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IMPA NEWS

THE OFFICIAL NEWS LETTER OF THE INDEPENDENT MEDICAL PRACTITIONERS ASSOCIATION

IMPA News

- A very successful medical update programme on "Gallstones Disease" By Dr S.Sivaganesh Senior lecturer & Honorary Consultant Surgeon and "Prostate Cancer" By Dr Ajith Malalasekera, Consultant Urological Surgeon, sponsored by the State Pharmaceutical Corporation of Sri Lanka was held on Sunday 25th February 2018 at the OPA Auditorium.

- The National STD and AIDS control programme (NSACP) has invited the IMPA to participate in a programme to engage the Private sector medical practitioners to expand HIV screening services in Sri Lanka for which a presentation will be held to the IMPA council on Sunday 8th April 2018 by Dr.Dayanath Ranathunga and Dr.G.Weerasinghe.

- The IMPA represented by the President Dr.A.H.A.Hazari was a signatory to the programme - No such thing as 'sterilization pills" by a group of well recognized members of the medical profession at a press conference held at the SLMA auditorium on Thursday 5th March 2018.

- The President of the Primary Care Diabetic Group , Dr.Ananda Perera (IMPA, Hony.Joint Secretary) has requested the assistance of the IMPA in organizing the DINISA Annual Diabetic Programme to be held in conjunction with the World Diabetic Day which falls on November 15th Annually.

- The IMPA was invited by the Ministry of Health for the "National Conference on Recent Health Development Initiative" at the BMICH on Friday 9th March 2018 for which the IMPA was represented by Dr. Ananda Perera.

- The IMPA is pleased to inform you that Dr. Prasanna Siriwardene (IMPA council member) was elected as the new President of the Vaccine Forum of Sri Lanka.

- The Vaccine Forum of Sri Lanka felicitated the IMPA senior council member Dr.Lucian Jayasuriya for his services rendered to the field of Vaccinology in Sri Lanka in December 2017 at the Hotel Cinnamon Lakeside. He was elected to the Post of Honorary Patron of the VFSL at the AGM.

- The IMPA was invited by the College of GPs to participate in the "Talk to your Neighbour Project" which was launched on Saturday 3rd March 2018.

- The OPA has organized the following seminars :-
  - "Future of Sri Lanka" - by the Prime Minister Hon.Mr. Ranil Wickremasinghe
  - "Say Goodbye to Spectacles" by Dr. Rajesh Fogla - Consultant Eye Surgeon, Apollo Hospital, India
  - "CKDu: An unforeseen Ecological Disaster with Unimaginable Human Suffering" by Dr. Kamal Gammanpill - Bio Medical Scientist.
  - "Essential leadership Skills for Professionals" by Prof. Ajantha Dharmasiri.
  - "Patient Involvement in Patient own safety" by Dr. S. Sridharan and Dr. Kushalani Jayatilleke.

Editor - Dr A L P de S Seneviratne

GALLSTONE DISEASE

Dr. S. Sivaganesh
Senior Lecturer & Honorary Consultant Surgeon,
University Surgical Unit, NHSL

Introduction
- Who gets them?
  - Typically 5 'F's - fat, fertile, flatulent, females in their forties & fifties
  - Young - haemolytic anaemia
- Types of stones
  - Mixed
  - Cholesterol
  - Pigmented

Spectrum of gallstone disease
- Majority 80 – 90 % - asymptomatic
- Symptomatic
  - Biliary colic
  - Dyspepsia & epigastric / RUQ pain / discomfort
- Complicated
  - Acute cholecystitis
  - CBD calculus and obstructive jaundice
  - Acute biliary pancreatitis

Presentation & Diagnosis
- Clinical
  - Biliary colic / pain
  - History of dyspepsia
  - Jaundice +/-
  - Constitutional symptoms - fever, ill
- Investigations
  - Inflammatory markers – WBC & CRP
  - LFTs - Bilirubin & ALP
  - Abdominal ultrasonography – post 6 hour fast

Management
- Biliary colic: self-limiting
  - May require brief stay in A&E
  - Analgaesia - diclofenac Na suppositories
  - Anti-emetics +/- IV fluids
- Biliary colic & obstructive jaundice
  - Refer to outpatient clinic
  - A&E for admission if persisting severe pain +/- fever? cholangitis
- Complicated gallstone disease
  - Acute cholecystitis
  - Acute cholangitis
  - Acute pancreatitis

Will require hospital admission
  - Fluid resuscitation
  - IV antibiotics
  - Monitoring
  - HDU / ICU care
  - Advanced interventional procedures - ERCP

Final common pathway for gallstone disease
- Symptomatic & complicated: Cholecystectomy (laparoscopic / open - rare)
- Asymptomatic : Observe

Why not operate on asymptomatic gallstones?
- Benefits vs risks & cost

- There are potentially life - threatening complications of gallstones, so isn't it better to operate while asymptomatic?
  - Yes, but only a small proportion become symptomatic i.e. ~ 10 - 15%
  - Of these only a small number become complicated
  - Asymptomatic --- Symptomatic --- Complicated

