source reduction, fogging, ULV spraying, larvicides, and larvivorous fish.
- **Social Mobilization:** Promote sanitation and vector control by engaging local communities**.**
- **Surveillance:** Monitor and report cases, investigate trends, and track deaths during outbreaks.
- **Communication:** Use media to raise public awareness and provide accurate information**.**

Effective community involvement, robust surveillance, and proactive vector control are crucial to containing Chikungunya outbreaks.

Epidemiology Unit
Ministry of Health and Mass Media
231, De Seram Place, Colombo 01000, Sri Lanka
Tele: (+94 11) 2695112, 2681548 Fax: (+94 11) 2696583
Email: chepid@sltnet.lk, epidunit@sltnet.lk Web: www.epid.gov.lk

EPD/379/2006
15 .01.2025

Provincial Director of Health Services – Western Province
Regional Directors of Health Services – Colombo / Gampaha / Kalutara

Initiation of surveillance measures for Chikungunya - 2025

It has been observed that Chikungunya and suspected Chikungunya like cases are being reported mostly from hospitals in the Western Province since latter part of 2024. Samples from these cases have been tested at the Medical Research Institute (MRI), Colombo and the disease has been confirmed to be Chikungunya. Chikungunya is a mosquito born viral disease transmitted to humans by the bite of infected *Aedes aegypti* or *Aedes albopictus* mosquitoes.

. **According to WHO case definition of Chikungunya,**

- **Suspected case:**
  A patient presenting with acute onset fever, usually accompanied by chills/rigors which lasting for 3 – 5 days, and multiple joint pains/swelling that may persist for weeks to months

- **Probable case:**
  A suspected patient with the above features with any one of the following:
  a) History of travel or residence in areas reporting outbreaks
  b) Exclusion of Dengue or any other known cause for fever with joint pain
  c) Presence of post-infection hyperpigmented rash

- **Confirmed case:**
  A patient with one or more of the following findings, irrespective of the clinical presentation.
  a) virus isolation in cell culture or animal inoculations from acute phase sera
  b) Presence of viral RNA in acute phase sera
  c) Seroconversion to virus specific antibodies in samples collected at least 1 – 3 weeks apart
  d) Presence of virus specific IgM antibodies in single serum collected after 5 days of onset of illness

Please ensure the implementation of the following steps in your district:

- Initiate fever surveillance in the Out Patient Departments of hospitals in your district. The current Chikungunya fever situation should be informed with the Consultant physicians and Consultant Paediatricians in the hospitals in your district.
- Medical staff at the Out Patient Departments and wards of all hospitals should be informed to notify suspected chikungunya cases using the standard notification form (H544) to the relevant Medical Officer of Health (MOH) areas during this period until further notice.
- Make arrangements to complete the special surveillance form of Chikungunya fever EPID/05/CG/2025 (attached) for all clinically diagnosed and/or serologically confirmed cases in hospitals and send to the Epidemiology unit. Infection Control Nursing Officers (ICNO) of all hospitals to assist this activity.
- MOH to initiate preventive measures against the spread of Chikungunya fever and to supervise the field investigation process and the implementation of preventive measures by Public Health Inspector (PHI)s. PHIs to conduct field investigation on the notified cases and to carry out other preventive measures on the confirmed cases in order to control mosquito breeding places.

For diagnostic confirmation, testing for Chikungunya-specific IgM antibodies is available at the Medical Research Institute (MRI), Colombo and please make aware the medical and field staff to send blood samples for testing for all suspected cases.

Your cooperation in strengthening surveillance and reporting is crucial to controlling the spread of Chikungunya.

