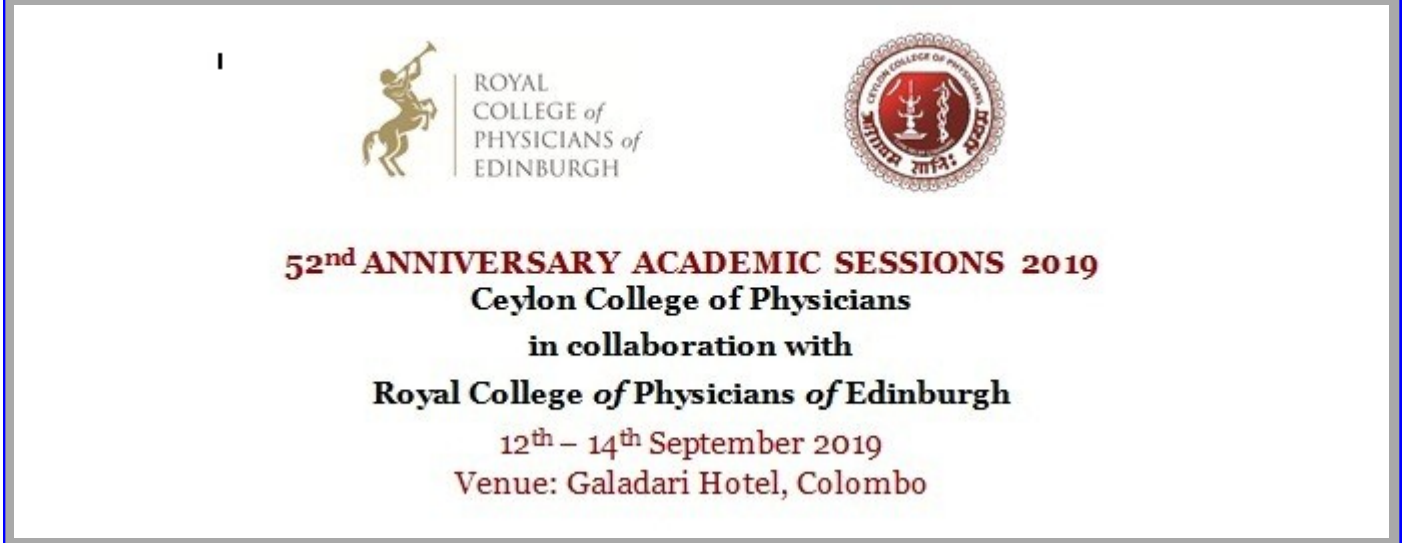
CCP News

Newsletter of the Ceylon College of Physicians

August 2019

Contents



1. President's message
2. Young Physicians' Forum and College Lecture
3. College Lecture August - Hypothyroidism-The known and the unknown
4. College Lecture - July- Should I stay or should I go? Challenges faced by a young consultant in Sri Lanka
5. Young Physicians Forum; Guillain – Barre Syndrome – "Known and unknown" An Update and Sri Lankan Scenario
6. Annual Academic Sessions 2019 at a Glance
7. Forthcoming events

Compiled and edited by:

Dr Shehan Silva
Dr Kishara Gooneratne

Ceylon College of Physicians
341/1, Kotte Road
Rajagiriya, Sri Lanka
Phone: +94 (0)11 2888146 or 3094140
Fax: +94 (0)11 2888119 E-mail: office@ccp.lk

President's message

Dear Fellows and Members,

The countdown to the 52nd Anniversary Academic Sessions have now begun and the team at the College are fine tuning the activities of it. The programme would have been emailed to you by now.

There are 3 pre-congress workshops on the 12th morning on Critical care, Research and Palliative care in the community. The topics included are essential aspects in these areas and workshop will be done in an interactive manner. The places are limited, and we will be able to accommodate only 40 per symposium, so register early to avoid disappointment!

There are 7 teaching capsules in the morning and evenings especially planned for the postgraduate trainees. Please inform your trainees and encourage them to register. The registration fee in only Rs 400 per capsule.

With 6 plenary lectures and 12 symposia on diverse areas of medicine, the Sessions promise to be an academic extravaganza not to be missed. This would be the only opportunity for both the busy Physicians and the postgraduates to get an overview of diverse specialties and topics under one room. The grand finale will be a panel discussion on Medical Negligence and the panelists will include Senior Lawyers from both the Attorney General's Department and the Private Bar and senior Medical Experts who have been actively involved with matters related to medical negligence. More details in the programme which is included in this letter!

Registration is now open online and at the College Office. Early bird registration has been extended until 6th September, just for you. So do visit http://51.15.253.67/events/ccp-2019/ or visit the College Office and register for the Sessions.

