CCP News

Newsletter of the Ceylon College of Physicians

May 2019

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President's message

Dear Fellows and Members,

In the aftermath of the Easter Sunday tragedy, Sri Lanka is slowly limping back towards normalcy. For those who were affected, life will never be "normal" again, for the rest, the fear of terrorism will now remain a distinct possibility for a very long time. My sincere hope is that all parties involved will take a more pragmatic course and try to find a long-lasting solution. It is imperative that we stand together united as Sri Lankans, that is the only way that we can defeat any kind of terrorism.

The College activities too continued as planned.

With the decline in obstetric causes, medical problems such as cardiac diseases and infections are now the major contributors to maternal mortality in Sri Lanka. The specialty day in Maternal Medicine was conducted by the College to enhance and upgrade the knowledge on medical disorders in pregnancy. The presentation covered most of the common medical issues that need to be managed optimally during pregnancy for better foetal and maternal outcomes. While the meeting was well attended by practicing clinicians, it was disheartening to note the suboptimal attendance by postgraduate trainees at this meeting. This highlights the need to encourage trainees to get away from the "exam oriented" training and prepare for real life situations that they will need to manage eventually. I would like to take this opportunity to request all of you to do so, we need better prepared trainees to effectively take up tomorrows challenges.

The College Lecture titled "Unseen aspects of Parkinson's disease" was delivered by Dr Nadee Ratnayake, Consultant Neurologist at District General Hospital, Matale. She discussed some of the important but much neglected aspects of Parkinson's disease. The presentation brought to attention the need to go beyond the acute problems in managing patients with chronic disorders, especially the older people who will have to contend with diseases of old age too.

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President's message

To support continued professional development of the members, CCP has strengthened our CPD programme. We now send an sms to all registered participants of our academic events with a link to obtain the CPD certificate. I request all of you to make use of this and obtain your certificates of participation. While facilitating the CPD programme, this system, we hope, will contribute towards reducing use of paper and support protection of our environment for a better tomorrow.

The College is currently updating the members' database. I request all of you to send you details via the Google Forum sent to you by sms and email links. This will enable the College to be in contact with all of you easily.

With best wishes,

Professor Chandanie Wanigatunge
President

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Specialty Day

The Specialty Day in May was themed on Maternal Medicine and was held in collaboration with the Sri Lanka College of Obstetricians and Gynaecologists on the 3rd of May at the ClinMARC auditorium. Drs. Chaminda Garusinghe, Hasitha Wijewantha, Lalindra Gooneratne, Duminda Munidasa and Sanjeewa Rajapakshe conducted talks on diabetes, thrombocytopaenia, SLE and cardiac disease related to pregnancy respectively. Prof. Athula Kaluarachchi (President - SLCOG) delivered a talk on maternal morbidity and mortality in Sri Lanka, while Prof Chandani Wanigatunge conducted the lecture 'Prescribing in Pregnancy'.

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Young Physicians' Forum and College Lecture

The Young Physicians' Forum and the College lecture was held on the 14th of May at the ClinMARC auditorium at the NHSL and the event was well attended. There were two YPF presentations. The first presentations was done by Dr T A Dilanka Tilakaratne, Senior Registrar in Respiratory Medicine - National Hospital for Respiratory Diseases, Welisara and the topic was "A Simplified Approach to a Complex Lung Condition – Interstitial Lung". The second presentations was done by Dr. Dhanushi Abeynayake - Senior Registrar in Gastroenterology and Hepatology, National Hospital of Sri Lanka on "Non Alcoholic Fatty Liver Disease -Is it all about weight?". The College lecture was delivered by Dr Nadie Rathnayaka, Consultant Neurologist, District General Hospital – Matale on "Unseen aspects of Parkinson's Disease". The event was sponsored by CIPLA.

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A Simplified Approach to a Complex Lung Condition – Interstitial Lung Disease

Dr T A Dilanka Tilakaratne– Senior Registrar National Hospital for Respiratory Diseases, Welisara

Interstitial lung disease is confusing from the onset as the term itself is a misnomer as these diseases not only involve the interstitium, but also the alveoli and parenchyma. These are better described by the new term Diffuse Parenchymal Lung Diseases (DPLDs).

One needs to have a basic knowledge on the common DPLDs, regarding the evolution of the disease and analysis and management of these disorders.

Idiopathic Pulmonary Fibrosis (IPF) has a worse 5 year prognosis than most of the cancers other than that of lung and pancreatic origin. The prevalence of DPLDs vary according to regions with 2- 8% in studied old age populations. DPLDs have been categorized into 4 main categories and include: ILDs of known association, Granulomatous ILD, Idiopathic interstitial pneumonias and miscellaneous.

