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ANCHOR

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SRI LANKA COLLEGE OF SPECIALIST FAMILY PHYSICIANS

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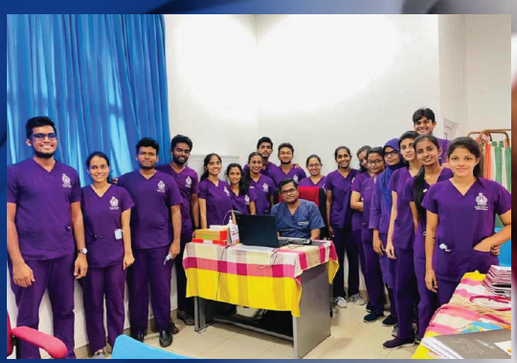
COVER STORY...

DAMBADENIYA PRIMARY CARE UNIT



STRIVING FOR EXCELLENCE THROUGH DEDICATION AND UNITY

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President's message

Dear Members of the Sri Lanka College of Specialist Family Physicians,

It is with great pride and honour that I address you all on this memorable occasion at the launch of the inaugural newsletter composed by the Sri Lanka College of Specialist Family Physicians (SLCSFP). As the current President of the SLCSFP, it is my privilege to welcome you all to this publication that will from now on serve as the official newsletter for our membership.

The year 2023 has been eventful and transformative for us, as we transitioned from being an academic association to a distinguished College. Launching the official newsletter is another step forward in the direction of continuing medical education. We hope that this newsletter marks a significant milestone in our journey to promote excellence and innovation in Family Medicine in Sri Lanka. This provides a unique opportunity to share our collective knowledge, experiences, and insights with all our readers. Furthermore, the newsletter will be able to foster a sense of unity and collaboration among our members and strengthen our commitment to improve the health and well-being of our fellow citizens.

The specialty of Family Medicine is progressing continuously to play a pivotal role in the Sri Lankan healthcare system by delivering first contact, patient-centred and comprehensive care striving always to parallel with the international standards. We are dedicated to providing quality healthcare that addresses the diverse needs of all individuals, their families and the communities. In addition, our role extends beyond the confines of the clinic where we become advocates for health, integral members of healthcare teams, community team leaders and coordinators with other specialties and health service providers.

This inaugural newsletter covers a wide area of interesting topics including clinical updates, research highlights, case studies,

and many more aspects related to our specialty. These contributions reflect the depth of knowledge and expertise within our membership. I encourage all our members to actively participate in the future editions of this newsletter, sharing your experiences and insights to enrich the collective wisdom of the membership. I firmly believe that this newsletter will be the ideal platform to disseminate innovative and updated knowledge as well as to share different perspectives of primary care that will be especially relevant to the Sri Lankan context.

As we embark on this journey, let us remember that our ultimate goal is to enhance the quality of life for our citizens and to contribute to the overall health of our nation. Through our commitment to this goal we will be contributing to achieve Universal Health Coverage by 2030. I would like to thank the Ministry of Health for working in close collaboration with us in the process to achieve this important sustainable development goal. The Sri Lanka College of Specialist Family Physicians is committed to this noble cause, and I am sure this newsletter will facilitate us to contribute further along with our membership.

I want to express my gratitude to the dedicated team that had worked tirelessly to bring this inaugural edition of the newsletter to life. Your unwavering commitment, creativity, and attention to detail has truly made this an impactful publication.

In closing, I look forward to the growth and development of our College, and I encourage each of you to continue your committed personal contributions in the field of Family Medicine. Together, we can make a meaningful impact within the healthcare system in Sri Lanka.

Thank you for your steadfast dedication and service to our community.

Dr. Malkanthi Galhena

President SLCSFP

Editorial

Establishing the discipline of Family Medicine

Clinical disciplines in medicine have evolved due to different factors. Epistemological (knowledge based), practical and administrative have been described as the main factors that define a discipline (McWhinney).

The epistemological basis is the agreement among its members about the important problems confronting the discipline and the appropriate knowledge for dealing with them. In clinical disciplines, this will include common clinical problems presented to the practitioners, the agreed clinical method for dealing with the problems and the agreement on a research agenda. For a clinical discipline to be truly independent, some research questions should only be addressed from inside the discipline.

The Sri Lanka College of Specialists Family Physicians (SLCSFP) has fulfilled the epistemological basis of the discipline of Family Medicine. It has the recognition of the highest educational authority, the PGIM confirming the knowledge component based on the fact that all members have acquired the MD with Board Certified Specialist status or in the PGIM pathway for board certification.

Another related knowledge factor is the continued professional development of the members and associates of the discipline of family medicine. Most primary care practitioners in both public and private sectors practise as 'family doctors' without any added postgraduate qualification. Therefore, the moral obligation and at least partial responsibility will fall on SLCSFP to educate and update these 'family doctors'. This shall enhance the professional image of the specialist family physician.

Research agenda of Family Medicine is an area overlooked by many Family Medicine MDs. Although board-certified members does a research project as a part of the training program, seldom it is published in a peer-reviewed journal. The paucity of research is a problem for all family physicians/general practitioners worldwide, as we showed in 2005 in an analysis of family medicine research in the Wonca publication journal Family Practice (Ref PubMed 16126822).

The administrative factors have been well established with the appointment of specialists in Family Medicine to posts in the Ministry of Health strengthening the delivery

of primary care at Apex hospitals. The Ministry of Education, through the faculties of medicine, have departments of Family Medicine, where Specialist Family Physicians are in charge of the undergraduate and postgraduate medical education.

Does the general public know about Family Medicine as a specialist discipline as other specialities such as Internal Medicine or Neurology? I think we have considerable work to do in educating the public about MBBS qualified doctors who practise as 'family doctors' and 'specialist family physicians'. We will invariably have to use the mass media, including traditional print and social media, in a well-organised manner to create this awareness about the discipline.

For an independent discipline, an academic body is essential for the advancement of the discipline and to groom the young professionals. The membership of all Academic Colleges in Sri Lanka is based on the MD obtained from the Post Graduate Institute of Medicine (PGIM). The SLCSFP has adhered to this national standard in the discipline of Family Medicine with a caveat - all members will have to be Board Certified MD in Family Medicine or in the PGIM pathway to the board certification. This step to allow MD-FM trainees to be members was taken by the unanimous decision of the board-certified members as a temporary measure considering the SLCSFP is a young College. Its important that we have cordial relations with all other professional Colleges in Sri Lanka to work together and enhance the quality of care provided to all citizens.

We are privileged to have an official newsletter of SLCSFP from the inception. The role of this newsletter is multifaceted: disseminating current news events, educational components, research news and fulfilling administrative functions. The publication committee invites you to share your thoughts and expertise in the SLCSFP Newsletter. We will be looking forward to publishing your articles on clinical problems, case discussions, quizzes, creative write ups, news related to the discipline and extracurricular activities of the membership. Please send your articles to publication. slcsfp@gmail.com.

The SLCSFP will be published in the last week of March, June, September and December each year.

Joint editors

Dr. Kumara Mendis

Dr. Aruni de Silva

29/10/2023

Striving for excellence through dedication and unity: History of SLCSFP

Dr. Lalantha Senaratne, *Consultant Family Physician*

MD in Family Medicine was introduced to medical officers from the Ministry of Health (MoH) in 2009. In the very first batch, there were only three trainees, including myself. The first batch of Consultant Family Physicians were instated to the Ministry of Health in 2014, and from then on, have been proactive lead points in government health institutions in providing Primary Care to the people of Sri Lanka.