This year too, the Conference Dinner tickets are priced at Rs 3000 only and we would like to see as many of you as possible. Do join us to relax, meet friends and enjoy.

Looking forward to seeing you at the Sessions.

Chandanie Wanigatunge
President

Back to contents

Young Physicians' Forum and College Lecture

The Young Physicians' Forum and the College Lecture for the month of August was held at the ClinMARC on Tuesday, 6th August 2019. Dr Anomali S Vidanagamage, Senior Registrar in Neurology conducted the lecture 'Guillain Barre Syndrome- known and unknown. An update and the Sri Lankan scenario'.

Dr H G C R Abeyrathne, Senior Registrar in Gastroenterology delivered a talk 'Haematuria beyond the scope'. The College Lecture 'Hypothyroidism – the known and unknown' was presented by Dr Madhuwanthi Hettiarachchi, Consultant Physician, Teaching Hospital Peradeniya.

The event was sponsored by Cipla Pharmaceuticals

Back to contents

College Lecture August - Hypothyroidism-The known and the unknown

Dr N Madhuwanthi Hettiarachchi
MBBS,MD,FCCP,FACP,FRCPE
Consultant Physician in Internal Medicine and Head, Toxicology Unit
Teaching Hospital Peradeniya

Hypothyroidism is defined as a failure of thyroid gland to produce sufficient thyroid hormones to meet the metabolic demands of the body. Ninety percent of the time Hypothyroidism occurs as a primary failure of the gland. It occurs more frequently in women, and in older people (>65 years) The female to male ratio is 10:1. 90% of the hormones secreted by the thyroid gland is T4, 10% is T3.

Hypothyroidism can be classified as primary (due to thyroid hormone deficiency), secondary (due to TSH deficiency), tertiary (due to thyrotropin-releasing hormone deficiency), and peripheral (extra-thyroidal). Central hypothyroidism and peripheral hypothyroidism is rare (1%).

Primary hypothyroidism can be again divided into overt and subclinical hypothyroidism. Subclinical hypothyroidism, commonly regarded as a sign of early thyroid failure, is defined by TSH concentrations above the reference range and free thyroxine concentrations within the normal range. When there is low TSH with low T4 levels the secondary hypothyroidism needs to be excluded.

The most common cause of Primary hypothyroidism in iodine-sufficient areas is chronic autoimmune thyroiditis (Hashimoto's disease).

Clinical manifestations of hypothyroidism are neither sensitive nor specific. It range from life threatening to no signs or symptoms. The most common symptoms in adults are fatigue, lethargy, cold intolerance, weight gain, constipation, change in voice, and dry skin, but clinical presentation can differ with age and sex, among other factors.Pain in the neck, fullness in the throat, exhaustion are common with Hashimoto's thyroiditis.

Back to contents

College Lecture August - Hypothyroidism-The known and the unknown

Hypothyroidism needs to be excluded in following conditions-When there is clinical suspicion, strong family history, newborns of mothers with thyroid diseases, past history of neck irradiation, RAI or thyroid surgery, patients on drugs such as lithium or amiodarone, children with Down syndrome, patients with other autoimmune diseases, patients who are on treatment for Graves disease/thyrotoxicosis, patients with hypertriglyceridemia/hypercholesterolemia, psychiatric patients, elderly men/women, post-partum women/women with multiple miscarriages and in subfertility.

Most sensitive screening tool for primary hypothyroidism is TSH assay. If initial screening - TSH is elevated, it should be repeated within 2–8 weeks with a free T4 level to confirm the diagnosis. Routine measurement of triiodothyronine (T3) is not recommended. If secondary hypothyroidism is suspected, further investigation of hypothalamic/pituitary function is indicated. In the history one has to look for clues of secondary hypothyroidism such as secondary amenorrhoea, hypotension, fine wrinkling of the skin, abnormal pallor etc. If there is associated secondary adrenal failure, thyroid hormone supplementation should only be commenced after glucocorticoid replacement, in-order to prevent an adrenal crisis.

In patients with subclinical hypothyroidism, TSH testing should be repeated every 6-12 months to document any biochemical progression. Presence of anti-thyroid antibodies and more pronounced TSH elevation increase the risk. Treating subclinical hypothyroidism remains controversial. Treatment is justified when serum TSH is greater than 10 mIU/L, when the TSH is consistently between 5–10 mIU/L and the patient is symptomatic. A 3–6-month trial of levothyroxine needs to be given. Treatment can be continued where there is symptomatic benefit. Treatment is also considered when the TSH is between 5–10 mIU/L with anti-TPO antibodies, the presence of a goitre, subfertility or planning a pregnancy.

