SRI LANKA COLLEGE OF PAEDIATRICIANS

Newsletter

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INSIDE, WE ALSO TALK ABOUT

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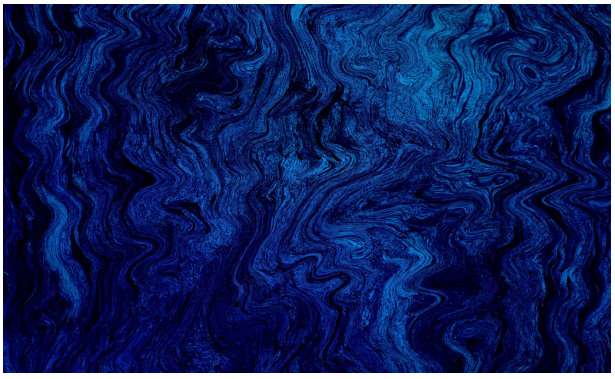

What's inside?

A Message from the President, Sri Lanka College of Paediatricians
Professor Pujitha Wickramasinghe

It is an honour to connect with you at a significant juncture, filled with both challenges and opportunities. Building on the impactful work of my predecessors, I am committed to broadening the reach of the SLCP and enhancing our efforts to serve our children and professionals even more effectively.

During my tenure, the College will focus on proactive, strategic initiatives across key domains. Central to our mission is advocating for equitable access to high-quality paediatric care, ensuring that no child is left behind. We will prioritize ongoing professional development by establishing clear guidelines and training pathways for all medical personnel, from primary care providers to Specialist Paediatricians. This will foster action, promote scientific activities, and elevate expertise within our vibrant community.

Our children face complex, evolving challenges; from rising childhood obesity amidst persistent undernutrition, to teenage pregnancies, substance abuse, unsafe environments, and uncertainties about their futures. These issues demand an involved and multi-faceted approach, rooted in compassion, innovation, and resolve.

Recognizing the potential of digital technology, we aim to make all our activities accessible and inclusive through electronic portals. Connecting stakeholders through the existing college platforms, will help us cultivate a healthier, safer environment for children across Sri Lanka. Our new goal is to empower a brighter tomorrow, harnessing all stakeholders involved in childcare, widening community engagement and using technology to reach every corner of our nation.

This journey calls for the dedication, enthusiasm, and collective efforts of all members. Together, we are poised to usher in a new era of growth, innovation, and compassion, guided by our theme: ***"Redefining Paediatric Care through Equity, Excellence, and Technology."***

Let us stride forward with resolve and unity, committed to shaping a healthier future for all children of Sri Lanka.

Professor Pujitha Wickramasinghe
President
Sri Lanka College of Paediatricians

Presidential Induction of SLCP 2025–2026

The Induction Ceremony of the President of the Sri Lanka College of Paediatricians (SLCP) for the year 2025–2026 was held in conjunction with the Annual General Meeting on 16th August 2025, at the UCFM Tower, Faculty of Medicine, University of Colombo.

Senior Professor Pujitha Wickramasinghe, an eminent academic and respected clinician from the Faculty of Medicine, University of Colombo, was inducted as the new President of the College. Professor Wickramasinghe's distinguished career in paediatrics, encompassing excellence in teaching, clinical practice, and research, has earned him wide recognition and admiration both locally and internationally.

The theme for the year, *"Redefining Paediatric Care: Blending Equity, Excellence, and Technology,"* reflects a forward-looking vision for child health in Sri Lanka. It emphasizes harnessing innovation and technology while ensuring equitable access and maintaining the highest standards of paediatric care.

The College also looks ahead with great enthusiasm to hosting the Asia Pacific Congress of Paediatrics 2026 in Sri Lanka, a landmark event that will bring together paediatricians and child health professionals from across the region to share knowledge, foster collaboration, and celebrate progress in child health.

The event was one replete with fellowship and camaraderie. All attendees enjoyed the atmosphere and the fare served. A sumptuous dinner was provided and there was a fine musical ensemble in attendance. As things went, it was also so good to see some participants putting their hair down to gyrate to the lilting music provided by the band too.

All in all, it was a very fine evening.

Dr Kausn Jayasundara
Joint Editor - SLCP Newsletter

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Balancing Benefit and Risk: The case of montelukast

Montelukast, a leukotriene receptor antagonist prescribed for asthma and allergic rhinitis in children, has been under scrutiny due to concerns about potential neuropsychiatric adverse effects.

In 2020, the U.S. Food and Drug Administration (FDA) issued a black box warning highlighting risks such as depression, aggression, hallucinations, and suicidal ideation in patients taking montelukast (1). Additional reported neuropsychiatric effects include speech disturbances, anxiety, behavioural changes, and sleep disturbances (2).

A retrospective cohort study from Canada reported that children on montelukast were more likely to experience neuropsychiatric adverse drug reactions leading to drug cessation compared to those on inhaled corticosteroids (3). In the UK, the Medicines and Healthcare Products Regulatory Agency (MHRA) received over 1,200 reports of suspected neuropsychiatric adverse drug reactions related to montelukast, with a significant proportion involving children under nine years old (2).

A population based case-crossover study conducted in South Korea with over 160,000 paediatric patients found an increased risk of neuropsychiatric adverse events associated with montelukast use, particularly within 28 days of initiation (4).

However, these concerns are not universally supported—a Swedish nationwide cohort study involving more than 740,000 children found no increased risk of neuropsychiatric events in montelukast users compared to those on long-acting beta-agonists (LABAs) (5). A recent systemic review though did not find an association between montelukast and increased risk of suicide-related events at a population-wide level has concluded that the overall neuropsychiatric safety of montelukast in children cannot be confirmed owing to heterogeneity in study outcomes (6).