In 2015, the specialty of Family Medicine was recognized by the World Federation for Medical Education (WFME), as one of the six major clinical disciplines that a medical school must offer to meet the basic standards of an educational programme that leads to a Primary Medical Qualification. However, many years before this revision of global standards for quality improvement in basic medical education, three universities in Sri Lanka had established Departments in Family Medicine. And after this revision, many more universities in Sri Lanka incorporated Family Medicine as a clinical subject into their medical curriculum. Consequently, there grew an interest among newly graduating young doctors to pursue Family Medicine in postgraduate education.

Until 2020, the prerequisites of candidates from MoH for the selection examination in MD in Family Medicine were, five years of experience in Primary Health Care and a Diploma in Family Medicine. These criteria were then changed, considering the years of time required to be eligible to pursue this postgraduate training programme, and to be in line with other postgraduate MD programmes conducted by the Post-Graduate Institute of Medicine, Colombo.

Furthermore, since 2020, the intake of trainees to the MD Programme in Family Medicine has increased up to 15. This is a result of the MoH identifying the importance of Family Medicine to strengthen Primary Care in Sri Lanka. Qualified manpower is essential to improve the quality of healthcare service delivery in Primary Care settings. Well-functioning frontline Primary Care Services is suggested by the World Health Organization as the solution to achieve Universal Health Coverage by 2030.

The curriculum and the training programme for the MD in Family Medicine was developed while keeping in mind the need to enhance knowledge, skills and attitudes which enable a specialist to contribute maximally to Primary Care reforms proposed by the MoH to ensure Universal Health Coverage. 50% of the training on patient management is based in Primary Care settings, while 50% is based in Secondary and Tertiary Care settings. The objective of this arrangement is to train the doctor in a multitude of aspects. The Primary Care Specialist must correctly identify red flag symptoms and signs of diseases. They must correctly identify patients who need referral or admission to Secondary and Tertiary Care settings, and this must be done at the correct point of time while minimising delays. They must skillfully manage individuals, understanding the overall context of health issues without overburdening and exhausting the resources of Secondary and Tertiary Care settings.

As Board Certified Consultants from a relatively new discipline employed by the MoH, we have had to face many adversities in actualizing our intentions to initiate change. Considering the collective strength that lies in teamwork, the Sri Lanka Association of Specialist Family Physicians was established in 2017, and I was Founding President. With time, the Association evolved to become a College in 2022. Our aim is to provide proper guidance and training to postgraduate trainees in Family Medicine, while improving the contribution from Family Medicine to MoH to improve healthcare service delivery in Sri Lanka. I am very happy to say that Consultants in Family Medicine provide very successful undergraduate and postgraduate training in multiple Primary Care settings in major hospitals and respective departments in state universities. I am excited to see what the future brings, and I hope it would be positive developments in greater benefit to the community at large.

All knowledge attains its ethical value and its human significance only by the human sense in which it is employed. Only a good man can be a great physician

Hermann Nothenagel [1841-1905]

Dambadeniya Primary Care Unit: An inspiration to Sri Lanka's primary care system

Dr. Sindoopa Seneviratne - Registrar in Family Medicine

In the heart of the ancient city of Dambadeniya stands a significant symbol of Sri Lanka's primary care system. It is the Primary Care Unit at Dambadeniya Hospital, under the leadership of Dr. K. H. D. Milroy, the specialist Family Physician at Base Hospital Dambadeniya. He plays a pivotal role in

delivering unique and indispensable primary care to the area's residents. Dr. Milroy commenced his service here in May 2018 and continues to provide exemplary care.

The doctors and the healthcare staff at the Outpatient Department (OPD) are deeply committed to providing first-contact care to the patients who visit the OPD. These doctors collaborate closely with the consultant to ensure patients receive comprehensive and well-informed opinions regarding their health concerns.

For follow-up care, the patients attend the Family Medicine Clinic, led by the specialist family physician. This unit is renowned for its dedication to holistic healthcare and welcomes patients of all ages, including adults and children. The team comprises the specialist, three designated doctors, postgraduate trainees in rotation, two nursing officers, and other supportive healthcare staff.

Dambadeniya Primary Care Unit not only serves patients but also contributes to training future primary care doctors in Sri Lanka. It offers postgraduate training for MD and DFM trainees and undergraduate training for medical students from Wayamba University, thereby nurturing the next generation of primary care physicians.

With necessary medical equipment, such as spirometry, biothesiometer, handheld Doppler devices, and more, this unit ensures that patients receive the highest standard of care. Additionally, a dedicated dispensary within the primary care unit streamlines medication distribution, enhancing patient convenience. The unit's laboratory offers a wide range of more than 30 diagnostic investigations.

The availability of a mini operating theatre for office-based surgical procedures significantly reduces healthcare costs by minimising the need for inpatient

admissions to the surgical ward. This mini theatre operates one day a week and has completed 153 day surgeries by the end of August for the year of 2023.

A notable feature that has greatly improved healthcare provision within the primary care unit is the implementation of electronic medical records. These records facilitate more effective communication with secondary care units, the pharmacy, the ECG room, the radiology department, the laboratory, and other healthcare facilities within the hospital.

The impact of the Dambadeniya Primary Care Unit goes beyond cost savings. Patients served by this unit express high levels of satisfaction, a testament to the exceptional care and attention provided by the team. In a country where the development of a comprehensive primary care system is still a work in progress, this unit shines as an

exemplary model and offers a glimpse of hope for the future of primary healthcare in Sri Lanka.

"I would be a lot healthier if you'd stop finding things wrong with me!"

Assessing sore throat in a Family Medicine clinic

Dr. Fazana Aththas - Acting Consultant in Family Medicine

A painful or sore throat is a common encounter in a Family Medicine clinic. Though national statistics are scarce in Sri Lanka, one epidemiological study shows sore throat is the fourth common presentation for acute upper respiratory tract infections in hospitalised children after fever, cough and cold.[1]

The commonest cause is viral pharyngitis. It is usually self-limiting and needs only symptomatic treatment. It may present as a single complaint of continuous pain aggravated by swallowing. Complex presentations with common respiratory infections are possible especially in children where presentations with nausea/ vomiting, abdominal pain and fever may lead to diagnostic confusions.[2]

Group A Streptococcal (GAS) pharyngitis is relatively rare. It may result in early suppurative (retropharyngeal abscess, peritonsillar abscess, suppurative cervical lymphadenitis, suppurative otitis media and/ or mastoiditis, suppurative sinusitis) or late non-suppurative immune mediated (post-streptococcal glomerulonephritis, acute rheumatic fever) complications.

Presentations of sore throat may be acute or chronic. A majority are acute.

Probability diagnosis

More than half of sore throat presentations will be due to viral pharyngitis. The presence of coryza (nasal congestion, rhinorrhoea, sneezing) cough, conjunctivitis or hoarseness support a viral aetiology.

Red flags

Epiglottitis is a life threatening condition that may present with a short febrile history with inability to swallow and drooling of saliva. Difficulty in breathing may be present but cough is unusual. Children are at more risk. Any patient with impending airway obstruction should be minimally handled and referred early for airway management by an experienced clinician.

GAS complications- Quinsy or peritonsillar abscess is suspected when patients have high fever, fast worsening sore throat with neck stiffness/ fullness of the neck, a muffled voice. Immunocompromised patients are more at risk.