Annual thyroid function testing is recommended in euthyroid patients who have positive antithyroid antibodies, as progression to hypothyroidism is more common in this patient group.

Back to contents

College Lecture August - Hypothyroidism-The known and the unknown

Thyroid radionucleotide has no role in the work-up for hypothyroidism.

The average daily dose of thyroxine is 1.6 μg per kilogram body weight. Lower initial doses are considered in patients who are frail or elderly, who have symptomatic angina. Starting dose for healthy patients < 50 years at 75-100 μg/day Starting dose for healthy patients > 50 years should be 50 μg/day. Dose ↑ by 25 μg/day, if needed, at 6 to 8 weeks intervals. Starting dose for patients with heart disease should be 12.5 to 25 μg/day and increase by 12.5 - 25 μg/day, if needed, at 6 to 8weeks intervals. In elderly and patients with IHD, treatment need to be started with low doses.

One of the most common reasons for failure to achieve euthyroid is noncompliance. When a patient has been noncompliant for a period and takes a large dose of thyroxine before their blood test it increases TSH with normal or elevated free T4. You should exclude factors affecting absorption and drugs accelerating metabolism. Calcium carbonate, ferrous sulphate, cholestyramine, proton pump inhibitorsand multivitamins can reduce the absorption.

There are trimester specific reference intervals for thyroid function in Pregnancy. First trimester 0.1–2.5 mIU/L, second trimester 0.2–3.0 mIU/L and third trimester 0.3–3.0 mIU/L. Women with overt or subclinical hypothyroidism should receive levothyroxine replacement to keep TSH within the trimester specific range. There should be four weekly thyroid function monitoring until 20 weeks of gestation, with less frequent monitoring thereafter. Increase the dose of levothyroxine by about 30 percent as soon as pregnancy is confirmed, after delivery reduce levothyroxine to pre-pregnancy levels.

Back to contents

College Lecture - July

Should I stay or should I go? Challenges faced by a young consultant in Sri Lanka

Dr Chamara Ratnayake, Consultant Cardiologist

Following the completion of nearly 2 decades of medical education (undergraduate and postgraduate), most new consultants who are part of the Ministry of Healthcare and Nutrition in Sri Lanka come to a crossroad as far as their career and life is concerned. After the struggle to complete all qualifications and expertise to be deemed worthy of being a Consultant in their respective fields, it is often the case that we are posted at first, to parts of the country we are rather unfamiliar with, i.e.: far from home. Then begins a long journey of transfers back and forth, until one day we may have the luxury of working out of your own hometown.

Having just returned from overseas training in the UK myself, I have been posted as the Consultant Cardiologist to General Hospital Vavuniya. Having to travel the nearly 250 km weekly, leaving my family including my almost 2-year-old daughter in Colombo always gives me a heavy heart. On top of this I have been constantly been bombarded with the questions……"Haven't you ever thought of going back to the UK and work?" and "Haven't you considered resigning and joining the private sector?". The questions certainly add fuel to the fire and always makes me question my life's choices. Should I stay and continue the struggle? Or should I look for greener pastures elsewhere?

Going by the data, I am most certainly not alone in this way of thinking. A recent survey of nearly 400 undergraduates and new graduates from the University of Colombo (1) found that nearly 25% had an intention to migrate even before starting their career in Sri Lanka. The most cited reasons for migration were a perceived better quality of life, better earnings and more training opportunities in the host country. Another study, looking at migration of medical specialists from Sri Lanka (2) found that around 10% either go back or never return following the mandatory overseas training period. The top reasons for staying in Sri Lanka were job security, income from private practice, proximity to family and a culturally appropriate environment. The top reasons for migration were better quality of life, having to work in rural parts of Sri Lanka, career development and social security.

Back to contents

College Lecture - July

Should I stay or should I go? Challenges faced by a young consultant in Sri Lanka

The key to a happy life is when one can achieve the best possible work: life balance. This balance I believe is based on three main pillars: Career, Family and Financial stability. Utopia would be if one can find balance in all three aspects. However, this is much easier said than done. Working in Sri Lanka, as a specialist in the Ministry of health, we are almost guaranteed a job. It may not be in the place we would like to be, nevertheless the job is secure. However, given the salary structure, it is inadequate to sustain a family, hence the indulgence to have a private practice and earn more. The sacrifice then is then less time with the family. Apart from this of course is the constant struggle with administrators, leaving a few less hairs than we started off with. Working overseas, the balance between work and life was much easier to achieve. Work was for a certain number of hours per week and the renumeration was quite adequate to have a comfortable life. Time with family was also quite easy to achieve. However, there was certainly a lot of stress involved working in an unfamiliar environment and the high demands of the work at hand. Peace of mind at times was found wanting. An added burden was not having any family around at the time of crisis, which at times could add to the already stressful days.