Do gallstones cause cancer?
- Yes, most common risk factor for gall bladder cancer!
  - 3 / 4 patients with GB cancer have gallstones
- But,
  - Gallstones are very common
  - Gallbladder cancer is rare
- Therefore,
  - cancer prevention is not an indication for surgery
- Single large stones – ? higher risk

Can one lead a normal life after removal of the gall bladder?
- Yes, no restriction in activities
- Yes, normal diet including oily food

What about non-surgical options?
- Only in selected patients
  - Unfit for GA - elderly, significant co-morbidities
  - Coagulopathies
  - Cirrhosis with significant varices
- Options:
  - Ursodeoxycholic acid
  - ERCP & sphincterotomy

Treatment of symptomatic gallstones
- Laparoscopic cholecystectomy - Gold standard
- Open cholecystectomy - rarely elective, mostly conversion form laparoscopic

Cont. on page 03

Conversion is usually in:
- Unclear anatomy / non progression of surgery
- Elderly men with a history of acute cholecystitis

Timing of laparoscopic cholecystectomy
- Biliary colics / pain / dyspepsia
  - Elective waiting list
- Acute cholecystitis
  - Early within 3 days – 'hot' cholecystectomy
  - Interval cholecystectomy 6 – 8 weeks later
- Acute gallstone pancreatitis
  - Same admission or within 2 weeks
- CBD stone
  - After ERCP
  - Interval cholecystectomy if associated cholangitis

How safe is lap cholecystectomy?
- Very safe in trained hands
- Complications
  - Bile duct injury
  - Hepatic artery injury
  - Bowel injury
- Low threshold for conversion
  - Safety over ego & scar
- Conversion rates < 5%

Recovery after laparoscopic cholecystectomy
- Day case: 24 hour hospital stay
- Discharged the next day
- If open cholecystectomy: additional day of hospitalization
- When fully awake / recovered from anaesthesia
  - Diet - light meal same evening of next morning
  - Mobilised out of bed

Instructions on discharge
- Diet?
  - Normal as before
- Restriction of fat intake?
  - Some recommend reduction in first couple of weeks
- Activity
  - Continue activities of daily living
  - Can climb stairs
  - Avoid lifting weights > 5-6 kg for 8 weeks
- Driving?
  - When comfortable and able to apply emergency brakes
- Sex?
  - When comfortable & willing
- Air travel?
  - After 1 – 2 weeks depending on risk for DVT
- Bath?
  - From day 1 or 2
  - Usually water resistant dressings
- Suture removal
  - Not required – subcuticular absorbable
- Analgaesia
  - Paracetamol +/- NSAID for 3 days
- Antibiotic
  - Not required
- Review by surgeon
  - Not routinely required unless complication
  - Follow-up visit to primary care Dr / GP
  - Review histology
- Time off work
  - Person dependent
  - On average 3 - 5 days

Advise to return to surgeon / hospital if:
- Worsening abdominal pain
- Nausea / vomiting
- Jaundice
- Fever
- Feeling 'unwell'

  - Low threshold to suspect bile duct or visceral injury
  - Early identification & intervention makes the difference

Burning Feet Syndrome - A difficult case to manage

Dr. Lakmali Bandara
MB.BS, DFM-REGISTRAR IN FAMILY MEDICINE
Dr. A.L.P. de Seneviratne
MB.BS, DFM, FCGP, MRCGP [INT.], MD

A 66 year old woman presented with a history of burning pain and numbness of the both feet for one year duration. On the initial stage of the problem she found it difficult to walk and some unsteadiness. This was persisted for few days and noticed numbness of the feet which was followed by burning pain in the both limbs. This has progressed over the last year and taken treatment from several doctors including consultant neurologist. She has visited a family physician on several occasions but not on regular basis. The day I saw the patient was after one year from the onset of the illness. Her initial complain was still persisting with little or minimum improvement with specialist

Cont. on page 04

care. Her main concern was to get some cure for her symptoms. There was no history of trauma to the back or in the lower limb area. There is no pain radiation along the back to the lower part of the leg. No episodes of frequent falls in the past. The bladder and the bowel movements are normal. No loss of appetite or weight loss had been noticed. Her sleep was not affected by the burning pain and the activities of daily living were not affected by this as well. There was no worsening of burning pain while touching the bed linen.

Examination
General appearance- Averagely built lady with a BMI of 22. Mood appears normal and had good eye contact while consultation. Blood preasure-130/70 mm Hg, pulse 76 beats per minute with good volume.

Focused examination of the lower limbs
Generalized loss of hair in the both limbs noted, no deformities, scars, ulcers or callosities had noticed in the lower limb area. The tone, power of the lower limb normal.

The pin prick sensation, vibration sense, light touch and the proprioception normal in the both the lower limbs. All the peripheral pulses felt and reflexes present. The Romberg's negative.

Upper limb examination
No obvious deformities detected on inspection, tone, power, sensation in all modalities and the reflexes normal.