Conclusion: Emerging evidence—particularly from post-marketing surveillance and observational studies—has raised concerns about potential neuropsychiatric adverse effects associated with the use of montelukast in children. Although not all studies have confirmed a causal relationship, the growing body of reports warrants a cautious and individualized approach to its use. Until more definitive evidence is available, it is prudent to reserve montelukast for cases where alternative treatments are unsuitable or ineffective, and to ensure close monitoring for any adverse neuropsychiatric symptoms.

Take home message to healthcare professionals caring for children

- Avoid prescribing montelukast unless there are no suitable alternatives
- Manage asthma and rhinitis with effective, safer and established treatment
- If prescribing montelukast, carefully weigh the potential risks against anticipated benefits. Consider the seriousness of adverse effects, extent of benefits offered by montelukast, individual risk factors for neuropsychiatric issues and the need for close monitoring
- To be alert for neuropsychiatric reactions in patients who are prescribed montelukast and discontinue treatment promptly with first suspicion
- Inform parents and caregivers about the potential neuropsychiatric risks and advise them to discontinue montelukast, and report the concerns to the healthcare provider immediately

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Endocrine Management and Bone Health in Children with Duchenne Muscular Dystrophy

Duchenne muscular dystrophy (DMD) is a severe and progressive neuromuscular disorder that requires a committed multidisciplinary approach for optimum management of both the primary manifestations and the secondary complications. This approach involves specialists such as paediatricians, paediatric neurologists, cardiologists, endocrinologists, pulmonologists and orthopaedic surgeons, as well as supportive healthcare professionals including psychologists, occupational therapists, physical therapists, and social workers.

What are the Endocrine Complications of DMD and their Treatment?

The most common complications that may have an endocrine basis are;

- Impaired growth
- Delayed puberty
- Adrenal insufficiency

The primary objectives of endocrine care of DMD are monitoring growth and development, detecting and diagnosing hormone deficiencies, administering hormone replacement therapy as needed and preventing potentially life-threatening adrenal crises.

Growth

Impaired linear growth is common in individuals with DMD which is exacerbated by glucocorticoid treatment. When assessing linear growth, standing height is the most appropriate measurement.

However, during the non-ambulatory period, sitting height, arm span, ulnar length, tibial length and knee height can be used for this purpose. However, none of these have been standardized for general usage.

The primary care provider should monitor the patient's height once every six months until puberty is completed and adult height is attained. Impaired linear growth is identified when the height curve shows a downward trend, when the growth velocity is less than 4cm per year, or when the height is below the third percentile.

If a disturbance in growth is identified, the child should be referred to a paediatric endocrinologist, who will carry out the baseline hormone functional tests along with left wrist and hand X-ray for bone age. Growth hormone stimulation tests may be considered. While recent single-centre studies have shown positive effects of the administration of growth hormone in children with DMD, larger randomized controlled trials are needed before its routine use can be recommended.

Puberty

Delayed puberty due to hypogonadism is a potential complication of glucocorticoid therapy that can be psychologically distressing and lead to impaired quality of life. Puberty assessment should be done six monthly commencing at the age of nine years. If testicular volume is less than 4ml at the age of 14 years, the patient should be referred to a paediatric endocrinologist who will perform FSH, LH and serum Testosterone levels.

Once hypogonadism is confirmed, treatment can be initiated with Intra-muscular Testosterone therapy.

Adrenal Insufficiency (AI)

Boys with DMD are susceptible to AI due to suppression of the hypothalamic-pituitary-adrenal (HPA) axis. Life-threatening situations can arise if glucocorticoids are stopped abruptly because of illness or following discontinuation of treatment. All individuals who are prescribed glucocorticoids should be educated about the signs, symptoms, and management of adrenal crisis. Stress doses should be prescribed to be used during severe illnesses, major surgery and major trauma for patients who are on prednisolone more than 12mg/m2 per day.

Bone Health and Osteoporosis Management
Boys with glucocorticoid-treated DMD often develop osteoporosis, presenting as low-trauma fractures in the vertebrae or long bones.

This outcome is expected due to the potent osteotoxic effects of glucocorticoid therapy combined with progressive muscle weakness, both of which significantly contribute to reduced bone strength. Approximately 20–60% of boys with DMD experience low-trauma fractures in the extremities, typically involving the distal femur, tibia, or fibula, while up to 30% develop symptomatic vertebral fractures. However, vertebral fractures are often asymptomatic and are frequently detected through monitoring programmes that include lateral spine radiographs, suggesting their true prevalence may be underestimated.

If left untreated, vertebral fractures can result in chronic back pain and spinal deformities, while leg fractures may lead to early and permanent loss of mobility

Even though the fracture prevalence is high among children with DMD, there isn't enough evidence to date to justify prescribing medicine to prevent the first fracture. Therefore, the recommended practice is to identify bone fragility early through periodic surveillance programmes and start treatment to improve bone density and to prevent further fractures.

To diagnose paediatric osteoporosis, the following criteria should be met. These are the indications to start medical treatment.
(1) The combination of a bone mineral density (BMD) Z-score ≤ −2 and a clinically significant fracture history, defined as the presence of either two or more long bone fractures before the age of 10 years or three or more long bone fractures at any age up to 19 years; or (2) One or more vertebral compression fractures occurring without high energy trauma or local disease irrespective of the BMD Z-score The guide to monitor children with DMD in view of bone health is summarized in *figure 1.*

This is expected to be carried out in general paediatric clinics and in paediatric neurology clinics where children with DMD are followed up. This will enable timely diagnosis and treatment which will optimize the care of children with DMD.

