ISSUE 02 | VOLUME - 23 | FEBRUARY 2018

IMPA NEWS

THE OFFICIAL NEWS LETTER OF THE INDEPENDENT MEDICAL PRACTITIONERS ASSOCIATION

IMPA News

- A successful medical update programme was held on Sunday 28th January 2018 at the Durdans Hospital Colombo at which the following presentations were made i) "Knee Replacement" by Dr. A.S.A. Abeyewardene, Consultant Orthopaedic Surgeon, ii) "Colon Cancers" by Dr. Nilesh Fernandopulle, Consultant Gastroenterologist and iii) "Interventional Cardiology" by Dr. Pandula Athauda Arachchi, Consultant Interventional Cardiologist.

- The Sri Lanka College of Microbiologists has invited the IMPA to be a partner in the International Conference on "Infectious Diseases and Antimicrobial Resistance" to be held in Colombo from 8th to 10th August 2018 at the Hotel Taj Samudra, Colombo.

- The College of General Practitioners of Sri Lanka - Spice Route Project has invited the IMPA to participate in a medical update programme to be held on Saturday 17th February 2018 at the Asiri Surgical Hospital.

- The Childhood Respiratory Disease Study Circle of Sri Lanka has invited the IMPA to participate in the 5th Annual programme to be held on Sunday 18th February 2018 at Hotel Kingsbury, Colombo.

- The 131st Anniversary International Medical Congress of the SLMA will be held from 25th - 29th July 2018 at the Hotel Galadari, Colombo.

- A successful seminar was held by the OPA on i) "Port City and future of Sri Lanka" on Thursday 25th January 2018. Ii) "Practice of Consensual Government and good Governance in arresting corruption - Merits and Demerits" on Friday 16th February 2018. iii) "Unity of Effort : Building Military - Civil partnership to counter Violent Extremism" on Friday 23rd February 2018.

- A training workshop on Clinical Audits for private sector healthcare institutions will be held on 22nd and 23rd February 2018 by the SLMA.

Editorial Notice

IMPA members are requested to forward articles to be published in the IMPA Newsletters and 2018 Journal.

The IMPA Directory of Members is to be published soon. All members who have not submitted the following details are request to forward them as soon early as possible

Surname - .....
Initials - .....
SLMC Reg. No. - .....
Membership No. - .....
Qualification - .....
Type of Practice - .....
Place of Practice - .....
Tel. (Office) - .....
Home Address - .....
Tel. (Res.) - .....
Mobile No. - .....
Email Address - .....
Fax No - .....

Editor - Dr A L P de S Seneviratne

CURRENT CONCEPTS IN OSTEOARTHRITIS (OA) MANAGEMENT

Dr Ashan Abeyewardene
Consultant Orthopaedic Surgeon
ashan_abey@yahoo.co.uk

Although OA occurs in people of all ages, osteoarthritis is most common in people older than 65 years. Common risk factors include increasing age, obesity, previous joint injury, overuse of the joint, weak thigh muscles, and family history in first degree relative. One in two adults will develop symptoms of knee OA during their lives. One in four adults will develop symptoms of hip OA by age 85. One in 12 people 60 years or older have hand osteoarthritis.

Some management principles are "OLD BUT GOLD". According to Obesity and increased burden of hip and knee joint disease in Australia: Results from a national survey, odds of OA was up to 7 times higher for obese individuals, compared with those classified as underweight/normal weight. Concurrent obesity and joint disease had a marked impact on several key aspects of wellbeing. Every pound of weight lost resulted in a fourfold reduction in the load exerted on the knee per step during daily activities.

Exercise and thigh and hamstring muscle strengthening has shown to have 25-47% reduction in OA progression according to the American Orthopaedic Association. And a recent double blind controlled study in Europe showed that exercise bike 5mins twice a day has 10 times more pain relief at one year than glucosamine.

Some "MYTHS". Glucosamine and chondroitin sulfate, substances found naturally in joint cartilage, can be taken as dietary supplements. Although patient reports indicate that these supplements may relieve pain, According to the American Orthopaedic Association (AOA) there is no evidence to support the use of glucosamine and chondroitin sulfate to decrease or reverse the progression of arthritis. In addition, the U.S. Food and Drug Administration does not test dietary supplements before they are sold to consumers. These compounds may cause side effects, as well as negative interactions with other medications. AOA also recommends to consult your doctor before taking dietary supplements.

Platelet rich plasma (PRP) - " FACT OR FICTION" In the authors own study in a group of 160 knees studied over a 6 month to 1 year period showed significant pain reduction in all form Osteoarthritis 78.6% at 6 months. Early OA (Gr I- IIOA) - 90.9 %, Moderate OA (Gr II- III OA) - 70.3%, and late OA(Gr III +) - 46.6 % one year pain reduction. Many other international studies have shown similar results. Hence PRP has good results for early OA, while in late OA the benefit is not that pronounced.