The final verdict I would say is, there is no right or wrong answer here. The decision to stay or go is pure based on an individual basis. The decision depends on the level of patience, priorities and most importantly, choice between work/life balance versus peace of mind. As Lord Buddha once said, contentment is the greatest wealth, hence whatever decision that is made, should be adhered to and an attempt at balance in life should be the key.

References

1. *de Silva, Nipun Lakshitha et al. "Why do doctors emigrate from Sri Lanka? A survey of medical undergraduates and new graduates." BMC research notesvol. 7 918. 16 Dec. 2014, doi:10.1186/1756-0500-7-918*
2. *De Silva, A Pubudu et al. "Migration of Sri Lankan medical specialists." Human resources for health vol. 11 21. 21 May. 2013, doi:10.1186/1478-4491-11-21*

Back to contents

Young Physicians Forum

Guillain – Barre Syndrome – "Known and unknown" An Update and Sri Lankan Scenario

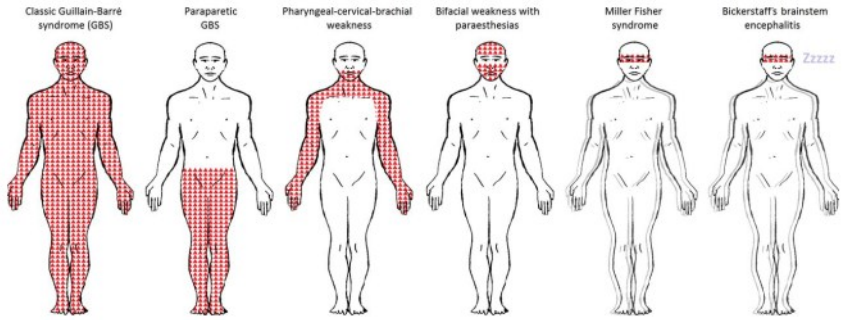
Dr Anomali S Vidanagamage, Senior Registrar in Neurology
National Hospital of Sri Lanka

Guillain Barre syndrome (GBS) is a frequently encountered neurological disorder in Sri Lanka, which keeps the medical personals alert, in order to not to miss the diagnosis, being aware of catastrophic complications of progressive disease.

The weakness in GBS is classically ascending and predominantly proximal with hypo or areflexia. The duration from onset of weakness to peak varies from 12 hours to 28 days which is usually around two weeks leading to a plateau phase which could last for weeks or months resulting recovery or residual deficit3.

The clinical presentation of GBS could vary, from the classical type to Miller-Fischer syndrome and other regional variants.

Patterns of weakness in Guillain-Barré syndrome (GBS) and Miller Fisher syndrome and their subtypes.



Benjamin R Wakerley, and Nobuhiro Yuki Pract Neurol 2015;15:90-99

PN

Back to contents

Although the clinical spectrum is variable, there are features shared, such as a history of antecedent infection, monophasic disease course, symmetrical cranial or limb weakness and other features like presence of cerebrospinal fluid albumino-cytological dissociation (raised protein, normal cell count), antiganglioside antibodies and neurophysiological evidence of axonal or demyelinating neuropathy3.