Summary
The endocrine and bone health complications of DMD require proactive monitoring and management to optimize patient outcomes.

Growth impairment, delayed puberty, and adrenal insufficiency are key concerns that necessitate regular assessments and timely interventions, including hormone replacement therapies when indicated.

Additionally, osteoporosis poses a significant risk due to glucocorticoid use and progressive muscle weakness, making early detection and fracture prevention strategies essential.

While further research is still needed to refine treatment protocols, existing guidelines emphasize surveillance and targeted management to improve quality of life. A multidisciplinary approach is crucial for providing comprehensive care. By following structured monitoring programmes, clinicians can minimize complications and enhance the long-term well-being of children with DMD.

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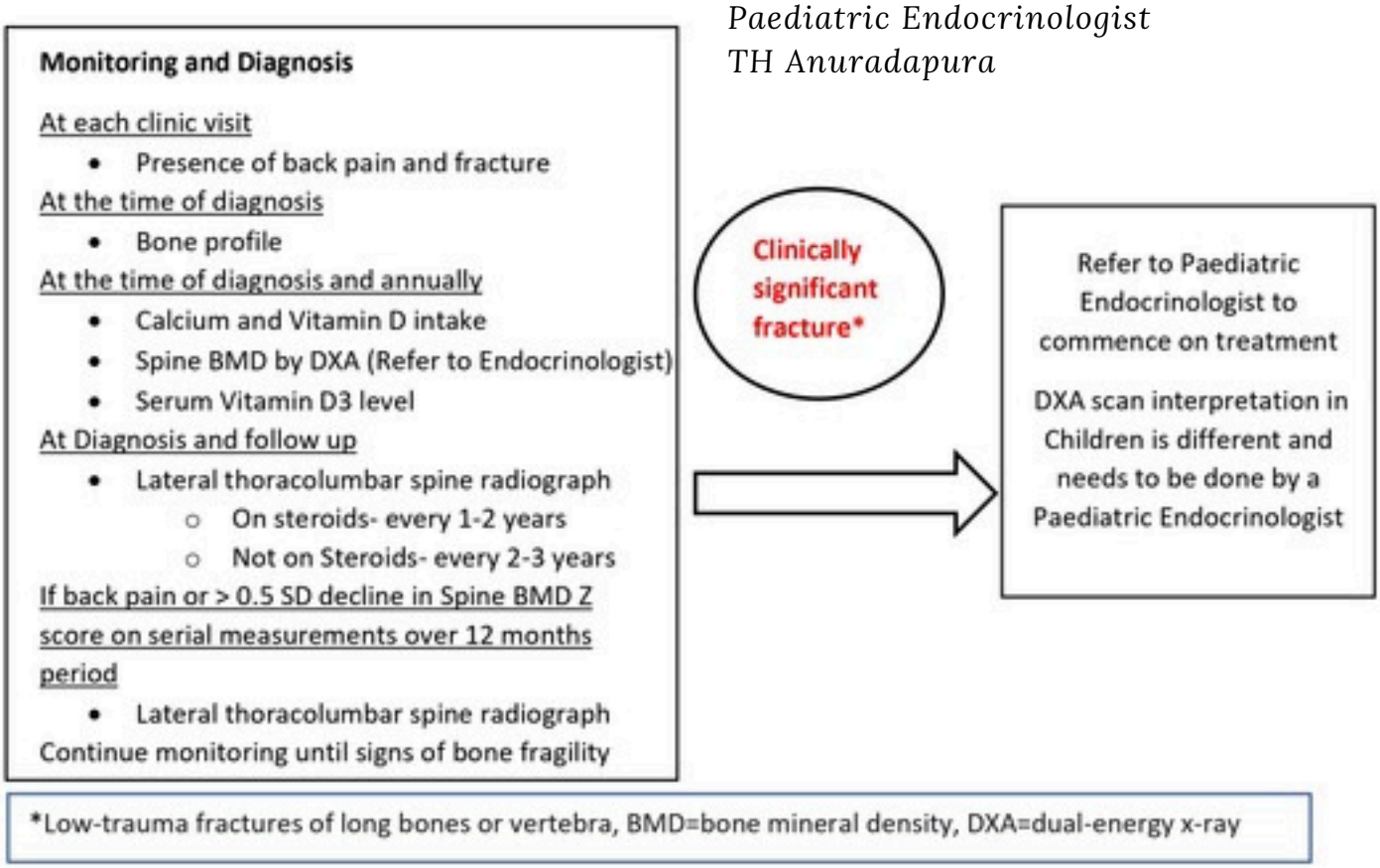

Figure 1 Guide to monitor osteoporosis in Children with DMD in Sri Lankan Set UP

New Advances in the Management of Kawasaki Disease

Abstract

Kawasaki disease is a systemic inflammatory disorder manifesting as vasculitis, with a predilection for coronary arteries. It mainly affects children <6 years of age and remains the leading cause of acquired heart disease in developed countries.

Its etiology remains elusive. Specific risk scores have been constructed by Japanese researchers to predict which patients are at a greater risk of developing coronary artery abnormalities in advance. The widely used main score is Kobayashi score.

In recent years many advances have been made in diagnostic accuracy, accurate risk stratification and improvement in treatment modalities to reduce incidence of coronary artery abnormalities.

