



IMPA

ISSUE 06 | VOLUME - 29 | JUNE 2025

THE OFFICIAL NEWS LETTER OF THE INDEPENDENT
MEDICAL PRACTITIONERS ASSOCIATION

NEWS

www.impa-sl.com



FROM THE PRESIDENT'S PEN...



Dear Esteemed Members,

It is with great pride that I reflect on another month of meaningful strides in medical education, collaboration, and innovation under the banner of IMPA. As we advance our mission to elevate healthcare standards, I am pleased to share key highlights of June and upcoming endeavors:

1. *Medical Educational Program - A Resounding Success*

In June, IMPA hosted a pivotal educational program at Durdans Hospital, addressing two critical areas:

- "Laparoscopic Surgery for Kidney Diseases" - Pioneering minimally invasive techniques to improve patient outcomes.
- "Chest Pain of Acute Onset: Diagnostic & Management Protocols" - Equipping practitioners with life-saving emergency insights.

The participation of the members at this event was not satisfactory compared to the previous CME programs. Reinforcing IMPA's role as a beacon of continuous professional development is a goal of the IMPA. My heartfelt gratitude to our sponsors Durdans Hospital for organizing this CPD event annually and IMPA CME coordinators for making this initiative a milestone.

2. *President's Induction Program - Save the Date!*

After meticulous planning by the Organizing Committee through multiple virtual and physical meetings, we are delighted to confirm:

- Venue: Waters Edge Hotel Battaramulla.
- Date: 22nd August 2025 at 7.00 pm
- This ceremony will not only mark a leadership transition but also celebrate IMPA's collective achievements. Further details, will follow shortly.

"A Call to Action"

As we forge ahead, I urge each member to:

- engage actively in IMPA's educational initiatives.
- nominate colleagues for leadership roles.
- contribute to our publications with your expertise.

Together, we are shaping the future of medicine.

With gratitude,

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

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- ◆ Message from the Country Coordinating Mechanism of Sri Lanka of the Global Fund Project
Dr Kanthi Ariyaratne
- ◆ Gazette Charges Display
- ◆ IMPA Journal Guidelines
- ◆ Guideline for Clinical Management of Chikungunya Infection through Disease Phases
- ◆ Paraprosthodontics
- ◆ Useful Shares
- ◆ Felicitations

IMPA Monthly CPD Programme

The Independent Medical Practitioners Association had the CPD program on Sunday, the 22nd June 2025, at 7.30 p.m. at Durdans Hospital Auditorium(11th Floor), Alfred Place, Colombo 03.

Two eminent speakers made the following presentations.

"Laparoscopic surgery for kidney diseases" by Dr Nuwan D Premachandra - MBBS (SJU), MD Surgery (Col), MRCS (Eng), Specialist in Genito Urinary Surgery

and

"Chest pain of acute onset" by Dr. Amila Walawwatte - MBBS (Col), MD Medicine (Colombo), Specialist in Cardiology

The event was Sponsored by *Durdans Hospital*



**The President and the Council of
The Independent Medical Practitioners Association
Invite**

Dr & Dr (Mrs).

On

“Dementia Diagnosis and Management”

By

Dr Harsha Ediriweera

Consultant Psychiatrist, South East Sydney Local Health District ,
Conjoint Senior Lecturer, UNSW Sydney

And

Associate Professor Sunera Fernando

Consultant Psychiatrist, Northern Sydney Local Health District ,
Clinical Associate Professor, Macquarie University, Sydney and
Clinical Associate Professor, Graduate School of Medicine,
University of Wollongong, NSW

On

Wednesday 2nd July 2025 at 4.00 p.m.

At

The IMPA Office, 275/75, Prof. Stanley Wijesundara Mawatha, Colombo 7
Followed by Refreshments.

Dress: Smart Casual

R.S.V.P:
Champa - 0112 501113
077 167 49 13

(Kindly confirm your participation as the attendance is limited to 20 participants)

Message from the Country Coordinating Mechanism of Sri Lanka of the Global Fund Project

Dr Kanthi Ariyaratne

Executive Secretary / Oversight Officer CCMSL

Congratulations IMPA!

IMPA has been selected for the new term (2025/2028) of the Country Coordinating Mechanism Sri Lanka (CCMSL) as the uncontested candidate for the

constituency of the "Private Sector". Hope IMPA will extend its fullest support in the fight against HIV and Tuberculosis in Sri Lanka while assisting in maintaining the zero indigenous cases of Malaria.

Cont. on page 05

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පෞද්ගලික වෛද්‍ය ආයතන (ගාස්තු) නියෝග පිළිබඳ දැනුම් දීම හා සම්බන්ධව

2006 අංක 21 දරණ පෞද්ගලික වෛද්‍ය ආයතන (ලියාපදිංචි කිරීමේ) පනතේ 18 (2) (ආ) වගන්තිය යටතේ, සෞඛ්‍ය ආරක්ෂණ හා පෝෂණ අමාත්‍යවරයා විසින් අංක 1526/7 දරණ 2007 දෙසැම්බර් 04 දිනැති අති විශේෂ ගැසට් පත්‍රයේ පළ කරන ලද 2007 අංක 02 දරණ පෞද්ගලික වෛද්‍ය ආයතන (ගාස්තු) නියෝග හා බැඳේ (පිටපත අමුණා ඇත. ඇමුණුම I).

02. එහි දක්වා ඇති පරිදි, සියළුම පෞද්ගලික වෛද්‍ය ආයතන විසින් සපයනු ලබන විවිධ සේවා වර්ගයන් සඳහා අයකරනු ලබන ගාස්තු සම්බන්ධයෙන් රෝගියාට හෝ රෝගියා සමඟ පැමිණෙන තැනැත්තාට දැනුම් දිය යුතුය.

03. නවද, සපයනු ලබන විවිධ සේවා වර්ග සඳහා අයකරනු ලබන ගාස්තු පිළිබඳ සම්පූර්ණ වගුවක් සේවා සපයන පරිශ්‍රයේ ප්‍රකටව පෙනෙන ස්ථානයක ප්‍රදර්ශනය කල යුතුය.

04. ඒ අනුව, සියළුම පෞද්ගලික වෛද්‍ය ආයතන 2006 අංක 21 දරණ පෞද්ගලික වෛද්‍ය ආයතන (ලියාපදිංචි කිරීමේ) පනතේ විධි විධානයන්ට අනුගතව ක්‍රියාකල යුතු බවට දන්වා සිටිමි.