Acute leukaemia- patients will often have non-specific, constitutional symptoms (weakness, lethargy, fatigue, breathing difficulty, fever, weight loss, bleeding). Lymphadenopathy and hepatosplenomegaly support the diagnosis.

Drug induced agranulocytosis- An absolute neutrophil count less than 100 neutrophils/ µL of the blood needs prompt detection and treatment to prevent mortality due to septicaemia. Cancer chemotherapies, analgesic and anti-inflammatory (gold, naproxen, and penicillamine), Anti-thyroid (carbimazole, propylthiouracil), Anti-arrhythmic (quinidine, procainamide), Anti-hypertensives (captopril, enalapril, nifedipine, Antidepressants/ psychotropics (clozapine, amitriptyline), Antimalarials (pyrimethamine, dapsone, sulfadoxine, chloroquine), Anticonvulsants (phenytoin, sodium valproate, carbamazepine), Antibiotics (sulphonamides, penicillin,

cephalosporins) are medications commonly known to cause agranulocytosis.

Oropharyngeal or tongue malignancy- persistent symptoms for over six weeks, failure to respond to repeated antibiotic courses and tonsillar asymmetry require prompt expedited referral to an ENT specialist[3]. Smoking tobacco, alcohol and betel quid use increase the risk for upper aerodigestive malignancies.

Supra-glottic foreign body may cause a sharp pain on swallowing and may not be visualised on examination.

Candidiasis due to immunosuppression (premature infants, oral or inhaled steroid use, diabetes, HIV/AIDs)- initial manifestation in an HIV-affected individual may include pharyngitis along with fever, sweats, malaise, lethargy, myalgia.

Pit falls

- Epstein Barr mononucleosis causing an exudative tonsillitis may be mistaken for a Streptococcal pharyngitis.
- Rhinitis with post nasal drip causing sore throat is common.
- Primary HIV may present with a sore throat along with other symptoms.
- Reflux oesophagitis with the irritant acidic gastric contents may cause sore throat.
- Tobacco smoke also causes throat irritation in primary and second-hand exposures where children are commonly affected.
- Acute herpetic pharyngitis is a common manifestation of the first episode of herpes simplex virus-1 (HSV-1) infection that needs to be suspected with risky behaviours. Gonococcal pharyngitis also may present in a similar manner.
- Vocal abuse (professional singers, public speakers, teachers) may cause hoarseness and sore throat.
- Nasal obstruction (large adenoids, allergic rhinitis) causes oral breathing leading to a dry and sore pharynx.

Masquerades of sore throat

- Diabetes causes immunosuppression resulting in candidiasis.
- Depression may present with sore throat.
- Some drugs may lead to aplastic anaemia, agranulocytosis and neutropenia leading to serious throat infections. Some drugs may cause gastric/ throat irritation.
- Thyroiditis may present as a sore throat.

History

Age - (child, young adult, elderly)- supports detection of a probable aetiology.

Characters of the complaint- to differentiate sore throat, deep throat pain or referred pain (neck). Oral intake of solids and liquids and the association to the complaint.

Associated viral features (cough, coryza, conjunctivitis, hoarseness, ulcers, diarrhoea, characteristic viral exanthem).

GAS pharyngitis – High fever temperature greater than 100.4°F (38°C), tonsillar exudates, and cervical adenopathy.[4] Abdominal pain, nausea, and vomiting can occur in children.

Contact history- (sore throat caused by viruses or bacteria is contagious through mucus, saliva, or nasal discharge. Respiratory viral infection: The incubation period varies between 1 and 6 days, depending on the pathogen. The patients are often contagious from 1 or 2 days before the onset of symptoms and can often shed virus for up to several weeks. Herpesvirus infections: Epstein Barr virus has an incubation period from 30 to 50 days. GAS: The incubation period for pharyngitis is 2 to 5 days. The patients are contagious up to 24 hours after the start of an effective antimicrobial treatment or for ~7 days after the resolution of symptoms in the case of no antimicrobial treatment. The risk of transmission to household contacts is ~25%).

High risk groups- immunocompromised states, personal or family history of rheumatic fever or rheumatic heart disease

Comorbidities- use of medications with haematological side effects, impaired immunity status.

Examination

General
Appearance (acutely unwell/ toxic / irritable)
Pallor, skin rashes, nasal mucosal oedema, halitosis, neck swelling Tender anterior cervical lymphadenopathy, sinus tenderness Fever
Oropharyngeal
Uvula, soft palate, tonsils, fauces and pharynx – oedema, erythema, exudate
Ulcers, palatal petechiae, masses, tonsillar asymmetry
Other systems
Ear inspection, hepatosplenomegaly

Investigations

Not usually performed. Throat swabs cannot differentiate clinical infection from commensals, results take time and are expensive.

Rapid antigen tests produce rapid results but carry low sensitivity.[5]

Clinical prediction rules

The National Institute for Health and Care Excellence (NICE) has recommended two clinical prediction rules to assist decision making in suspected streptococcal throat infections.

1. Centor criteria

In the original Centor score four signs and symptoms were used to estimate the probability of acute streptococcal pharyngitis in adults with a sore throat. The score was later modified by adding age and was

validated for adults and children (Fig 1). The cumulative score determines the likelihood of streptococcal pharyngitis and the need for antibiotics.[4]

A score of zero or 1 indicates very low risk for streptococcal pharyngitis and does not require testing or antibiotic therapy. According to the Centor criteria patients with a score of 2 or 3 should be tested. If results indicate a bacterial infection antibiotic therapy should be implemented. Nevertheless, in clinical practice most clinicians do not prescribe specific investigations but opt for an individualised decision for antibiotics considering the clinical picture. The National Guidelines for empirical and prophylactic use of antibiotics 2016 recommends starting antibiotics after specimens have been sent for culture and antibiotic sensitivity whenever possible and later adjusting antibiotic therapy guided by the sensitivity results.[6] Patients with a score of 4 or higher are at high risk of streptococcal pharyngitis, and empirical antibiotics should be started.

Figure 1 Modified Centor Score

Patient with sore throat

Apply streptococcal score

Criteria	Points
Absence of cough	1
Swollen, tender anterior cervical nodes	1
Temperature >100.4°F (38°C)	1
Tonsillar exudates or swelling	1
Age 3 - 14 years 15 - 44 years 45 years or older	 1 0 1
Cumulative Score	____

2. FeverPAIN criteria

Fever (during previous 24 hours)

Purulence (pus on tonsils)

Attend rapidly (within 3 days after onset of symptoms) Severely Inflamed tonsils

No cough or coryza (inflammation of mucous membranes in the nose)

Each feature will score 1 point if noted in the patient. Higher scores suggest more severe symptoms and a likely streptococcal aetiology.

0 or 1 - 13 to 18% likelihood of isolating streptococcus.

2 or 3 - 34 to 40% likelihood of isolating streptococcus.

4 or 5 - 62 to 65% likelihood of isolating streptococcus[7].

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Frailty syndrome: Are we ready for it?

Dr. Oshani Illangasekera - Senior Registrar in Family Medicine

Introduction

The elderly population in Sri Lanka (SL) is on the rise. The reduction in mortality rates and economic growth with advancements in health care resulted in an increase in life expectancy. The WHO publication on SL "Growing old, before becoming rich" projected elderly population to rise to 28% by 2050.[1]

Given the present economic crisis strong implications towards lack of optimum health care is forecasted. The future is yet to reveal the impact it would have on population health. A comparatively smaller younger workforce will need to sustain the growing elderly population. The older adults with multiple comorbidities will be vulnerable to the effects of this challenging situation. Therefore optimum health and physical independence of the elderly will improve their quality of life, and benefit the society at large.