Osteochondral grafting, mosaic plasty, alone or together with selected osteotomies, are other newer methods used to treat localized cartilage loss. While partial knee replacement is a good option where just the affected area (inner or outer knee) can be resurfaced leaving the other less damaged native knee. However the ultimate solution for late stage OA is a total knee replacement. With modern techniques of using a computer aided navigation system, the PRECISION of the knee replacement is accurate to 1 degree!! , and is now the gold standard.

So where can all this be done?? Right here in Sri Lanka!!!

SCREENING FOR COLO-RECTAL CARCINOMA AND THEIR PRE-CANCEROUS LESIONS

Dr Nilesh Fernandopulle
Consultant Gastroenterologist, University Surgical Unit, National Hospital of Sri Lanka.

Colo-rectal carcinoma (CRC) is the third most common cancer in men and the second most common cancer in women worldwide. It accounts for nearly 10% of all cancers. The Five-year survival is 90% if the disease is diagnosed while still localized (ie, confined to the wall of the bowel), 68% for regional disease (ie, disease with lymph node involvement), 10% if distant metastases are present. Recent trends in CRC incidence and mortality reveal declining rates, due to reduced exposure to risk factors, screening's effect on early detection, prevention through polypectomy and improved treatment options.

Due to its slow progression from detectable precancerous lesions and to the much better prognosis of patients diagnosed at early stages, the potential for reducing the burden of the disease by early detection is significant.

Possible symptoms of CRC are non-specific: Blood in the stool or iron deficiency anemia, recent change in bowel habits, unexplainable weight loss or persistent feeling of a need to pass stools. Therefore screening and early detection of lesions are important to have good long term outcomes.

Current screening technologies fall into 2 general categories:

1. Stool tests - best suited for the detection of cancer, although they also will deliver positive findings for some advanced adenomas
   a) Tests for occult blood
      - Guaiac-based fecal occult blood test (gFOBT)
      - Fecal immunochemical test (FIT)
   b) Exfoliated DNA
2. Structural exams - achieve the dual goals of detecting adenocarcinoma as well as identifying adenomatous polyps: Flexible sigmoidoscopy, Colonoscopy, Double-contrast barium enema, and CT colonography

Stool Blood Tests-gFOBT and FIT

- Blood in the stool is a nonspecific finding but may originate from CRC or larger (>1 to 2 cm) polyps.
- Three stools samples are required from consecutive bowel movements. Collection of all 3 samples is important because test sensitivity improves with each additional stool sample.
- FOBT detects blood in the stool through the pseudoperoxidase activity of heme or hemoglobin, while immunochemical-based tests (FIT) react to human globin. Because globin is degraded by digestive enzymes in the upper gastrointestinal tract, FIT also are more specific for lower gastrointestinal bleeding, thus improving their specificity for CRC.
- There are no clear patterns of superior performance in overall test performance between a high-sensitivity guaiac-based test (Hemoccult SENSA) and a variety of FIT. But FIT does not require a restricted diet, and the sampling procedures for some forms of FIT are less demanding. The optimal number of FIT stool samples is not established, but 2 samples may be superior to one

Preparation for FOBT is important:

- o Stop Aspirin and other nonsteroidal anti-inflammatory drugs (stop for 7 days)
- o Vitamin C (avoid for 3days)
- o Red meat (avoid for 3 days)
- o Avoid raw cruciferous vegetables few days before the test

Stools DNA test

- Tests stool for the presence of known DNA alterations in the adenoma-carcinoma sequence of colorectal carcinogenesis. Adenoma and carcinoma cells that contain altered DNA are continuously shed into the large bowel lumen and passed in the feces. Because DNA is stable in stool, it can be differentiated and isolated from bacterial DNA found in the feces
- No single gene mutation is present in cells shed by every adenoma or cancer. Thus, a multi target DNA stool assay is required to achieve adequate sensitivity.
- Test sensitivity for CRC in studies ranged

Cont. on page 04

from 52% to 91%, with specificity ranging from 93% to 97%.
- But the significance of a positive test result in a patient with a negative follow-up evaluation is unknown.

Colonoscopy

Colonoscopy remains the gold standard tool of screening with a high sensitivity and specificity (over 95%). This test affords the opportunity to detect and resect neoplasia and precancerous lesions across the entire large bowel and is the definitive examination when other screening tests are positive. The complications rates are 1:1000 for perforations but are most often due to a polypectomy rather than the act itself. But still missed rates for small adenomas are of the order of 25-50%, but the significance of this is as yet unclear. 10-12% of larger adenomas (1 cm) especially in the right colon can be missed. Improving quality standards of colonoscopy remains the best way to reduce such missed rates.

