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IMPA NEWS

THE OFFICIAL NEWS LETTER OF THE INDEPENDENT MEDICAL PRACTITIONERS ASSOCIATION

FROM THE PEN OF THE PRESIDENT. . .

In last December 31st 2019 an outbreak of pneumonia of undetermined origin was first reported from Wuhan City in Hubei Province of China. On January 30th WHO declared a Public Health Emergency of International Concern and the disease as COVID-19. Notable features for the membership are :

1. The incubation period is reported as 2-14 days.
2. R0 (Basic reproduction number) is estimated as 1.4 to 2.5. (R0 = the number of cases one case generates on average over the course of its infectious period, in an otherwise uninfected or not immune)
3. Sustained human-to-human transmission outside China has been declared
4. The demographic characteristics of the Italian population differ from other countries. In 2019, approximately 23% of the Italian population was aged 65 years or older. COVID-19 is more lethal in older patients, so the older age distribution in Italy may explain, in part, Italy's higher case-fatality rate compared with that of other countries.
5. R0 for SARS-CoV-2 is 2-3 when compared with Influenza virus which is 1.3 Therefore the corona virus exponentially increases the spread
6. Series interval is the interval between the onset of symptoms in a index patient to the second patient infected from index patient In SARS-CoV-2 it is 5-7.5 and in Influenza virus 2.5

CASE IDENTIFICATION CRITERIA ACCORDING TO CHINESE PHYSICIANS

Table 1 Screening Criteria for Suspected COVID-19 Cases

EPIDEMIOLOGICAL CRITERIA

1. Within 14 days before the onset of the disease, the patient has a travel or residence history in the high-risk regions or countries;
2. Within 14 days before the onset of the disease, the patient has a history of contact with those infected with SARS-CoV-2 (those with a positive NAT result);
3. Within 14 days before the onset of the disease, the patient had direct contact with patients with fever or respiratory symptoms in high-risk regions or countries;
4. Disease clustering (2 or more cases with fever and/or respiratory symptoms occur at such places as homes, offices, school classrooms, etc. within 2 weeks).

Editor - Dr A L P de S Seneviratne

BE SURE OF RELIEF FROM PAIN

3X EFFECTIVE PAIN RELIEF vs PLACEBO*[1]

Panadeine

Formulation: With the combined strength of paracetamol and codeine, Panadiene offers relief from strong pain

Indication: Used in backache and muscular pain

Voltaren

Penetrates deep through the skin and fights pain at the source, by sensitising the pain receptors and inhibiting the activity of the pain-responsive nerve cells[2]

Pain reduces by half, after **24 hours**†[1]

*vs placebo in acute neck pain † Pain at rest in acute neck pain

References: 1. Predel HG. *et al.* efficacy and safety of diclofenac diethylamine 1.16% gel in acute neck pain: a randomized, double-blind, placebo-controlled study. *BMC Musculoskeletal Disord.* 2013;14:250. **2.** Brune K. Persistence of NSAIDs at effect sites and rapid disappearance from side-effect compartments contributes to tolerability. *Curr Res Opin.* 2007; 23:2985-95.

Use as directed on pack. Do not exceed recommended dose and frequency, as excessive dosage could be harmful to the liver. If fever persists, consult your doctor.
For adverse events reporting please call on 0112636341 or email on pharmacovigilance@gsk.com

CHSRI/CHPAND/0003/18

CLINICAL CRITERIA

1. The patient has fever and/or respiratory symptoms;

2. The patient has the following CT imaging features of COVID-19: multiple patchy shadows and interstitial changes occur early, particularly at the lung periphery. The conditions further develop into multiple ground-glass opacities and infiltrates in both lungs. In severe cases, the patient may have lung consolidation and rare pleural effusion;

3. The white blood cells count in the early stage of the disease is normal or decreased, or the lymphocyte count decreases over time.

SUSPECT COVID 19 IF :

1. The patient meets 1 epidemiological history and 2 clinical manifestations. Admit the patient to a designated hospital and NAT testing done there

2. The patient has no epidemiological history and meets 3 clinical manifestations. Admit the patient to a designated hospital and NAT testing done there

EXPERT CONSULTATION IF :

The patient has no epidemiological history, meets 1-2 clinical manifestations, but cannot be excluded from COVID-19 through imaging.