The basic patterns of HRCT should be evaluated for zonal distribution, features of fibrosis, presence of ground glass opacities and consolidations, presence of nodular opacities and lucent lesions. The three major histological patterns are the usual interstitial pneumonia-UIP, nonspecific interstitial pneumonia – NSIP, organizing pneumonia – OP.

The analysis of a patient begins with a thorough history. The salient feature will be shortness of breath. Due to the gradual progression, some patients will adapt their lifestyle to compensate for their disability, which further delays seeking medical attention. Some may have a dry cough as well as malaise and weakness. A thorough history with regards to occupational and environmental exposure needs to be soughted in a chronological order. Attention should be paid with regards to features of connective tissue disease (CTDs) as well as smoking and drug use. A thorough history will make a difference in diagnosis as well as management. The salient feature in the examination is the bibasal end inspiratory 'Velcro' type crepitations with cyanosis and clubbing as the disease advances. It is of value to look for pulmonary hypertension as well.

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A Simplified Approach to a Complex Lung Condition – Interstitial Lung Disease

The work up includes a chest x-ray which might range from being completely normal, having subtle lower zone opacity and to bilateral prominent opacities with volume reduction. The mainstay of diagnosis is a properly performed High Resolution CT (HRCT). The aetiological analysis is by way of inflammatory marker and antibody testing (ie:-ANA, rheumatoid factor, anti CCP levels and other immune markers of CTDs). Bronchoscopy may aid in the diagnosis of OP or chronic HP. A restrictive ventilatory defect with a low carbon monoxide diffusion capacity is characteristic. This finding is useful at follow up visits in taking decisions on management. The 6 minute walk test is also useful. Lung biopsy is seldom used now as the evidence has shown that it may not be beneficial in border-line cases, and the risk can out weigh the benefits of surgery.

The collective decision making by means of a multidisciplinary meeting has revolutionized ILD management as it brings together physicians, radiologists and pathologists to make decisions regarding management and follow up. It also minimizes the need for lung biopsy.

Usual interstitial pneumonia on HRCT will have features of fibrosis with a cranio-caudal distribution. The characteristic honeycomb pattern with traction bronchiectasis will be evident in the basal as well as the sub pleural regions. This pattern can be seen in connective tissue disease such as rheumatoid arthritis and chronic HP. If no secondary cause is found and there are no overlapping features towards NSIP or OP, the disease is termed Idiopathic pulmonary fibrosis (IPF).

IPF has a predilection for males ages 60 to 70 years. The majority have a history of smoking and due to its long standing nature some may have clubbing (30%). The mainstay of management is with anti-fibrotics like pirfenidone and nintedanib. The objective of treatment will be to reduce the rate of progression. Even with novel treatment options patients with IPF have a median survival of 3 years.

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NSIP pattern is the most prevalent pattern seen in CTDs and is common in scleroderma, SLE and myositis spectrum diseases. ILD can manifest due to the CTD or due to drugs used for CTD such as methotrexate. Less commonly the diagnosis of ILD may be made before features of CTD appear – "lung dominant CTD". The typical feature in HRCT would be basal ground glass opacities with sub pleural sparing.

In OP the main HRCT findings are peripheral and peribronchovascular sharply demarcated consolidative lesions. The aetiology can be secondary to infection, drugs, or CTD. The term cryptogenic organizing pneumonia term is used if no cause can be discerned.

Hypersensitivity pneumonitis is common in our part the world and goes hand in hand with exposure to organic and inorganic dust exposure. This may be due to occupation, vocational activities or the home environment. It has an acute, sub acute as well as a chronic stage with distinct HRCT features. The prominent features in HRCT would be the predilection for the upper lobes with air trapping and later stages fibrotic changes.

The basis of treatment for NSIP, OP and HP would be immune therapy by means of steroids and steroid sparing agents. The duration of treatment can vary as well as the intention to treat. The aim of treatment in cellular NSIP, OP and acute HP would be to achieve complete remission. However, in fibrotic NSIP the target is to maintain disease stability.

It may be challenging to manage a patient with ILD coming with worsening shortness of breath as there are multiple possibilities. As general practitioners and physicians come into first contact, they should entertain the possibilities of whether it is a disease exacerbation of ILD itself, an infection, heart failure, onset of pulmonary hypertension or the less likely possibilities of pulmonary embolism, pneumothorax or malignancy.

With the new advances of ILD there is a lot of potential to treat and prevent morbidity, however early diagnosis is crucial. Hence the way forward is with collaborative efforts of the primary care doctors, general physicians and chest physicians.

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Non Alcoholic Fatty Liver Disease -Is it all about weight?