The current management strategies.

The main treatment of Kawasaki disease, also considered as the standard treatment was IVIG infusion of 2g/kg over 10-12 hours combined with aspirin 30-50 mg/kg/day, or 80-100 mg/kg/day divided every 6 hours orally until the patient is afebrile for at least 48 hours.

This acute stage treatment is followed by convalescent stage treatment with aspirin 3-5 mg/kg/day orally until coronary artery findings persist throughout the disease course.

In case of coronary abnormalities, aspirin 3-5 mg/kg/day orally must be continued preferably along with oral clopidogrel 1mg/kg/day with addition of warfarin or low molecular weight heparin for patients with high risk of thrombosis

In cases of acute coronary thrombosis...

Prompt fibrinolytic therapy with tissue plasminogen activator or other thrombolytic agent under supervision of a pediatric cardiologist is the preferred treatment modality.

IVIG resistant Kawasaki disease....

The treatment modalities which were available so far for IVIG resistant Kawasaki disease were either infusion of a second dose of IVIG, IVIG combined with a corticosteroid, monoclonal antibodies like infliximab, second line drugs like cyclosporin, cyclophosphamide and trying plasma exchange, mostly as a last resort.

New advances in diagnosis and management....

In recent years, advances were made in many fields related to Kawasaki disease, supporting for a timely accurate diagnosis and management with minimal complications.

- Risk stratification systems
- Cardiovascular imaging
- Medications and drugs
- Surgical modalities
- ·Lifestyle recommendations.

Risk stratification systems.

In recent years, new risk stratification systems were introduced to classify which patients are at greater risk of coronary artery abnormalities.

E.g.

Son MB, Gauvreau K, Kim S, Tang A, Dedeoglu F, Fulton DR, Lo MS, Baker AL, Sundel RP, Newburger JW. Risk model development and validation for prediction of coronary artery aneurysms in Kawasaki disease in a North American population. J Am Heart Assoc. 2019 Jun 4;8(11):e011319.doi:10.1161/JAHA.118.011319

These criteria facilitate more intensive initial treatment strategies, aiming to mitigate severe cardiac outcomes.

Cardiovascular imaging techniques...

Recent advances in cardiovascular imaging techniques have improved the detection of coronary artery dilatations and stenoses. Currently ongoing research is also there to determine the optimal frequency and imaging modalities to effectively monitor and manage myocardial ischemia risks.

Medications...

In the field of medications, infliximab a monoclonal antibody targeting Tumor Necrosis Factor-α have been investigated as an alternate treatment for IVIG resistant Kawasaki disease patients. Studies indicate that infliximab is safe, well tolerated and effective in reducing fever duration and inflammation.

Interleukin 1 inhibitors like Anakinra are currently under investigation for its potential to suppress inflammatory response in Kawasaki disease. Preclinical studies have suggested its effectiveness in preventing cardiac arrhythmia and dysfunction. It's now in phase iii clinical trials to assess its efficacy and safety in children with Kawasaki disease.

Cyclosporin, a calcineurin inhibitor, has been explored for its anti-inflammatory properties. It inhibits T-cell activation and cytokine release. However, data on its efficacy are mixed, requiring further studies to establish its role in management.

Medications like Ulinastatin, available only in certain countries is a urinary trypsin inhibitor that has anti-inflammatory effects. It may prevent organ and tissue damage, particularly neutrophil- mediated injury, which is a mechanism underlying refractory Kawasaki disease. Although less effective as initial monotherapy, it has a role in combination with IVIG and aspirin in acute stage.

And recent researches have been eliciting initial IVIG therapy combined with corticosteroids have a greater efficacy in preventing coronary artery abnormalities And interestingly, a staggered regimen of oral prednisolone with gradual tailing off has shown to be more effective than IV methylprednisolone 30mg/kg pulse regime in Japanese clinical trials as opposed to North American trials showing no difference in either steroid regime.

Miscellaneous agents like pentoxifylline, a methyl xanthine compound used in treatment of vascular diseases, e.g. claudication have been shown effective in preventing Kawasaki disease related coronary abnormalities. Its precise mechanism of action is unknown, but it inhibits erythrocyte phosphodiesterase, leading to increased Cyclic Adenosine Monophosphate activity.

Advances in the Surgical field....

Recent advances in surgical field have also improved the outcome of patients who develop coronary artery abnormalities. 2017 AHA guidelines have included clear recommendations for mode of revascularization in Kawasaki disease.

CABG is preferred to PCI in Kawasaki disease patients with left main coronary artery disease, multi-vessel coronary artery disease with reduced left ventricular function, or multi-vessel coronary artery disease with lesions not amenable to PCI. it's also preferred in older children. PCI is preferred in patients with single vessel or focal multi-vessel disease.

Use of intravascular ultrasound during PCI to ensure adequate stent sizing and deployment, and use of drug eluting stents (DESs) during PCI in patients who do not require long term anticoagulation have served as new advances in managing patients with complications.

Lifestyle approaches...

Not only drug management, but there are also many new lifestyle recommendations and transitional care standards for Kawasaki disease. The threshold for treatment of risk factors like hyperlipidemia and hypertension, are much lower than for normal pediatric population, proposed in accordance with severity of coronary involvement.

Screening for dyslipidemia in all Kawasaki disease patients more than 2-year-old by either a fasting lipid profile, or lipid profile with directly measured LDL-C one year after acute phase of their disease is the current recommendation.

The importance of a heart-healthy-diet, regular exercise and avoiding smoking as adults and passive smoking as children is emphasized.

