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IMPA NEWS

THE OFFICIAL NEWS LETTER OF THE INDEPENDENT MEDICAL PRACTITIONERS ASSOCIATION

FROM THE PEN OF THE PRESIDENT. . .

Dear Members

Regarding the ongoing recruitment activity of the new members for the IMPA we have so far succeeded in enrolling only 10 new members. Therefore, I earnestly request the support of the membership to recruit more and more of new members so that we will have a vibrant group of private practitioners with us in the IMPA.

We have initiated a survey advocated by the last council to find out regarding the postal expenditure and the mode of continuous professional development activities. The result of which will be posted to the membership in the month of October tentatively.

We have successfully repaired the windows of the IMPA office with the financial constraints we already have.

Please remember our annual general meeting will be held in December 15th 2019. But we already have started various activities planned for the event. IMPA journal is one such item in the agenda. We request the membership to submit original articles relevant to private clinical practice. Also please remember to collect advertisements for the annual journal so that we can successfully carry on the task profitably.

Dr Ananda Perera

Measles... no more!

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On 9th July 2019 at the World Health Organization Regional meeting held in New Delhi it was announced that Sri Lanka has eliminated measles. Measles is a highly infectious disease responsible for a high incidence of morbidity and mortality among children. Complications of measles include pneumonia (1-6%), diarrhea (8%), ear infections (7-9%). Nearly one in 100,000 develop encephalitis, which is often fatal, and results in devastating consequences and long-term disability among survivors. The fatality rate is reported to be 1-2/1,000 and is higher in low-income countries. An additional, albeit quite rare, delayed complication that has onset seven to 10 years after infection is

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subacute sclerosing panencephalitis (SSPE). Those at most risk of complications are children < 5 years of age and adults > 20 years of age, pregnant women and those who are immunocompromised.

Measles was once quite common but can now almost always be prevented with a vaccine and Sri Lanka has done exactly that. As a result of high vaccination rates, Sri Lanka was able to achieve this tremendous milestone in eradicating yet another vaccine preventable disease.

The health policy of the government of Sri Lanka is to provide comprehensive free health care to the entire population on an equitably distributed universal basis. Immunization against communicable diseases in the country dates back to 1886 when the Vaccination Ordinance was promulgated. The Expanded Program on Immunization (EPI) began in 1977 on a phased basis and was made operational throughout the country in the following year. The EPI was accelerated in 1985, with the simultaneous island-wide introduction of the measles vaccine. The measles vaccine is routinely administered to infants on completion of their ninth month of life. By 1990, overall measles immunization coverage had increased to 80%. During the next few years, the coverage gradually increased and has been maintained at >90% since 1996. Elimination of measles is achieved when a country interrupts transmission of indigenous virus for three years.

(CNN) *- Sri Lanka has defied the global trend in the battle against measles, with the country declared free of the highly infectious disease by the World Health Organization on Tuesday.*

The country reported its last homegrown case of the virus in May 2016, Sporadic cases reported in the last three years were imported from abroad but were quickly detected, investigated and received a rapid response, WHO added.

"Sri Lanka's achievement comes at a time when globally measles cases are increasing," Dr. Poonam Khetrapal Singh, regional director WHO South-East Asia, said in a statement.

"The country's success demonstrates its commitment, and the determination of its health workforce and parents to protect children against measles," she said.

This highly contagious viral disease has made a comeback across the globe in both high, middle and low income countries. The major contributors being ignorance or lack of access to vaccines coupled with complacency.

How did Sri Lanka eradicate measles?

- **Measles vaccination**

Measles vaccines were first licensed globally in 1963. Currently, only live attenuated products are available in the market. Several live attenuated measles vaccines are available, either as monovalent vaccine or in combination with rubella, mumps, or with varicella vaccines. When using the combined measles-rubella (MR) vaccine, measles-mumps-rubella (MMR) vaccine, or measles - mumps - rubella- varicella (MMRV) vaccine, the protective immune response to each individual vaccine antigen is largely unchanged. Although the duration of protection following measles vaccination is more variable than following wild-type virus infection, evidence indicates that a single dose of correctly administered measles vaccine which results in seroconversion will afford lifelong protection for most healthy individuals.

