

INSIDE, WE TALK ABOUT...

Recent trends in influenza, enteroviral meningitis, and dengue

Cough syrups: Beneficial or risky? Key messages to prescribers

Masks, Mythology and Healing: The Medical Imagination of Traditional Sri Lanka

Management of Acute Procedural Pain in Young Children - "From Crying to Comfort"

The United Kingdom Moves to the MMRV Vaccine: A Review Based on the MHRA MMRV Factsheet

Academic and professional development activities

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Influenza on the Rise

Data from the National Influenza Centre at the Medical Research Institute (MRI) reveals a sharp, mid-year escalation in laboratory-confirmed influenza cases across Sri Lanka during the first half of 2026. For paediatricians, who manage the brunt of seasonal respiratory surges, understanding these specific viral dynamics is crucial for timely diagnosis and clinical management. Here is a breakdown of the current epidemiological trend.

The Strain Shift: Dominance of Influenza B

As illustrated in image-1, the year began with a typical presentation of Influenza A as the primary driver. In January, Influenza A accounted for majority of the confirmed influenza cases, while Influenza B remained low.

However, a distinct epidemiological shift occurred as the months progressed. By February, Influenza B surpassed Influenza A. It maintained this dominance throughout the first quarter. Following a brief, synchronized decline in April, May witnessed an aggressive resurgence. Influenza B positive samples more than doubled, while Influenza A remained stable.

For clinical settings, this confirms that the current respiratory wave is overwhelmingly

driven by Influenza B, a strain known to cause severe complications, myositis, and gastrointestinal symptoms in paediatric populations.

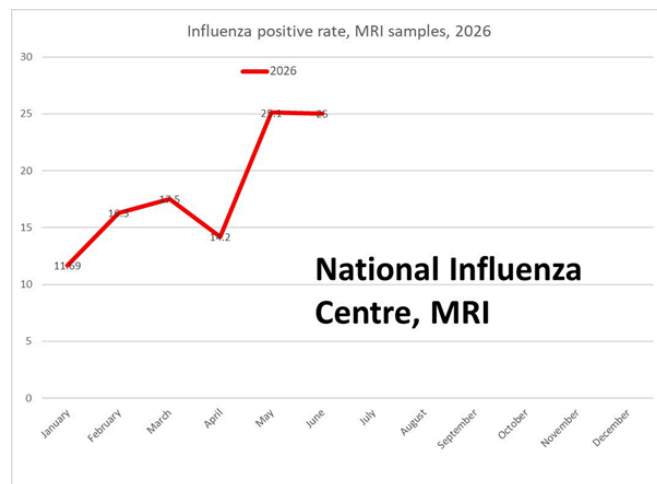


Image-2 Influenza positive rate
Paediatric Considerations & Guidance

Because Influenza B thrives in high-density environments like schools and daycare centres, paediatricians should maintain a high index of suspicion for influenza in children presenting with acute febrile respiratory illnesses.

- **Differential Diagnosis:** Distinguishing influenza from other circulating seasonal pathogens (such as Dengue or RSV) remains critical, especially given the concurrent 25% positivity threshold.
- **Proactive Management:** Early antiviral intervention (where indicated), monitoring for secondary bacterial superinfections, and reinforcing the importance of annual influenza vaccination—particularly for high-risk paediatric cohorts with underlying asthma or cardiac conditions—remain our strongest lines of defense.

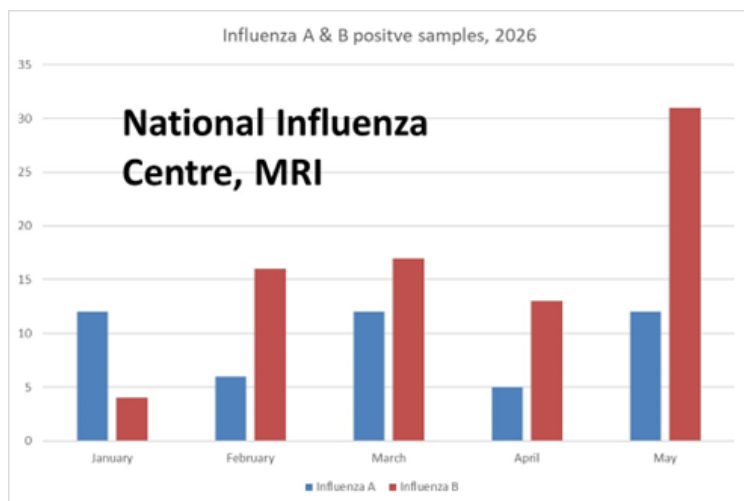


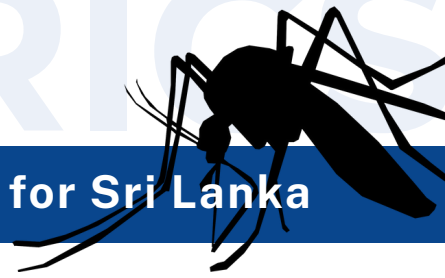
Image-1 – Influenza A and B positive samples

Acknowledgements

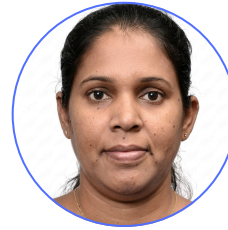


The editors of the SLCP newsletter sincerely thank Dr. Jude Jayamaha, Consultant Virologist, for providing data that contributed to this article.

Dengue Serotype Dynamics and Implications for Sri Lanka



- The dengue virus comprises four antigenically distinct serotypes (DENV-1, DENV-2, DENV-3, and DENV-4).
- Primary infection with one serotype induces long-lasting homotypic immunity against the infecting serotype and transient heterotypic immunity against the remaining serotypes.
- Following the waning of heterotypic immunity, subsequent infection with a different serotype may result in antibody-dependent enhancement (ADE), leading to increased viral replication, enhanced immunopathogenesis, and a higher risk of severe dengue and its complications.
- Sri Lanka remains a hyperendemic country where all four dengue virus serotypes co-circulate especially serotypes 2 and 3 along with 1 and 4 to a lesser extent although the predominant serotype changes over time.
- Recent molecular surveillance has demonstrated shifts in the dominant circulating serotype of type 2, reflecting the dynamic nature of dengue epidemiology in the country. Such serotype replacement, together with waning population immunity to the newly predominant serotype, may increase the risk of large outbreaks and severe dengue in susceptible populations.
- Sustained vector control, strengthened clinical surveillance, and continuous molecular surveillance including dengue virus serotyping and genomic characterization are essential to detect serotype shifts early, monitor viral evolution, and guide public health interventions aimed at mitigating future outbreaks and severe disease.



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Cough syrups: Beneficial or risky? Key messages to prescribers

On 13 October 2025, the World Health Organization (WHO) issued a health advisory warning against the use and distribution of three cough syrups believed to be responsible for the deaths of several children in India over the previous month. This was after the Central Drugs Standard Control Organization (CDSCO) of India reported to WHO the presence of Diethylene Glycol (DEG) in at least three oral liquid medicines containing active ingredients commonly used to relieve symptoms of the common cold, flu, or cough. The CDSCO has informed the WHO that none of the contaminated medicines have been exported from India and there was no evidence of illegal export. However, in the context of proximity of Sri Lanka to India and daily reporting of boats containing illegal goods crossing the Palk Straits, we are uncertain to what extent we can believe this statement.

It is so sad because from the 1937 Elixir sulfanilamide disaster in the United States (over 100 children perished) which brought major changes in the drug regulation in USA to repeated outbreaks in India, Nigeria, and Indonesia, DEG contamination of liquid preparations continue to kill children. Despite nearly a century of regulatory evolution, the persistence of such incidents reflects ongoing gaps in excipient quality assurance, supply chain integrity, and enforcement. This write up is an appeal to the prescribers for children. If you take adequate precautions, you can protect children from harmful effects of cough preparations even if the regulation and supply system fail to do so.

Beyond the well-recognized risks of toxic contamination, cough syrups themselves present significant pharmacological and safety challenges in paediatric populations, ranging from variable opioid metabolism and central nervous system effects to limited clinical efficacy and the risks associated with multi-ingredient formulations. Efficacy evidence is weak for most antitussives in children, especially for acute viral coughs. Many regulatory authorities have moved toward age-based restrictions (e.g., no cough/cold medicines <2 yrs; caution in 2–6 yrs). Key System-Level Risks with Cough Preparations in Resource-Limited Settings including Sri Lanka are given in Box 1.

The British National Formulary lists significantly more cautions and precautions for cough preparations than benefits and indications. The WHO, Food and Drug Administration (FDA) and other regulatory authorities have also highlighted the imbalance between the risks and benefits of cough preparations. These are summarized in Table 1.

Advice to prescribers:

The recurring global experience with DEG contamination, together with the inherent limitations in efficacy and safety of many cough preparations, underscores that the risks associated with these medicines extend beyond pharmacology to include manufacturing quality, supply chain integrity, and regulatory robustness.

In resource-limited settings, where these safeguards such as regulatory oversight, supply chain integrity, and pharmacovigilance systems may be variably implemented, prescribers must adopt a cautious, evidence-based approach, recognizing that even appropriately selected products may carry uncertainties. Rational prescribing, coupled with caregiver education and vigilance, remains the most reliable strategy to minimize harm while managing a symptom that is often self-limiting in children.