All patients with Kawasaki disease should avoid sedentary lifestyle and counselling should address the value of aerobic exercise.in those with known coronary abnormalities, recommendations for participation in competitive or high intensity sports are guided by investigation results of inducible myocardial ischemia and exercise induced arrhythmia as well as risk of bleeding.

Patients with Kawasaki disease should receive all routine childhood vaccines in the immunization schedule, but caution should be taken to substitute other antiplatelet agents like clopidogrel for aspirin during episodes of influenza or chicken pox for the known association of aspirin therapy and influenza with Reye syndrome. For this reason, influenza vaccine is typically important in patients on chronic aspirin therapy. Adolescent females with coronary artery aneurysms should receive reproductive counselling and if pregnancy occurs, currentrecommendations is to follow similar guidelines for obstetric patients with prosthetic heart valves, for anticoagulation.

Outcomes of pregnancy in women with coronary artery abnormalities in a small series has been excellent.

Despite improvements in risk stratification, investigation and imaging modalities, surgical intervention upgrades and public health recommendations on lifestyle modifications, challenges are still being posed by evolving coronary artery abnormalities in Kawasaki disease, which yearns for new research addressing treatment advances.

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Fever and Maculopapular Rash Surveillance – A Cornerstone for Measles Elimination in Sri Lanka

Background

Measles remains one of the most contagious human infections, which can cause serious complications, transmitted through respiratory secretions. Measles caused an estimated 107,000 deaths globally in 2023, primarily among young children. As humans are the only reservoir, elimination is biologically achievable through high vaccination coverage coupled with robust case detection and surveillance.

Progress and Recent Experience in Sri Lanka

Sri Lanka achieved measles elimination in 2019 following decades of sustained immunization coverage exceeding 98% and a strong national surveillance system. However, global and regional disruptions during the COVID-19 pandemic led to a resurgence of transmission in 2023–2024. Most affected were infants below nine months of age and young adults aged 20–30 years with a historical immunity gap. Transmission has since been interrupted, with no indigenous cases reported since January 2025. The national target is to regain elimination status by 2026, supported by strengthened fever and rash surveillance.

The Changing Clinical Picture

Investigations during recent outbreaks revealed that approximately one-third of laboratory-confirmed cases did not present with the classical triad of cough, coryza, and conjunctivitis. Many had only a fever and a maculopapular rash. This underscores the importance of reporting all cases of fever with a maculopapular (non-vesicular) rash for laboratory confirmation, regardless of associated symptoms.

The Role of Clinicians

Each suspected case triggers an immediate public health response, including case investigation, contact tracing, household screening, and catch-up immunization. With a basic reproduction number (R_0) of nearly 18, a single undetected case can rapidly ignite community transmission. Paediatricians and clinicians thus serve as the first line of defence in early case detection and notification on suspicion.

Suspected cases must be notified immediately to the area Medical Officer of Health (MOH) where the patient resides using the statutory H–544 notification form, and to the Epidemiology Unit through the “Blue Form” for fever and rash cases, and by telephone or email*. Laboratory confirmation is performed at the National Reference Laboratory, Medical Research Institute (MRI), using both oropharyngeal swabs for viral RNA detection (within 0-7 days after rash onset) and blood samples for serology (from 3 days after rash onset up to 28 days). Testing of samples from private healthcare institutions is facilitated at the MRI free of charge. Weekly reporting by institutions, including nil returns, ensures continuous vigilance. The infection control nurses (ICNO) play a vital role in measles surveillance in hospital settings.

Be sure to consistently inquire about measles vaccination status for all eligible children aged 9 months to 3 years. Ensuring that every child is appropriately vaccinated is a critical step towards maintaining population immunity and preventing future outbreaks.

Paediatricians play a vital role in building vaccine confidence by providing accurate information, addressing parental concerns with empathy, and reinforcing the benefits of immunization.

Conclusion

Failure to notify even a single case risks silent transmission and threatens elimination gains. Paediatricians have a pivotal responsibility to maintain high clinical suspicion, ensure prompt notification, and guide junior staff in surveillance procedures.

Every child presenting with fever and a rash must be viewed as a potential measles case until proven otherwise. Vigilance, prompt reporting, and leadership provided by the clinical team will safeguard Sri Lanka's children and sustain measles elimination beyond 2026.

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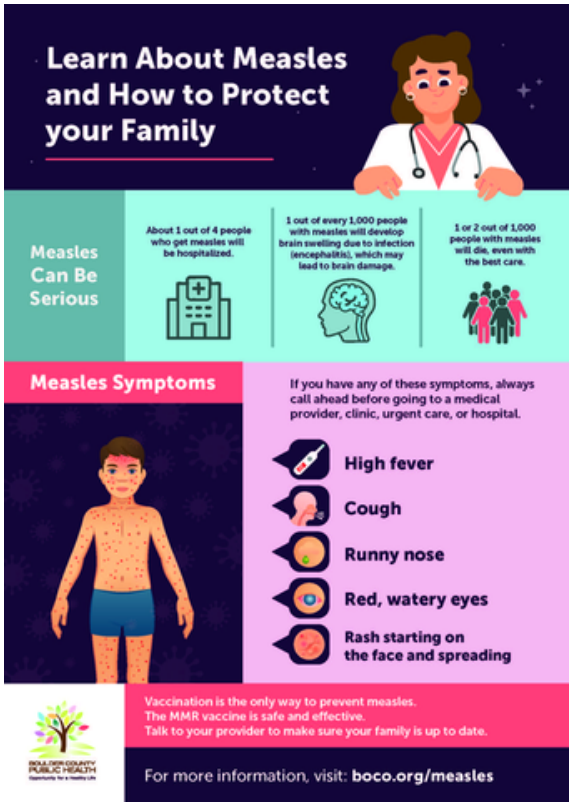