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 සෞඛ්‍ය සේවා අධ්‍යක්ෂ ජනරාල්
 සෞඛ්‍ය අමාත්‍යාංශය
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 385, පූජ්‍ය බද්දේගම විමලවංශ හිමි මාවත,
 කොළඹ 10.

පිටපත් - සියළුම පළාත් සෞඛ්‍ය සේවා අධ්‍යක්ෂවරු කා.දැ.ගැ.ස සහ අදාල කටයුතු සඳහා
 සියළුම ප්‍රාදේශීය සෞඛ්‍ය සේවා අධ්‍යක්ෂවරු කා.දැ.ගැ.ස සහ අදාල කටයුතු සඳහා

385, පූජ්‍ය බද්දේගම විමලවංශ හිමි මාවත, කොළඹ 10. 385, வணக்கத்துக்குரிய பத்தேகம விமலவங்ச தேரோ மாவத்தை இ கொழும்பு 10. 385. Rev. Baddeema Wimalawansa Thero Mawatha. Colombo 10. Sri Lanka.



ශ්‍රී ලංකා ප්‍රජාතාන්ත්‍රික සමාජවාදී ජනරජයේ ගැසට් පත්‍රය

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අංක 1526/7 - 2007 දෙසැම්බර් 04 වැනි අඟහරුවාදා - 2007.12.04

(ආණ්ඩුවේ බලයපිට ප්‍රසිද්ධ කරන ලදී)

I වැනි කොටස : (I) වැනි ඡේදය - සාමාන්‍ය

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2006 අංක 21 දරන පෞද්ගලික වෛද්‍ය ආයතන (ලියාපදිංචි කිරීමේ) පනත

2006 අංක 21 දරන පෞද්ගලික වෛද්‍ය ආයතන (ලියාපදිංචි කිරීමේ) පනතේ 18(2) (ආ) වගන්තිය යටතේ සෞඛ්‍ය ආරක්ෂණ හා පෝෂණ අමාත්‍යවරයා විසින් සාදන ලද නියෝග.

නිමල් සිරිපාල ද සිල්වා,
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2007 නොවැම්බර් මස 29 වැනි දින,
කොළඹ දී ය.

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1. මේ නියෝග 2007 අංක 2 දරන පෞද්ගලික වෛද්‍ය ආයතන (ආස්ක) නියෝග යනුවෙන් සඳහන් කරනු ලැබේ.
2. අවස්ථාවේර්ථික පරිදි, වෛද්‍ය වෘත්තීයේ නියැලී සිටින හෝ වෛද්‍ය, ශල්‍ය වෛද්‍ය හෝ දන්ත වෛද්‍ය යන වෛද්‍ය වෘත්තීන්වල කටයුතු කරන යම් වෛද්‍ය වෘත්තීකයෙකු, දන්ත ශල්‍ය වෛද්‍යවරයකු, වෛද්‍ය විශේෂඥයකු හෝ සාමාන්‍ය වෛද්‍ය වෘත්තීකයකු විසින් -
 - (අ) එක් එක් වෛද්‍යවරයා විසින් සපයනු ලබන විවිධ සේවා වර්ග සම්බන්ධයෙන් එම වෛද්‍ය වෘත්තීකයා දන්ත ශල්‍ය වෛද්‍යවරයා, වෛද්‍ය විශේෂඥවරයා හෝ සාමාන්‍ය වෛද්‍ය වෘත්තීකයා විසින් අයකරනු ලබන ආස්ක සම්බන්ධයෙන් රෝගියාට හෝ රෝගියා සමඟ පැමිණෙන තැනැත්තාට දැනුම් දිය යුතු ය ; සහ
 - (ආ) ඔහු විසින් සපයනු ලබන විවිධ සේවා වර්ග සම්බන්ධයෙන් අයකරනු ලබන ආස්ක පිළිබඳ සම්පූර්ණ විග්‍රහණයක් සහ සාමාන්‍ය ස්ථානයේ හෝ තමා උපදේශන සේවා පවත්වන පරිශ්‍රයේ ප්‍රකටව පෙනෙන ස්ථානයක ප්‍රදර්ශනය කළ යුතු ය ; නැතහොත් එසේ ප්‍රදර්ශනය කිරීමට කටයුතු සලස්වනු ලැබිය යුතු ය.
3. සෞඛ්‍ය ආරක්ෂණ සේවා සපයනු ලබන සහ මේ පනත යටතේ ලියාපදිංචි වී ඇති සෑම පෞද්ගලික වෛද්‍ය ආයතනයක් විසින්ම -
 - (අ) එම ආයතනය විසින් සපයනු ලබන විවිධ සේවා වර්ග සම්බන්ධයෙන් එම ආයතනය විසින් අයකරනු ලබන ආස්ක පිළිබඳව රෝගියාට හෝ රෝගියා සමඟ පැමිණෙන තැනැත්තාට දැනුම් දිය යුතු ය ; සහ

1A- G 009156 -930 (2007/12)

(ආ) එම ආයතනය විසින් සපයනු ලබන විවිධ සේවා වර්ග සම්බන්ධයෙන් අයකරනු ලබන ගාස්තු පිළිබඳ සම්පූර්ණ වගුවක් තම ආයතනයේ ප්‍රකටව පෙනෙන ස්ථානයක ප්‍රදර්ශනය කළ යුතුය : නැතහොත් එසේ ප්‍රදර්ශනය කිරීමට කටයුතු සලස්වනු ලැබිය යුතු ය.

4. යම් පෞද්ගලික වෛද්‍ය ආයතනයක් සම්බන්ධයෙන් වන විට, එම ආයතනය විසින් සපයනු ලබන සේවා සඳහා එම ආයතනය මේක රෝගියා විසින් ගෙවිය යුතු ගාස්තු සඳහන් වූ කුඩා අත්පොතක් සහ එම ආයතනයේ දී තම සේවා සපයන වෛද්‍ය විශේෂඥවරුන් විසින් අයකරනු ලබන ගාස්තු ඇතුළත් වන ගාස්තු පිළිබඳ සම්පූර්ණ වගුවක් රෝගීන්ගේ දැන ගැනීම සඳහා එම ආයතනය විසින් ලබා දිය යුතු ය.