What is frailty?

Frailty is a syndrome affecting multiple body systems, leading to loss of physiological reserves and increased vulnerability to stressors. Multiple mechanisms occurring at the cellular level will lead to pathological changes, resulting in the clinical manifestations of frailty. Ageing per se causes loss of physiological reserves predisposing to frailty, but it is not synonymous with the condition. Different individuals experience ageing as "successful" or "pathological" depending on the level of frailty. People experience difficulty regaining their normal functional state after physical or mental illness, accidents, surgeries and stressors of life when frailty sets in.

Fried et al. in a study published in 2001 revealed the salient features of frailty to be unintentional weight loss, slow gait speed, weak grip strength, exhaustion and low level of physical activity. Many other measures of frailty were introduced later on by adding components of physical, psychological and social aspects leading to frailty.[2]

The condition prevails as a spectrum leading from 'robust', 'pre-frail", "frail" and 'dependent state", while interchangeability and reversibility is possible up to an extent.

The consequences of frailty are multiple including;

- Fragility fractures
- Falls
- Polypharmacy
- Disability
- Malnutrition
- Reduced cognition
- Recurrent hospitalizations
- Mortality
- Increased healthcare costs

The importance of identifying frailty is justified to minimise the complications associated.

What leads to frailty?

Multiple factors contribute towards the onset of frailty. Physiological factors including chronic inflammation, neuroendocrine derangements, sarcopenia as well as social factors including isolation, poverty, multiple comorbidities, alcohol and smoking show an association. Local studies reveal an association between age, gender, marital status, education, depression, physical activity levels, economic status, social support with frailty[3].

How does frailty present?

Encountering 5 common presentations should raise suspicion of the presence of frailty syndrome[4].

1. Falls
2. Immobility
3. Delirium (e.g. acute confusion or sudden worsening of confusion in someone with previous dementia or known memory loss).
4. Incontinence
5. Susceptibility to adverse effects of medication

Prevalence of frailty

Community studies worldwide have identified varying prevalence rates in different countries. Ronen o'caoimh et al in a study described global prevalence to be between 12-24% among adults more than 50 years of age, with a pooled prevalence of 12% (95%CI=11-13%; n=178)[5]. Local studies too indicate the prevalence of frailty to be 14.9% in Colombo district among elderly more than 60 years of age[3]. The prevalence varies according to the method and the definition used for diagnosis. The author conducted a study among 220 elderly patients with diabetes attending a divisional hospital clinic in Kandy district and identified the presence of frailty to be 21% among the population selected. The presence of 3 or more comorbidities including hypertension, dyslipidemia increased the presence of frailty. Diabetes is an individual risk factor for frailty and is known to increase the risk of frailty 3-5 folds. Accordingly, this study too indicated a higher proportion of frailty in diabetes.

Diagnosis of frailty

The diagnosis of frailty depends on the definition identified. Commonly used definitions and models of diagnosis are;

— Physical phenotype model of Fried et al (The rapid FRAIL screen used)

— Deficit accumulation model of Rockwood and Mitnitski et al (considers signs, symptoms, multimorbidity)

— Edmonton frailty scale (mixed physical and psychosocial models)

The FRAIL scale is a simple 5 item questionnaire, which has been validated in many studies and recommended to use in primary care. Clinical Frailty scale (CFS), Vulnerable Elders Survey-13 (VES-13) are two other simple, fast assessments for frailty with the latter able to be administered by health staff or self- administered[6].

The World Health Organisation (WHO) too has focused on screening persons for decreases in intrinsic capacity using the "Integrated Care for Older People" (ICOPE) instrument during the covid pandemic. This though not designed to measure frailty can be tailor made to the primary care setting with validation. The author used an interviewer-administered questionnaire designed in Sinhalese and validated to be used in Sri Lankan settings to identify frailty. Health care staff could be trained to use this tool in a busy clinic[3].

Anthropometric measurements to detect sarcopenia, get up and go test (>10 sec), walking speed (less than 0.8/s or taking more than 5 sec to walk 4m), hand grip dynamometer readings for muscle strength are simple tests to be done.

Frailty in primary care

The prevention of frailty will minimise related adverse outcomes and healthcare costs, while improving quality of life and well-being for the individual. It can also be used as a predictor of adverse health outcomes in the elderly. Primary care physicians encounter elderly patients commonly in the practice setting and are placed ideally to identify and provide personalised, comprehensive care to these patients. Practical frailty screening and management strategies will help improve quality of life in general. Screening for frailty in elderly patients with DM will help minimise related complications, reduce morbidity and mortality. The International Conference of Frailty and Sarcopenia Research (ICFSR) has formulated evidence-based guidelines for the identification and management of physical frailty.[7]

Research indicates that geriatric assessment, exercise and nutrition management represent effective, evidence-based interventions in primary care. Primary care providers can collaborate with Geriatricians, physiotherapists, nutritionists, occupational therapists and social workers to provide comprehensive, personalised, multidisciplinary care to these patients. Most frail elderly could be managed effectively at a home environment with implementation of suitable support systems. Family physicians are able to provide necessary guidance via home visits in these situations.

Recommendations compiled by expert panels on screening and management of frailty are as follows;

Based on these recommendations Consensus Best Practice Guidance for the care of older people living with frailty in community and outpatient settings, was published by the British Geriatrics Society. (Fit for frail model)

Accordingly, levels of prevention of frailty can be practised in primary care as follows;

Primary prevention

1. Provide community education and reinforce to do aerobic and resistance exercise regularly

2. Yearly screening with a rapid screen for frailty questionnaire (FRAIL or ICOPE)

Secondary prevention

If frailty screen is positive:

1. Look for and treat possible reversible causes
2. Advise on an appropriate exercise program and adequate protein intake
3. Consider grip strength, 4m gait speed and short physical performance battery

Tertiary prevention

1. Check ADLs and IADLs
2. Comprehensive geriatric assessment
3. Refer to physical and occupational therapy and geriatrician as appropriate
4. Optimise home environment
5. Provide guidance for a long -term exercise program

Summary

Elderly population and diabetes are twin problems affecting health care. Frailty affects the elderly and hinders their general well -being, reduces quality of life and leads to increased health care costs. Early detection and interventions can prevent or delay progression of frailty. Simple tools can be used to identify frailty and should be incorporated into the comprehensive geriatric assessment when- ever possible. Screening for frailty in diabetes will help prevent disability, morbidity and increased mortality. Multicomponent interventions for management of frailty should be based on the patient's health needs, priorities and level of frailty. Hence personalised, comprehensive, holistic care to manage frailty is a need for better outcome.

Structured resistance training exercises, dietary Interventions, medication review to avoid polypharmacy, managing multimorbidity and strengthening social networks are key factors in management.

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A child with a patchy hair loss

Dr. S M Halpe *- Registrar in Family Medicine, NCTH Ragama*

Dr. S M A M Sethunge *- Registrar in Family Medicine, NCTH Ragama*

Dr. D M Amarathunga *- Consultant Dermatologist, NCTH Ragama*

A 2-year-old boy presented to the clinic with the mother complaining of a patchy hair loss as shown below for 1 month. Initially the mother noticed an itchy papule which gradually developed into a mass (fig 1). No prior treatment was taken . Other family members were not affected. There were no skin rashes or similar lesions elsewhere.

What is your diagnosis and management?