A primary care group from the Department of Family Medicine in the Faculty of Medicine Ragama is preparing a guideline for which the IMPA president is also invited to contribute.

Dr. Ananda Perera

Case Report

LEFT LOWER ABDOMINAL PAIN WITH BLOATING AND CONSTIPATION, A COMMON PRESENTATION IN THE ELDERLY.

Dr. Shalani Malintha MB.BS;DFM
Registrar In Family Medicine
SLMC Reg. 17135

Mrs. KL a 67 year old housewife, a mother of one child, presented to The Medical Clinic giving a history of left sided lower abdominal pain for the last 3 to 4 weeks. The pain was a mild to moderate intensity dull ache associated with bloating and discomfort which is more after meals. On further inquiry it was revealed that she had been having on and off constipation for the past two to three years, to which she had taken an aurvedic preparation. She denies passage of blood or mucous per rectum. There was no of loss of appetite or loss of weight. There was no family history of bowel malignancy.

She did not have any medical problems in the past and nor was she on any long term medication. A Total Abdominal Hysterectomy (TAH) was done due to menorrhagia, when she was at the age of 48 years.

She was worried that these symptoms would be due to a serious illness and she wanted an abdominal scan to exclude any serious pathology.

On examination she was a well looking, neatly dressed lady with a satisfactory level of self-care but anxious regarding her condition. Her conjunctivae were pink and she did not have signs of localized or generalized lymphadenopathy.
Abdominal examination elicited mild tenderness on deep palpation over the left iliac fossa (LIF). There were no palpable intra-abdominal or pelvic masses. Rest of the abdominal examination as well as the examination of other systems were normal. Digital rectal examination was also found to be normal.

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Differential Diagnosis (DD) considered in Mrs. KL

- Diverticulitis
- Large bowel malignancy (colorectal carcinoma)
- Inflammatory Bowel Disease(IBD)
- Irritable Bowel Syndrome(IBS)

Arriving at a working diagnosis

The most probable diagnosis according to the history and examination is diverticulitis. Age of the patient, typical history of LIF pain associated with abdominal bloating and discomfort, altered bowel habits with on and off constipation for years, makes diverticulitis highly possible in her. But when considering her age and alteration in bowel habits, large bowel malignancy must be excluded as a sinister cause. IBD though one of the DD is a rare possibility in this scenario. IBS which comes under the differential diagnosis, due to the presentation of abdominal pain, discomfort and bloating after meals, is rather unlikely to develop at this age and is a diagnosis of exclusion.

Management done at the Family Practice clinic

Patient education regarding the condition - Patient was given a reasonable explanation about the possible cause of her symptoms alleviating her fear of a cancer.

Considering her concerns and expectations an abdominal ultrasound scan was ordered. There was no significant finding in the USS abdomen.

Following a discussion with the patient, she was referred for a colonoscopy which confirmed multiple diverticula in the large bowel.

A course of omeprazole and domperidone was prescribed as symptomatic treatment. Paracetamol was given to relieve pain.

Discussion

DIVERTICULAR DISEASE

Formations called diverticula are key components of diverticular disease. Diverticula are pouches that occur along digestive tract, most often in, colon particularly the sigmoid colon. The term diverticulosis indicates the presence of diverticula.

These pouches are form when weak spots near the blood vessels in the intestinal mucosa balloon outwards due to the increased intraluminal pressure with thickening of the muscle layer. An alternative explanation is the cholinergic denervation with increasing age which leads to hypersensitivity and increased uncoordinated muscle contraction. When these pouches become inflamed, or bacteria gather in them and cause an infection, it is termed diverticulitis. Diverticular colitis refers to inflammation on the folds in areas of diverticulosis. This occurs when feces obstruct the neck of the diverticulum causing strangulation and bacterial growth leading to inflammation. It is perhaps better to use the more general term diverticular disease, as often it is difficult to be sure whether the diverticula are inflamed.