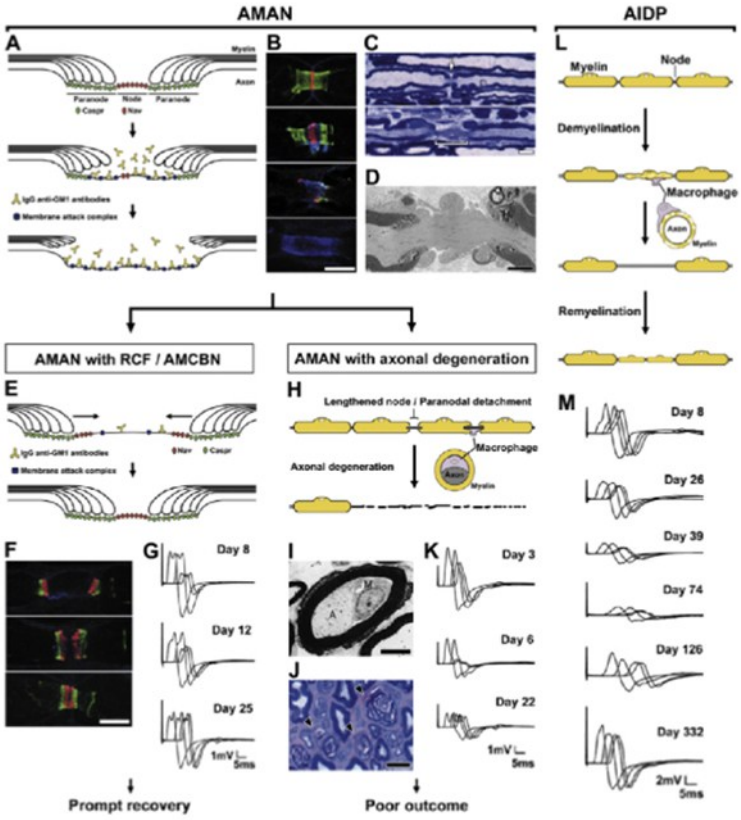
GBS is an acute immune mediated polyradiculoneuropathy, where the immune mechanisms are triggered following an antecedent event such as infection, autoimmune illness, vaccination or surgery4.
The primary targets in neurons are the myelin sheath of Schwan cells or the axolemma acting through molecular mimicry. The knowledge regarding these mechanisms is now expanding and the node of Ranvier, which facilitates saltatory conduction leading to fast conduction through nerves is found to be affected in certain axonal types of GBS1.

The axonal types of GBS are acute motor axonal polyneuropathy (AMAN) and acute motor sensory axonal polyneuropathy (AMSAN). Although the known mechanism is through axonal degeneration due to immune mediated injury, which will result poor outcome, there are axonal types of GBS observed which has relatively fast recovery, in contrast to what is expected. The second type of axonal type of GBS, identified is characterized with reversible conduction failure due to antibodies binding at the node or the paranode.

These antibodies are found to be antiganglioside antibodies1. Gangliosides are sialic acid-containing glycosphingolipids those present abundantly on the cellular surfaces of neuronal cells.

The type of antibodies identified are mainly GM1 antibody and GD1a antibody in axonal types whereas anti GQ1b antibody is present in Miller – Fischer syndrome and other variants with brain stem signs1.

Back to contents



Intravenous immunoglobulins and therapeutic plasma exchange are the main mode of therapy in GBS. However, 20% of the patients are unable to walk after 6 months while 2-10% die3. Once the recovery is prolonged, repeating same treatment strategy or switching to the other is being practiced. SID – GBS trial, a multicentre double-blind randomized control trial, evaluating the outcome of second course of IV immunoglobulin vs placebo, has showed more serious adverse events in the treatment group. However, the adverse events were mainly of vascular origin.

Compliment system has a main role in these immune mechanisms in GBS and compliment inhibitors such as eculizumab are currently under human trials, with successful results on animal studies.

Back to contents

In Sri Lanka few studies have been carried out about types and pattern of GBS, and aetiology. Sri Lanka share the common pattern as rest of the world.

Further studies need to be done about aetiology and treatment aspects.

References

1. *Nodo-paranodopathy: Beyond the demyelinating and axonal classification in anti-ganglioside antibody-mediated neuropathies. Antonino Uncini, Keiichiro Susuki , Nobuhiro Yuki. Clinical Neurophysiology 124 (2013) 1928–1934*
2. *Peripheral neuropathies and anti-glycolipid antibodies. Hugh J. Willison1, Nobuhiro Yuki Brain (2002), 125, 2591±2625*
3. *Mimics and chameleons in Guillain– Barré and Miller Fisher syndromes. Benjamin R Wakerley, and Nobuhiro Yuki. Pract Neurol 2015;15:90-99*
4. *Yhojan Rodriguez et al, Cellular and molecular immunology 15:547-562,201*

Back to contents

Back to contents

Back to contents

Back to contents

ROYAL COLLEGE of PHYSICIANS of EDINBURGH

52nd ANNIVERSARY ACADEMIC SESSIONS 2019
Ceylon College of Physicians
in collaboration with
Royal College *of* Physicians *of* Edinburgh
12th – 14th September 2019
Venue: Galadari Hotel, Colombo