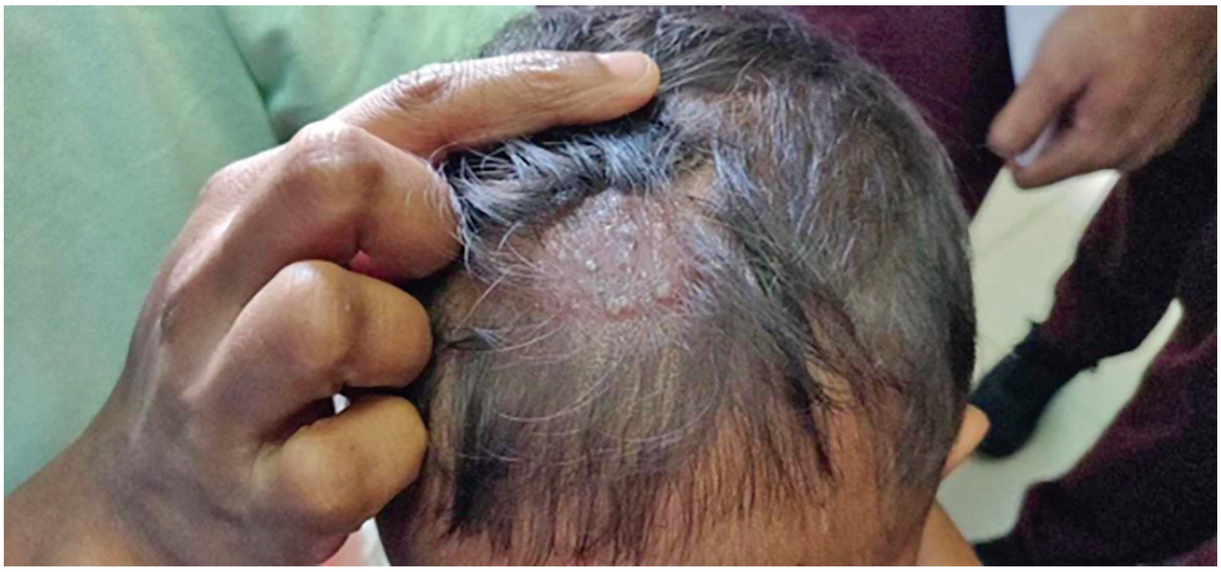

Fig 1 - 2 year old with a patchy hair loss and lesion

The lesion on the scalp was found to be a boggy mass filled with pus. The hairs within the lesion were loose and easily removable. The child was afebrile with regional lymphadenopathy. He had a pet dog at home. A diagnosis of KERION was made based on the clinical findings. Hair samples and skin scrapings were sent for microscopy.

He was treated with Griseofulvin 10 mg/kg to be taken after meals and terbinafine cream for local application, oral flucloxacillin and antihistamines. The lesions gradually improved after the treatment course for 6 weeks.

Discussion:

A kerion is caused by a dramatic immune response to a dermatophyte fungal infection. Causative organisms are typically zoophilic species, namely, Trichophyton verrucosum or Trichophyton mentagrophytes. Delayed treatment could result in permanent hair loss from scarring. Careful removal of crusts using wet compresses should not be neglected and the possibility of coexisting bacterial infection should be considered.[1] The lesions will resolve completely with systemic antifungal treatment. The absorption of Griseofulvin is enhanced particularly with a fatty meal. There is no role of surgical incision and debridement in the case of a kerion.[2] Kerion is commonly mistaken for a bacterial abscess which has led to scarring alopecia upon incision and drainage.

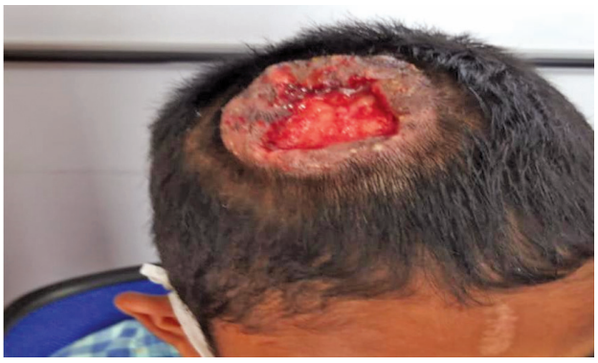

Fig 2 - Scarring alopecia following surgical treatment of Kerion

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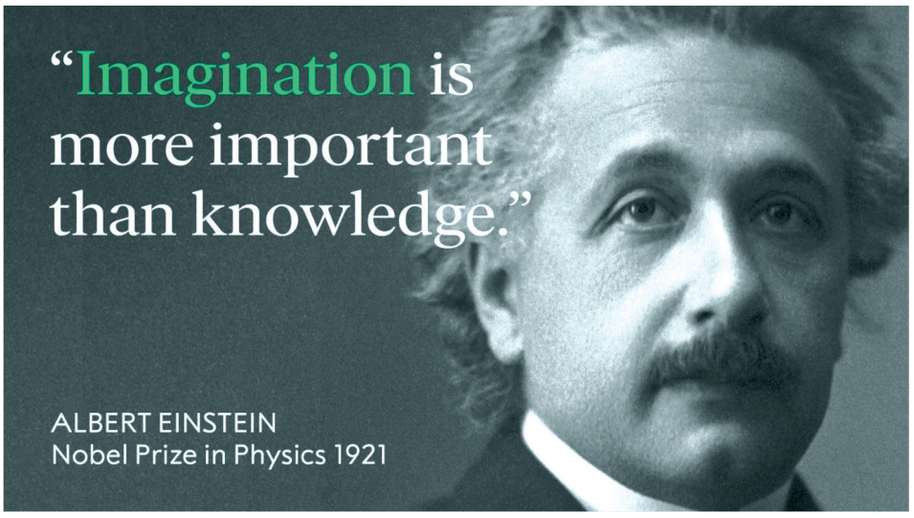


Generalized urticarial skin eruption following Diltiazem therapy

Dr. G L P H Nanayakkara *- Registrar in Family Medicine*

Dr. B G S Ransimali *- Registrar in Dermatology*

Dr. M Rupasinghe *- Senior Lecturer, Department of Family Medicine, Faculty of Medicine, University of Kelaniya*

Case summary

A 74-year diagnosed female with hypertension for 4 years and osteoarthritis of bilateral knee joints for 10 years, presented with generalized itchy rash for 5 days.