5. එම අත්පොතේ හෝ වගුවේ නිශ්චිතව දක්වා ඇති ගාස්තු හෝ අයකිරීම්වල ප්‍රතිශේෂයක් පිළිවෙහොත්, අවස්ථාවෝචිත පරිදි එම ගාස්තු පිළිබඳ වගුව හෝ කුඩා අත්පොත යාවත්කාලීන කිරීමට සහ නව ගාස්තු ක්‍රියාත්මක වන්නේ කවර දිනයක සිට ද යන්න සඳහන් කිරීමට සැලැස්වීම් ද එම වෛද්‍ය විශේෂඥවරුන්ගේ හෝ පෞද්ගලික වෛද්‍ය ආයතනයේ කාර්යය වන්නේ ය.

6. මේ නියෝගවල විධිවිධාන කඩ කරන යම් තැනැත්තෙක් වරදකට වරදකරු වන්නේ ය.

7. මෙම නියෝගවල -

“පනත” යන්නෙන් 2006 අංක 21 දරන පෞද්ගලික වෛද්‍ය ආයතන (ලියාපදිංචි කිරීමේ) පනත අදහස් වේ.

ශ්‍රී ලංකා ප්‍රජාතාන්ත්‍රික සමාජවාදී ජනරජයේ ගැසට් පත්‍රය

අති විශේෂ

The Gazette of the Democratic Socialist Republic of Sri Lanka

EXTRAORDINARY

අංක 1526/7 - 2007 දෙසැම්බර් 04 වැනි අඟහරුවාදා - 2007.12.04
No. 1526/7 - TUESDAY, DECEMBER 04, 2007

(Published by Authority)

PART I : SECTION (I) — GENERAL

Government Notifications

L.D.B. 8/2006

PRIVATE MEDICAL INSTITUTIONS (REGISTRATION) ACT, No. 21 OF 2006

REGULATIONS made by the Minister of Healthcare and Nutrition under Section 18(2) (B) of the Private Medical Institutions (Registration) Act, No. 21 of 2006.

Nimal Siripala De Silva,
Minister of Healthcare and Nutrition.

Colombo,
29th November, 2007.

Regulations

1. These regulations may be cited as the Private Medical Institutions (fees) Regulations No. 2 of 2007.
2. Any medical practitioner, dental surgeon, medical specialist or general practitioner who is engaged in the medical profession or practicing medicine, surgery or dentistry as the case may be,
 - (a) shall inform the patient or the person accompanying the patient of, the fees that would be charged by such medical practitioner, dental surgeon, medical specialist or general practitioner, in respect of the different categories of services rendered by each of them ; and
 - (b) shall exhibit or cause to be exhibited in a conspicuous place of the clinic or premises in which such person carries on his consultation, a complete table of fees charged in respect of the different categories of services being rendered.

1 A

3. Every private medical institution which provides healthcare services and which, is registered under the Act,

- (a) shall inform the patient or the person accompanying the patient, the fees that would be charged by such institution in respect of the different categories of services rendered by such institution ; and
- (b) shall exhibit or cause to be exhibited in a conspicuous place of the institution, a complete table of fees charged in respect of the different categories of services being rendered.

4. In the case of any private medical institution, such institution shall make available for the information of the patients a brochure setting out the fees payable by the patient to the institution for the services being rendered by such institution, and a complete table of fees including the fees being charged by the medical specialist who would be rendering their services at such institution.

5. It shall be the duty of the medical specialist or the private medical institution to cause the table of fees or the brochure as the case may be to be updated, if there has been a revision of the fees or charges specified therein, and also to state the date from which the new charges are to be effective.

6. Any person who contravenes the provisions of these regulations shall be guilty of an offence.

7. In these regulations.—

“Act” means the Private Medical Institutions (Registration) Act, No. 21 of 2006.

12-453

ශ්‍රී ලංකා ප්‍රජාතාන්ත්‍රික සමාජවාදී ජනරජයේ ගැසට් පත්‍රය

අති විශේෂ

இலங்கைச் சனநாயக சோசலிசக் குடியரசு வர்த்தமானப் பத்திரிகை

அதி விசேஷமானது

අංක 1526/ 7 - 2007 දෙසැම්බර් 04 වැනි දිනට - 2007.12.04
1526/7 ஆம் இலக்கம் - 2007 ஆம் ஆண்டு திசம்பர் மாதம் 04 ஆந் திகதி செவ்வாய்க்கிழமை

(අරසාங்கத்தின் அதிகாரத்துடன் பிரசுரிக்கப்பட்டது)

பகுதி I: தொகுதி (I) - பொது

அரசாங்க அறிவித்தல்கள்

ச.வ.பி.8/2006.

2006 ஆம் ஆண்டின் 21 ஆம் இலக்க, தனியார் மருத்துவ நிறுவனங்கள் (பதிவு செய்தல்) சட்டம்

2006 ஆம் ஆண்டின் 21 ஆம் இலக்க, தனியார் மருத்துவ நிறுவனங்கள் (பதிவு செய்தல்) சட்டத்தின் 18 ஆம் பிரிவின் (2) ஆம் உட்பிரிவின் (ஆ) என்னும் பந்தியின் கீழ் சுகாதார கவனிப்பு மற்றும் போசணை அமைச்சரினால் ஆக்கப்பட்ட ஒழுங்குவிதிகள்.

நிமல் சிறிபால த சில்வா,
சுகாதார கவனிப்பு மற்றும் போசணை அமைச்சர்.

கொழும்பு,
2007, நவம்பர் 29.

ஒழுங்குவிதிகள்

1. இவ்வொழுங்குவிதிகள் 2007 ஆம் ஆண்டின் 2 ஆம் இலக்க, தனியார் மருத்துவ நிறுவனங்கள் (கட்டணங்கள்) ஒழுங்குவிதிகள் என எடுத்துக்காட்டப்படலாம்.