Programme

Day 1 Thursday - Pre-Congress 12th September 2019			
8.00 – 9.00 am	Registration		
	Parallel session – Hall A	Parallel session – Hall B	Parallel Session – Hall C
Session 1 9.00– 10.30 am	Pre-congress Symposium 1 **Principles and Practice of Critical Care** **9-9.30 - Daily goals: a holistic approach to individual patient care** Dr Graham Nimmo **9.30 -10 - Fluid management** Dr Susan Nimmo **10-10.30 - Managing the patient who is difficult to ventilate/oxygenate** Dr Graham Nimmo	Pre-congress Symposium 2 **Research for the Physicians** **9-9.30 - Formulating research questions; guidance for beginners** Prof SAM Kularatne **9.30 – 10.00 - Identifying research areas of local relevance** Prof Saroj Jayasinghe **10-10.30 - The importance of study design** Prof A Pathmeswaran	Pre-congress Symposium 3 **Palliative Care in the Community** **9.00 - 9.30am - Role of the GP in Palliative care** Prof Scott Murray **9.30 – 10.30 - Principles of symptom control and basic management of common symptoms** • **Pain** - Dr Udayangani Ramadasa • **Restlessness and agitation** - Dr Gamini Pathirana • **Breathlessness**- Dr Ravini Karunathilake • **Nausea and vomiting, constipation** Dr Hasitha Wijewantha
10.30 – 11.00 am	Tea		
	Pre-congress Symposium 1 **11-11.30 - Analgesia in the critically ill** Dr Susan Nimmo **11.30 -12.00 pm - Sepsis** Dr Graham Nimmo	Pre-congress Symposium 2 **11 – 11.30 - Ethics, confidentiality and conflicts of interest** Dr Panduka Karunanayake **11.30 – 12.00pm - How to write a good project proposal**	Pre-congress Symposium 3 **11.00 – 11.30 - Terminal care at home** Dr Shyamale Samaranayake **11.30 – 12.00pm - Loss, grief and bereavement** Dr Mahesh Rajasuriya
	12 -12.30pm - Clinical decision making Dr Graham Nimmo	Prof Sarath Lekamwasam **12.00-12.30pm - How to write a good paper** Prof Janaka de Silva	**12.00 – 12.30pm - Questions and discussion** All speakers and participants
12.30 – 1.30 pm	Lunch		
Session 3 **6.00 pm – 10 pm**	**Inauguration Ceremony** **Chief Guest – Dr SinhaRaja Tammita-Delgoda** **Guest of Honour – Prof Derek Bell OBE** ***CCP Oration* – Prof Kamani Wanigasuriya**		

Back to contents

Annual Academic Sessions 2019 at a Glance

Day 2 Friday 13th September 2019			
7.00 – 8.00 am	BC 1 - Numbness of hands and feet Dr Umapathy N Thirugnanam	BC 2 – Nephrology Dr Kelum Wimalaratne	
8.00 – 8.30 am	Registration		
	Hall A		
Session 4 8.30 – 9.00 am	Plenary 1 The Clinician and the Patient: re-defining the relationship Prof Derek Bell OBE FRCPE President, Royal College of Physicians of Edinburgh		
Session 5 9.00 – 9.30 am	Plenary 2 How to evaluate an asymptomatic patient with raised liver enzymes Prof Janaka de Silva Senior Professor of Medicine, University of Kelaniya and Director, PGIM		
Session 6 9.30 – 10.00 am	Plenary 3 Placebo and nocebo Professor Ali Jawad Vice President (Global), Royal College of Physicians, London		
10.00 –10.30 am	Tea		
Session 7 10.30 – 11.15 am	Dr EV Peiris Memorial Oration Professor S Niru Nirthanan		
	Parallel session – Hall A	Parallel session – Hall B	Parallel session - Hall C
Session 8 11.30 – 1.00 pm	Symposium 1 – Everyday Cardiology Risk Factors in Ischemic Heart disease- when to intervene Prof Indira Samarawickrema Cardiac imaging for Physicians Dr Prakash Priyadarshan	Symposium 2 - Emerging infections Global perspective of Emerging Infections Dr Nick Beeching Meliodosis Dr Enoka Corea	Free paper session 1 Oral presentations
	Heart Failure with Preserved Ejection Fraction: a misunderstood disease in search of a therapy Dr Naomali Amarasena	Cutaneous Leishmaniasis in Sri Lanka: an overview Dr Nayani Madarasinghe	
1.00 – 2.00 pm	Lunch		
Session 9 2.00 -3.30 pm	Symposium 3 - Maternal Medicine for Physicians Hypothyroidism in pregnancy Dr Noel Somasundaram Acute Fatty liver in Pregnancy Dr Manajala Senanayake Thromboembolic disorders Dr Lalindra Gooneratne & Dr Anoma Weerawaradane	Symposium 4 – Optimizing medicines use Interpreting evidence and its application to routine clinical practice Dr Fraz Mir Cambridge University Hospitals NHS Foundation Trust Addenbrooke's Hospital, UK Good practice in Prescribing for Older Adults Dr Susan Pound Consultant in Geriatric Medicine, Victoria Hospital, Kirkcaldy, UK Enabling visually/hearing disabled patients use medicines independently: The Sri Lankan Experience Dr Chamari Weeraratne Faculty of Medicine, University of Colombo	Free paper session 2 Oral presentation
Session 10 3.30 – 4.45 pm	Symposium 5 – Respiratory Medicine Parapneumonic effusion to empyema Dr Ed Nevil	Symposium 6 – Palliative care Integrating palliative care into day to day practice in Sri Lanka	Free paper session 3 Poster presentations

