



# IMPA

## NEWS

THE OFFICIAL NEWS LETTER OF THE INDEPENDENT MEDICAL PRACTITIONERS ASSOCIATION

## FROM THE PEN OF THE PRESIDENT...



Dear Colleagues,

Please let me summarize all about the projects we have initiated so far. There are 2 projects we have designed and plan to execute. First the Sri Lankan drug Index and Formulary (SLDIF). Second is the Primary Care Morbidity Registration System (PCMRS). Following matters and the progress so far are worthy of note. More updates will follow In the next newsletter

### SLDIF

1. Upto 12:10 PM 4/24/2019 100 drugs registered
2. Upto 4:56 PM 4/28/2019 200 drugs registered
3. Upto 10:57 AM 5/14/2019 245 drugs registered
4. It is known that the total drugs registered is around 8000.
5. We are far below the expectations
6. But all this was achieved by just 1 letter and 2 emails
7. We plan to forge ahead once the country's situation improves - sending reminders and personal communication
8. Development of a web app for the convenience of the drug registration for the Index and the Formulary
9. Change of focus from the initial meeting of the drug index sub-committee of the IMPA:
  - a. Initial focus was on re-printing the published SLDI 2010
  - b. A formulary too was planned as the 2010 index was out of date beyond recognition
  - c. A formulary was considered too expensive and elaborate for the time being and focus was shifted towards printing a totally new Drug Index
  - d. As the index and formulary are in fact 2 faces of a single coin it was later decided at the last drug index meeting to focus on the Index printing as well as the Formulary
9. Index would be published and printed - logistic will be decided at the next drug index subcommittee meeting
10. Several members planned to go for funds and publish an online national formulary

### PCMRS

1. The morbidity core group has prepared a research protocol for the PCMRS project
2. A representative of the core group met Dr. Amal Harsha De Silva Dr. Amal Harsha de Silva DDG (MS) II to get his support for this project
3. Dr. Amaml Harsha De Silva referred the matter to the Director of the PHSRC
4. The group will submit the proposal to the Director of PHSRC
5. IMPA representative at PHSRC will act as the intermediary between the IMPA core group and the PHSRC
6. The core group plans to prepare a project proposal and the Gantt chart for task analysis
7. Several other funding organizations will also be approached
8. PCMTRS will be executed in 2 phases - phase 1 research based implementation study and phase 2 would be the project proper of a continuous morbidity registration for private primary care services in Sri Lanka
9. For logistical reasons we will focus on private primary care services in Sri Lanka

Dr Ananda Perera



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## OBITUARY



### Dr. DENNIS J ALOYSIUS

Dr. Dennis Aloysius, a giant of the medical profession in Sri Lanka, who passed away recently is sadly missed by many. He touched the lives of most persons he met.

He was a leader of family medicine practice in Sri Lanka. Although he had a first class in the final MBBS he decided to embark on a career in family practice. He started at the Philip Memorial Hospital. He soon shifted to his own practice in Dehiwala. The Dehiwala Clinic became well known in the area very soon. He was known as a kind doctor who had time to listen to his patients not only about their medical problems but on any other matters affecting them.

He was ably assisted by his ever loving wife Crissy, whom he had met when they were university student. Crissy was the manager of his clinic. She also knew his patients and their families. Dennis and Crissy were inseparable. They were lifelong friends for more than 60 years. Crissy would accompany Dennis to all functions where she was able to come. If Dennis was invited for a meeting where Crissy was not which ended with dinner, Dennis would not stay for dinner but go home for dinner with his wife.

I came to know this great upright gentleman in the 1980s when I came as a Director of General Hospital Colombo. We became good friends very soon. I remember his telling me to join any medical associations possible, an advice I followed.

Dennis was a live wire in any organisation he was involved. He was a Past President for the Sri Lanka Medical Association, College of General Practitioners of Sri Lanka and The Sri Lanka Paediatric Association (although he was not a paediatrician). In the Sri Lanka Medical Association he was a council member for over 30 years and took an active part in any event and especially the annual SLMA concert.

He was an active member of the Independent Medical Practitioners Associations (IMPA) and was its Vice President for many years.

He is a pioneer and activist in the establishment of North Colombo Medical College (NCMC) - the first private medical school in Sri Lanka. He was a member of the board of the governors of the NCMC. By that time I was Director General of Teaching Hospitals and the Teaching Hospital, Ragama, where the medical students of the NCMC studied came under my purview. There was good cooperation between the NCMC and our Ministry. I was regularly invited for the meetings of the NCMC. Dennis was down hearted when the NCMC was taken over by the government in 1989, but bore it stoically.