2. விடயத்துக்கேற்ப மருத்துவ உயர்தொழிலில் அல்லது மருத்துவ தொழிலில், சத்திரசிகிச்சையில் அல்லது பல் மருத்துவத்தில் ஈடுபட்டுள்ளவர்களான மருத்துவ தொழிலர், பல் மருத்துவர், மருத்துவ நிபுணர் அல்லது பொது மருத்துவத் தொழிலர் எனும்-

(அ) அவர்கள் ஒவ்வொருவரினாலும் அளிக்கப்படுகின்ற சேவைகளின் வெவ்வேறு பிரிவுகள் தொடர்பில் அத்தகைய மருத்துவ தொழிலரினால், பல் மருத்துவரினால், மருத்துவ நிபுணரினால் அல்லது பொது மருத்துவத் தொழிலரினால் அறவிடப்படக்கூடிய கட்டணங்களைப் பற்றி நோயாளிக்கு அல்லது நோயாளியுடன் கூடவரும் ஆளுக்கு அறிவித்தல் வேண்டும்; அத்துடன்

(ஆ) அத்தகைய ஆள் அவருடைய மருத்துவ ஆலோசனையைக் கொண்டு நடத்த சிகிச்சை நிலையத்தில் அல்லது வளவுகளில் அளிக்கப்படும் சேவைகளின் வெவ்வேறு பிரிவுகள் தொடர்பில் அறவிடப்படும் கட்டணங்களின் பூரணமான பட்டோலை ஒன்றை வெளிக்காட்டி வைத்திருத்தல் வேண்டும் அல்லது வெளிக்காட்டி வைத்திருக்கச் செய்வித்தல் வேண்டும்.

3. சுகாதார கவனிப்பு சேவைகளை வழங்குகின்றதும் இச்சட்டத்தின் கீழ் பதிவு செய்யப்பட்டிருக்கின்றதுமான தனியார் மருத்துவ நிறுவனம் ஒவ்வொன்றும் -

(அ) அத்தகைய நிறுவனத்தினால் அளிக்கப்படும் சேவைகளின் வெவ்வேறு பிரிவுகள் தொடர்பில் அத்தகைய நிறுவனத்தினால் அறவிடப்படக்கூடியதான கட்டணத்தை நோயாளிக்கு அல்லது நோயாளியுடன் கூடவரும் ஆளுக்கு அறிவித்தலும் வேண்டும்; அத்துடன்

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I කොටස : (I) ඡේදය - ශ්‍රී ලංකා ප්‍රජාතාන්ත්‍රික සමාජවාදී ජනරජයේ අති විශේෂ ගැසට් පත්‍රය - 2007.12.04

ප්‍රකාශන I : தொகுதி (I) - இலங்கைச் சனநாயக சோசலிசக் குடியரசு வர்த்தமானப் பத்திரிகை - அதிவிசேஷமானது - 2007.12.04

(ஆ) அளிக்கப்படும் சேவைகளின் வெவ்வேறு பிரிவுகள் தொடர்பில் அறவிடப்படும் கட்டணங்களின் பூரணமான பட்டோலை ஒன்றை நிறுவனத்தின் துலாம்பரமான இடமொன்றில் வெளிக்காட்டி வைத்தல் வேண்டும் அல்லது வெளிக்காட்டி வைத்திருக்கச் செய்வித்தல் வேண்டும்.

4. ஏதேனும் தனியார் மருத்துவ நிறுவனத்தின் விடயத்தில், அத்தகைய நிறுவனம், அத்தகைய நிறுவனத்தினால் அளிக்கப்பட்டுவரும் சேவைகளுக்காக நிறுவனத்திற்கு நோயாளியினால் செலுத்தப்படற்பாலதான கட்டணங்களைத் தருகின்ற விபரங்கொத்து ஒன்றையும் அத்தகைய நிறுவனத்தில் அவர்களுடைய சேவைகளை அளிக்கின்றவருமான மருத்துவ நிபுணரினால் அறவிடப்பட்டுவரும் கட்டணங்கள் உட்பட கட்டணங்களின் பூரணமான பட்டோலை ஒன்றையும் நோயாளியின் தகவல்களிற்க்கென கிடைக்க செய்வித்தல் வேண்டும்.

5. விடயத்திற்கேற்ப, கட்டணங்களின் பட்டோலை அல்லது விபரத்தொகுப்பை, அத்தகைய கட்டணங்களின் பட்டோலை அல்லது விபரத்தொகுப்பில் குறித்துரைக்கப்பட்ட கட்டணங்களின் அல்லது அறவீடுகளின் மீளாய்வு ஒன்று இருப்பின், நாளதுவரை சீராக்கச் செய்வித்தலும் அத்துடன் புதிய அறவீடுகள் எந்தத் திகதியிலிருந்து பயனுறுகின்றதோ அந்த திகதியைக் குறிப்பிடுதலும் மருத்துவ நிபுணர்களின் அல்லது தனியார் மருத்துவ நிறுவனங்களின் கடமையாதல் வேண்டும்.

6. இவ்வொழுங்குவிதிகளின் ஏற்பாடுகளை மீறுகின்ற எவரேனும் ஆள் தவறொன்றிற்குக் குற்றவாளியாதல் வேண்டும்.

7. இவ்வொழுங்குவிதிகளில்,

“சட்டம்” என்பது, 2006 ஆம் ஆண்டின் 21 ஆம் இலக்க, தனியார் மருத்துவ நிறுவனங்கள் (பதிவு செய்தல்) சட்டம் எனப் பொருள்படும்.

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இலங்கை அரசாங்க அச்சுத் திணைக்களத்திற் பதிப்பிக்கப்பெற்றது.

Guideline for Clinical Management of Chikungunya Infection through Disease Phases

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Date) 13/06/2025

සෞඛ්‍ය හා ජනමාධ්‍ය අමාත්‍යාංශය சுகாதார மற்றும் வெகுஜன ஊடக அமைச்சு Ministry of Health & Mass Media

Provincial Directors of Health Services

Regional Directors of Health Services

All Heads of Institutions

RE: Guidelines for Clinical Management of Chikungunya Through Disease Phases (Reviewed and Updated, June 2025)

Chikungunya fever continues to be a public health concern due to increased seasonal vector activity. Several districts including Colombo, Gampaha, Kandy, Matara and Galle, have reported patients presenting with chikungunya-like illness.

Although in the majority the illness is self-limiting, some individuals especially high-risk groups, have persistent symptoms, mostly with arthritis or arthralgia, that may persist for weeks or months. These sequelae can substantially impair quality of life and daily functioning, especially in older individuals and those with underlying conditions.

This updated guideline addresses the clinical approach to post-acute and chronic manifestations of Chikungunya. It is intended to support uniform, evidence-based care across all levels of the health system, minimize long-term disability, and ensure appropriate referral and rehabilitation. The guideline is directed at all healthcare professionals involved in the care of patients with arboviral infections, including those in primary care, outpatient settings, inpatient wards, and rehabilitation services. These guidelines are in addition to the Guideline for Laboratory Diagnosis and Clinical Management of Chikungunya issued in April 2025, (number EPID/379/2006 dated 22/04/2025).