Problems identified -
1. Bi lateral lower limb burning sensation and the numbness for 1 year duration,
2. Diabetes and hypertension
3. Poor response to the medical treatment

Investigation findings -
- EMG studies of the lower limbs- Finding were consisted with bilateral lumber radiculopathy with L4,L 5.
- MRI scan of the Lumber spine- Posterior disc bulge/Posterior central focal disc protrusion at L4, L5 level impinging cauda equine and Trans versing L5 nerve roots. Right foramina stenosis impinging existing nerve roots. Posterior disc bulge at L5/S1 level minimally compressing them.

Discussion and the management plan -
During the initial presentation she has visited the general practitioner whom she trusts on. After taking the history, examination and the basic hematological investigations she was started on Amitriptyline 10 mg at night, Vitamins B12 supplements and foot care advice was given. The symptoms were reduced for a minor extent and she visited a neurologist to get further advice. She was extensively investigated by the neurologist. MRI scan and the EMG studies have shown the lumber radiculopathy compressing the L4 and L5 nerve roots. Even though, the clinical history and the examination finding did not show any evidence of root compression, except the burning pain and feeling of numbness.

What is the most likely etiology of her condition? Is this due to Diabetes or Nerve root compression? Any other underlying psychological issue is manifesting as this? Is this burning feet syndrome?

Even though the patient was having Diabetes for 10 years, clinical findings for detecting the symmetrical polyneuropathy were negative. No subjective evidence of loss of sensation in any modalities was detected. In the MRI scan has shown that the L5 nerve root compression due to disc bulge, there were no motor or sensory impairment noted while on examination of the lower limbs. By considering the all the above factors the final probable diagnosis would be the burning feet syndrome. She was started on Duloxetine 30 mg XR, gabapentin 75mg and Neurobion 1 twice a day. She was advised on keeping the foot on cold water basin for relive of pain.

She has visited the medical center after one week, and only a minor improvement has occurred. Had been noticed. Her drug doses were adjusted. Cold water emulsion of the legs was not practiced on a proper way and it was re-emphasized.

She visited 2 weeks later with complaining of 50% reduction of her symptoms.

What is burning feet syndrome?
Burning feet syndrome (BFS) has been described anecdotally in the literature for over 200 years. Described subjectively by patients as burning, prickling and unremitting with nocturnal exacerbations, the condition draws parallels with the burning dysaesthesia found in diabetic peripheral neuropathy, and appears to display a similar chronicity. Despite being a common symptom,especially among the elderly, its etiology in non-specific and often marked by a lack of objective clinical signs. Historically, burning feet syndrome has been recorded in situations of poor nutrition, including malnourished African populations in the early 20th century, South American plantation workers in the 1920s and during food shortages in the Spanish Civil War. Perhaps the best described and largest outbreak of burning feet occurred amongst prisoners of war (POWs) of the Japanese during the 2nd World War in South East Asia and the Far East[1].

1.[1] Welch E, Peach N, Parkes M, Gill G. Burning feet syndrome: An old tropical syndrome revisited. Ann Trop Med Public Heal [Internet]. 2013 [cited 2018 Feb 21];6(1):65. Available from: http://www.atmph.org/text.asp?2013/6/1/65/115206

FROM DENNIS TO CRISSIE, TILL WE MEET AGAIN

Dr. Dennis Aloysius
Senior Member, IMPA

I met you so many years ago, at a picnic you were there when I saw you
My heart went pang, little realizing I had started a journey long
I walked up to you to see you smiling and you looked at me with mischievous eyes
And handed me a cup of tea.
This was the first of billions of cups you would hand me, my love

It took some time to realize the pang was love, and my first love
It was my greatest joy to hear you say Dennis I loved you at first sight.
But the romance was taboo and many tried to break our bond
It was then that we realized our strong bond would never die

When they would not compromise, we left to face the world together
When left them Chrissie, you were crying, but never did you look back my love
Your pain would not die because you lost so much my love
But I proved strong and so did you, we withstood the storm together
Later I became the best son-in-law her dad had and the rest accepted us
Now all united and happy as could be, love had won again

My mother Ann met us at the door, she listened and she gave her blessing
She asked Chrissie are you hungry dear, while Chrissie ate she stitched a gown
Actually, the only woman I loved before was my mother Ann
An on the fifteenth of May, Chrissie, you became my wife and we were so happy

Then five children did we two have, and now we were complete.
With our little bundles of joy, growing up till an accident
Did shatter our lives, My darling Ruvani the youngest
Was crushed but not down we had more happy years together but she
Left us twenty years later, now she is with Chrissie in the stars
My Chrissie did you not promise me, one day we would die together
I had made all my plans to be with you, but now I in the dark, and lonely too.
Then GOD made a miracle when my three children did step in
With all their love the darkness got better, I'm sure you made sure

Now I sit in the dark sometimes and I close my eyes
And there you are now by my side again laughing and talking
Like the time we first met, it's like though you never left me
I will be joining you Chrissie soon and this time
My darling we will never part.

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