Dennis had a special interest in vaccines. He took an active part in formulation of the SLMA Guidelines and Information on Vaccines. He was a member of the core review group who critically reviewed every chapter.

Crissy was the founder and the president of the Doctors Wives Associations for many years. Dennis was very active in that association, although he was not a member.

Dennis and Crissy were practising devout Catholics. Even though Dennis had a busy practice they had time to attend daily Mass.

Dennis was a vibrant fun loving gentleman who helped any person who sought his help.

Dennis could not bear the loss of Crissy less than two years ago. He gradually withdrew from active life.

His son Dr Rohan Aloysius who is a consultant paediatrician and daughters could be proud of their dear father.

May Dennis and Crissy enjoy eternal rest.

*Dr. Lucian Jayasuriya*

# Effects of “plate model” as a part of dietary intervention for rehabilitation following myocardial infarction: a randomized controlled trial

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## Abstract

**Background:** Reducing body weight by nutritional management is an integral element of cardiac rehabilitation and in secondary prevention of cardiovascular diseases. Administration of a “plate model” is one practical aspect to control calorie intake. The study aimed to evaluate the effectiveness of the plate model as a part of dietary modification in losing excess weight in post-myocardial infarction (MI) patients.

**Methods:** An interventional, randomized, single-blinded study with parallel subject allocation was conducted among patients with a history of troponin-positive acute coronary syndrome (ACS). A total of 120 patients were recruited to intervention and control groups. The Intervention cluster was provided with ‘plate model’ and both groups received standard cardiac rehabilitation care. Anthropometric, clinical and metabolic parameters were measured at recruitment and repeated during 4<sup>th</sup> and 12<sup>th</sup> week.

**Results:** A sample of 79 patients (the intervention group: 40, the control group: 39) completed the study. At the end of 12 weeks participants in the intervention group exhibited a significant weight loss ( $-1.27 \pm 3.58$  vs.  $-0.26 \pm 2.42$  kg;  $P=0.029$ ) and a significant reduction in BMI ( $-0.48 \pm 1.31$  vs.  $-0.10 \pm 0.89$  kg/m<sup>2</sup>;  $P=0.023$ ). Overweight and obese patients (BMI  $>23$  kg/m<sup>2</sup>) displayed greater weight loss ( $-2.13 \pm 3.46$  vs.  $0.12 \pm 2.62$  kg;  $P=0.013$ ). Many of overweight and obese patients in the test group (35.7%) experienced a weight loss  $\geq 5\%$  compared to the control group (13.04%) which was a nearly significant result ( $P=0.065$ ). No significant changes observed in other metabolic parameters.

**Conclusions:** Plate model is an effective dietary intervention in view of weight reduction in post-MI patients.

**Keywords:** Cardiovascular disease; weight loss; plate model; post-myocardial infarction (post-MI); dietary intervention

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## Introduction

Recurrent coronary events are a common phenomenon following myocardial infarction (MI) (1). A large-scale national Swedish registry study showed that the risk of cardiovascular events appeared high beyond the first year post-MI, indicating a need for prolonged surveillance, particularly in patients with additional risk factors (1). Number of pharmacological and non-pharmacological rehabilitation programmes are known to reduce recurrent events and improve outcome in survivors of MI. Cardiac rehabilitation encompasses comprehensive programmes aimed at limiting physiological and psychological effects of cardiac illness and reintegrating the patients to a satisfactory functional status (2). The physiologic parameters targeted by cardiac rehabilitation interventions include an improvement in exercise tolerance and in exercise habit, optimization of coronary risk factors, including improvement in lipid and lipoprotein profiles, body weight, blood glucose levels, blood pressure levels and cessation of smoking. Psychological factors include reduction of stress and anxiety and lessening of depression (3).

The benefits of cardiac rehabilitation include reduction in mortality, morbidity, improvement of quality of life and the cardiovascular risk profile (2,4). More importantly, a comprehensive programme initiated soon after a MI, can be economically justified (5). An effective implementation of a rehabilitation programme depends on addressing all the core components including dietary modifications, improving physical activity level and support for psycho-social health (6). Exercise (7) and dietary (8) interventions are such integral elements of cardiac rehabilitation and secondary prevention of cardiovascular disease.