- Avoid routine use of cough preparations in children, especially for uncomplicated, self-limiting viral coughs.
- Avoid use in children under 6 years
- If used in children ≥ 6 years, select a single-ingredient product where possible, limits to one preparation, and calculate the dose for each ingredient.
- Limit duration of therapy to short courses (typically 3–5 days) and avoid repeated or prolonged use.
- Be familiar with 1-2 preparations and prescribe only those if really required
- Educate and reassure caregivers about the natural course of cough and when symptomatic treatment is or is not needed.
- Discourage self-medication and sharing of medicines between children.
- Read labels carefully, identify ingredients, ensure correct dosing for each ingredient, and check for regulatory approval/registration of the product. Educate the parents as well on the above as they may go for OTC cough and cold preparations.

- Monitor and counsel on adverse effects (e.g., sedation, irritability, respiratory symptoms) and advise prompt medical review if they occur.
- Encourage reporting of adverse drug reactions and suspected product quality issues through appropriate pharmacovigilance channels.
- Be cautious of industry promotion and combination products, and rely on independent, evidence-based guidelines for decision-making.

Table 1: Cough Preparations for children: Ingredients, Issues, and Recommendations

Ingredient / Category	Safety / Lack of Evidence Issue	Current Recommendation (FDA / WHO / Guideline consensus)
Codeine	• Codeine is metabolized to morphine by CYP2D6. Variable metabolism (CYP2D6 ultra-rapid metabolizers) → unpredictable morphine levels; risk of respiratory depression, sedation, and death; • No proven benefit in children for cough	Use of cough suppressants containing codeine phosphate should be avoided in children 12 years of age and in children of any age if they are CYP2D6 ultra-rapid metabolizers
Dextromethorphan	• Central nervous system side effects at higher doses • Potential for misuse/abuse • Limited evidence of efficacy in young children	• Avoid in young children (especially <4 years) • Use cautiously in older children only if necessary
Expectorant cough preparations	• No evidence that any drug can specifically promote expectoration	• Not recommended for children under 12 years



Ingredient / Category	Safety / Lack of Evidence Issue	Current Recommendation (FDA / WHO / Guideline consensus)
First-generation (sedating) antihistamines (e.g., diphenhydramine, chlorphenamine (chlorpheniramine))	• Sedation, anticholinergic effects, paradoxical excitation in children • Weak evidence for cough relief	• Children under 6 years should not be given OTC cough and cold medicines containing chlorphenamine • Not recommended for routine use for cough in older children
Guaifenesin containing expectorants	• Limited evidence of clinically meaningful benefit in children; • Generally, well tolerated	• Not recommended in young children • May be used with caution in older children (> 12 years) if indicated
Salbutamol or bronchodilator-containing syrups	• No benefit in non-asthmatic acute cough • Unnecessary exposure to β_2-agonist adverse effects (tachycardia, tremor)	• Not recommended for cough unless underlying bronchospasm/asthma is present
Compound cough and cold medicines (mostly available over-the-counter (OTC))	• Multiple active ingredients leading to increased risk of dosing errors, adverse effects and duplication • No evidence of overall benefit	• Not recommended for children under 6 years • Cough and cold preparations containing one or more of the following ingredients * should not be given for children under 6 years • They can be considered for children aged 6-12 years provided • possible non-pharmacological methods have been tried

		• limited to only one preparation (there can be overlap in ingredients) • dose is correctly calculated to each ingredient • none of the ingredients are contra-indicated in that age group, and • duration is limited to five days
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* Antihistamines: Brompheniramine, chlorphenamine, diphenhydramine, doxylamine, promethazine or triprolidine

Cough suppressants: Dextromethorphan

Expectorants: Guaifenesin, ipecacuanha

Decongestants: Phenylephrine hydrochloride, pseudoephedrine hydrochloride, ephedrine hydrochloride, oxymetazoline or xylometazoline hydrochloride

Box 1: Key System-Level Risks with Cough Preparations in Resource-Limited Settings including Sri Lanka

- (1) Variable drug quality and regulatory control
- (2) Illegal import of substandard or falsified medicines.
- (3) Supply chain vulnerabilities
- (4) Limited excipient quality assurance.
- (5) Over-the-counter availability and self-medication:
- (6) Limited pharmacist involvement and counseling.
- (7) Weak pharmacovigilance and underreporting
- (8) Unethical and uncontrolled promotion by pharmaceutical companies



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Masks, Mythology and Healing: The Medical Imagination of Traditional Sri Lanka



Mythology has shaped the cultural identity of nearly every civilization in human history. From the gods of ancient Greece and Rome to the traditions of China, Africa, Latin America and the Middle East, myths have served as explanations for creation, disease, morality, suffering and mostly to answer the unknown at the time. In many societies these mythologies evolved into elaborate systems of ritual and healing that deeply influenced culture, religion and medicine.

Sri Lanka possesses a mythology that is both unique and difficult to define. Unlike the well-preserved mythological systems of Greece, Sri Lankan mythology survives largely through oral traditions, ritual performances, chants, masks and healing ceremonies rather than through extensive written texts or stone inscriptions. Currently It exists in fragments within kolam performances, bali rituals, thovil ceremonies and customs and traditions. Although heavily influenced by Buddhism and elements of Hindu ideology, Sri Lankan mythology developed its own identity through local beliefs surrounding demons, guardian deities, illness and ritual healing pointing towards the possibility of customs and rituals dating back even before Buddhism .

For centuries these traditions were not merely entertainment or superstition. But rather they were used as social medicine, psychological reassurance and communal healing systems within traditional Sri Lankan society.

The Nature of Sri Lankan Mythology

One of the most prominent figures in Sri Lankan mythology is King Ravana. In popular tradition Ravana is remembered not simply as the antagonist of the Ramayana, but as a powerful ruler, scholar and healer. Oral traditions attribute to him mastery in multiple disciplines including aviation, astrology and Ayurvedic medicine. Stories surrounding the Dandumonara flying craft and ancient medical manuscripts continue to circulate within Sri Lankan cultural memory.

Whether Ravana belongs entirely to mythology or partially to history remains debated. Yet his continued presence demonstrates an important feature of Sri Lankan mythology. Myth and history often coexist without clear separation. Unlike purely fictional mythologies, Sri Lankan traditions frequently treat legendary figures as possible historical figures that may.

However, Sri Lanka's mythology cannot be studied solely through kings and legends which is still up for debate. Its richest expressions survive within rituals and healing performances. In many cases, the mythology itself is encoded within chants recited during bali ceremonies and masked dances rather than formal literary texts.

Mythology Preserved Through Ritual

Traditional Sri Lankan healing rituals such as Bali thovik, Sanni Yakuma, Gara Yakuma and Mahasohon Samayama etc preserve mythological stories concerning the origin of the world, the creation of disease and the relationship between humans and supernatural beings.

These traditions reveal an idea in which the universe is inhabited by gods, demons, yakshas, nagas and other supernatural beings who influence human life and illness. Oral ritual storytelling describe a universe formed through cycles of destruction and recreation. According to one creation narrative preserved in bali chants, the world was repeatedly destroyed by fire, wind and flood before being recreated through the intervention of Maha Brahma. Two celestial beings descended into the dark primordial world and gradually became the first humans. Desire, emotion and social conflict eventually emerged, leading to the election of the first rulers, Manipala Devi and Mahasammatha.

These stories contain traces of stories relating to some parts of Buddhist culture while simultaneously incorporating indigenous beliefs and Hindu influences. Unlike formal Buddhist philosophy, the narratives here are deeply human, emotional and symbolic rather than philosophical. In this ideology hunger, lust, jealousy, disease and fear become central forces in the creation of society itself.

The universe (sakwala) is described as containing multiple continents, sacred mountains, celestial realms, zodiac systems and supernatural kingdoms ruled by deities and yakshas. Oceans are guarded by Manimekala, lands by Mahi Kantha, while underground realms belong to Mara and other demonic beings. Such descriptions demonstrate how mythology provided traditional communities with a structured explanation for both the physical and spiritual world.

Mythological Origins of Disease

Perhaps the most medically fascinating aspect of Sri Lankan mythology is its attempt to explain illness and ways that was in place to treat them.

Many ritual narratives describe disease not merely as physical dysfunction, but as the result of emotional, moral or supernatural disturbance. One myth describes the first illness occurring after Wasawartha Maraya, the ruler of the underworld, attempted to seduce Queen Manipala by taking the form of a viper and hiding within her body. The queen subsequently became gravely ill, and ritual healing through Bali Yaga was recommended.

Another version describes the king himself becoming ill after dreaming of a serpent falling upon him. Despite various remedies, recovery was only achieved through ritual intervention.

Such narratives reflect an ancient tendency to associate illness with emotional disruption, fear, sexuality, dreams and unseen spiritual forces as opposed to direct physical changes in the body. While modern medicine does not interpret disease through demonic causation, these myths may represent early symbolic attempts to understand psychosomatic illness and unexplained medical conditions which are even up to this day is a mystery.

Among the most sophisticated healing traditions is the Sanni Yakuma ritual. According to oral tradition, the terrifying demon Maha Kola Sanni Yaka emerged from a tragic act of violence and vengeance. From him arose eighteen different forms of illness-causing demons known as the Dahan Sanniya or Eighteen Sanni Demons. Each Sanni demon became associated with a recognizable category of disease or symptom complex. For example:



Kana Sanniya caused blindness and visual impairment.