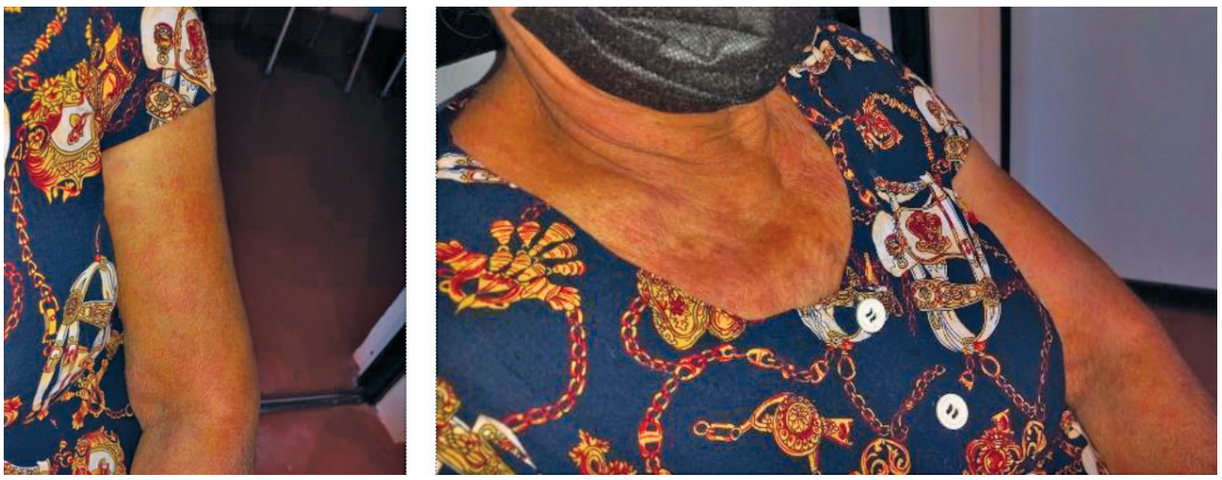
Despite she was on losartan 50 mg twice daily, there was a poorly controlled blood pressure. Subsequently, she was added on Diltiazem 30mg three times per day, during her last routine clinic visit two weeks back. On the 9th day of the treatment with diltiazem, she was noted to have itchy erythematous plaques of variable sizes throughout the body. An individual lesion lasted more than 24 hours. But it was not associated with migratory lesions or bullae. Patient denies associated fever, arthralgia, haematuria, epistaxis, and headache. In addition to that, the condition was not associated with loss of appetite, loss of weight or other constitutional symptoms. Furthermore, there was no history suggestive towards autoimmune connective tissue disorder. On inquiry of her medications there were no such to proceed. Except hypertension and osteoarthritis, there were no significant medical illnesses requiring clinic follow up, up to now.

On examination, she was average built. There was no alopecia, pallor, exophthalmos, oral ulcers, lymphadenopathy goitre or joint swelling. On cutaneous examination, there were well defined erythematous, non-scaling, non-blanching plaques of variable sizes distributed throughout the body. Mucosal membrane, palms and soles and scalp were characteristically spared. There were no ulcerated or bullous lesions.

Her blood pressure was 144/78mmHg. Other system examinations were remarkably normal. FBC, liver and renal functions were normal. ESR was 12mmHg. Patient was reluctant for a chest X Ray.

We have identified a possible aetiology, leading to this cutaneous eruption as diltiazem, which was withheld and observed, while switching to hydrochlorothiazide 12.5mg mane. On a subsequent clinic visit after one week, to assess her progress and blood pressure there was a significant reduction in the number of cutaneous lesions. In addition, there were no new lesions developed. Existing lesions were not markedly palpable. The blood pressure was satisfactorily controlled with Losartan and Hydrochlorothiazide.

Discussion



Appearance of rash on Day 1

Diltiazem, a Dihydropyridine calcium channel blocker belonging to the benzothiazepine subtype, used in the management of hypertension for a long time in history. In addition, it is also implicated in ischemic

heart disease and heart failure. Although used less frequently than non-dihydropyridine CCBs, it is particularly used for control of heart rate when beta blockers are contraindicated. All calcium channel blockers are known to cause a spectrum of cutaneous manifestations, and diltiazem has the commonest association. Incidence of cutaneous eruptions with diltiazem is around 1%. Although categorised as a rare side effect, the incidence of rash may be more frequent than the post marketing surveillance studies suggest[1]. The time of onset of symptoms since the initiation of drug, has been varying in different reports and ranged from 3 days to 6 weeks[2,3]. The onset within 2 weeks and the rapid resolution following stopping the drug, are suggestive of drug aetiology in the index patient in our report.

The skin reactions may range from maculopapular rashes, urticaria, urticarial vasculitis and pruritus, to severe adverse effects like acute generalised exanthematous pustulosis, subacute cutaneous lupus erythematosus, toxic epidermal necrolysis, and leukocytoclastic vasculitis leading to ulceration. Jones et al reported a case of worsening angina due to a severe rash in the scale of erythroderma, worsening the condition of a patient with co-existent heart failure[2]. Photosensitivity as well as photo-distributed hyperpigmentation were described[3].

With the persistence of eruptions more than 24 hours a urticarial vasculitis should be considered as the first differential diagnosis[4]. Even though these lesions were discrete palpable erythematous lesions, there were no petechiae or purpura, suggestive of leukocytoclastic vasculitis.

The histology in a patient with similarly described rash showed mild spongiosis, a superficial dermal infiltration of neutrophils, mast cells and eosinophils,

and perivascular lymphedema, with vasculitis[3]. Many authors have reported positive patch tests for drug dilutions, but cross reactivity between different calcium channel blockers is less established[5].

Conclusions

Calcium channel blockers, especially diltiazem can cause a wide range of cutaneous reactions that would easily disappear on drug withdrawal. It is wise to identify the temporal association of initiation of the drug and initiation of cutaneous reaction. There should be a high index of suspicion for drug induced phenomena is a useful tip for primary care physicians when treating dermatoses. Stopping the particular drug itself would be sufficient to manage the condition at clinic level, without unnecessary admission.

Key words: Diltiazem, Skin eruption

Disclosures

Authors report no relevant financial relationships.

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Nature, time and patience are the 3 great physicians.

Bulgarian proverb

Preparation for success: Sri Lanka College of Specialist Family Physicians organises an MD preparatory course

Dr. Asela Anthony *- Chairperson, Exam Preparatory Committee - SLCSFP*

The Sri Lanka College of Specialist Family Physicians organised a clinical preparatory course for the candidates selected for the second part of the MD in Family Medicine selection exam. This three-step initiative was designed with the goal of offering candidates the essential practice for OSCE case scenarios, using simulated patients.

The program consisted of two Zoom sessions on "How to Prepare for OSCE and OSPE, followed by a physical OSCE session at the ClinMARC building, NHSL. The OSCE consisted of four cases that resembled the exam structure. The course was designed to help candidates understand the requirements of the exam, familiarise themselves with the exam format, and to identify areas where they needed more practice.

The chief organiser Dr. Asela Anthony, a senior lecturer and a Specialist in Family Medicine, led a team which included Dr. Harsha Gunasekara, Dr. Sanath Keerthi, Dr. Fazana Aththas, and Dr. Udantha Rathgamage. The program also included a group of enthusiastic senior registrars and registrars who provided invaluable support to the organising committee.

The preparatory course had a participation rate of over 95% of eligible candidates. All candidates who participated in the program commended the organising committee for their efforts and the program's effectiveness. They appreciated the opportunity to practise with simulated patients, which helped them gain real-time experience and to prepare better for the exam. Furthermore, the program helped the candidates to build self-confidence and to reduce anxiety, which is critical when facing a clinical examination.

The Sri Lanka College of Specialist Family Physicians plans to continue this program regularly in a more comprehensive and effective manner to provide even more support and guidance to prospective MD Family Medicine entrants. The organising committee is firmly committed to build on the success of this initiative and help candidates excel in their careers.

Continuous professional development activities

Medical education is a continuum in an ever-updating body of knowledge. Professional development, not only encompasses the updated knowledge but also includes personal and attitudinal change in the medical professionals. Cultivating the habit of seeking updated knowledge among primary care medical officers is a need of the hour in Sri Lanka. Opportunities to transfer updated primary care oriented medical knowledge are scarce. It was with this great esponsibility; the Sri Lanka College of Specialist Family Physicians organised a series of CPD events for MD/ Family Medicine trainees, primary care physicians and General Practitioners.

Eye in primary care - 23rd February 2023

A workshop on eye in primary care was conducted in association with the College of ophthalmologists of Sri Lanka. The session was conducted with the objective of educating the registrars in Family Medicine on common eye problems in primary care.