- Providing maximum coverage with two doses of measles and rubella vaccines through the childhood immunization programme. The vaccination coverage in Sri Lanka has been consistently high - over 95% with both the first and second dose of measles and rubella vaccine provided to children under the routine immunization programme.

- Mass vaccination campaigns with a measles-rubella vaccine have been held periodically to plug the immunization gaps, the last one in 2014.

- Sri Lanka has a strong surveillance system and all vaccine-preventable diseases are an integral part of the communicable disease surveillance system

- Measles is a notifiable disease in Sri Lanka.

- Post-exposure prophylaxis - In unimmunized or insufficiently immunized individuals, measles vaccine may be administered within 72 hours of exposure to measles virus to protect against the disease.

While announcing Sri Lanka's measles-free achievement at the South-East Asia Regional conference held in India, WHO Regional Director said "The risk of importations of measles virus from countries near and far will remain, especially from those that have significant population movement with Sri Lanka. Further strengthening immunity of

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the vulnerable population, capacities to detect and readiness to respond to measles virus both at the national and sub-national levels, would be the key to the country's continued measles-free status in the coming years".

Sri Lanka is the fourth country in South-East Asia Region to eliminate measles and control rubella, a flagship priority programme of WHO in the Region, ahead of the 2020 regional target. Last year Sri Lanka achieved rubella control, along with five other countries - Bangladesh, Bhutan, Maldives, Nepal and Timor-Leste.

(Sources- WHO, Epidemiology Unit Sri Lanka)

How is the disease transmitted?
Transmission from an infected to a non-infected person is through airborne transmission where the infection enters through the susceptible person's respiratory tract. If he/she does not have adequate protection, disease signs and symptoms will develop, usually after 14-21 days of the exposure. This is the incubation period of the disease in which the virus will grow inside the body and start spreading to others even before any signs of the disease.

Symptoms & signs
Measles signs and symptoms appear around 10 to 14 days after exposure to the virus. Signs and symptoms of measles typically include the following which could mimic chickenpox (Figure - Chicken pox vs measles)

- Fever
- Dry cough
- Runny nose
- Sore throat
- Inflamed eyes (conjunctivitis)
- Tiny white spots with bluish-white centers on a red background found inside the mouth on the inner lining of the cheek - also called Koplik's spots
- A skin rash made up of large, flat blotches that often flow into one another

The infection occurs in sequential stages over a period of two to three weeks.

- Infection and incubation. For the first 10 to 14 days after you're infected, the measles virus incubates. You have no signs or symptoms of measles during this time.

- Nonspecific signs and symptoms. Measles typically begins with a mild to moderate fever, often accompanied by a persistent cough, runny nose, inflamed eyes (conjunctivitis) and sore throat. This relatively mild illness may last two or three days.

- Acute illness and rash. The rash consists of small red spots, some of which are slightly raised. Spots and bumps in tight clusters give the skin a splotchy red appearance. The face breaks out first.

  Over the next few days, the rash spreads down the arms and trunk, then over the thighs, lower legs and feet. At the same time, the fever rises sharply, often as high as 104 to 105.8 F (40 to 41 C). The measles rash gradually recedes, fading first from the face and last from the thighs and feet.

- Communicable period. A person with measles can spread the virus to others for about eight days, starting four days before the rash appears and ending when the rash has been present for four days.

(Source - Mayo clinic)

The bottom-line is that Global eradication or elimination of measles is possible. The available vaccine seems to be potent to control the spread of the virus worldwide. The essentiality of public education and commitment on the part of government agencies and the parents of young children cannot be overemphasized in the eradication of measles.