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Excess adiposity as measured by BMI is associated with an increased risk of recurrent coronary events following MI, particularly among those who are obese (9). Therefore hypo caloric diet aimed towards intentional weight loss in obese patients is recommended for cardiovascular disease prevention (10). Moreover, a targeted weight management intervention should be an integral part of a cardiac rehabilitation program (11). Low carbohydrate diet is known to decrease body weight as well as improve cardiovascular risk factors (12). Increased consumption of vegetables and fruits, characteristic to a prudent traditional diet is considered to be cardio protective (13). The Mediterranean diet which confers mortality and morbidity benefits to patients with cardiovascular disease, also consists of increased amounts of vegetables and plant based foods (14).

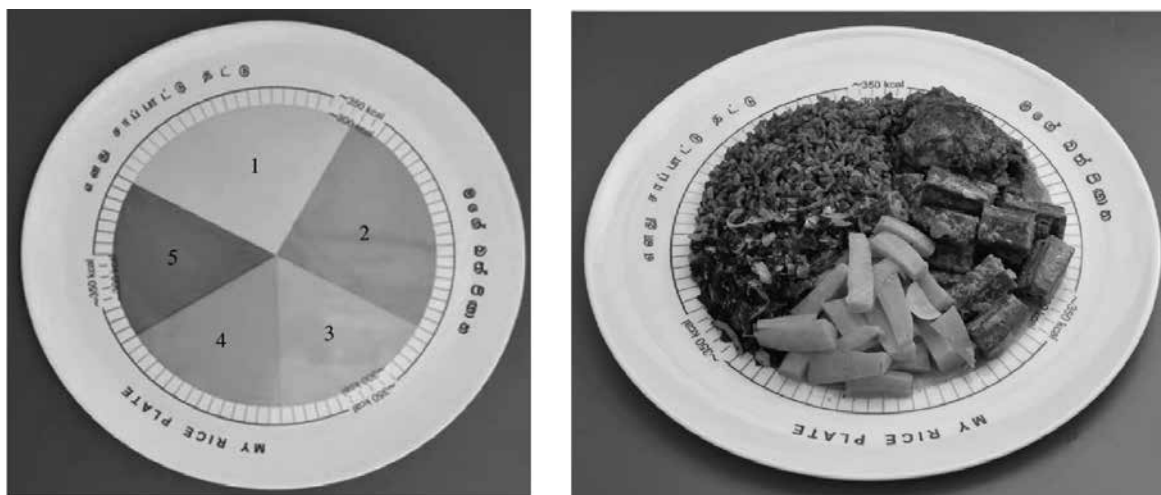
Despite being a main macronutrient, there is sparse evidence on recommendation of protein intake for cardiac patients. However the Mediterranean diet as well as American Heart Association dietary guidelines recommend sufficient intake of protein rich foods especially fish (14).

Most of the evidence on these dietary recommendations is derived from the western world. However, a diet should undoubtedly be culturally sensitive for successful practical implementation. Cardiovascular diseases are the main cause of mortality among Sri Lankan adults (15). Unhealthy dietary habits could be one of contributing factor for high cardiovascular mortality rate in Sri Lanka. The pattern of energy and nutrient intake among Sri Lankans differs from that of western world as well as the other Asian countries. Sri Lankan adults consume a very high carbohydrate diet (16).

In the Sri Lankan diet, 72% of calories are derived from carbohydrate whereas protein and fat are responsible for 10% and 18% of the total caloric intake respectively (17). Moreover, fruits and vegetables consumption is very low among Sri Lankan adults, with only 3.5% of population achieving the ‘five fruits and vegetable per day’ target (17).

Hence a substantial proportion of adult population in the local setting, fail to follow recommended dietary guidelines (16). Although there are no published data as of yet on dietary habits of post MI patients in Sri Lanka, our previous data shows that there is no significant change in their dietary habits irrespective of socio-economic factors or presence of diabetes and obesity (16).

The concept “plate model” is one of the practical methods to overcome the prevailing dietary pattern by reducing the average portion size of staple food in main meals, which also could ensure the sufficient intake of vegetables and protein foods simultaneously. The plate introduced in this study is divided into five segments by printed lines so that one-quarter of the plate is for rice (Figure 1). Another quarter is for protein-containing foods and the remaining half is for non-starchy vegetables. The segment representing the vegetables is again divided into three equal areas: one-third for green leafy salads and the other two-thirds for two different vegetables, including one green (18). Since the plate is divided into segments it highlights the different types of foods that should be included in a healthy meal and it shows the ideal portions of starch food, protein food and vegetables for a balanced intake. Therefore, the study aims to evaluate the effects of a plate model on modification of selected cardio metabolic risk factors in overweight patients with a history of MI.