'Let's Adjust the Sails', Managing hypertension in primary care -6th March 2023

The inaugural CPD lecture was delivered by the college president, Dr. Malkanthi Galhena, Consultant Family Physician, Base Hospital Panadura. The topic of Managing hypertension in a primary care perspective was discussed under the title "Let's Adjust the Sails". The lecture was based on updated guidelines on the management of hypertension in primary care by the Ministry of Health Sri Lanka.

The event was hosted by Dr. Vimarshani Hewageegana, registrar in Family Medicine. It was attended by around 160 primary care doctors from all around the country.

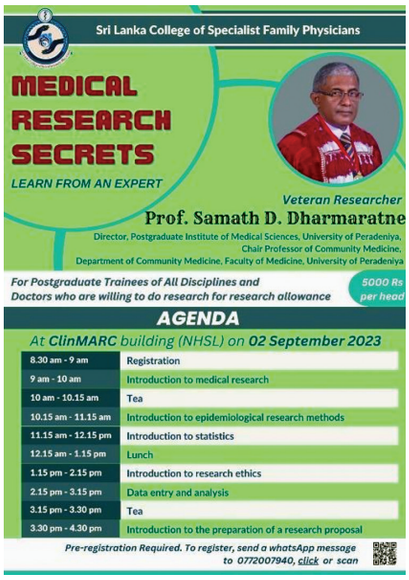
Events in collaboration with the Ministry of Health and other professional colleges

Capacity building for medical professionals in primary care – 30th May, 2023

Capacity Building for Medical Professionals in primary care is a CPD programme conducted in collaboration with the Ministry of Health and other professional colleges.

Outreach programmes were conducted in different districts with the participation of all OPD medical officers and primary care doctors are the spotlight of this programme.

Dr. Aeshana de silva conducting a case-based discussion with the objective of improving the communication skills of medical professionals



Medical research secrets: Learn from an expert – 2nd September 2023

A research methodology workshop was held with the participation of post graduate trainees including registrars and senior registrars in Family Medicine and other disciplines as well. The resource person was Prof. Samath Dharmaratne, Professor in community medicine and the Director of Post Graduate Institute of Medicine, Peradeniya.

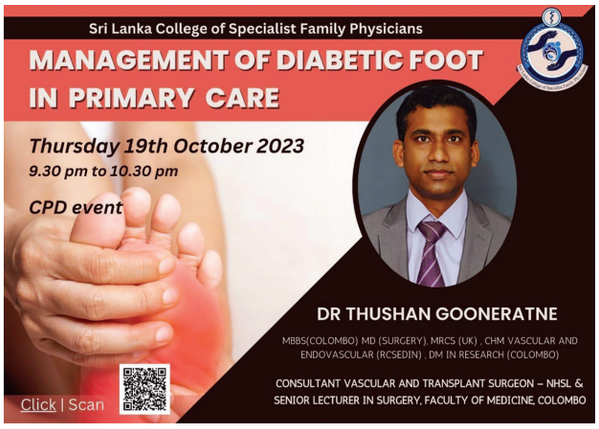
Clinical pearls in cardiology- Guideline updates - 8th September 2023

Under the theme of capacity building in primary care professionals, a guideline update has been conducted on clinical cardiology in collaboration with the ministry of Health and Sri Lanka College of cardiology. Dr. Malkanthi Galhena, president, represented the Sri Lanka College of Specialist Family Physicians.

Common breast diseases in primary care – 19th September 2023

The monthly expert talk was relaunched with a fresh perspective, featuring its first presentation by. Dr. Kanchana Wijesinghe, Consultant Surgeon and Senior lecturer at the University of Sri Jayewardenepura.

The session was based on common breast diseases in Primary care with a participation of nearly 100 participants.



Management of diabetic foot in primary care – 19th October 2023

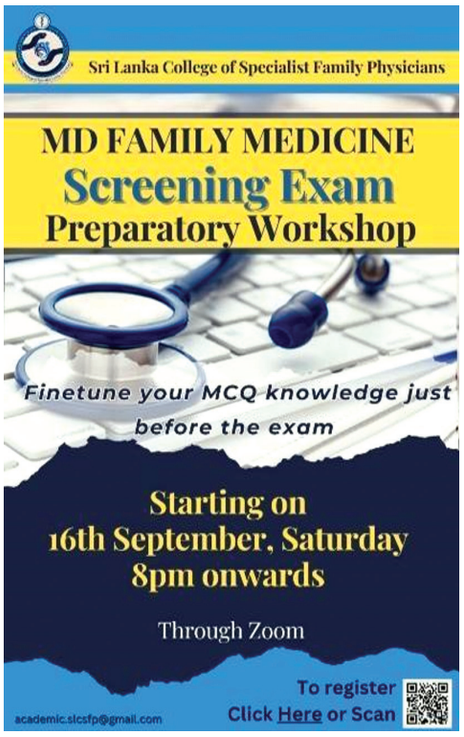
Dr. Thushan Goonaratne, consultant Vascular Surgeon and senior lecturer in Surgery, Faculty of Medicine, University of Colombo, delivered a lecture on the management of Diabetic foot in Primary Care. The lecture conducted through zoom platform and were attended by more than 100 primary care doctors and General Practitioners.

MD Family Medicine screening examination preparatory course - September 2023

Sri Lanka College of Specialist Family Physicians conducted a successful MCQ course for the Pre-MD screening exam. More than 90 participants joined through Zoom, for the 8 MCQ discussion sessions.

The workshop commenced on the 16.09.2023.

Our membership contributed as resource persons for educational sessions conducted by other academic forums



South Asia regional panel discussion : "We need food not tobacco" – 31st May 2023

Dr. Shane Halpe participated in the South Asia regional panel discussion organised by WONCA South Asia for World "No Tobacco Day"

Clinical case-based discussions were conducted by registrars in Family Medicine at the GP's Café of the Spice Route movement of Sri Lanka

"A private bus driver who cannot overtake"
by Dr. Prabath Nanayakkara - 18.02 2023

'Hiding in Plain Sight"
by Dr. Shane Halpe - 18.03.2023

"An Ignored Pandemic"
by Dr. S. A. Farahath - 17.06.2023

"The Cough Caught in Time"
by Dr. Hasara Kulathunga - 29.04.2023

Young Family Physician's Forum – 2023

A platform for young Family Physicians to share their clinical expertise with colleagues scheduled every other Friday at 9.30pm

Sense of smell - 1st of September 2023

An interactive case-based discussion on Olfactory Reference Syndrome by Dr. Tharindra Pathiratne

Three shades of darkness – 6th Oct. 2023

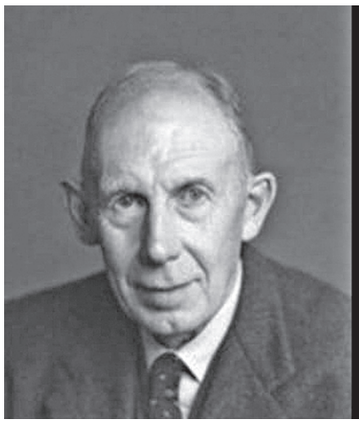
3 different presentations of morbid jealousy and management by Dr. P.W.N. Teklani

A teenage girl with bothering skin lesion – 15th September 2023

The diagnosis and management of acne by Dr. V. Thriyampakan

A masquerading case of limb weakness – 20th October 2023

An unusual presentation of critical limb ischemia done by Dr. Helika Illangakoon



General practice is at least as difficult, if it is to be carried on well and successfully, as any special practice can be, and probably more so; for the G.P. has to live continually, as it were, with the results of his handiwork.