Quality standards in the colonoscopy

- Adequate bowel preparation - needs to be mentioned in the report.
- Ceacal intubation rate - 95% (confirmed by land marks not by distance of the scope).
- Ileal intubation rate - 85%.
- Adenoma/polyp detection rate - 15-20%.
- Rectal retro-flexion should be performed in 90% of cases.
- Rectal examination or omission should be recorded in 100% of cases.
- A withdrawal time (not insertion time) of at least 6-10 min is associated with a higher adenoma detection rate compared to shorter withdrawal time.

CT Colonoscopy or virtual colonoscopy

In the overall detection of CRC, the pooled sensitivity of CT colonography (96%) was not statistically significant from that of colonoscopy (95%). Patient must take the same preparation as for colonoscopy in addition to the same discomfort during procedure insufflation and there are risks associated with contrast allergy, radiation exposure. A colonoscopy is needed to confirm positive findings seen radiologically.

Recommendations for screening

- No FH/risk factors of CRC - begin after 50yrs
  - ~ Stools test - annually
  - ~ Colonoscopy - 10 yearly
  - ~ Flexible sigmoidoscopy / Virtual colonoscopy - 5 yearly

- FH of CRC in a 1st degree relative (parents, siblings) - Need colonoscopy
  - ~ If relative less than 60yrs - begin at 40yrs or 10yrs before age at diagnosis
  - ~ If relative more than 60yrs - begin at 40yrs

(Same if Advanced adenoma or documented advanced serrated lesions)

The importance of detecting precancerous and early colo-rectal cancers is that they can be resected endoscopically without having to undergo surgical resection of the colon. Using colonoscopy we are not only able to detect lesions but using image enhancing techniques the histology of such lesions could also be predicted without the need for tissue biopsy. This enables endoscopic resection techniques such as Endoscopic mucosal resection (EMR) or Endoscopic submucosal dissection (ESD) to be used effectively to resect these lesions.

Diet and CRC

Dietary pattern with a low potential to contribute to inflammation in the colon: High intake of Green leafy vegetables, dark yellow vegetables, coffee and tea and low intake of processed meat, red meat, refined grains and sugar-sweetened beverages have shown to reduce the risk of CRC.

References

1. Ries L, Melbert D, Krapcho M, et al. (eds). SEER Cancer Statistics Review, 1975-2004. Bethesda, MD: National Cancer Institute; 2007.
2. Lieberman DA, Weiss DG. One-time screening for colorectal cancer with combined fecal occult-blood testing and examination of the distal colon. N Engl J Med 2001; 345: 555-560.
3. Sidransky D, Tokino T, Hamilton SR, et al. Identification of ras oncogene mutations in the stool of patients with curable colorectal tumors. Science 1992; 256: 102-105.
4. Fred K. Tabung et al. Association of Dietary Inflammatory Potential With Colorectal Cancer Risk in Men and Women. JAMA Oncol.

65 year old lady with history of head injury

A 65 year old presented with a left sided headache of two weeks duration. She had a fall two weeks ago and had knocked her head on that side. Headaches were episodic. Mild and not increasing in severity, no visual disturbances.

At the time of the event no loss of consciousness or bleeding from ENT. She had no dizziness, focal neurological deficits, seizures, unsteady gait or persistent vomiting Her past history was not significant. She was not on any long term medication.
She was worried about her symptoms and requested reassurance as she was traveling overseas in two days.

Examination
Alert. Conscious and rational. No external evidence of depressed skull fractures or haematoma. B/L PERTL. No papilledema. CNS and CVS Examination was normal. BP130/80mmHg

Probable diagnoses
SDH (excluded - red flags negative) Local pain due to fall (most likely diagnosis in the absence of sinister clinical features)

Management
Explanation about the probable diagnosis and reassurance Simple analgesics for pain relief Safety-netting

Techniques that are useful to elicit "red flags"
Use open questions, followed by further 'open' probing, e.g. 'Can you tell me a bit more about your symptoms and how they all started', 'Is there anything else that you think may be important?' or 'And what happened then?' Find out the reason for the consultation? Explore the presenting symptom(s) in detail. Patient's idea, concerns Actively search for important 'hidden' red flags Combinations of symptoms that may suggest serious disease (e.g. older age, tiredness, weight loss AND rectal bleeding can indicate bowel cancer)

In this consultation red flags were actively searched for and intracranial hemorrhage was ruled out. As the symptoms were of short duration diagnoses such as brain tumour were not included in the hypotheses.

In the absence of "red flags" the patient was reassured and patients concerns were addressed.

PUBLISHED BY
INDEPENDENT MEDICAL PRACTITIONERS ASSOCIATION
275/75, PROF. STANLEY WIJESUNDARA MW, COLOMBO 7. Tel: 0112 501 113 Fax: 0112 500 818
E-mail: champa.impa@gmail.com | info@impa-lk.org Web: www.impa-lk.org