Dr Hasitha Tissera
Chief Epidemiologist
Epidemiology Unit

Dr. H.A. Tissera
Actg. Chief Epidemiologist
Epidemiology Unit
231, De Saram Place
Colombo 10

Copies:

1. Deputy Director General (PHS) 1
2. Provincial Epidemiologist - Western Province
3. Regional Epidemiologist (Consultant Community Physician) – Colombo/ Gampaha/ Kalutara
4. Medical Officer - Epidemiology - Colombo/ Gampaha/ Kalutara

Dengue Is Now a Vaccine-Preventable Disease

WHO has recommended the use of vaccines in highly endemic countries and travelers

Consideration should also be made in specific populations that are vulnerable to severe dengue

- (eg, older adults)

WHO. 2024. Accessed September 1, 2024. https://www.who.int/news-room/questions-and-answers/item/dengue-vaccines

Conclusion

- Vaccination cannot replace mosquito control or other measures that prevent virus transmission
- Ongoing real-world evidence is important for understanding how to use dengue vaccine effectively
- Integration of imperfect tools where strengths of one will negate the weaknesses of others
- A combined strategy of mosquito control, vaccination, and other preventive measures is needed to combat dengue

Get the vaccine before departing Sri Lanka to certain countries

Meningococcal infection can be deadly to you and your family

BY KUMUDINI HETTIARACHCHI

Is the deadly meningococcal fection diagnosed on and off in i Lanka, due to close contact ith a person who has returned om an endemic country or is it mmunity-based now?

"If you are heading to a menin-ococcal endemic country, take ur vaccine against this disease. therwise, it can harm you and our loved ones on your return, as revention is the key," was the rgent appeal from the President f the Vaccine and Infectious Diseases Forum of Sri Lanka (VIDFSL), Dr. Kanthi Nanayakkara.

Whatever is triggering infec-ions in Sri Lanka, it is good to take the vaccine, the VIDFSL reit-erated, urging all those heading to West Asia including on the Haj pilgrimage in May, to get the jab which is one dose per person.

Dr. Nanayakkara said that it is also "highly" recommended that undergraduates going for studies to countries such as the United States of America (USA), the United Kingdom (United Kingdom) and Australia should get the vaccine before departure from Sri Lanka. (See Box)

With regard to the meningococ-cal infection, according to the World Health Organization (WHO), the extended 'meningitis belt' of sub-Saharan Africa, stretches from Senegal in the west to Ethiopia in the east (26 coun-tries). It has the highest rates of the disease.

It is the Galle National Hospital's Consultant Microbiologist, Dr. Bhagya Piyasiri, who talks about the recent burden of meningococcal disease with firsthand experience in the recent past.

On August 19, 2023, a person who had been released from the Galle Prison a few days earlier had been admitted to hospital, diagnosed with meningococcal disease, treated and released,

Dr. Kanthi Nanayakkara

Dr. Bhagya Piyasiri

Vaccine at Assistant Port Health Office in Borella

The vaccine to prevent meningococcal disease is available at the Assistant Port Health Office located within the premises of the Medical Research Institute (MRI), very close to the Borella junction, at No. 527, Dr. Danister De Silva Mawatha (Baseline Road), Colombo 8.

The vaccine is an injection.

The office maybe contacted on Phone: 011-2675182 between 8.30 a.m. and 2 p.m. on weekdays, Monday through Friday.

Meningococcal infection

Meningococcal infection is caused by the bacterium *Neisseria meningitidis*.

Meningococcal infection includes:

Meningococcal meningitis: Severe bacterial infection of the membrane that covers the brain and spinal cord.

Meningococcaemia: An infection of the blood, sepsis

Neisseria meningitidis

Symptoms

- Sudden fever
- Red or purple rash
- Vomiting
- Headache
- Nausea
- Stiff neck or backache
- Sensitivity to light
- Confusion

- The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person.
- Prevention through vaccination.
- Early treatment saves lives.

while another prisoner with the same symptoms admitted on August 20 had died within two hours. Two other prisoners had also been brought to hospital earlier in the month, one of whom had died, while the other recovered.

Following these events, Dr. Piyasiri says that all the prisoners and staff – around 1,200 – of the Galle Prison had been given prophylactic antibiotics to prevent them from catching the infection.