Ginijala Sanniya caused severe fever and convulsions. Golu Sanniya caused muteness.

Kora Sanniya caused lameness and swollen joints.



Pith Sanniya was associated with biliary disease.

Gulma Sanniya represented abdominal illness and parasitic disorders.

Maru Sanniya symbolized death or delirium. Mahakola Sanniya represented devastating epidemics and madness.



The classification attempts to organize disease into recognizable syndromes within a mythological framework.

Masks and Healing

The masks used in Sri Lankan ritual performances are not merely decorative woodwork or claywork. They are visual embodiments of disease, fear and supernatural power.

According to one legend, the origins of masked performance began when a pregnant queen developed an unusual craving to witness masked dancers. Unable to satisfy her wish, the king became desperate until the god Sakra instructed

Vishwakarma, the divine craftsman, to create masks from sandalwood and leave instructions for performance. These performances later evolved into Kolam traditions.

Over time masks became central to healing ceremonies. The exaggerated facial expressions, bulging eyes, fangs and vivid colors of Sanni masks transformed invisible illnesses into visible beings that could be confronted and expelled through ritual.

The healing ceremonies themselves combined dance, drama, music, chanting and comedy. Patients suffering from chronic illness, mental distress or unexplained symptoms were brought before ritual specialists who invoked demons, negotiated with them and supposedly drove them away.

Importantly, these ceremonies were not isolated medical interventions. They were collective social events involving families, neighbors and entire villages. Through performance, fear was externalized and shared to the entire community rather than carried privately by the affected individual alone.

From a modern perspective, it is possible to view these rituals as early forms of psychological healing and social therapy. The dramatic performances may have reduced anxiety, provided emotional ventilation and restored social reassurance during periods of illness and uncertainty. The ritual specialist functioned simultaneously as healer, priest, dramatist and supposedly a counselor.

Yet it would be simplistic to reduce these traditions purely to psychology. For traditional communities, the supernatural dimension was perceived to be entirely real. The healing power of the ritual depended upon belief system.

Gara Yakuma and Mahasohon Traditions



Other healing rituals reveal equally complex mythological structures.

Gara Yakuma revolves around the story of Dalakumara, a supernatural being associated with destructive appetite. After committing incest and descending into violence, he was eventually controlled by King Wesamuni and transformed into a subordinate spiritual force. The ritual tradition that developed around Gara demons became associated particularly with women's illnesses, fertility disturbances.

Similarly, Mahasohon Samayama originates from the legend of Jayasena, whose decapitated body was given the head of a bear and transformed into the terrifying graveyard spirit Mahasona.



This demon became associated with death, cemeteries and nocturnal illness. Such legends reveal recurring themes within Sri Lankan mythology - the thin boundary between human and demon, and the possibility of controlling destructive forces through ritual negotiation.

Mythology, Medicine and Cultural Memory

The healing traditions of Sri Lanka should not be dismissed simply as superstition. They represent complex cultural attempts to understand disease, suffering, mental distress and social instability in a world without modern medical knowledge.

In many rural communities these rituals also provided something modern medicine sometimes struggles to offer which was the isolation of the affected individual. In the traditional way illness was given a story, a face and a place within a larger supernatural force. The patient was not isolated but reintegrated into the community through ritual participation.

Even today, masks used in Sanni Yakuma and related traditions continue to fascinate anthropologists, artists, physicians and historians because they exist at the intersection of mythology, psychiatry, religion and medicine.

Sri Lankan mythology may not survive in a way comparable to Greek mythology, nor in extensive literature. Instead, it survives through living performance traditions, ritual chants and healing ceremonies passed from generation to generation.

Within these traditions lies a uniquely Traditional Sri Lankan understanding of illness – one that recognizes fear, emotion, morality, community and spirituality, religion as parts of human suffering and healing.



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Management of Acute Procedural Pain in Young Children - “From Crying to Comfort”



Acute Pain in young children is a very distressing event for parents. Poorly managed acute pain can result both short term and long-term consequences. The common etiologies for acute pain are accidental injuries, trauma, functional pains and medical procedures (1). Among these etiologies, medical procedures result in significant anxiety and fear in children. For instance, the pain related to vaccination, cannulation, venipuncture is often very short, however resulting impact could be long lasting (2,3).

Understanding acute procedural pain in children

Pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage (4). It is an extremely subjective experience. Hence two individuals might describe the same pain experience very differently (4,5).

Most of the medical procedures are performed without adequate analgesia in most of the health care settings (2). These traumatic experiences can get compound over time. For an example, a child born in Sri Lanka receives at least eight or more vaccinations and might undergo several more episodes of blood tests and cannulations by five years (6). These procedures can result in significant distress and needle phobia as an adult. Despite that, there are only very few studies and statistics available in Sri Lanka regarding acute pain management (7).

• Pain in Newborns and Infants- Are they more vulnerable to pain?

It is a common misconception that newborns and infants do not feel pain as older children and adults.

However, they are extremely sensitive to pain (8). Newborns have higher density of peripheral nociceptive receptors. As a result, their ascending pain pathways are activated at low pain thresholds. Adding on to that, immaturity of the descending inhibitory neurons contributes to enhanced pain sensitivity (8).

Repeated painful sensory inputs may affect neuronal plasticity, resulting in permanent or semi-permanent developmental changes in the brain (8). These changes result in altered pain perception and altered behavioral response. In other terms, untreated neonatal pain may shape the pain response adversely in later life.

• Pain is more than a physical sensation- Bio-Psychosocial model

The pain experience of an individual depends on the interaction of biological, psychological and social factors (9). Individual pain sensation is influenced markedly by biological factors such as genetics and epigenetics. Endocrine differences, neurological factors and immunity can result further differences. For instance, children with higher peripheral pain receptor density will be more sensitive to pain where as children with higher endogenous opioid activity may have less sensitivity.

Psychological factors also play an important role in pain modulation. Anxiety, fear, low mood and previous pain experiences could enhance pain severity. For an example, a child with previous traumatic experience from a medical procedure will be more sensitive to similar procedural pain.

However, advanced developmental age and development of coping skills could be helpful to modulate the pain.

Social background, cultural beliefs and environment factors also can influence the pain response. A calm reassuring parent can help the child to reduce anxiety and cope up well than a parent driven by anxiety. Furthermore, Social beliefs, attitudes towards pain can also influence the pain perception and expression.

Procedural Pain Management - Multimodal Approach

Multimodal approach is the most effective strategy in procedural pain management and enables to use lower doses of analgesics due to synergistic activity and thereby minimize possible pharmacological side effects (10). This approach includes pharmacological and non-pharmacological methods. Non pharmacological interventions are equally important and as effective as pharmacological interventions (1,3, 10).

- Pre-procedural care

Pain management should be commenced well before the first needle or instrument touches the child.

- Child friendly Environment

There should be a designated area for procedures. The environment should be calm, organized and welcoming. Pictures, toys, books and audio-visual distractions could make the room more child friendly. Gentle music can add a sense of safety. In comparison a congested room filled with medical equipment, needles, medical trolleys will be more intimidating.

The attitude and appearance of the health care staff also matter a lot. A calm and soft-spoken health care staff can alleviate anxiety and pain,

- Prepare the parents

The presence of a parent throughout the procedure is often also helpful.

However, a distressed parent can unintentionally increase the pain and fear. Hence, counseling the parents regarding the procedure and making them reassured and composed is equally important.

- Asses the child and prepare

Pain management strategies should be individualized and altered according to the need of the child. Developmental age, cognitive abilities, social and cultural background are important deciding factors in selecting management options.

A child with good communication abilities will express his/ her previous pain experiences, and concerns. Answering their concerns, explaining the steps of the procedure and teaching coping skills can be useful.

Furthermore, self-expression of pain is the best way of identifying pain severity and useful to introduce appropriate pain relief according to the pain ladder.

For nonverbal child or infant, observational pain scales can be used to determine the pain severity. Depending on the age, various pain scales are being used. Higher degree of observer dependent variability is the main short coming of these methods.

Pre-procedure local analgesia when appropriate

Pre procedure local/ topical analgesia is being used in most of the countries prior to painful procedures. Applying EMLA cream prior to venipuncture, cannulation, dental procedures is a common example. This gives and non-invasive effective pain relief. The delay of the analgesic effect and the cost are the main limiting factors.

- Pain relief during the procedure

The pain management should be tailored according to the type of procedure, expected pain severity, duration, involved body part, age of the child, and communication capability.

- **Non pharmacological management**

These methods mainly act through higher functions by controlling pain perception, anxiety and distress.

Distraction is a very successful method. Storytelling had been used from the ancient times as a distraction method. Toys, videos, music, or virtual reality tools are more popular current distraction techniques. Cognitive and behavioral techniques such as breathing techniques and guided imagery are extremely useful in controlling anxiety and sympathetic activity successfully.

Physical methods ensure the feeling of safety and comfort in young children. Breast feeding, tactile stimulation, skin to skin contact and non-nutritive sucking are proven effective measures. Parental presence and comfort positioning are simple but very effective.

- **Pharmacological management**

Pharmacological therapy is the cornerstone for pain management. The target of the therapy is to provide correct analgesia in correct doses in correct time to correct child.