— Henry Howarth Bashford —

All lectures can be accessed through official youtube channel of SLCSFP. Kindly subscribe to get more CPD notifications.

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College website-www.slcsfp.lk

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Obituary

In loving memory of Dr. Velayuthan Sarangan, Registrar in Family Medicine.

Dr. Sarangan embarked on his medical journey at the Faculty of Medicine, University of Jaffna, graduating with MBBS. He obtained the DFM from University of Colombo and was reading for the MD in Family Medicine and for the MCGP diploma. Dr. Sarangan was also a visiting lecturer at his Alma Mater.

Living in Jaffna, he was deeply connected to the community and served as a trusted healthcare provider. Dr. Sarangan's compassion and commitment to his patients made him a beloved figure in the region. His dedication to family medicine was apparent in the way he approached his clinical practice, with a holistic approach and a patient-centered mindset.

Tragically, on May 2023, we bid farewell to Dr. Velayuthan Sarangan, leaving a lasting memory on our hearts and a loss for the community. His premature departure is a great loss to our discipline, and his absence will be deeply felt by all who knows him.

Let us honor his legacy by continuing to advance the field of Family Medicine, cherishing the values he upheld, and striving to provide holistic and patient-centered care to those in need. He will forever be remembered as an inspiring colleague, a dedicated scholar, and an esteemed member of the Family Medicine community in Sri Lanka. May his soul rest in peace.

Dr. Kasunjith D. Vitharanage

Registrar in MD Family Medicine

Australian Family Medicine in a nutshell

Dr. Nuwandi Mallikarachchi- *GP Carrum Down Doctors - Melbourne, Australia.*

As a general practitioner working in Australia for the past 8 years, I am pleased to share my experiences of the Australian General Practice (GP) system with my colleagues in Sri Lanka. Having a systematic standard of referral in primary care in any country is valuable to reduce the burden on hospital Dr emergency services and other specialties.

In the majority of countries, some of the general population and even some health care professionals do not give the due recognition to the general practitioners. However, my perspective is that family medicine is a specialty which covers the most complex and demanding areas of medicine and that requires a wide knowledge of all the specialities.

I am impressed by the rapid growth of the specialty of Family Medicine in Sri Lanka. In Australia, most GP centres consist of several GPs (up to 20) and a team of nurses and allied health practitioners along with other staff including receptionists. The "Practice Manager" takes full responsibility of the administrative work and coordinates the functions of the staff. The local GP practice plays an important role in providing primary care to the population registered with the particular practice. The government provides financial aid to all residents seeking health care via a publicly funded universal medical insurance called "Medicare". Therefore, Medicare covers the cost of health practitioners up to a certain level.

In Australia, as in many developed countries, the general practitioner is most likely to be the first point of contact in matters of personal health. The GP explores the patient's signs and symptoms in order to reach a diagnosis and provide appropriate care. If the situation warrants specialist attention, the GP refers the patient to the relevant specialist centre either in the public or private sector. This way the specialist health care can address more complex situations. Following initial management of the conditions, some are reviewed by the specialist at regular intervals while the GP also continues the care as required. This is called "Shared Care". After stabilising the condition, they get discharged from specialist to the GP care in order to continue their treatment plan if they need long term care.

The GP cares for patients of all ages, any gender and any disease category. In addition the GP treats patients taking a "whole person" approach and in the context of their work, family and community. A person's GP sometimes cares for the entire family during their lifetime. The GP also performs varied procedures such as certification of legal documents and provision of reports in relation to motor vehicle accidents or work injuries. As a result, the GP may receive requests to be present in the courts to provide testimony pertaining to the medical circumstances of certain incidents.

The general practitioner plays a vital role in both curative and preventive aspects. We have a set of guidelines that we are expected to follow in order to provide quality evidence based care to all patients. The GP Colleges ensure all members keep up to date with their knowledge by mandatory participation in Continuous Professional Development (CPD) programs. Each GP has to collect a minimum number of points for a given period of time to continue practising and be able to access the payments through the government Medicare program.

Finally, I would like to wish all the very best to emerging consultant family physicians in Sri Lanka. May the College of Specialist Family Physicians be a force to reckon with among all other specialities.

"Identity crisis in Family Medicine: Who we are"

Dr Deshan Kotugodella

- Registrar in Family Medicine -

Recently my 14y old daughter was asked to introduce herself. During her introduction, she said her father is a Family Medicine registrar. The teacher asked what family medicine is. My daughter, was convinced that the teacher had never heard of family medicine.

The teacher has also inquired "what sort of consultant will he be?"

This incident highlights the major issue our discipline is facing. That is none-other than the "identity crisis".

In the early days as a GP I myself was puzzled about my identity. . What is Family Medicine? Who is a General Practitioner? Is Family Physician another name for GP? Then who is a Consultant Family Physician? Is a Specialist Family Physician a specialist or a generalist?

Family medicine is in a paradigm shift. The Ministry of Health, Sri Lanka has a vision to develop primary care in Sri Lanka and finally, Family Medicine has been given the due recognition and position in Sri Lanka's healthcare delivery system. Nevertheless, have we sorted out the identity crisis? This is the most critical question we have to answer.

In the documents issued by the Ministry of Health Sri Lanka, there is no position named 'Consultant', but there are Specialist Medical Officers. Therefore, those who are Board Certified in Family Medicine would be referred to as "specialist medical officers in Family Medicine".

After completing the MD in Family Medicine, Postgraduate Institute of Medicine, board certifies as "Specialist in Family Medicine". Historically GPs had their recognition conflicts with other specialists. However, in recent years that issue has been settled in most countries, and GPs are in the same specialist registry as other specialists in Australia, and other European countries.

According to the RACGP, 'GPs are medical specialists recognised under the Health Practitioner Regulation National Law Act 2009. The term' specialist general practitioner' is a protected title. GPs undergo significant training in medicine, including completing a five to six-year Bachelor of Medicine and Bachelor of Surgery (MBBS), followed by two years of postgraduate hospital training and three years of supervised general practice training.

Following this, prospective GPs must pass examinations of an accredited general practice training program, such as Fellowship of the Royal Australian College of General Practitioners (FRACGP), before being able to use the specialist general practitioner title. After completing these requirements and registering with the Australian Health Practitioner Regulation Agency (AHPRA), GPs undertake ongoing quality improvement and continuing professional development activities each year to maintain their registration.'

According to RCGP, 'The Royal College of General Practitioners (RCGP), the British Medical Association (BMA) and the General

Medical Council (GMC) recognise that GPs are expert medical generalists, and as such are specialists in general practice'.

With these progressive developments in developed countries, identifying family medicine/general practice as a unique discipline, the World Federation for Medical Education (WFMA) has recognised Family Medicine as the sixth clinical discipline to include in the undergraduate medicine curriculum. Accordingly, the Sri Lanka Medical Council SLMC also has recognized Family Medicine as a clinical discipline.

With the recent advancements in the discipline, SLCSFP has an obligation to support the Ministry of Health in establishing a well-organised primary care system in Sri Lanka. In addition, the responsibility of the SLCSFP also includes educating the general public about Family Medicine as a speciality and its scope in providing quality holistic care in the present context of healthcare in Sri Lanka.

My daughter's interview highlighted this most critical factor we have yet to address at our College level.

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