All Heads of healthcare institutions are requested to take immediate steps to ensure that relevant clinical staff are made aware of these revised and updated guidelines on Chikungunya management through the disease phases.

Please arrange to bring the contents of this guideline annexed to this letter to the notice of all officers concerned in your Province / District / Institution / Unit / Ward and provide a copy of this circular to relevant primary care doctors in your administrative jurisdiction/institution.


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Director General of Health Services

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Cc: Secretary, Ministry of Health and Mass Media
Additional Secretary (MS & PHS)
DDG (MS / LS / (PHS) I & II / ET & R)
Chief Epidemiologist
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All Other Technical DDGs & Directors
Medical Directors of Tri Forces & Police Hospital

**Guideline for Clinical Management of
Chikungunya Infection through Disease Phases**

June, 2025

Epidemiology Unit, Ministry of Health

Guideline for Clinical Management of Chikungunya Infection through Disease Phases

Introduction

This guideline provides a structured approach to the clinical management of Chikungunya virus (CHIKV) infection, which progresses through distinct phases: acute, sub-acute, and chronic. Each phase presents with specific clinical features and requires phase-specific management strategies.

Scope

The purpose of this guideline is to support clinicians in the diagnosis and management of patients with suspected or confirmed Chikungunya virus infection, across all clinical phases.

Target Audience

This guideline is intended for healthcare providers involved in the care of patients with arboviral infections. It is applicable at all levels of the health system, including community-based care, primary care, and secondary and tertiary care settings. It covers the management of acute, sub-acute, and chronic Chikungunya infection, including severe presentations.

Background

Chikungunya is a re-emerging vector-borne viral disease caused by the Chikungunya virus, an *alpha* virus of the *Togaviridae* family. The illness commonly presents with fever and severe joint pain, though symptoms can range in severity. While most patients recover, severe or even fatal outcomes may occur in neonates, older adults, and those with underlying medical conditions. No specific antiviral therapy exists; management is primarily supportive. First identified in Tanzania in 1952, CHIKV caused sporadic outbreaks in Africa and Asia until the first recorded urban transmission in Thailand in 1958. Since 1960, disease outbreaks in South East Asia have been reported in India, Sri Lanka, Myanmar, Thailand, Indonesia, the Philippines, and Malaysia. Since 2004, Chikungunya outbreaks have become increasingly widespread, aided by viral adaptations that enhance transmission through *Aedes albopictus* mosquitoes. As of 2024, Chikungunya has been reported in 119 countries, with over 460,000 global cases—predominantly from the Americas, Eastern Mediterranean, and South-East Asia Regions.

In Sri Lanka, the first outbreak occurred in the early 1960s, followed by decades of epidemiological silence. A major resurgence occurred in 2006–2008, with tens of thousands affected. Since the latter part of 2024, Chikungunya and suspected Chikungunya-like cases

have been reported mostly from hospitals in the Western Province. Confirmed cases have been reported based on laboratory testing conducted at the Medical Research Institute (MRI), Colombo.

Chikungunya virus (CHIKV) infection progresses through distinct clinical stages—each characterized by specific features and requiring tailored management strategies. Clinically, the illness is classified into **acute, sub-acute, and chronic phases**.

Incubation period:

CHIK virus causes an acute febrile illness with an incubation period of 3-7 days (range 2-12 days). Viremia persists for up to 7 days from the onset of symptoms.

A. Progression of Chikungunya illness through disease phases

1. Acute Phase

(Includes Acute Febrile and Acute Arthritic Stages)

1.1. Acute febrile Phase

The febrile phase typically lasts up to 7 days but may extend beyond a week in some cases. It is characterized by the sudden onset of high-grade fever ($>39^{\circ}\text{C}/102^{\circ}\text{F}$), severe arthralgia or arthritis, and a maculopapular or erythematous rash—forming the classic triad. The rash usually appears between the 2nd and 5th day of fever and may involve the face, chest, abdomen, limbs, palms, and soles.

Other symptoms include myalgia, headache, and possible oral ulcers. Neuropathic pain (burning, tingling, or numbness), especially in the elderly, may also occur early in this phase. Patients with chikungunya fever are mostly symptomatic; however, asymptomatic infections have been reported in 3% to 25% of cases.

Manifestations such as abdominal pain, diarrhea, vomiting, may also be found. If a patient with suspected Chikungunya presents with prominent diarrhoea, it's important to assess for co-infections like dengue or bacterial gastroenteritis.

1.2. Acute Arthritic Phase (up to 2 weeks)

This stage occurs within the first two weeks of illness and may overlap with the febrile stage. It is characterized by the abrupt onset of arthritis or arthralgia involving multiple joints—

most commonly the small joints of the hands, wrists, ankles, and feet—accompanied by joint swelling, stiffness, and pain.

2. Sub-acute Arthritic Phase (>2 weeks to 3 months)

The sub-acute arthritic phase, persisting or developing arthritis 2 weeks after fever resolution, and persists up to 3 months is characterized by arthralgia and arthritis, joint stiffness, tenosynovitis, bursitis, fatigue, and a pigmented rash may appear during the second week and typically resolves within 6 weeks. In some cases it is possible to experience arthritis without the initial febrile phase.

3. Chronic Arthritic Phase (> 3months)

The chronic arthritic phase, arthritis persisting more **than 3 months after fever resolution**, may last from several months to years and is characterized by chronic or recurrent inflammatory arthritis, tendinopathies, enthesopathies, persistent fatigue, and symptoms that may mimic chronic rheumatic diseases such as rheumatoid arthritis or spondyloarthritis.

Long-Term effects

- 50% of patients may experience prolonged symptoms
- Risk factors: older age, female gender, severe acute illness, inadequate rest during the acute phase, and pre-existing musculoskeletal conditions

The table 1 illustrates the timeline-based categorization of Chikungunya infection.

Table 1. Timeline-Based Categorization of Chikungunya Infection

Phase	Time Frame
Acute	
○ Acute Febrile phase	Up to Day 7
○ Acute Arthritic phase	Up to 2 weeks
Sub-Acute	> 2 weeks to 3 months
Chronic	> 3 months

B. Laboratory diagnosis

In an epidemic, diagnosis of the disease is mainly clinical, while laboratory investigations will help in diagnosis, differentiation from other conditions, and the monitoring of disease progression and complications.

1. Confirmation of Diagnosis

Definitive diagnosis in the acute phase can be achieved through **reverse transcription polymerase chain reaction (RT-PCR)**, which detects viral RNA typically within the first seven days of illness.