Paracetamol and NSAIDS are used for mild pains. The gold standard treatment for Moderate to severe pain is Opioids (Morphine, Codeine, Oxycodone, oxymorphone, Fentanyl, Methadone). Non pharmacological measures are very useful adjuncts to minimize opioid over doses and side effects. Ketamine, Gabapentin, Clonidine, Amitriptyline are other adjuvant medications used in specific circumstances.

Post Procedure Pain management

Anticipation and planning of the post procedure pain management start at pre procedural stage. Caregivers should be educated about the severity of pain, warning signs, and methods to provide appropriate post procedure care.

Patient/ parent-controlled analgesia is always preferred to nurse controlled analgesia.

For major surgeries, analgesia is initiated early and continued to post operative period. The pain is greatest at immediate post-operative period and then gradually weans. Hence reverse ladder type pain management should be encouraged.

Looking Ahead – Global trends

Precise pain assessment and individualized pain management are the ultimate requirements for successful pain management. Artificial intelligence and modern technology are becoming more and more useful in achieving this with reduced observer variability.

Artificial Intelligence assisted facial analysis systems are increasingly being used for more accurate pain assessment (11). Monitoring of physiological parameters and determination of pain severity is done more precisely with modern machines. Wearable bio sensor which can be used similar to smart watch is an example (11,12). Non pharmacological pain management techniques are also enhanced with artificial intelligence. For instance, immersive virtual reality is used as a very successful method (13).

Modern Drug delivery systems are developed to provide safe, pain free, effective treatment with more precise analgesia. For example, Nano technology-based drug carriers will provide site specific drug delivery minimizing unwanted effects (14).

Genetic variations in drug metabolism specially in opioids is a challenge for effective pain management. Polymorphism in CYP2D6 gene result unpredictable metabolism of codeine causing either ineffective doses or dangerously toxic doses in some children.

Ongoing pharmacogenomic studies is focused on finding a solution to this obstacle (15). In addition, novel therapeutic targets for chronic pain management are being under exploration. Glial cell modulators, monoclonal nerve growth factor antibodies are examples for new therapeutic targets (16).

Conclusion-Changing the attitude towards “Crying to Comfort”

Paediatric pain management in Sri Lanka is not the ideal at present. Most of the instance, procedural pain was considered as trivial and accepted as a norm. Changing this attitude in medical staff is the most important and difficult initiative. Next important steps are to be persistently mindful and proactive of pain in children and to prepare a suitable child friendly environment. Repeated practice of these simple measures needs to be implemented for a better pain management that will change the scene from “crying to comfort”.



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References

1. Friedrichsdorf SJ, Goubert L. Pediatric pain treatment and prevention for hospitalized children. *Pain Rep.* 2019;5(1):e804. doi:10.1097/PR9.0000000000000804.
2. Trottier ED, et al. Managing pain and distress in children undergoing brief diagnostic and therapeutic procedures. *Paediatr Child Health.* 2019;24(8):509–21. doi:10.1093/pch/pxz026.
3. Raja SN, Carr DB, Cohen M, Finnerup NB, Flor H, Gibson S, et al. The revised International Association for the Study of Pain definition of pain: concepts, challenges, and compromises. *Pain.* 2020;161(9):1976–82. doi:10.1097/j.pain.0000000000001939.
4. Fillingim RB. Individual differences in pain: understanding the mosaic that makes pain personal. *Pain.* 2017;158 Suppl 1:S11–8. doi:10.1097/j.pain.0000000000000775.
5. Epidemiology Unit, Ministry of Health, Sri Lanka. National Immunization Schedule. Colombo: Ministry of Health; [no date].
6. Silva KDN, Kankanarachchi I, Darshana ILAN, De Silva WND, Liyanarachchi N. Pain assessment in venepuncture among children: experience from a single centre study in Sri Lanka. *Sri Lanka J Child Health.* 2022;51(3):369–76. doi:10.4038/sljch.v51i3.10225.
7. Perry M, Tan Z, Chen J, Weidig T, Xu W, Cong XS. Neonatal pain: perceptions and current practice. *Crit Care Nurs Clin North Am.* 2018;30(4):549–61. doi:10.1016/j.cnc.2018.07.013.
8. Gatchel RJ, Peng YB, Peters ML, Fuchs PN, Turk DC. The biopsychosocial approach to chronic pain: scientific advances and future directions. *Psychol Bull.* 2007;133(4):581. doi:10.1037/0033-2909.133.4.581.
9. Wren AA, Ross AC, D'Souza G, Almgren C, Feinstein A, Marshall A, et al. Multidisciplinary pain management for pediatric patients with acute and chronic pain: a foundational treatment approach when prescribing opioids. *Children (Basel).* 2019;6(2):33. doi:10.3390/children6020033.
10. Cascella M, Esposito D, Muzio MR, Cascella V, Cerrone V. Artificial intelligence for pain assessment via facial expression recognition (2015–2025): a systematic review. *Explor Med.* 2025;6:1001370.
11. De Sario GD, Haider CR, Maita KC, Torres-Guzman RA, Emam OS, Avila FR, et al. Using AI to detect pain through facial expressions: a review. *Bioengineering (Basel).* 2023;10(5):548. doi:10.3390/bioengineering10050548.
12. Teh JJ, Pascoe DJ, Hafeji S, Parchure R, Koczski A, Rimmer MP, et al. Efficacy of virtual reality for pain relief in medical procedures: a systematic review and meta-analysis. *BMC Med.* 2024;22(1):64. doi:10.1186/s12916-024-03266-6.
13. Bhansali D, Teng SL, Lee CS, et al. Nanotechnology in pain management: current and future approaches. *Pharmaceutics.* 2024;16(11):1479. doi:10.3390/pharmaceutics16111479.
14. Matic M, Nijenhuis M, Soree B, de Boer-Veger NJ, Buunk AM, Houwink EJP, et al. Dutch Pharmacogenetics Working Group (DPWG) guideline for the gene-drug interaction between CYP2D6 and opioids (codeine, tramadol and oxycodone). *Eur J Hum Genet.* 2022;30(10):1105–13. doi:10.1038/s41431-021-00920-y.
15. Palomba R, Bonaccia P, Graffi M, Costa F. The novel therapeutic targets in the treatment of chronic pain. *Transl Med UniSa.* 2012;3:57–61. Retracted in: *Transl Med UniSa.* 2014;12:4.
16. Stevens BJ, Abbott LK, Yamada J, Harrison D, Stinson J, Taddio A, et al. Epidemiology and management of painful procedures in children in Canadian hospitals. *CMAJ.* 2011;183(7):E403–10. doi:10.1503/cmaj.101341.



The United Kingdom Moves to the MMRV Vaccine: A Review Based on the MHRA MMRV Factsheet

The United Kingdom introduced the combined Measles, Mumps, Rubella and Varicella (MMRV) vaccine into its routine childhood immunisation programme on 1 January 2026. This development represents another important step in simplifying vaccination schedules while expanding protection against vaccine-preventable diseases. The introduction of MMRV provides an opportunity for paediatricians and public health professionals worldwide to review the evidence supporting combination vaccines and their role in strengthening immunisation programmes.

What is the MMRV Vaccine?

MMRV is a combined live attenuated vaccine that protects against four infectious diseases (measles, mumps, rubella, and varicella). It replaces the traditional MMR vaccine in the UK's routine two-dose childhood vaccination schedule, while adding protection against varicella.

Each of these infections has the potential to cause significant morbidity. Measles remains one of the most contagious infectious diseases and can lead to severe complications such as pneumonia, encephalitis, and death. Mumps may result in meningitis, orchitis, and hearing loss. Rubella poses particular risks during pregnancy, causing congenital rubella syndrome. Varicella, although often perceived as a mild childhood illness, can lead to secondary bacterial infections, pneumonia, encephalitis, and severe disease in immunocompromised individuals. By combining protection against all four diseases into a single vaccine, the MMRV programme aims to reduce disease burden while maintaining high vaccination coverage.

Safety and Effectiveness

The MMRV vaccine has undergone extensive evaluation for safety, quality, and effectiveness before approval for routine use. Similar vaccines have been used safely for many years in countries including Canada, Germany, and Australia.

Like other licensed vaccines, MMRV is subject to continuous post-marketing surveillance. In the UK, the Medicines and Healthcare products Regulatory Agency (MHRA) monitors vaccine safety through the Yellow Card reporting system, ensuring that any potential adverse events are rapidly identified and investigated.

Importantly, the risks associated with natural infection far exceed those associated with vaccination. Measles, mumps, rubella, and varicella continue to cause serious complications globally, particularly in under-vaccinated populations.

Who Can Receive the Vaccine?

Most children can safely receive the MMRV vaccine. The vaccine is suitable for children with common allergic conditions such as asthma, eczema, hay fever, and food intolerances.

A notable point for clinicians is that severe egg allergy is not a contraindication. The vaccine contains no egg products, allowing children with egg allergy to be vaccinated safely in routine settings.

Contraindications and Precautions

As with other live attenuated vaccines, MMRV should not be administered to children with significant immunodeficiency. Careful clinical assessment is required when considering vaccination in children with congenital or acquired immune

disorders or those receiving immunosuppressive therapy.

Children who have experienced anaphylaxis following a previous dose of MMRV or to a vaccine component should not receive further doses. Additionally, children with severe gelatin allergy should receive a gelatin-free MMRV formulation where available.

These precautions highlight the importance of careful pre-vaccination screening and appropriate specialist consultation when necessary.