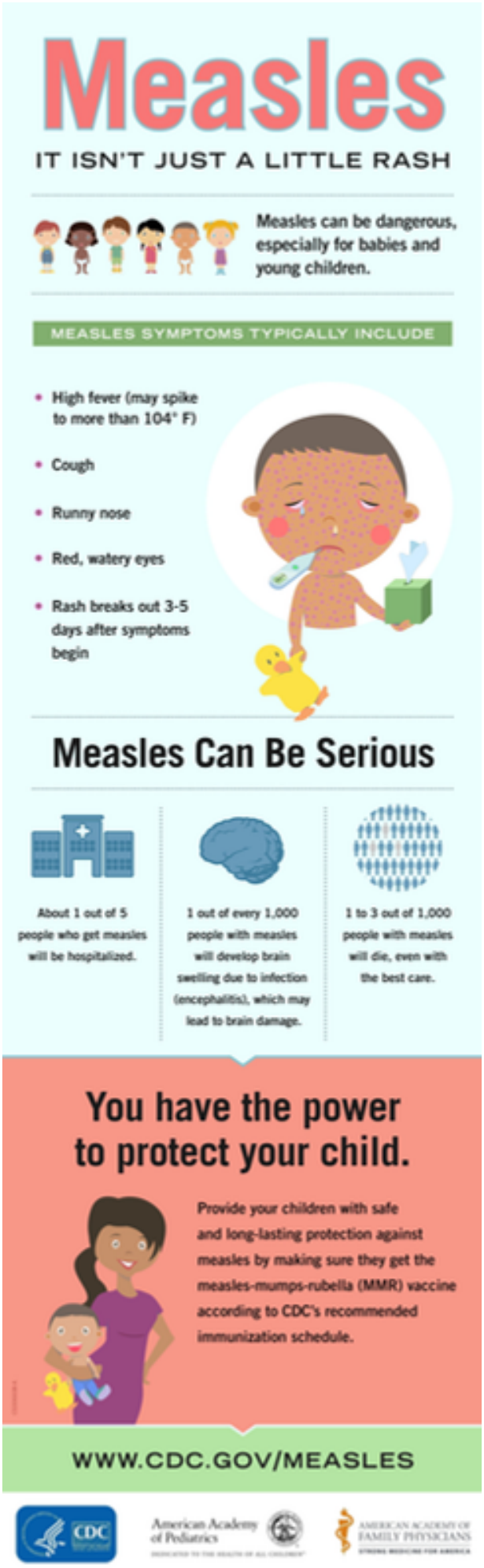

"Lama Piyasa Galle " - A Place Where Violence Ends and Healing Begins

"Lama Piyasa" is a specialised institution dedicated to providing holistic care for children who have faced violence, abuse, exploitation, or neglect. The concept was initiated in 2011 under the "Creating Safe Communities for Children" programme of the Child Protection Committee (CPC) of the Sri Lanka College of Paediatricians (SLCP).

Recognising that children affected by violence require sensitive and comprehensive care—beyond what can be offered in general paediatric or gynaecology wards—the CPC proposed the establishment of child-friendly safe spaces within health institutions. In response, the Ministry of Health granted approval to set up such facilities, and the first Lama Piyasa was inaugurated in April 2015 at the Colombo North Teaching Hospital, Ragama.

Building on this success, in 2020, the CPC, together with the Ministry of Health and the Ministry of Women and Child Affairs, proposed expanding the model to cover all nine provinces. This proposal received Cabinet approval in 2022, paving the way for the establishment of Lama Piyasa facilities across the country.

After a decade, the second Lama Piyasa was officially opened on August 28, 2025, at the National Hospital, Galle (NHG). The construction and furnishing of this facility were fully funded by the Roshan Mahanama Trust (RMT).

The Galle Lama Piyasa includes:

- An inward care unit for psychosocial rehabilitation and reintegration of affected children.
- A video evidence recording unit to support child-sensitive legal procedures.

Children up to 16 years of age who have experienced violence, abuse, exploitation, or neglect and are referred to NHG receive care at Lama Piyasa. Each child benefits from a multidisciplinary team comprising Paediatricians, Psychiatrists, Judicial Medical Officers, Medical Officers, and Nursing Staff. The unit functions under the Director, NHG, and is supervised by a Paediatrician as the Head of Unit.

In addition, Police Officers from the Women and Children's Bureau, Probation Officers, National Child Protection Authority (NCPA) Officers, and Child Rights Promotion Officers play vital roles in the multi-sectoral management of each child.

Regular Institutional Case Conferences (ICCs) are held to review every case. These meetings enable the team to formulate comprehensive action plans for long-term child and family support. The outcomes are documented by the Probation Officer and formally communicated to the courts.

The Lama Piyasa initiative stands as a remarkable milestone in Sri Lanka's child protection and healthcare landscape—creating safe spaces where violence ends and healing begins. Through continued collaboration between the health sector, law enforcement, and child protection authorities, Lama Piyasa aims to restore dignity, safety, and hope to every child in need.