While it was rare before the 20th century, diverticular disease is now one of the most common health problems in the Western world. It's a group of conditions that affect the digestive tract. Diverticulitis is the most serious type of diverticular disease. Diverticulitis often requires treatment because it typically causes symptoms and can lead to serious health complications.

Disease progression

Diverticula themselves can be harmless. Having diverticula that aren't infected or inflamed, is diverticulosis. This condition typically causes no symptoms and doesn't need treatment.

If diverticulosis does cause symptoms, it's called symptomatic uncomplicated diverticular disease (SUDD).The good news for people with diverticulosis is that only 10 to 20 percent of people with this condition progress to SUDD. And of those, about 4 percent get acute diverticulitis. It typically takes about 7 years for this progression to diverticulitis to occur. And of the 4 percent of people with diverticulitis, only 15 percent have complications. An episode of diverticulitis, can recur as an acute, or short-term, problem. However, that's not a definite. According to a study about assessment of risk for recurrence in diverticulitis, in those who have had one episode, around 39 percent of individuals have another acute attack within five years. And the same study had found that the first attack is typically the worst one. This may be because scar tissue builds up

Cont. on page 05

in the diverticula and helps prevent future perforations. But for some, diverticulitis can progress into a chronic, or long-term, problem. For these people, the condition can be much more serious. Surgery to remove the diseased tissue is generally considered.

Risk factors for diverticular disease

While there are several risk factors for diverticulitis, the key risk factor is age. Diverticulosis, the precursor to diverticulitis, is very common in older adults, especially those over 60. In people over age 70, 60 percent have diverticulosis, while 75 percent of people 80 years and older have the condition. However, young people have their own level of risk. A study on long term risk of acute diverticulitis among patients with incidental diverticulosis found during colonoscopy, found that the younger the patient is when receiving a diagnosis of diverticulosis, the higher your risk is of the condition progressing to diverticulitis.

Risk factors for the development of diverticulitis

A low-fiber diet: A lack of dietary fiber has long been suspected as a risk factor, but research has had conflicting results. Nevertheless, it's still thought by some to be related to the onset of diverticulitis.

Heredity: Diverticulitis seems to have a hereditary link. A study of siblings and twins proposes that more than 50 percent of potential risk of diverticular disease comes from genetics.

Obesity: Being obese is a clear risk factor for diverticulitis. Research has shown that obesity raises the risk of diverticulitis and bleeding, but researchers aren't sure of the reason behind this link.

Lack of physical exercise: It's unclear if a sedentary lifestyle is a real risk factor. However, research suggests that exercise reduces the risk of diverticular disease. People who exercise less than 30 minutes a day appear to have increased risk.

Smoking: Research shows that smoking increases the risk of symptomatic and complicated diverticular disease.

Certain medications: Regular use of aspirin and other NonSteroidal Anti-Inflammatory Drugs (NSAIDs) may raise your risk of diverticulitis. The use of opiates and steroids appears to raise your risk of perforation, a serious complication of diverticulitis.

Lack of vitamin D: One study found that people with complicated diverticulitis may have lower levels of vitamin D in their system than people with uncomplicated diverticulosis. This study suggests that vitamin D levels seem to be related to complications of the disease, although the exact reason is unclear.

Sex: In people age 50 and younger, diverticulitis appears to be slightly more common in men than women. In people older than 50, it seems slightly more common in women.

Symptoms of diverticulitis

The most common symptoms of diverticulitis include.

- abdominal pain
- fever
- nausea
- vomiting
- increased urge to urinate, urinating more often than usual, or burning sensation while urinating
- constipation
- diarrhea (Blood in the stool, as well as bleeding from the rectum, can occur in both diverticulosis and diverticulitis).

Diagnosis of diverticulitis

A detailed history and clinical examination is vital in the diagnosis. Abdominal as well as Digital Rectal Examination is vital in this context. Following investigations are done to confirm the diagnosis.