Adverse Events Following Immunisation

The majority of adverse effects following MMRV vaccination are mild and self-limiting. Common reactions include:

- Mild fever
- Transient rash
- Local soreness at the injection site

These symptoms generally occur within one to two weeks after vaccination and resolve within a few days.

Parents should be advised regarding routine supportive care, including maintaining hydration, avoiding excessive clothing during fever, and using paracetamol when appropriate.

Understanding the Risk of Febrile Convulsions

One of the most discussed adverse events associated with MMRV vaccination is febrile convulsion. Approximately one in 1,000 children may experience a febrile seizure following their first MMRV dose, typically during the second week after vaccination.

While this risk should be communicated transparently, it must be interpreted within the broader clinical context. Febrile convulsions are common in childhood, affecting approximately one in 25 children before the age of five years. Furthermore, measles infection itself carries a

substantially greater risk, with approximately one in 43 infected children developing febrile convulsions.

Most vaccine-associated febrile convulsions resolve completely without long-term neurological consequences.

Rare but Serious Adverse Events

Very rare adverse events include thrombocytopenic purpura presenting as bruise-like spots, generalized varicella-like rash, and encephalitis.

The risk of encephalitis following MMRV vaccination is estimated to be fewer than one case per million vaccinated children. In contrast, among children who develop measles infection, the risk of encephalitis ranges between approximately one in 200 and one in 5,000 cases. This comparison underscores the substantial protective benefit of vaccination.

Healthcare providers should educate parents regarding warning signs requiring urgent medical attention, including seizures, altered behaviour, loss of consciousness, focal neurological deficits, or significant rash.

Lessons for Immunisation Programmes

The introduction of MMRV in the United Kingdom reflects a broader trend towards combination vaccines that simplify immunisation schedules while expanding disease protection. Such approaches may improve vaccine acceptance, reduce the number of injections, and enhance programme efficiency.

As vaccine hesitancy continues to challenge public health efforts globally, transparent communication regarding both benefits and risks remains essential. The MMRV experience reinforces a fundamental principle of modern vaccinology: while no medical intervention is entirely risk-free, the benefits of vaccination overwhelmingly outweigh the risks of natural infection.

For paediatricians, the successful implementation of MMRV vaccination serves as another reminder that sustained investment in immunisation remains one of the most effective strategies for protecting child health and preventing serious infectious diseases.

Acknowledgements

The authors sincerely thank Professor Krisantha Weerasooriya and Professor Shalini Sri Ranganathan for sharing the MMRV vaccine factsheet and for suggesting this topic for the article.

Author's note: This review is based on the MHRA publication “MMRV Vaccine Factsheet – Information for Parents and Caregivers” and related UK immunisation guidance documents. <https://www.gov.uk/government/publications/mmr-vaccine-factsheet-information-for-parents-and-caregivers/mmr-vaccine-factsheet-information-for-parents-and-caregivers>



Diagnosis of Enterovirus Meningitis at Base Hospital Deniyaya: A Remarkable Diagnostic Approach by a Peripheral Healthcare Facility

Background

Deniyaya is situated in the Matara district of the Southern Province, Sri Lanka, bordering the Sinharaja rainforest. It is an area characterized by its unique natural environment, distinct cultural and socioeconomic features, and a multiethnic community. Deniyaya is prominent for high-quality tea exportation; consequently, the sociodemographic factors associated with the tea estate community play a significant role in the regional health profile.

Outbreak Identification

During the first two weeks of April 2026, the paediatric unit experienced a sudden surge in admissions of children presenting with clinical features suggestive of meningitis, including fever, headache, vomiting, photophobia, and phonophobia. Initial laboratory investigations of blood and cerebrospinal fluid (CSF) samples were inconsistent with a bacterial etiology, which is typically the primary consideration in children presenting with such clinical signs. Due to this diagnostic dilemma, opinions were sought from senior paediatricians and a paediatric neurologist, leading to the consideration of a viral aetiology.

Diagnosis of Enterovirus Meningitis

Enterovirus is a stable RNA virus with high environmental resilience and a known propensity for causing viral meningitis outbreaks. The specialist clinical team, liaising with consultant virologists, detected Enterovirus RNA in CSF samples using molecular testing, thereby confirming an enteroviral aetiology by the fourth week of April 2026.

Public Health Awareness

The hospital administration and the Medical Officer of Health (MOH) were promptly notified of the outbreak to implement necessary public health and sanitary measures. Educational and school authorities, alongside parents, were convened at major local schools to conduct targeted public awareness campaigns regarding the clinical symptoms and prevention of the illness.

Preventive Sector Involvement and Data Dissemination

Meningitis cases were formally notified via H 544 notification forms through the hospital's infection control unit and uploaded to the EpiNet surveillance system without delay. To facilitate continuous epidemiological surveillance, the hospital maintained a shared Google Spreadsheet updated daily, ensuring seamless data flow between the specialist clinical team and the epidemiology department.

Challenges in a Resource-Limited Setting

Amidst resource constraints, isolating suspected cases from the general paediatric population was critical. Two dedicated isolation bays were established and operated by separate staff cohorts to minimize the risk of nosocomial cross-infection. Furthermore, environmental cleaning schedules were intensified, and strict hygiene protocols, including hand washing with soap and water and mandatory face mask compliance were enforced within the paediatric unit.

Management of the Crisis Situation

Admissions peaked during the fourth week of April 2026, highlighting the urgent need for standardized clinical management guidelines. The Sri Lanka College of Paediatricians intervened by providing clinical management guidelines and implementing standardized case definitions. Clinicians were strictly advised to monitor for severe complications, specifically myocarditis, viral sepsis, and septic shock, which were identified risks of this particular outbreak strain.

By the fourth week of May 2026, approximately 68 cases had been officially notified. Among these, 20 cases were clinically classified as viral meningitis, and 5 cases were laboratory-confirmed as Enterovirus meningitis via viral isolation from CSF samples. Enterovirus was also successfully isolated from several nasopharyngeal aspirates and stool samples of suspected cases, with further viral typing currently arranged.

Conclusion and Achievements

The healthcare workers at Deniyaya Hospital demonstrated tireless dedication, working around the clock under sustained pressure due to staffing shortages and limited institutional capacity. By enforcing enhanced infection control measures and prioritizing patient safety, the staff successfully mitigated the crisis, resulting in a marked reduction in new cases by the second week of May 2026.

Although the hospital staff remains highly vigilant, the successful management of this outbreak serves as an exemplary model of multisectoral collaboration, demonstrating how early epidemiological identification can be achieved by effectively linking the curative sector, the preventive sector, and the community.



Dr. T.D.N Warnasuriya

Associate Specialist in General Paediatrics,
Base Hospital Deniyaya

The Foreskin in Childhood: A Practical Guide for Paediatricians

Introduction

The foreskin (prepuce) is a normal anatomical structure and an important component of male genital development. Misinterpretation of physiological non-retractability frequently leads to unnecessary referrals, forced retraction, and avoidable circumcision. Paediatricians should be able to distinguish normal developmental variations from pathological conditions requiring intervention.

Embryology, Anatomy and Function

At birth, the inner foreskin is naturally adherent to the glans penis. The foreskin protects the glans and urethral meatus from trauma, contamination, and irritation while maintaining a moist mucosal environment. Its persistence throughout mammalian evolution suggests an important biological function.

Natural History

Virtually all newborn boys have a non-retractile foreskin. This is physiological and should not be confused with phimosis. Separation of the foreskin from the glans occurs gradually through epithelial desquamation, erections, and penile growth. Approximately 95% of boys achieve retractability by adolescence, while only 1–3% remain non-retractile into late adolescence.¹

Normal findings include:

- Non-retractile foreskin.
- Partial adhesions.
- Ballooning during voiding.
- Smegma pearls.

These usually resolve spontaneously and require reassurance rather than treatment. Forced retraction should never be performed because it may cause pain, bleeding, infection, and scarring.

A normal foreskin becomes pathological most commonly because of repeated forced retraction.

Physiological versus Pathological Phimosis

Feature	Physiological	Pathological
Appearance	Healthy, supple foreskin	White fibrotic scarring
Course	Improves with age	Progressive worsening
Symptoms	Usually asymptomatic	Pain, bleeding, dysuria, infections
Ballooning	Usually benign	May indicate obstruction
Steroid response	Usually good	Variable
Circumcision	Rarely required	May be required

Indications for Intervention

Urinary Tract Infection

An intact foreskin is a recognized risk factor for urinary tract infection during infancy. Circumcision may be considered in recurrent febrile urinary tract infections or when significant urinary tract abnormalities are present.⁶

Pathological Phimosis

Features include a fibrotic scar ring, progressive loss of retractability, painful erections, recurrent balanoposthitis, and voiding difficulty.

Topical corticosteroids are effective in many children and should generally be considered before surgery.⁵

Recurrent Balanitis or Balanoposthitis

Recurrent or severe episodes affecting quality of life may justify intervention.

Balanitis Xerotica Obliterans

BXO is characterized by progressive scarring of the foreskin and may involve the meatus. Circumcision is usually required.⁶

Red Flags Requiring Urgent Assessment

Paraphimosis

Acute urinary retention

Suspected BXO with meatal involvement

Severe penile infection or cellulitis

Morbidity of Circumcision

Although generally safe, circumcision is not complication-free.