**Figure 1.** Food items indicated by each color segment of “My Rice Plate”. 1: Rice or equivalent; 2: meat or equivalent; 3: green vegetables; 3: yellow/red vegetables; 4: mallum/green salad.

## **Methods**

An interventional, randomized, single-blinded study with parallel subject allocation was conducted among the patients with a history of troponin positive acute coronary syndrome (ACS). The details of the study have been discussed elsewhere (19). The present study was conducted with accordance to the guidelines laid down in the Declaration of Helsinki and was approved by the Ethics Review Committee (ERC), National Hospital of Sri Lanka and Faculty of Medicine, University of Colombo. This is registered under Sri Lanka Clinical Trials Registry (SLCTR/2016/22). Written informed consent was obtained from all the eligible subjects.

### ***Inclusion and exclusion criteria***

Recruitments were carried out from diagnosed patients with troponin positive MI admitted to Institute of Cardiology, National Hospital of Sri Lanka, Colombo. Study subjects fulfilling the inclusion and exclusion criteria were selected. (I) The patients included had a confirmed troponin positive ACS during the 1 month preceding the date of recruitment and were between the age of 20–70 years. (II) The subjects consumed rice for at least two main meals per day. Patients with end stage renal failure, congestive cardiac failure, chronic liver cell disease, severe anemia or other severe systemic disease, pregnant and breast-feeding mothers, patients with systemic infection were excluded. Patients who were already on a modified diet or dietary supplements were also excluded.

### ***Assignment***

The participants were randomly allocated to intervention and control groups. Then the participants were stratified according to gender and an even quota of male and female subjects in both groups were ensured. Detailed information on sampling has been previously described (19).

### ***Justification of sample size***

The sample size was selected on the basis of a pilot survey, and the number needed for recruitment was determined to account for a confidence level of 95%, a confidence interval of 10%, and 80% statistical power. A 10% hypothesized difference of participants' body weight between the control and intervention groups following the plate model diet at the end of 12 weeks was taken as the primary outcome when calculating the sample size. Because the other biochemical parameters [blood pressure (BP), lipid profile (total, LDL and HDL cholesterol), triglyceride (TG), fasting blood sugar (FBS), and ALT] were prone to vary with

medication and compliance with medication, they were not regarded in sample size calculations. A subsequent 5% withdrawal rate and another 40% loss to follow-up (total of 45%) were accounted for in the calculation. A total sample of 120 was recruited over an anticipated period of 3 months.

### ***Intervention***

Patients assigned to the control group received standard cardiac rehabilitation following MI. Intervention arm was provided with the 'model plate' in addition to routine rehabilitation care. The details of the plate model have been described elsewhere (19). In summary, the subjects received a plate made of melamine which is divided into segments to ensure adherence to a few dietary practices. Plate model encouraged consumption of non-starchy vegetables (half of the plate) and protein rich food such as fish (quarter of the plate) and discouraged over consumption of rice (only quarter of the plate) (Figure 1). Furthermore, a food poster was given to the patients following the plate model diet in order to enhance their knowledge on different food choices under each category. These patients were provided with nutrition advice customized according to patients' social, economic and personal preferences.

The patient management team was blinded to the nature of intervention the patient was subjected to. The participants were thoroughly advised not to convey the information regarding the nature of intervention they were undergoing to other study participants to avoid breach of single blinded study design.

### ***Measurements and follow-up***

All the patients were given an interviewer administered questionnaire at recruitment through which demographic data, coronary risk factors, data on diagnosis and management were gathered. Baseline anthropometric measurements including body weight, height, waist circumference, hip circumference was measured using standard guidelines and blood pressure measurements were taken. Overnight fasting blood was collected to measure blood glucose, lipids and liver enzymes.

Patients were followed up at 4- and 12-week intervals. At these follow-up visits, blood pressure, anthropometric measurements were repeated. Fasting blood glucose and liver enzyme levels (ALT) were obtained at both follow-up visits. Lipid profile (total, LDL and HDL cholesterol) was repeated at 12 weeks.

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

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