- Full blood count
- imaging studied such as an abdominal ultrasound or an abdominal CT scan,
- urine full report
- stools occult blood
- stool test to check for GI infections
- pelvic examination in women to rule out gynecologic problems
- Colonoscopy

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Complications of diverticulitis

- Perforation and peritonitis
- Abscess formation
- Fistula formation
- Intestinal obstruction with strictures

Treatment of diverticulitis

Depends on the severity of the condition.

If symptomatic uncomplicated or chronic diverticulitis,

- Rest
- Bowel resting with clear fluids and gradually incorporate into the regular diet with response.
- Broad spectrum antibiotic to cover both aerobic and anaerobic bacteria
- Pain relief with simple analgesic like Paracetamol. Avoid using NSAIDS.

If acutely ill with dehydration or failing ambulatory management

- In hospital management
- Intravenous fluids
- Parenteral antibiotics
- Parenteral analgesics

If complication occur

- Perforation and peritonitis - Emergency laparotomy, colectomy and peritoneal cleaning
- Abscess – drainage
- Fistula / strictures – surgical removal

Reflective learning points

Though diverticulitis is a common condition in the elderly possibility of a bowel malignancy should always be excluded in the elderly. And addressing patients concerns and expectations in situations like this is very important in patient satisfaction. This patient was sent for an USS scan abdomen according to her wish colonoscopy should ideally be done. Also dietary advice should have been given to her in order to avoid food items that will make her symptoms more such as dairy products, legumes, cabbage and cauliflower.

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APPRECIATION - Dr K Sivapalan

It is with sadness I pen these few thoughts of my dear friend and colleague Dr K Sivapalan who suddenly passed away on Tuesday 25th February 2020.

I have known him for several years as a member of the Independent Medical Practitioners Association (IMPA) of Sri Lanka, and as a council member of the IMPA while I was serving as the President from 2015 - 2018. He had always supported and advised me on several matters during my tenure.

He was a dedicated medical practitioner and many of his articles have been published in the IMPA monthly newsletters and the Annual Journal.

He was a well-respected Doctor in Jaffna serving the community even during the troubled times of the war, and was never afraid to voice his opinion courageously on matters of importance to the community.

His sudden death while travelling back to Jaffna after attending the IMPA council meeting shocked all of us who had attended and exchanged pleasantries having no hint that he would be snatched away from our midst so soon. We will miss a dear colleague

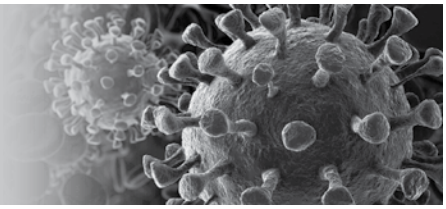
My deepest sympathies and heartfelt condolences to his family, friends and patients.

May his soul rest in peace.

Dr A H A Hazari
Immediate Past President
IMPA

COVID NEWS

FDA Warns Providers About Limits of SARS-CoV-2 Antibody Tests



By Amy Orciari Herman

Edited by **David G. Fairchild,** MD, MPH, and **Jaye Elizabeth Hefner,** MD

The FDA late last week issued a letter warning healthcare providers about the limits of serological tests to detect SARS-CoV-2 antibodies. The agency is urging clinicians to "not use serological (antibody) tests as the sole basis to diagnose COVID-19 but instead as information about whether a person may have been exposed."

In mid-March, the FDA "provided regulatory flexibility" for test developers, the agency noted, which has resulted in scores of antibody tests quickly hitting the market without the agency's usual review. As of April 18, just four antibody assays had received emergency use authorization from the FDA.

The agency said it "is not aware of an antibody test that has been validated for diagnosis of SARS-CoV-2 infection." The tests measure IgM or IgG antibodies, but IgM antibodies may not develop at all, and IgG antibodies usually don't develop until later in the disease process. Therefore, using such tests to diagnose COVID-19 will miss infections.

A New York Times story details the low accuracy seen with many of the tests on the market – sometimes as low as 20–30%. Not only do they miss infections, but most tests "detect" antibodies in some people who don't have them. One infectious disease expert told the Times: "People don't understand how dangerous this test is. We sacrificed quality for speed."

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