Early complications include bleeding, infection, pain, and wound problems. Late complications include meatal stenosis, skin bridges, inclusion cysts, trapped penis, cosmetic dissatisfaction, and the need for revision surgery. Rare but serious complications include urethral injury, glans injury, and significant haemorrhage.

Circumcision should therefore be regarded as a therapeutic procedure with defined indications rather than a routine treatment for physiological non-retractability.⁶

Advice for Paediatricians and Parents

Physiological non-retractability is normal.

Do not forcibly retract the foreskin.

Reassure parents regarding normal development.

Wash only the external penis until natural retractability occurs.

Refer children with pathological phimosis, recurrent significant infection, urinary obstruction, paraphimosis, or suspected BXO.

Conclusion

Most foreskin-related concerns in childhood represent normal physiology rather than disease. Understanding the natural history of the foreskin allows paediatricians to provide reassurance, avoid iatrogenic injury, and identify the small number of children who require intervention.

Perhaps the most important message for paediatricians and parents alike is that the greatest harm associated with the childhood foreskin is often not the foreskin itself, but the misconception that physiological non-retractability is a disease.



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References

1. Øster J. *Arch Dis Child.* 1968;43:200–203.
2. Moreno G, et al. *Cochrane Database Syst Rev.* 2014; (9):CD008973.
3. European Association of Urology. *EAU Guidelines on Paediatric Urology.* Latest edition.
4. American Academy of Pediatrics Task Force on Circumcision. *Pediatrics.* 2012;130:e756–e785.
5. Morris BJ, Wiswell TE. *J Urol.* 2013;189:2118–2124.
6. Couper MP, Hutson JM, Southwell BR. *Med J Aust.* 2015;203:177–178.



Batticaloa Regional Sessions 2026

The Sri Lanka College of Paediatricians (SLCP), in collaboration with the Batticaloa Medical Association (BMA) and the Sri Lanka Association for Child Development (SLACD), successfully conducted a series of educational programmes in Batticaloa on 11th May 2026. These initiatives reflected a strong commitment to strengthening child healthcare services in the Eastern Province through multidisciplinary professional development.

The excellent participation and engagement observed across all three programmes underscored the value of regional educational initiatives. These sessions exemplified SLCP's ongoing efforts to decentralize continuing professional education and strengthen the capacity of healthcare professionals involved in the care of Sri Lankan children.



Sri Lanka College of Paediatricians
in collaboration with
Batticaloa Medical Association

Batticaloa REGIONAL SESSIONS

CME for Doctors

11th May 2026 At Main Auditorium, TH Batticaloa

ENTRANCE FREE

CPD Points Awarded

08.00 AM Registration
08.25 AM Opening Remarks : Professor Pujitha Wickramasinghe, President, SLCP
08.30 AM **Nutritional Rehabilitation: New Insight**
Professor Pujitha Wickramasinghe, Senior Professor in Paediatrics, University of Colombo
08.55 AM **Approach to a Child with a First Seizure**
Professor Sarangi Wijesekera, Professor in Paediatrics, University of Sri Jaywardenepura
09.20 AM **Dengue: Optimising Fluids for Zero Mortality**
Dr Lakshmi Fernando, Senior Consultant Paediatrician
09.45 AM **Poisoning in Children: Recognition and Management**
Professor Viji Thirukumar, Professor in Paediatrics, Eastern University of Sri Lanka
10.10 AM **Update on Management of Childhood Nephrotic Syndrome**
Professor Randula Ranawaka, Professor in Paediatrics, University of Colombo
10.30 AM Tea Break
10.55 AM **Clinical Genetics in Practice: Everyday Insights**
Dr Vindya Subasinghe, Consultant Paediatric Geneticist, Lady Ridgeway Hospital
11.20 AM **Approach to a Child with Short Stature**
Dr Chandini Nishantha, Consultant Paediatric Endocrinologist, TH Anuradhapura
11.45 AM **Child Safeguarding: Role of a Primary Care Physician**
Dr M H F Nowreen, Acting Consultant Paediatrician, BH Kalmunai North
12.10 PM **Clinical Audits: Towards Excellence in Paediatric Care**
Dr B J C Perera, Senior Consultant Paediatrician
12.35 PM Quiz Competition : Dr Vindya Subasinghe, Assistant Secretary, SLCP
01.15 PM Closing Ceremony & Lunch

More info: www.slcp.lk

SCAN HERE TO REGISTER

Prof P Wickramasinghe Dr C Fernando Prof S Wijesekera Prof V Thirukumar Prof P Ranawaka Dr V Subasinghe Dr C Ranawaka Dr M H F Nowreen Dr B J C Perera

Sri Lanka College of Paediatricians
in collaboration with
Batticaloa Medical Association

Batticaloa REGIONAL SESSIONS

CME for Midwives

11th May 2026 At RDHS Auditorium, Batticaloa

ENTRANCE FREE

CPD Points Awarded

08.00 AM Registration
08.25 AM Opening Remarks : Dr Janani Suntharesan, Council Member, SLCP
08.30 AM **Identifying a Sick Neonate and Responding Effectively**
Dr M V Nabas Mohammed, Consultant Neonatologist, TH Batticaloa
09.00 AM **Common Childhood Illnesses: Essential Knowledge for Midwives**
Dr Dimuthu Subasinghe, Consultant Paediatrician, BH Epitaya
09.30 AM **Responsive Feeding in Children**
Dr V Vijayakanth, Associate Specialist in General Paediatrics, BH Valaichenai
10.00 AM **Use of Growth Charts and Timely Interventions**
Dr Janani Suntharesan, Consultant Paediatric Endocrinologist, SBSCH
10.30 AM Tea Break
11.00 AM **Early Detection of Developmental Delays Among Children**
Dr Phirathana Kamalanathan, Consultant Community Paediatrician, TH Batticaloa
11.30 AM **Strong Teeth, Healthy Child: A Midwife's Guide**
Dr Livitan Saravanamuthu, Dental Surgeon, TH Batticaloa
12.00 PM **Bridging the Gap: Feeding Techniques for Infants with Cleft Lip & Palate**
Dr Binarchana Prashana, Associate Specialist Paediatrician, BH Sammanthurai
12.30 PM **Recognising Red Flags: A Nurse's Guide to Child Abuse & Neglect**
Dr S Thanushriya, Associate Specialist in General Paediatrics, BH Kinnya
01.15 PM Closing Ceremony & Lunch

More info: www.slcp.lk

SCAN HERE TO REGISTER

Dr Janani Suntharesan Dr N Mohammed Dr Dimuthu Subasinghe Dr V Vijayakanth Dr P Kamalanathan Dr L Saravanamuthu Dr S Prashana Dr S Thanushriya

Sri Lanka College of Paediatricians
in collaboration with
Batticaloa Medical Association

Batticaloa REGIONAL SESSIONS

CME for Nurses

11th May 2026 At Nurses Training Centre, Batticaloa

ENTRANCE FREE

CPD Points Awarded

08.00 AM Registration
08.50 AM Opening Remarks : Professor Imalka Kankanaratchchi, Secretary, SLCP
09.00 AM **Heel Prick Test & Newborn Screening: What Every Nurse Should Know?**
Professor Imalka Kankanaratchchi, Professor in Paediatrics, University of Ruhuna
09.25 AM **Routine Patient Monitoring: Why It Matters?**
Dr Hasitha Gajaweera, Consultant Paediatric Pulmonologist, National Hospital Galle
09.50 AM **Paediatric Resuscitation: Essential Skills in Basic & Advanced Life Support**
Dr Malithi Guruge, Lecturer in Paediatrics, University of Sri Jaywardenepura
10.15 AM **Communicating with Care: Tackling Challenges in Paediatric Nursing**
Dr Nayani Suraweera, Consultant Paediatrician, TH Anuradhapura
11.05 AM Tea Break
11.30 AM **Understanding the Basics of IV Fluid Therapy in Children**
Dr Nimasha Wimalaguna, Acting Consultant Paediatrician, DGH Ampara
11.55 AM **Approach to a Child with Acute Neurological Concerns**
Dr Sanjaya Fernando, Consultant Paediatric Neurologist, Lady Ridgeway Hospital
12.20 PM **Beyond the Drug Chart, What Can We Do To Improve Pharmacotherapy?**
Dr A C Luckshanth, Acting Consultant Paediatrician, BH Kaluwankudy
12.45 PM **Recognising Red Flags: A Nurse's Guide to Child Abuse & Neglect**
Dr Sadani Vithana, Lecturer in Paediatrics, Sabaragamuwa University of Sri Lanka
01.25 PM Quiz Competition : Dr Sadani Vithana
01.30 PM Closing Ceremony & Lunch

More info: www.slcp.lk

SCAN HERE TO REGISTER

Prof I Kankanaratchchi Dr N Egodawera Dr Nalin Gunige Dr Nayani Suraweera Dr S Wimalaguna Dr Sanjaya Fernando Dr A C Luckshanth Dr Sadani Vithana



"The practice of medicine is an art, based on science. The good physician treats the disease; the great physician treats the patient who has the disease."