Back to contents

Annual Academic Sessions 2019 at a Glance

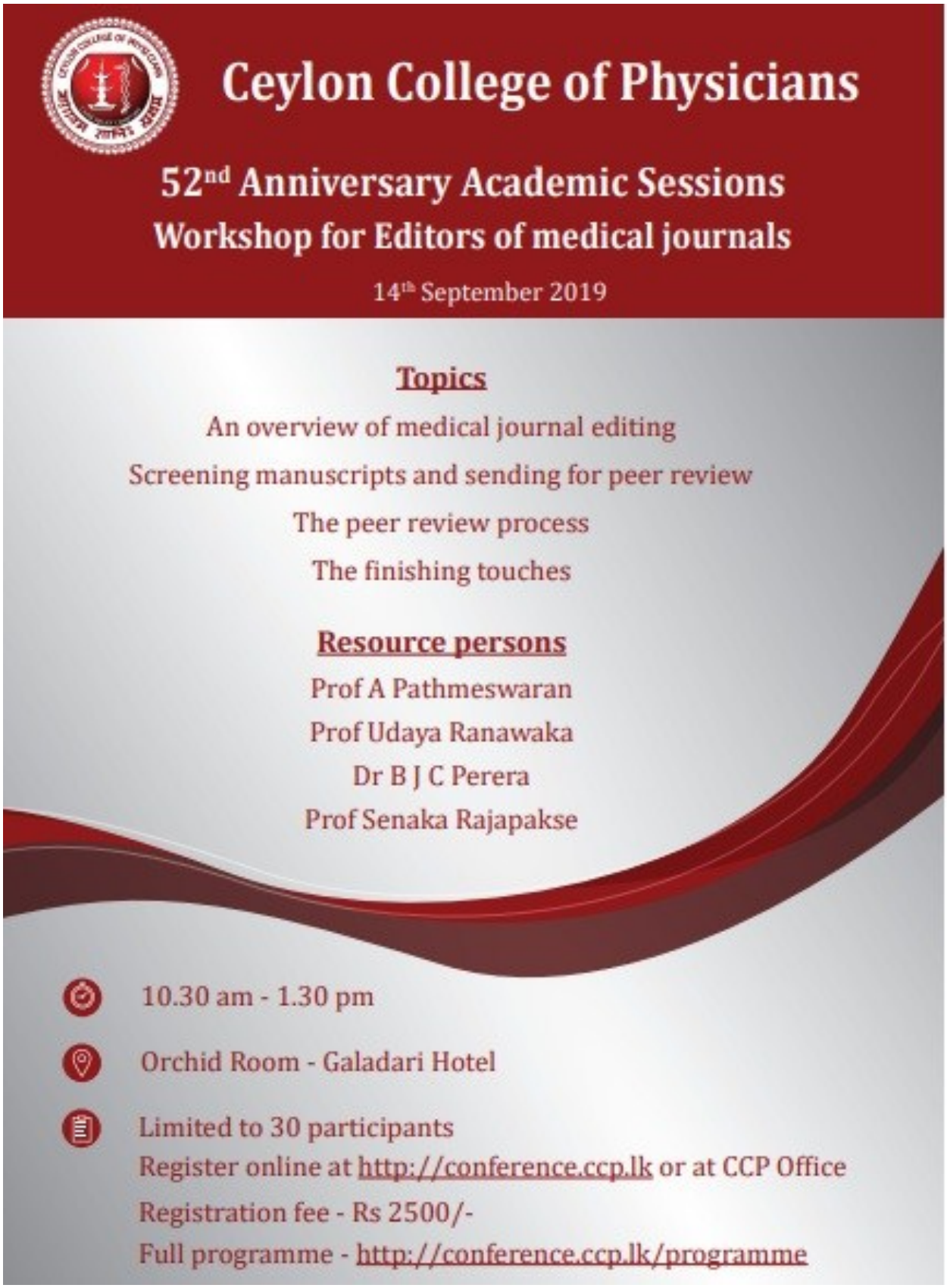
	Latent TB Dr Jakki Faccenda Consultant in Respiratory Medicine, Peterborough & Stamford NHS Foundation Trust, UK **Obstructive Sleep Apnoea** Dr Chandimani Undugodage	Dr Udayangani Ramadasa **Role of the interdisciplinary team in palliation** Prof Scott Murray St Columba's Hospice Chair of Primary Palliative Care, Edinburgh, UK **Decision making and ethical dilemmas in palliative care** Dr Dilhar Samaraweera	
4.45 – 5.00 pm	**Tea**		
5.00 – 6.00 pm	**Evening Capsule 1 – Vertigo** Dr Daminda Domingoaracchi	**Evening Capsule 2 – Assessment Backache** Prof Ali Jawad	
6.00 – 7.00 pm	**Evening capsule 3 – Cranial nerves and eye movements** Dr Umapathy Thirugnanam		