Following this period, **serological testing** becomes more relevant. Detection of **IgM antibodies**—which usually become detectable around day seven of illness, indicates recent infection, while the presence of **IgG antibodies** suggests past exposure or late-phase infection. The table 3 illustrates preferred laboratory investigations for Chikungunya based on the time since symptom onset.

Table 3. Laboratory Investigations for Chikungunya

Time since symptom onset	Preferred test	Sample
0–7 days	RT-PCR (molecular)	Serum
>7 days	IgM/IgG (serology)	Serum

2. Exclusion of Differential Diagnoses

Given the clinical similarity between Chikungunya and other febrile illnesses such as dengue, leptospirosis, and bacterial infections, laboratory investigations are essential for accurate differentiation. The **NS1 antigen test** is particularly useful in identifying dengue in the early phase, while a **full blood count (FBC)** can reveal hematological patterns that aid in distinguishing between these infections.

3. Supporting Ongoing Management and Complication Monitoring

In patients experiencing prolonged symptoms, particularly persistent joint pain or stiffness, investigations continue to play a supportive role. These may include the assessment of **renal and hepatic function** to evaluate possible organ involvement. **Inflammatory markers** such as erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP) values are highly variable in chikungunya and can be normal. When it is high, it assists in monitoring disease activity and guiding anti-inflammatory or analgesic therapy

Note: In cases of classical chikungunya, elevated C-reactive protein (CRP) reflects the severity of the inflammatory response. It should not be used as an indicator of bacterial

infection. Therefore, routine initiation of antibiotics is not recommended and should be discouraged unless there is clear clinical or laboratory evidence of a secondary bacterial infection

Differential diagnosis

Fever with or without arthralgia is a very common manifestation of several other diseases. Some of the diseases which can be considered as close differential diagnoses are: Dengue fever, Leptospirosis, Enteric fever, Rheumatic fever, Reactive arthritis, COVID-19

Due to the overlapping symptoms, particularly during co-circulation with dengue, clinicians should be cautious and use available diagnostic tests to differentiate among these conditions.

C. Phase-Specific Management

There is no specific antiviral drug against CHIK virus. Treatment is entirely symptomatic and management should be tailored to the clinical phase.

1. Management in Acute Febrile Phase

In the febrile phase, the focus is primarily on alleviating fever and pain, ensuring adequate hydration, encourage rest and activity as tolerated, managing other acute symptoms, and preventing immediate complications

- Rest: Adequate physical rest is crucial during the acute phase to aid recovery and may play a role in reducing the likelihood of developing chronic sequelae. Patients should be advised to limit physical activity.
 - Hydration: Patients should be encouraged to consume plentiful oral fluids, such as water, fruit juices, or oral rehydration solutions (ORS), to prevent dehydration, especially during the febrile period. A target urine output of more than one liter in 24 hours is a useful indicator of adequate hydration.
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- Strongly discourage self-medication, especially with NSAIDs, steroids, or antibiotics
 - Analgesics (First-line): Paracetamol (Acetaminophen) is the analgesic and antipyretic of choice for managing fever and joint pain. It is particularly preferred in dengue-endemic areas until dengue fever can be definitively ruled out, owing to the risk of hemorrhagic manifestations associated with other analgesics like NSAIDs.

- Dosage (Paracetamol): For adults weighing more than 50 kg, the usual dose is 500 mg to 1 g every 4 to 6 hours, not exceeding 4 doses per 24 hours and with a maximum daily dose not exceeding 3 to 4 grams. For pediatric patients, the dose is 10-15 mg/kg of body weight every 6 hours, with a maximum daily dose of 60 mg/kg.
- Paracetamol can be combined with codeine for moderate pain (PCM + codeine preparation).
- Nonsteroidal Anti-inflammatory Drugs (NSAIDs): NSAIDs are strongly advised against during the febrile phase.
- Corticosteroids: The use of corticosteroids in the febrile phase of Chikungunya is generally not recommended for managing musculoskeletal symptoms. This is due to the potential for adverse effects, lack of proven long-term benefits for arthralgia, and the risk of rebound arthritis upon withdrawal.

2. Management of Acute Arthritic Phase

- **Paracetamol** (same doses as above); may be combined with codeine for moderate pain, and gabapentin if neuropathic pain is suspected.
- NSAIDs (e.g., ibuprofen, naproxen) can be considered after 7–10 days of the illness when patient is afebrile. In a dengue-endemic setting dengue needs to be excluded due to bleeding risk. Co-prescribe PPIs or H2 blockers to reduce GI side effects.
 - *Examples: Ibuprofen (e.g., 200-400 mg three times daily) Naproxen, Diclofenac.*
 - *Combination of different NSAIDs should not be used due to increased GI adverse effects*
- Corticosteroids are not advised in the acute arthritic phase.
 - Assess for neuropathic pain and consider gabapentin, initiated at a low dose (e.g., 100-300 mg at bedtime) if indicated.
Features of neuropathic pain are burning sensation especially in the soles and hands, cold or heat sensation in the legs, tingling or electric shock like sensations, itching
- **Outpatient care using the above guide is usually sufficient for the acute febrile and acute arthritic phases; only severe or complicated cases may be referred to a specialist or admitted**

Indications for Referral/Admission

- Fever persisting for more than 5 days.
- Intractable joint pain unresponsive to recommended analgesia.
- Altered sensorium, confusion, or severe lethargy.
- Postural dizziness, cold extremities, or signs of hemodynamic instability.
- Decreased urine output (oliguria).
- Any bleeding manifestations (e.g., petechiae, purpura, epistaxis, gum bleeding).
- Incessant vomiting or inability to tolerate oral fluids.
- Jaundice.

*High risk groups:

Patients with certain conditions are considered high-risk. Chikungunya infection in these individuals is likely to lead to severe manifestations and adverse outcomes. High-risk conditions include hypertension, diabetes, coronary artery disease (CAD), cardiovascular disease (CVD), and chronic obstructive pulmonary disease (COPD). Patients below one year of age, above 65 years, and pregnant females are also at greater risk for complications. Clinicians must closely monitor them.