Recalling that on the evening of August 21, 2023, two more prisoners had also been admitted, treated and discharged later, she looks at a pattern of meningococcal disease thereafter, not only from the prison but also from the community.

The hospital admissions had included: five prisoners with one death in January 2024; two prisoners in February 2024; four prisoners with one death in July 2024; two patients from the community (a two-month-old baby whose mother had visited the prison and another elderly person with no contact with the prison); and one prisoner in early November 2024. There had also been sporadic cases.

Dr. Piyasiri sends out a strong plea to all those who are hoping to visit West Asia to get the vaccine. "Don't take it lightly. Otherwise, you can return as carriers and spread the disease among your loved ones, especially in congested household settings. Among the vulnerable in your homes are children and young adults."

Looking at the bacteria causing meningococcal disease, she says that there are 12 serotypes, but those causing the majority of cases are A, B, C and Y.

"There are two vaccines – one is 'A, C, Y and W-135' and the other is 'B'. However 'B' is not a common disease causative bacterium. The ones which caused trouble in Galle belonged to the 'A, C, Y and W' group and as such the vaccine which needs to be taken is 'A, C, Y and W-135'.

Many of these symptoms can also be caused by other less serious conditions. Seek medical advice if your child has any of these symptoms

Sri Lankan Medical & Dental Association in the UK (SLMDA)

Address for correspondence
26, Broad Field Road
Yarnton
Oxford
OX5 1UL

15.02.2025

Dear Madam/Sir

SLMDA Research Grants 2025 Announcement

The SLMDA have decided to offer **TWO research grants** (of £500 each) to Sri Lankan junior doctors or junior research students, for carrying out research projects or studies.

It is a pre-requisite of the award that the two successful candidates get their study findings accepted for presentation at a high level National conference or be accepted for publication in a National or international Journal. On receiving the award, 50% of the money would initially be given to the awardee. The rest of the award and the award certificate would be given once the grant pre-requisite has been fulfilled.

To apply for this research grant, the completed application form (template available on the SLMDA website) should be submitted (by Email) **by 15th March 2025**. Note: only the completed standard application form should be submitted, and no other attachments should be included.

The applications should be emailed to:
mahengonsal@gmal.com and suran200@yahoo.co.uk

Prof Suranjith L Seneviratne and Dr Thanuja Yasawardena
SLMDA Research Grant Sub-committee

SLMDA RESEARCH GRANTS 2025

Applications are called for TWO research grants of £500 each

The grant is targeted at young researchers in the early stages of their career.

They are offered for research proposals on any branch of medicine or dental science.

To apply for this research grant, a two page research project proposal (together with a breakdown of how the funds are to be used) and the application form should be submitted by 15th March 2025.

The award winners would receive £250 at the time of commencement of the project and the remaining £250 and their award certificate, on successful completion of the grant pre-requisite.

The applications should be emailed to:
mahengonsal@gmal.com and suran200@yahoo.co.uk

Prof. Suranjith L Seneviratne and Dr. Thanuja Yasawardena
SLMDA Research Grant Sub-committee

Heartiest Congratulations to

Prof Neelika Malavige

Heartiest Congratulations

Mr Rajeev Amarasuriya

(IMPA Legal Adviser)

The Honorary Legal Adviser to the IMPA, *Mr Rajeev Amarasuriya*, has been elected as the President of the Bar Association of Sri Lanka, 2025/2026. We, the President, Council Members, and Members of the IMPA, convey our Heartiest Congratulations on this prestigious appointment.

Heartiest Congratulations

Prof Sanath Lamabadusuriya

Prof Sanath Lamabadusuriya received the prestigious award at the opening ceremony and presentation of the Healthcare Achievers Awards at Medicare-The International Healthcare Exhibition 2025 on 28th February 2025.

The award was presented to ***Prof Lamabadusuriya*** in recognition of his outstanding contributions to Sri Lanka's healthcare sector. ***Prof Lamabadusuriya*** was the first recipient of this Medicare award which is given honoring medical professionals, researchers, and institutions that have made a significant impact.