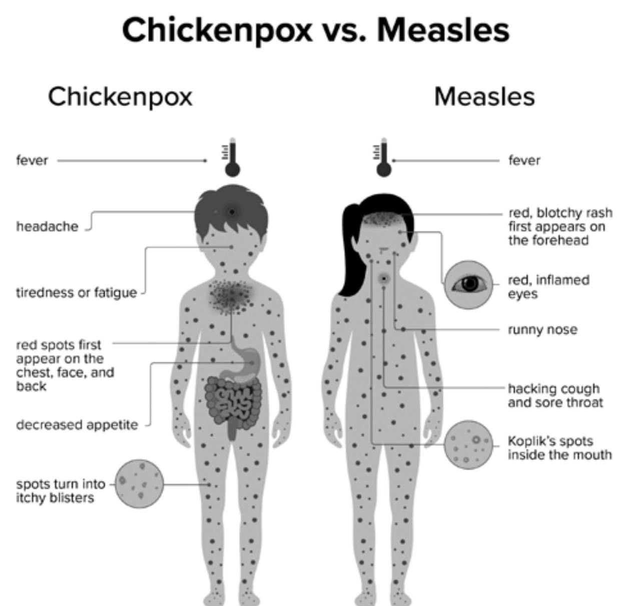

Figure 1. Chicken pox vs measles

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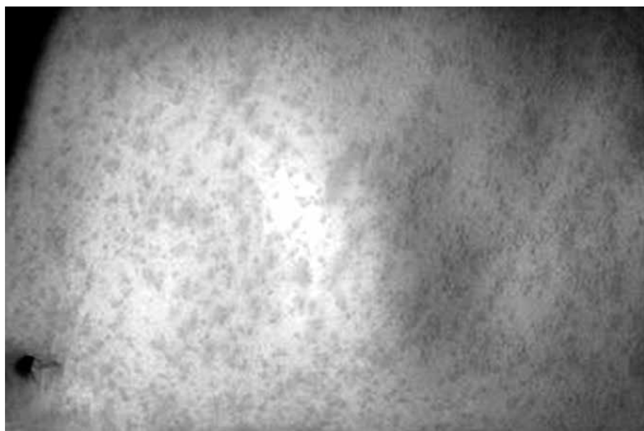

Figure 2. Measles rash

Figure 3. Child being vaccinated

THE ART AND SCIENCE OF REASSURANCE

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Reassurance is one of the most frequently dispensed therapeutic agents in the medical world. Hardly a medical consultation ends without those familiar phrases "don't worry", "nothing is wrong", "everything is fine" etc. But are they make the patient comfortable and therapeutic? Probably "failed reassurance" is one of the most frequently encountered therapeutic challenges, we face in family practice.(Barsky et.al 2005, Rief et.al. 2005, Hitchcock and Mathews 1992). To have a clear understanding of this phenomenon in Family practice one must have a basic understanding of what the normal illness behaviors and abnormal illness behaviors are. This write up is an attempt to synthesize what is known and also to propose a step care approach to implement an evidence based approach to the giving of reassurance to patients in Family Practice.

The research evidence that perception, evaluation, attribution, emotions, beliefs, attitudes, motivations, intentions and needs, affect the process of illness experience. (Morris et.al 1992, Crosland and Jones 1995, Cornford 1998, Cheng et.al. 2000, Coffin et.al. 1994, Lemann et.al. 1991, Mearin et.al. 1991, Barsky et.al. 1998, Barsky et.al. 1999, Cheng 2000).

The above steps simply reflect the sequence of cognitive processes which is unleashed when a patient experiences a symptom or symptoms. Evaluation of cognitive processes underlying the illness experience will ultimately give a clear indication of not only the Reason For Encounter (RFE) and the key symptoms but also almost everything a practicing primary care physician needs to know about the patient to handle the index consultation. There is strong research evidence in favor of many variables in the cognitive process of illness experience being critical in the outcome of medical consultation. For instance illness label, belief about the cause, timeline, consequences, control and emotions generated during the illness experience are all critical factors influencing either satisfaction or dissatisfaction and the outcome from the index medical consultation (Petrie et.al. 1996, Moss-Morris and Petrie 2001, Petrie et.al. 2002, Frostholm et.al. 2005, Barsky et.al. 1998, Barsky et.al. 1999).