High-Risk Populations (Need close monitoring or early referral)

- **Pregnant women:** Paracetamol is recommended for the symptomatic patient and NSAIDs are to be avoided. Especially near term; obstetric consultation is essential. C-section does not prevent transmission.
- **Children: Use paracetamol only; avoid opioids.** *Pediatric dose of PCM - 10-15 mg/kg per dose 6 hrly not to exceed 3gm/24 hrs*
- **Older adults/comorbidities:** Monitor for decompensation. Adjust chronic medications, avoid over-aggressive BP control, consider early insulin in diabetics, avoid beta-blockers that mask tachycardia

Secondary and tertiary Care: Provide individualized clinic and inpatient care for complications or comorbidities

3. Management in Sub Acute Arthritic Phase

Management during the sub-acute arthritis phase focuses on controlling pain, reducing inflammation, and preventing progression to chronic arthritis, with treatment tailored to the severity of symptoms and close monitoring for recurrence during medication tapering.

A thorough assessment is critical and should include:

- Standardized Assessment Tool: Regular use of validated patient-reported outcome measures is essential for quantifying pain, functional disability, and overall disease impact. The Visual Analogue Scale (VAS) for pain is recommended for this purpose.

Pharmacological Management

- Start with paracetamol; may combine weak opioids for moderate pain. Make sure to prescribe routinely, not on as needed basis
- Consider gabapentin for neuropathic symptoms
- Corticosteroids are indicated for severe polyarthritis with synovitis or tenosynovitis and for moderate to severe pain (VAS 4–10), and should be initiated after two weeks from fever onset, during the subacute phase.
 - *The preferred regimen is prednisolone 10–15 mg/day, tapered gradually over 8–12 weeks by reducing the dose every two weeks, with close monitoring for flare-ups or recurrence during tapering.*
- Intra-articular steroids may be considered for resistant localized synovitis or bursitis. NSAIDs are not recommended due to gastrointestinal risks and limited efficacy, and concurrent use of NSAIDs and steroids should be avoided to prevent GI bleeding.
- Disease-modifying antirheumatic drugs (DMARDs) are not recommended at this stage and should only be considered after 8–12 weeks if arthritis persists, with input from a rheumatologist.

4. Management in Chronic Phase

Management in the chronic phase aims to prevent joint damage, minimize functional limitations, and improve overall quality of life in patients with persistent joint symptoms following CHIKV infection.

4.1 Specialist Involvement

- The chronic phase should be managed by a **rheumatologist**, particularly when symptoms are prolonged or worsening

4.2 Criteria for Rheumatology Referral

- Joint symptoms persisting >3 months, or
- Recurrence of arthritis following steroid tapering

4.3 Pharmacological Management (By Rheumatologist)

- DMARDs: **Hydroxychloroquine (HCQ)**, **Methotrexate (MTX)**, or **Leflunomide (Lef)**, are the preferred agents with or without **low-dose corticosteroids**

Note: HCQ monotherapy is generally inadequate; **combination therapy** is typically required for effective disease control

4.4 Non- Pharmacological Management (for Rehabilitation)

- **Physiotherapy** to maintain joint mobility and reduce stiffness
- **Occupational therapy** to support daily functional independence
- **Psychological support** for individuals experiencing emotional distress or disability related to chronic symptoms

Following link is to be used by the treating clinicians to report suspected/ confirmed cases of Chikungunya: <https://bit.ly/Epid-cgCRF>

Annexure:

1. Synopsis of Management

Phase	Time Frame	Main Clinical Features	Management Strategy
Acute Febrile Phase	Day 0–7	High-grade fever, severe arthralgia, rash, myalgia, headache	<ul style="list-style-type: none"> ○ Rest, hydration, Paracetamol (avoid NSAIDs and steroids) ○ Monitor for complications ○ Avoid antibiotics unless clear bacterial infection
Acute Arthritic Phase	Day 0–14 (may overlap with febrile phase)	Symmetrical polyarthrititis/arthralgia, joint swelling, stiffness	<ul style="list-style-type: none"> ○ Paracetamol ± codeine ○ Consider gabapentin for neuropathic pain ○ NSAIDs after 7–10 days if afebrile and dengue excluded
Sub-Acute Phase	>2 weeks to 3 months	Persistent arthralgia, arthritis, tenosynovitis, fatigue, pigmented rash	<ul style="list-style-type: none"> ○ Consider short course of corticosteroids in selected cases (with caution)
Chronic Phase	>3 months	Chronic/recurrent arthritis, tendinopathy, fatigue, mimics rheumatoid/spondyloarthritis	<ul style="list-style-type: none"> ○ Rheumatology referral ○ DMARDs if indicated ○ Individualized physical rehab plan ○ Rule out differential diagnoses
Laboratory Diagnosis	Throughout illness	RT-PCR (0–7 days), IgM/IgG (>7 days), exclude dengue/leptospirosis, monitor organ functions, CRP variable	<ul style="list-style-type: none"> ○ Use diagnostics to confirm ○ Differentiate from other conditions, and monitor prolonged symptoms ○ Avoid routine antibiotics unless clear secondary bacterial infection

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3. List of Contributors

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Paraprosdokians

Paraprosdokians are figures of speech in which the latter part of a sentence or phrase is surprising or unexpected and is frequently humorous. (Winston Churchill loved them).

1. Where there's a will, I want to be in it.
2. The last thing I want to do is hurt you, but it's still on my list.
3. Since light travels faster than sound, some people appear bright until you hear them speak.
4. If I were to agree with you, we'd both be wrong.
5. We never really grow up; we only learn how to act in public.
6. War does not determine who is right, only who is left.
7. Knowledge is knowing a tomato is a fruit. Wisdom is not putting it in a fruit salad.
8. To steal ideas from one person is plagiarism. To steal from many is research.
9. I didn't say it was your fault, I said I was blaming you.
10. You do not need a parachute to skydive. You only need a parachute to skydive twice.
11. I used to be indecisive, but now I'm not.
12. To be sure of hitting the target, shoot first and call whatever you hit the target.
13. Going to church doesn't make you a christian anymore than standing in a garage makes you a car.
14. You're never too old to learn something stupid.
15. I'm supposed to respect my elders, but it's getting harder and harder for me to find one now.

Prof. Lamabadusuriya honoured with lifetime achievement award and induction into Hall of Fame of College of Paediatricians

(Citation presented by Dr B. J. C. Perera on 08th June 2025 at the Inauguration Ceremony of the Annual Congress of the Sri Lanka College of Paediatricians.)

Ladies and Gentlemen, this year, the Sri Lanka College of Paediatricians has commenced a new enterprise. It is the inauguration of a Lifetime Achievement Award with automatic induction into the Hall of Fame of the college. Our college is the very first medical academic organisation in Sri Lanka to commence such an award of unrestrained splendour.