—William Osler

Regional Insight

Arbovirus Infection Webinar

On Sunday, 12th April 2026, the Asia Pacific Pediatric Association (APPA) partnered with the SLCP to host an impactful regional webinar, "Arbovirus Infection in the Asia Pacific - The Growing Concern," featured in WhatsApp Image 2026-04-12 at 6.35.52 AM.jpeg. Opened by APPA President Dr. Joselyn A. Eusebio, the session provided critical updates on vector-borne diseases. Sri Lankan experts took center stage, with Prof. Pujitha Wickramasinghe introducing basic care strategies and Dr. Lakkumar Fernando navigating the tightrope of dengue fluid management. Prof. Wantpreeya Phongsamart from Thailand followed with an essential discourse on control and prevention. Moderated by Prof. Datuk Dr. Zulkifli Ismail and concluded by Prof. Imalke Kankanararachchi, this international exchange provided clinicians with vital, region-specific strategies to battle rising arboviral threats.

ASIA PACIFIC PEDIATRIC ASSOCIATION WEBINAR

ARBOVIRUS INFECTION IN THE ASIA PACIFIC - THE GROWING CONCERN

SPEAKERS

- ARBOVIRUS INFECTION IN THE ASIA PACIFIC: BASIC CARE STRATEGIES**
PROF. PUJITHA WICKRAMASINGHE (SRI LANKA)
- DENGUE FLUID MANAGEMENT: NAVIGATING THE TIGHTROPE**
DR. LAKKUMAR FERNANDO (SRI LANKA)
- TACKLING ARBOVIRUS IN ASIA PACIFIC: CONTROL & PREVENTION**
PROF. WANTPREEYA PHONGSAMART (THAILAND)

12 April 2026, Sunday 3:00 PM (HK Time)

Registration

Navigating Critical Care: Paediatric Sepsis Update

Marking Sepsis Week, the Paediatric Intensive Care Chapter of the SLCP held a vital seminar titled "Paediatric Sepsis: An Update- What's New in 2026" on 20th April 2026 at the New Auditorium, Lady Ridgeway Hospital. Detailed in WhatsApp Image 2026-04-17 at 12.10.17 PM.jpg, the program focused heavily on the Surviving Sepsis Campaign Guideline 2026. An elite panel of consultant paediatric intensivists led the clinical sessions: Dr. Nilupulee Sumanasekera delivered the foundational pathophysiology overview, followed by Dr. Deshan Adhihetty on evaluation and management. Dr. Nalin C. Kitulwatte addressed septic shock, while Dr. Manjula Hewageegana and Dr. Sham Weerasinghe dissected sepsis-induced cardiac and organ dysfunctions, respectively, equipping frontline clinicians with lifesaving, up-to-date critical care competencies.

PAEDIATRIC SEPSIS: AN UPDATE
What's New in 2026

Sepsis Week: 19th - 25th April 2026
Discussion on Updates of Surviving Sepsis Campaign Guideline 2026

DATE 20th April 2026 **TIME** 8:00AM onwards
VENUE New Auditorium, Lady Ridgeway Hospital

- DR NILUPULEE SUMANASEKERA**
Overview of Paediatric Sepsis and Pathophysiology
Consultant Paediatric Intensivist
- DR DESHAN ADHIHETTY**
Evaluation and Management of Sepsis
Consultant Paediatric Intensivist
- DR NALIN C. KITULWATTE**
Septic Shock
Consultant Paediatric Intensivist
- DR MANJULA HEWAGEEGANA**
Sepsis-Induced Cardiac Dysfunction
Consultant Paediatric Intensivist
- DR SHAM WEERASINGHE**
Sepsis-Induced Organ Dysfunction
Consultant Paediatric Intensivist

SLCP Monthly Clinical Update: Inherited Metabolic Disorders

The Sri Lanka College of Paediatricians held a hybrid Monthly Clinical Update on May 22, 2026, at the New Auditorium, LRH. The session featured an invaluable clinical lecture on the Approach to a neonate with Inherited Metabolic Disorder by international expert Dr. Anil Jalan (Mumbai),

complemented by an excellent illustrative case presentation from Dr. Imesh Galappaththi (Senior Registrar in Neonatology).



Monthly Clinical Update



Clinical Lecture:
**Approach to a neonate with
Inherited Metabolic Disorder**

Dr Anil Jalan
Metabolic and Genetic Consultant
NIRMAN, Mumbai



Case Presentation
Dr Imesh Galappaththi
Senior Registrar in Neonatology
Dr Soyza Maternity Hospital for Women
Colombo





22ND MAY 2026
12 PM – 1 PM
NEW AUDITORIUM, LRH

SLCP Monthly Clinical Update: Enterovirus Infections and Meningitis

The Sri Lanka College of Paediatricians (SLCP) conducted its Monthly Clinical Update on 10th June 2026 as a hybrid session at the New Auditorium, Lady Ridgeway Hospital. The programme featured two insightful clinical lectures on Enterovirus Infections in Children by Dr. Kasun Jayasundara and Meningitis: Viral or

Bacterial by Professor Jithangi Wanigasinghe. The session provided participants with practical, evidence-based updates on the diagnosis and management of common paediatric infectious diseases, reinforcing current best practices in clinical care.



The poster for the SLCP Monthly Clinical Update features a light blue background with a subtle pattern of purple and pink virus-like particles. At the top center is the SLCP logo, which consists of a circular emblem with a stylized 'S' and 'L' and the text 'SRI LANKA COLLEGE OF PAEDIATRICIANS' around it. Below the logo is a dark blue rounded rectangle with the text 'Monthly Clinical Update' in white. The poster lists two clinical lectures. The first lecture is titled 'Enterovirus Infections in Children' by Dr. Kasun Jayasundara, who is shown in a circular portrait. He is a man with dark hair and a beard, wearing a suit and tie. His title is 'Head of the Department of Paediatrics and Neonatology, Faculty of Medicine, University of Moratuwa'. The second lecture is titled 'Meningitis: Viral or Bacterial' by Prof. Jithangi Wanigasinghe, who is shown in a circular portrait. She is a woman with dark hair, wearing a yellow top. Her title is 'Professor in Paediatric Neurology, Faculty of Medicine, University of Colombo'. At the bottom of the poster, there are three icons: a calendar icon for the date '10th June 2026', a clock icon for the time '12 noon', and a location pin icon for the venue 'New Auditorium, LRH'. Below these icons, it says 'Hybrid Session: Zoom Link Available at slcp.lk'. A QR code is located at the bottom right of the poster.

Monthly Clinical Update

Clinical Lecture:
Enterovirus Infections in Children
Dr. Kasun Jayasundara
Head of the Department of Paediatrics and Neonatology,
Faculty of Medicine, University of Moratuwa

Clinical Lecture:
Meningitis: Viral or Bacterial
Prof. Jithangi Wanigasinghe
Professor in Paediatric Neurology
Faculty of Medicine, University of Colombo

10th June 2026 **12 noon** **New Auditorium, LRH**

Hybrid Session:
Zoom Link Available at slcp.lk



Newborn Screening Workshop

On 26th June 2026, the Workshop on "Newborn Screening" was successfully conducted at the UCFM Tower by the Perinatal Society of Sri Lanka (PSSL) in collaboration with UNICEF and the Sri Lanka College of Paediatricians (SLCP) under the theme "Beyond Survival: Thriving with Advanced Maternal and Neonatal Care." The CPD-accredited programme brought together over 280 participants and featured expert-led sessions on maternal and newborn screening, congenital anomalies, neonatal hearing screening, critical congenital heart disease, congenital hypothyroidism, inherited metabolic disorders, and genomic newborn screening.

Live demonstrations and discussions on current screening practices and future innovations highlighted the importance of early detection, multidisciplinary collaboration, and strengthening national newborn screening programmes to improve neonatal health outcomes in Sri Lanka.

Workshop on "Newborn Screening"

Perinatal Society of Sri Lanka

in collaboration with

United Nations International Children's Emergency Fund (UNICEF) & Sri Lanka College of Paediatricians

7.30 AM	Registration
8.00 AM	Inauguration
8.10 AM	Address by Prof Ruwanthi Perera, President PSSL
8.15 AM	Address by Prof Pujitha Wickramasinghe, President SLCP
8.20 AM	Address by the Chief Guest, Dr. Abner Daniel Health and Nutrition Manager, UNICEF Sri Lanka Country Office
8.30 AM	Address by Dr Chandima Sirithunga, Director Family Health Bureau
8.35 AM	Presentation of the Audit on Newborn Screening
Plenary Sessions	
8.45 AM	The First 1000 Days: Integrating Universal Screening with Precise Nutritional Support Prof. Nishani Lucas, Professor in Neonatology
9.05 AM	Maternal Screening for Fetal Anomalies Prof. Tiran Dias, Cadre Chair and Professor in Fetal Medicine
9.25 AM	Maternal Infection Screening Dr. Gayana Gunaratna, Consultant Clinical Microbiologist
9.45 AM	Newborn Examination Dr. Dilani Dehigama, Consultant Neonatologist
10.05 AM	Optimizing the Intrauterine Environment to Mitigate Global NCD Risk Prof. Chandana Jayasundara, Professor in Obstetric and Gynaecology
10.25 AM	Tea
Symposium 01 : Neonatal Hearing Screening	
10.45 AM	Neonatal Hearing Screening Dr. Rukmini Rupasinghe, Consultant ENT Surgeon
11.05 AM	Screening in Action: Live Technique Demonstration Jeyarajah Thaneraj, Audiologist Sanjayani Gunaratne, Biomedical Engineer
Symposium 02 : Newborn Screening for Congenital Heart Disease	
11.20 AM	CCHD Screening: Interpretation and Clinical Workflow Dr. Nimesha Gambewage, Consultant Neonatologist
11.40 AM	Caught by Pulse-Ox or Crashing at Bedside: Stabilizing the Neonatal Heart : Cardiologist's Perspective Dr. I R Raghunathan, Consultant Paediatric Cardiologist
12.00 AM	Screening in Action: Live Technique Demonstration N.M.P.V.S Ekanayaka
Symposium 03 : Newborn Screening for Congenital Hypothyroidism	
12.15 PM	Public Health Perspective in Newborn Screening Dr. Nethmini Thenuwara, Consultant Community Physician
12.35 PM	Collection, Transport and Analysis of Heel Prick Sample Prof. Manjula Hettiarachchi, Professor in Nuclear Medicine
12.55 PM	Management of a Positive Screening Result Dr. Navoda Atapattu, Consultant Paediatric Endocrinologist
Symposium 04 : Future Prospects in Newborn Screening	
1.15 PM	Expanded Screening for Inherited Metabolic Disorders Prof. Imalte Kankananarachchi, Professor in Paediatrics and Head of the Nuclear Medicine Unit
1.35 PM	Genomic Newborn Screening Dr. Vindya Subasinghe, Consultant Clinical Geneticist
1.55 PM	Closing remarks