Lamapiyasa Galle - Direct Telephone No
☎ 091-2240848

“Lama Piyasa Galle ” - A Place Where Violence Ends and Healing Begins

A Heartfelt Thanks: The Sri Lankan Community's Gratitude for the Take Heart Mercy Mission

A Heartfelt Thanks: The Sri Lankan Community's Gratitude for the Take Heart Mercy Mission

The Take Heart Mercy Mission (THMM) represents a profound act of compassion, generating deep and enduring gratitude within the Sri Lankan community for over two decades. From the perspective of local cardiac care, this UK-led initiative, spearheaded by experts like Professor John Simpson, is more than a charity; it is a decades-long partnership focused on providing life-saving care for children with complex heart disease at the National Hospital Galle.

The mission operates under the stringent guidance and close monitoring of the Ministry of Health, Sri Lanka, and the Sri Lanka Medical Council, ensuring the highest standards of international practice are maintained on Sri Lankan soil.

This institutional oversight is matched by the crucial support of the patronage of the Director of the National Hospital Galle and the dedication of our core local consultants: Paediatric Cardiologist Dr. Geeth Sooriyasena, Consultant Cardio Thoracic Surgeon Dr. Tolusha Harischandra, and Anaesthetist Dr. Gihan Piyasiri. Their commitment ensures the continuity of care and the success of the clinical knowledge transfer.

The beneficiaries are hundreds of impoverished children who, by 2024, saw their lives transformed.

The mission's success is defined not just by the surgical count (over 270 lives saved), but by the technical complexity achieved. For instance, the 2025 mission performed 16 major surgeries.

Addressing challenging conditions such as Tetralogy of Fallot repairs, an Ebstein Anomaly repair, Homologous Grafting of the pulmonary artery, a Mitral Valve Replacement, and an Aortic Valve Replacement.

This high-level intervention, combined with invaluable equipment donations and constant professional training, strengthens our local capacity. Crucially, the Take Heart Mercy Mission affirms its unwavering commitment and willingness to proceed forward in the future, maintaining its vital, decades-long collaboration with the National Hospital Galle, ensuring a sustainable source of hope for our little hearts.

Implementation of Newborn Baby Cots in the Postnatal Ward – Base Hospital Wathupitiwala

The project was initiated in December 2024 in response to longstanding concerns regarding the lack of appropriate sleeping arrangements for newborn babies and their mothers in the postnatal ward.

When I assumed duties at Base Hospital Wathupitiwala, there were no cots available in the ward. As a result, newborns routinely shared beds less than three feet wide with their mothers. This situation posed a significant risk of accidental suffocation and injury to the babies. Recognizing the urgent need to improve infant safety, a Consultant Paediatrician led the initiative in collaboration with a donor, a technician, hospital health staff, and administrative personnel.

The primary objective of the project was to promote a safe sleeping environment for newborns and to align postnatal care practices with international recommendations established by the World Health Organization (WHO) and the American Academy of Pediatrics (AAP). In addition, other objective was facilitating continuous monitoring of babies by health care staff.

According to the above objectives we have innovated the new born baby cot

SRI LANKA COLLEGE OF PAEDIATRICIANS

Monthly Clinical Update

Thalassaemia

Case Presentation

DR NUWAN DISSANAYAKA

Senior Registrar, University Paediatric Unit
LRH

Thalassaemia Care: The Role of Paediatrician in the Era of Bone Marrow Transplant

DR RUWANGI DISSANAYAKE

Consultant Paediatrician, University Paediatric Unit
LRH

Cure for Thalassemia: Haemopoietic Stem Cell Transplantation in Thalassemia

DR SHANIKA VITHARANA

Consultant Haematologist
Bone Marrow Transplant Unit
LRH

HYBRID SESSION, JOIN US!

21st November 2025 | 12- 1 PM

New Auditorium, LRH | Online via Zoom
Lunch will be provided

Zoom Link available at www.slcp.lk

Upcoming Events of SLCP

AGENDA

Time	Topic	Resource Person
07:30-08:00 am	Registration	
08:00-08:15 am	Welcome Speech	**PROF PUJITHA WICKRAMASINGHE** President, SLCP
08:15-08:30 am	Opening Speech	**DR SURANTHA PERERA** President, SLMA
	Symposium I- Neonatal Neurology	
08:30-09:00 am	Utilizing cranial scans in neonatal care	**DR NIMESHA GAMHEWAGE** Senior Lecturer, Consultant Neonatologist, Faculty of Medical Sciences- University of Sri-Jayawardenepura
09:00-09:30 am	Seizures in the newborn: Current concepts in diagnosis and management	**DR RAJATH PEJAVER** Consultant Neonatologist, Manipal Hospital, India
09:30-10:00 am	Neurodevelopmental outcomes in preterm/term - What can we do for the improvement?	**PROF NISHANI LUCAS** Professor in Neonatology, Consultant Neonatologist, Faculty of Medicine, University of Colombo
10:00-10:30 am	Management of IVH in preterm	**DR NALIN GAMAATHIGE** Consultant Neonatologist, De Soysa Hospital for Women, Colombo
	Symposium II- Neonatal Cardio- Respiratory	
10:30-11:00 am	Lung protection in neonates	**DR NIMESHA GAMHEWAGE** Senior Lecturer, Consultant Neonatologist, Faculty of Medical Sciences - University of Sri Jayawardenepura
11:00-11:30 am	Tea	
11:30 am-12:00 pm	Delivery room respiratory support - What is new?	**DR AMIT GUPTA** Clinical Lead, Consultant Neonatologist, John Radcliffe Hospital, Oxford University Hospitals- NHS, United Kingdom
12:00-12:30 pm	Managing a near term/term infant with respiratory failure	**DR AMIT GUPTA** Clinical Lead, Consultant Neonatologist, John Radcliffe Hospital, Oxford University Hospitals- NHS, United Kingdom
12:30-01:00 pm	Choosing the right inotrope	**DR GEZA VASS** Consultant Neonatologist, John Radcliffe Hospital, Oxford University Hospitals- NHS, United Kingdom
01:00-01:30 pm	How to do preterm counselling	**DR KATHERINE WOOD** Consultant Neonatologist, John Radcliffe Hospital, Oxford University Hospitals- NHS, United Kingdom,
01:30-02:00 pm	Lunch	