At the Council Meeting of the College on the 11th of April 2025, a name was proposed for this award. It was approved unanimously. That laureate is Professor Sanath Punsara Lamabadusuriya. Providing a citation for him is perhaps akin to taking coal to Newcastle, as the man and his achievements are well-known. I will only attempt to provide a bird's-eye view of the person to suit this formal occasion.

In the year 49 BC, the uncrowned Roman Emperor Julius Caesar crossed the Rubicon River with his army, and loudly exclaimed in Latin, "Alea iacta est," which means "the die has been cast." Sanath, when you were born on the 30th of December 1942, to a family with the surname starting with "Lama", meaning 'child', the die was indeed cast. Destiny had perhaps decreed that you would become a Paediatrician; a calling which started your long road to undisputed fame.

Sanath Lamabadusuriya, a 20-year-old Royalist, entered the Colombo Medical Faculty in 1962, not as a future prodigy but as a bit of a dark horse. Then, in their final MBBS Examination in 1967, the guy bloomed, overtook everybody else, secured 2nd Class Honours with Distinctions in Medicine and Obstetrics and Gynaecology and was placed first in the combined order of merit of those who qualified from Peradeniya and Colombo, the only two Faculties of Medicine in Sri Lanka at that time.

He may dreamt big, but he had to prove himself, before others determined that he really belonged. In a glorious career, he has secured DCH(England), MRCP(UK), FRCP(London), FRCP(Edinburgh), FRCP(Glasgow), FRCPCH(UK), Honorary FRCPCH(UK), FCCP, FSLCPaed, Honorary FCCP(SL), and most importantly PhD (London), and DSc (Ruhuna). The jewel in the crown was the receipt from Her Late Majesty Queen Elizabeth I, the MBE, the Membership of the most Excellent Order of the British Empire. He is the first clinician in Sri Lanka to secure a PhD by a research thesis and the only Sri Lankan domiciled in Sri Lanka in



Prof. Lamabadusuriya receiving the award from Dr. Dumindu Samarasinghe, President of the Sri Lanka College of Paediatricians

the modern era, to receive a Royal Honour from Great Britain. He was the Chair Professor of Paediatrics in Ruhuna and Colombo and retired on the 30th of September 2008. However, he did not stop there. He stepped in when there was a lack of teaching staff in the newer universities and continues to teach as a Visiting Professor in the Universities of Rajarata and Sabaragamuwa. This is his 56th year as a medical teacher. All in all, he has taught in four Medical Faculties in Sri Lanka and one Foreign University in Saudi Arabia while he was on Sabbatical Leave. He gave away his capital freely, not monetary wealth, but the wealth of knowledge. His students would even worship the ground he walks on. To top it all, he was the Dean of the Faculty of Medicine, University of Colombo, from 2002 to 2005 and the Chairman of the Board of Study in Paediatrics of the Postgraduate Institute of Medicine of the University of Colombo, continuously from 1991 to 2002.

Just for the record, he has made numerous scholarly discourses, delivered many Invited Plenary Lectures, presented 3 scientific orations, as well as 2 landmark invited addresses, and published over 140 peer-reviewed research articles in journals. He has not sat back on his laurels even after his PhD.

Professor Lamabadusuriya was the President of the Sri Lanka Paediatric Association, the forerunner of our college, in 1960, and I was the Honorary Secretary under him. The man gave me a free hand to do whatever had to be done. He had a very successful year in office as the President.

In recognition of his services to Paediatrics, the Association of Paediatric Societies of the South-East Asian Region (APSEAR), which later became the Asia Pacific Pediatric Association

(APPA), honoured him with the "Outstanding Paediatrician of Asia" title in 1997. He was the President of the very same Asia Pacific Pediatric Association (APPA) from 2006 to 2008. There are a whole host of other achievements which I am not able to present here, purely due to limitations on time.

Mr President, Ladies and Gentlemen, I am 5 years younger and 3 years junior to him in service. We have been virtual contemporaries and know each other very well. Behind his back, of course, I call him "The King", or "Sija Thama". Sanath and I have been close friends, but that rapport is kind of a quaint but strange alliance, thriving in accord, as well as in discord. We have openly argued about many things, even in public, but we have never raised our voices against each other, as we believe that reasoning and courage do not have to reach higher decibel levels. If I provided evidence to support a stance I took, he would accept it, and I reciprocated in the same manner. Over the years, we have tacitly and implicitly agreed even to disagree, without being disagreeable.

Mr President, Ladies and Gentlemen, Professor Sanath Punsara Lamabadusuriya, by his supreme contribution to child healthcare in Sri Lanka, undeniably deserves this honour. It is the ultimate accolade, designed and commissioned to reflect our respect, symbolise our admiration, and convey our superlative appreciation for his commitment to Paediatrics in Sri Lanka. It is also a notable feather in the cap of our college to have someone like him as the inaugural recipient of this award.

Mr President, I am definitely over the moon to present my close friend, the Good Professor, for the conferment of this unique, pivotal and priceless tribute.



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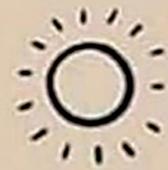
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- Eating food
- Celebrating little wins



OXYTOCIN THE LOVE HORMONE

- Playing with a dog
- Playing with a baby
- Holding hand
- Hugging your family
- Give compliment



SEROTONIN THE MOOD STABILIZER

- Meditating
- Running
- Sun exposure
- Walk in nature
- Swimming
- Cycling



ENDORPHIN THE PAIN KILLER

- Laughter exercise
- Essential oils
- Watch a comedy
- Dark chocolate
- Exercising



Felicitation

Hearliest Congratulations and Good wishes from the IMPA President, Council and the Members to Professor Sanath Lamabadusooriya who was honoured and awarded a Lifetime Achievement Award and inducted to the Hall of Fame.

on Sunday the 8th of June 2025, at the Inauguration

of the Sri Lanka College of Paediatricians Annual Conference, Professor Sanath Lamabadusooriya was honoured and awarded a Lifetime Achievement Award and inducted to the Hall of Fame. He is the first person to receive that honour in Sri Lanka, as none of the other Colleges have done so as yet!





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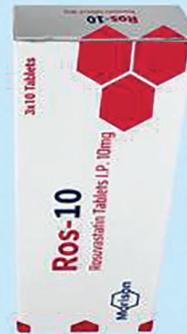
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