Day 3 Saturday 14th September 2019			
7.00 – 8.00 am	**BC3 - Interpreting ECG** Dr Mevan Wijetunge/ Dr Susitha Amarasinghe	**BC 4 – Imaging: Case based discussion** Dr Lakmali Paranahewa	
8.00 – 8.30 am	**Registration**		
Session 11 8.30 – 9.00 am	**Plenary 4 – Data sharing, confidentiality and autonomy - a series of oxymorons?** Dr Ed Nevil Consultant Respiratory Physician, Portsmouth, UK		
Session 12 9.00 – 9.30 am	**Plenary 5 – Acute illness in frail older patients** Dr Susan Pound Consultant in Geriatric Medicine, Victoria Hospital, Kirkcaldy, UK		
Session 13 9.30 – 10.00 am	**Plenary 6 – Dying: different for different diseases and different cultures** Prof Scott Murray St Columba's Hospice Chair of Primary Palliative Care, Edinburgh, UK		
10.00 – 10.30 am	Tea		
	Parallel session – Hall A	**Parallel session – Hall B**	**Parallel Session – Hall C**
Session 14 10.30 – 12.00 pm	Symposium 7 – Endocrinology **Diabesity: the modern pandemic** Dr Manilka Sumanathilaka **Interpreting discordant thyroid function tests - case based perspectives** Dr A G Unnikrishnan **Rational use of vitamin D therapy** Prof Sarath Lekamwasam	Symposium 8 – Haemato-oncology **Improving out comes of haematological malignancies: a physician's perspective** Dr Saman Hewamana **Multiple Myeloma** Dr Hari Menon **Hodgkin lymphoma** Dr Buddhika Somawardane	**Workshop** **for Editors of medical journals** **By prior registration only** **Rs 2500**
Session 15 12.00 – 1.30 pm	Symposium 9 - Nephrology **CKD of agricultural communities – of**	Symposium 10 -Medical Humanities **A history of Western medicine in 20**	

Back to contents

	the known and the unknown Dr Chula Herath **AKI – What's new?** Dr Kelum Wimalaratne **Post renal transplant issues** Prof Mohammad Ghnaimat	**minutes** Dr Panduka Karunanayake **Understanding Illness: Narrative Medicine** Dr Mevan Wijeyatunga **Where there is love of art, there is love of medicine** Dr Shehan Silva	
1.30 - 2.30 pm	**Lunch**		
Session 16 2.30 – 3.45 pm	**Symposium 11 – Rheumatology** **Current and Future Use of Biologics in Rheumatology** Prof Suranjith Seneviratne **Systemic sclerosis - an update on a hard disease** Dr Voon Ong **Complementary and alternative therapy in Rheumatology** Prof Ali Jawad	**Symposium 12 – Psychiatry** **Delirium: a guide for the modern physician** Dr Sayuri Perera **Dissociation/ Conversion disorders and somatization** Dr Prabhath Wickrama **Psychiatry in epilepsy** Dr Chathurie Suraweera	
3.45 – 4.45 pm	**How to keep trouble at bay – Case based discussion on Medical Negligence**		
4.45 – 5.15 pm	Tea		
7.00 – 10.30 pm	Conference dinner		

Back to contents

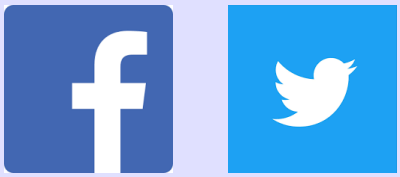


Back to contents

Forthcoming events

September

- Young Physicians' Forum: September 3rd at ClinMARC Auditorium National Hospital of Sri Lanka
- 52nd Anniversary Academic Sessions 2019: September 12th - 14th at Hotel Galadari
- PACES Preparatory Course : September 22nd at ClinMARC Auditorium at National Hospital of Sri Lanka

Follow us now on 

Back to contents