Reassurance Characteristics and Prerequisites

1) Patient will have a worry, concerns, fear, phobias, anxiety or depression
2) Patients problems' origin must be explored
3) Identify all the problems and if many prioritize them
4) For each problem identified go through the following sequence
5) Perception - what is the input, what is the algorithm (eg. pain under the left nipple =>pain in these areas are serious => chest pain)
6) Evaluation - patient tries to answer the following questions - what is it due to, why did it happen to me, why now not earlier nor later, what diseases I know can explain my chest pain heart problem, gastric problem, muscular ache
7) Attribution - patient decides on the cause as a heart problem
8) Meaning search is triggered - if it is heart problem, will I die, will I get bed bound, house bound, what happens to my job, how I am going to feed my children, how I am going to give my daughters in marriage, what will happen to me after death etc. etc.

Eliciting Ideas, Concerns and Expectation

1) Open ended interviewing

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2) Prod the patient for more information
3) Prod the patient for the illness-narrative or the illness story
4) Validate the patient's experience - acknowledge and normalize
5) Show empathy
6) Direct inquiry about emotions and coping

Reassurance

1) Identify the stimuli for PERCEPTION
2) Identify key symptoms on which patient's illness experience is based on
3) Characterize the evaluation process
4) Characterize the attribution process
5) Ascertain the meaning for the patient
9) Ascertain resilience and how the patient is already coping

Stimuli For Perception

1) Bodily sensations
2) Minor pathology
3) Major pathologies
4) Physiology
5) Stress
6) Emotions
7) Knowledge
8) Media alerts
9) Social alerts

Nature of Evaluation Process

1) Identify the symptom schema
2) Identify the illness schema
3) Identify the BeViMAN

Symptom Schemas Examples

1) Chest pain is a serious problem
2) Hemiparesis is best managed by ayurvedic doctors
3) Fractures are best managed by ayurvedic doctors
4) Sprains and strains need ayurvedic therapy
5) Gas and acid problems needs body cooling
6) Rakthaya needs ayurvedic treatment
7) Bruises can turn into tumors
8) Rat bites can cause vitiligo
9) Dath miti kema - panu amaru
10) Sleeping prone - panu amaru
11) Face skin rash - panu kevili

Illness Schemas Examples

1) Heart attack needs emergency treatment at a hospital
2) Deiyanne leda needs no treatment other than pleasing gods
3) Sexual dysfunction is a personal problem which does not have any medical treatment
4) Nocturnal emission is a body-wasting event
5) Masturbation is a bad thing to do
6) Head injury is a contraindication for bathing

Common Health Beliefs

(as causes of symptoms)

1) Phlegm (headaches, cold and coughs)
2) Ushne or Heat (rashes, erythemas)
3) Acid (retrosternal burn)
4) Gas (abdominal distension)
5) Ajeeranaya (diarrhea)
6) Arsus or Piles (bleeding PR, prolapsing anal masses)
7) Bile (vomiting yellow colored matter)
8) Le adu pressure (fatigue, poor memory, disability)
9) Le vadi pressure (headache, generalized body aches)
10) Thalma (swellings, headache)
11) Gedi (abdominal swelling)
12) Visa (vomiting, fatigue, psychiatric problems)
13) Blood poisoning (rashes)
14) Deiyanne leda (fevers with rashes)
15) Panu amaru (abdominal pain, sleeping prone)
16) Cockcroach urine contact (rashes)
17) Evil eyes (psychiatric problems)
18) Teething (fever, diarrhea)
19) Somebody has done something
20) Devils influenze
21) Rat bites and sudu kabara
22) Vatha amaru
23) Panu amaru
24) Ange durvalakama (usually no investigations and further treatment required, all that is necessary is some vitamins and good nutrition - necessary for reframing)
25) Possession states to explain odd behaviors

Reassurance Never-Tos

1) Never say don't worry - patient is already worrying that is why the index consultation
2) Never say all in your head - that shows your ignorance about the cognitive processes of illness perception
3) Never say nothing to worry - patient is worrying because there is some stimuli for perception
4) Never say don't think - only dead bodies do not think
5) Never say all the reports are normal therefore there cannot be anything the matter with the patient

Second Part of this Article will continue in the Next Newsletter.

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