Excellence in Paediatric Endocrine Care

On 23rd May 2026, the Sri Lanka College of Paediatricians, in collaboration with the Asia Pacific Paediatric Endocrine Society (APPES), hosted a prestigious international scientific session at Jetwing Colombo 7. Titled "Excellence in Paediatric Endocrine Care: Global Challenges, Innovations & Way Forward," the event offered 6 valuable CPD points to participants.

An esteemed international faculty delivered cutting-edge updates across four core areas: neonatal endocrine disorders, metabolic conditions like Type 1 Diabetes and adolescent PCOS, bone and growth disorders, and strategies for optimizing clinical outcomes. By bridging global expertise with local practice, this high-impact academic session successfully equipped clinicians with the latest advancements to elevate endocrine care for children island-wide.

Excellence in Paediatric Endocrine Care: Global Challenges, Innovations & Way Forward

Opportunity to Listen to an Esteemed International Faculty

Date: 23rd May 2026
Venue: Jetwing Colombo 7, Sri Lanka

08:00 AM Welcome Address

Neonatal Endocrine Disorders

08:30 AM ABC of Disorders of Sex Differences - **Dr Reiko Horikawa** 🇯🇵

09:00 AM Congenital Adrenal Hyperplasia Diagnostic & Management Strategies - **Dr Kenichi Kashimada** 🇯🇵

09:30 AM Congenital Hypothyroidism Among Preterm Newborns: Transient or Real - **Dr Sylvia Estrada** 🇵🇭

10:00 AM Questions & Answer Session

10:30 AM Break

Metabolic Disorders

10:45 AM Type 1 Diabetes in the 21st Century - Progress & Possibilities - **Professor Maria Craig** 🇦🇺

11:15 AM PCOS in Adolescent: Evidence-based Approach for the Paediatricians - **Professor Alexia Pena** 🇦🇺

11:45 AM Hidden Fats, Hidden Facts: Paediatric Lipid Disorders - **Dr Joanna Tung** 🇸🇮

12:15 PM Questions & Answer Session

12:45 PM Lunch Break

Bone & Growth Disorders

01:30 PM Bone Pains & Fragile Bones: What Can You Do? - **Dr Azriyanti Binti Anuar Zaini** 🇲🇾

02:00 PM Diagnosis & Treatment of McCune Albright Syndrome - **Professor Junfen Fu** 🇨🇳

02:30 PM Sharing the Chinese Experience
Genetics of Growth - **Dr Noriyuki Namba** 🇯🇵

03:00 PM Questions & Answer Session

03:30 PM Lunch Break

Optimising Outcomes

03:45 PM Hypoglycaemia - **Professor Wu Wei** 🇨🇳

04:15 PM Too Soon or Too Late: Case-based Discussion on Pubertal Disorders in Children - **Dr Sharmin Mahbuba** 🇧🇩

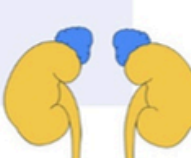
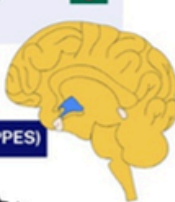
04:45 PM Childhood Cancer: What Happens After Cure - **Dr Cindy Ho** 🇨🇳

05:15 PM Questions & Answer Session

05:30 PM Closing Remarks

SAVE THE DATE



Sri Lanka College of Paediatricians in collaboration with Asia Pacific Paediatric Endocrine Society (APPES)



Registration Now Open!
Early : 3500LKR
Late : 5000LKR





★★★★★
6 CPD Points Awarded

Atypical HUS in Children

The SLCP's Monthly Clinical Update on 24th April 2026 tackled nephrological complexities with its session, "Atypical HUS in Children: Exploring the Clinical Diversity," as presented in WhatsApp Image 2026-04-24 at 5.18.10 AM.jpg. Held as a hybrid event live from the New Auditorium, LRH, and via Zoom, the session unraveled the challenging presentations of atypical Hemolytic Uremic Syndrome. Professor Randula Ranawaka, a leading Consultant Paediatric Nephrologist from the University of Colombo, delivered an authoritative clinical lecture on its diverse manifestations.

Complementing the theory, Senior Registrar Dr. Dulani Nelson presented a detailed case study illustrating real-world diagnostic pathways. This focused hour proved essential for local practitioners aiming to improve early recognition and targeted intervention for this severe condition.



Monthly Clinical Update

Atypical HUS in Children: Exploring the Clinical Diversity



Clinical Lecture
Professor Randula Ranawaka
*Professor in Paediatric Nephrology
 University of Colombo
 Consultant Paediatric Nephrologist
 Lady Ridgeway Hospital for Children*



Case Presentation
Dr Dulani Nelson
*Senior Registrar in Paediatric Nephrology
 Lady Ridgeway Hospital for Children*



Pre Congress Childhood Origins to Adult Outcomes in Endocrinology

13th August 2026

Lotus Ballroom, Shangri-La, Colombo, Sri Lanka

08:00 AM - 08:45 AM

08:45 AM - 09:05 AM

09:05 AM - 09:25 AM

09:25 AM - 09:45 AM

09:45 AM - 10:00 AM

10:00 AM - 10:30 AM

10:30 AM - 11:00 AM

11:00 AM - 11:25 AM

11:25 AM - 11:45 AM

11:45 AM - 12:00 PM

12:00 PM - 12:20 PM

12:20 PM - 12:40 PM

12:40 PM - 01:00 PM

01:00 PM - 01:15 PM

REGISTRATION

Principles of Insulin Dosing in Type 1 Diabetes

Dr Shenali Amaratunga

Consultant Paediatric Endocrinologist

Department of Paediatrics, Motol University Hospital, Prague, Czech Republic

Growing Up with Diabetes: Case-Based Challenges in Children and Adolescents : Sri Lankan Perspective

Dr Dinendra Siriwardena

Consultant Paediatric Endocrinologist

Teaching Hospital, Rathnapura, Sri Lanka

Utilization of Novel Technologies in Diabetes Management in a Resource-Limited Setting

Dr Shenali Amaratunga

Consultant Paediatric Endocrinologist

Department of Paediatrics, Motol University Hospital, Prague, Czech Republic

Interactive Discussion

Faces, Brains, and Hormones: Interpreting MRI in Pituitary Diseases

Prof MUDr Jan Lebl

Consultant Paediatric Endocrinologist and Chair Emeritus,

Department of Paediatrics, Charles University, 2nd Faculty of Medicine, Prague, Czech Republic

TEA BREAK

The Changing Spectrum of Growth Disorders: How We Approach

Prof MUDr Jan Lebl

Consultant Paediatric Endocrinologist and Chair Emeritus,

Department of Paediatrics, Charles University, 2nd Faculty of Medicine, Prague, Czech Republic

Too Short or Too Tall? A Case-Based Approach to Growth Disorders

Dr Dimarsha De Silva

Consultant Paediatric Endocrinologist

National Hospital, Galle, Sri Lanka

Interactive Discussion

Rising Weights, Rising Risks: Confronting the Childhood Obesity Epidemic in Sri Lanka

Dr Chamidri Naotunna

Consultant Paediatric Endocrinologist

Teaching Hospital, Anuradhapura, Sri Lanka

Obesity is a Brain Disease

Prof MUDr Jan Lebl

Consultant Paediatric Endocrinologist and Chair Emeritus,

Department of Paediatrics, Charles University, 2nd Faculty of Medicine, Prague, Czech Republic

Childhood MASLD

Dr Wathsala Hathagoda

Senior Lecturer in Paediatrics

Faculty of Medicine, University of Colombo, Sri Lanka

Interactive Discussion

Limited seats are available. Register on or before 01st August, 2026

Registration Fee - Local Delegates : LKR 5,000
Foreign Delegates : USD 100

Sri Lanka College of Endocrinologists
No.04, Siri Dhamma Mw., Colombo 10, Sri Lanka.

011 2 693 055 / 077 4 983 829

www.slendo.lk

PAEDIATRICS

Guidelines on submission of articles for the SLCP NEWSLETTER

All communications should be addressed to
Dr Hasitha Gajaweera & Dr Kasun Jayasundara,
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.