Contact: Sri Lanka Medical Association, Wijerama House, No. 6, Wijerama Mawatha, Colombo 07 +94 11 269 3324 https://slma.lk office@slma.lk

ENDOCRINE DAY 2025

Organised By Sri Lanka College of Paediatricians

Date: 13th December 2025

Venue: New Auditorium, Lady Ridgeway Hospital

ACADEMIC SESSION

08:00AM Registration

08:30AM Welcome Speech & Introduction

08:50AM "From Sample to Diagnosis: Biochemical Investigations in Endocrine Disorders"
Dr Majitha Ibrahim, Consultant Chemical, Pathologist, Lady Ridgeway Hospital

09:20AM "Abnormal Glucose Metabolism in Infancy: Bridging Clinical Management & Genetic Insights"
Dr Dinendra Siriwardana, Consultant Paediatric Endocrinologist, Teaching Hospital Ratnapura

09:50AM "Neonatal Endocrine Challenges: From Early Recognition to Active Management"
Dr Chamidri Naotunna, Consultant Paediatric Endocrinologist, Teaching Hospital Anuradhapura

10:20AM TEA BREAK

10:50AM "From Fractures to Deformities: Role of Orthopaedic Surgeons in Paediatric Bone Disorders"
Dr Dimuthu Tennakoon, Consultant Orthopaedic Surgeon, Lady Ridgeway Hospital

11:20AM "Protecting Young Bones: Managing Bone Health in Chronic Childhood Conditions"
Dr Senani Gamage, Consultant Paediatric Endocrinologist, Teaching Hospital Kurunegala

11:50AM "Early Detection of Complications in Childhood Diabetes: Preventing the Future Burden"
Dr Jananie Suntharesan, Consultant Paediatric Endocrinologist, SBSCH, Peradeniya

12:20PM "Sellar & Suprasellar Tumours: Long Term Impact on Paediatric & Adolescent Health"
Professor Sumudu Seneviratne, Professor in Paediatrics, University of Colombo

12:50PM LUNCH BREAK

01:50PM "Thyroid Disease in Childhood: Clinical Spectrum, Genetics, and Outcomes"
Dr Navoda Atapattu, Consultant Paediatric Endocrinologist, Lady Ridgeway Hospital

02:20PM "Crisis in Hormones: Case-Based Insights into Endocrine Emergencies"
Dr Dimarsha De Silva, Consultant Paediatric Endocrinologist, National Hospital Galle

02:50PM Quiz Competition

03:30PM Closing Remarks & Refreshments

REGISTRATION FEE: 2500LKR

★★★★★
CPD Points Awarded

Registration available at slcp.lk

CLICK HERE

FOR MORE INFO 0777 508 218 WWW.SLCP.LK

Guidelines on submission of articles for the SLCP NEWSLETTER

All communications should be addressed to the Joint Editors of the Newsletter.

Only electronic submissions to the following email address are accepted and no hard copies will be entertained as submissions.

Email: paednewsletter@gmail.com
Intellectual responsibility for pictures/articles submitted lies with the person submitting the pictures/articles and The Sri Lanka College of Paediatricians (SLCP) will not assume any responsibility whatsoever for them.

Contents

- Cover Page/ Front Page

A photograph – Can be submitted by any member of Sri Lanka College of Paediatricians. It should be followed by the cover story not exceeding 150 words. A nature photograph/ a photograph of a college function will be accepted.

- Inner pages

You are kindly requested to submit articles under the following topics for the Newsletter in MS Word format. Tables and figures should be submitted separately. Pictures should be of high quality (at least 300 DPI).
Any article with an academic interest/ non-academic interest falling under following categories will be accepted. Maximum word count is 1000 for academic and 800 for non-academic articles. Only 2 pictures, photographs (300 DPI) or tables are allowed in one article.

ARTICLES RELATED TO PROFESSIONAL DEVELOPMENT

- Review articles/ Review of a review
- Case History or Case Based Discussion
- Patient Story with a picture
- Young Paediatricians' Niche – Open only for Registrars and Senior registrars in Paediatrics and related sub-specialties, and writing on current practice of a common disease. This has to be a detailed and up to date narrative. It will be checked for plagiarism.
- Monthly clinical update
- MCQ corner

ARTICLES RELATED TO PERSONAL DEVELOPMENT

- Non-technical article – An article on a song/ book/ painting/ cartoon/ movie
- Information Technology related articles
- Finance management
- Articles on any other topic of interest too can be submitted.

ARTICLES RELATED TO UNIT/TEAM DEVELOPMENT

- New innovations in your unit/ any new developments related to paediatrics and child health by a paediatrician.
- Briefings on regional sessions held.
- Any other collaborative sessions related to paediatrics.

Please submit the documents to paednewsletter@gmail.com with a cover letter.

Articles submitted before the 10th of each month will be considered for publication on that month's issue. Late submissions will be considered for the next issue. However depending on the availability of space and similarity of the articles they may be considered for upcoming issues.