Dr. Dhanushi Abeynayake -Senior Registrar in Gastroenterology and Hepatology, National Hospital of Sri Lanka

Non alcoholic fatty liver disease (NAFLD) is the hepatic steatosis detected by imaging or histology after excluding secondary causes of fat accumulation in the liver (e.g. significant alcohol consumption, drugs and possible medical conditions). NAFLD is further categorized histologically to non alcoholic fatty liver and non alcoholic steatohepatitis. Non alcoholic fatty liver is hepatic steatosis without inflammation in the form of hepatocyte ballooning. Non alcoholic steatohepatitis is hepatic steatosis with lobular or portal inflammation and hepatocyte ballooning with or without fibrosis.

The natural progression of NAFLD is fatty liver progressing to steatohepatitis in 10-20% patients and of these 25-50% develop fibrosis. Fibrosis may progress to cirrhosis in 2-5% patients per year. Of these 2-3% of patients will ultimately end up with hepatocellular carcinoma.

Risk factors for NAFLD are mainly obesity, insulin resistance, type 11 diabetes mellitus, dyslipidaemia and metabolic syndrome.

The Pathogenesis starts from hepatic steatosis leading to inflammatory reaction mediated by cytokines, adipokines, mitochondrial dysfunction and oxidative stress ultimately leading to hepatocellular injury. There are several hypothesis accepted worldwide based on this mechanism.

The prevalence of NAFLD does not necessarily overlap with the prevalence of obesity. According to various studies done in different parts of the world, there is a significant percentage of patients with NAFLD who are not obese or overweight.

Lean NAFLD is hepatic steatosis in a patient who is not overweight or obese as per region specific Body Mass Index (BMI) which is <23kgm2 for Asians and <25kgm2 for non Asians.

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Non Alcoholic Fatty Liver Disease -Is it all about weight?

Overall epidemiological data suggests that the prevalence of lean NAFLD in Asia is 5-26% and 7-20% in the West. Clinical and biochemical characteristics of lean NAFLD have been analysed worldwide. Such patients have a higher BMI and a higher prevalence of metabolic derangements compared to healthy controls. Moreover, in comparison to obese/overweight NAFLD patients have a lower BMI, waist circumference and a lower prevalence of metabolic disorders. These lean NAFLD patients are termed "Metabolically obese normal weight" individuals.

There is no proven possible single mechanism for the pathogenesis of lean NAFLD. Visceral obesity, which is considered as more metabolically hazardous than other fat may play a major role in the pathogenesis. Waist circumference and neck circumference are measures to detect visceral obesity. Shift in body weight form normal weight to obesity/overweight is more hazardous than being overweight/obese. Environmental factors such as diet high in fructose and cholesterol, genetic factors like PNPLA3 gene, insulin resistance, dyslipidaemia, cytokines, different patterns of gut microbiota, decreased capacity for storing fat in subcutaneous adipose tissue, reduced mitochondrial function and increased de-novo lipogenesis in the liver are possible mechanisms. Multiple hits acting together on a genetically predisposed lean subject is the most likely mechanism inducing NAFLD.

There is evidence in certain studies that Asians have higher proportion of visceral fat for a given BMI than Europeans and higher tendency of metabolic derangements and higher prevalence of metabolically unhealthy normal weight individuals.

There is limited data for clinical implications of lean NAFLD. Generally lean NAFLD patients have less severe metabolic derangements and less severe disease than obese NAFLD patients. However, there is emerging contradictory evidence as well.

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Diagnosis is made primarily by imaging or histology. Non invasive methods such as Fibrosis-4 score(FIB-4) and NAFLD fibrosis score are useful methods for detection of fibrosis. Transient elastography and MRI elastography are highly accurate methods for detection of severity of fibrosis and assessing the need for liver biopsy.

There is no recommended pharmacological management. Life style modifications with weight loss, dietary modifications and exercise have shown some evidence of regression of steatosis in lean NAFLD patients. Patients could be advised on diet low in Fructose and cholesterol. Dyslipidaemia should be treated. Insulin sensitizers and antioxidants have a role only in biopsy proven NASH.

Screening for lean NAFLD is a practical problem faced by the physician since the easily recognizable obesity is not seen. Therefore, vigilant screening of lean subjects with other metabolic risk factors should be done with a low threshold for early detection of lean NAFLD.

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Unseen aspects of Parkinson's Disease

Dr Nadie Rathnayaka, Consultant Neurologist, District General Hospital - Matale

Parkinson's Disease is the second most common neurodegenerative disorder second only to Alzheimer's dementia. The most evident and cardinal features are the motor manifestations like resting tremor, rigidity, bradykinesia and postural instability caused by reduced levels and dysfunction of Dopamine - one of the key neurotransmitters found in the basal ganglia. As initially thought Parkinson's is not a disease confined to basal ganglia, the initial insult being to the gut and the olfactory pathways.

It is this impact on areas other than basal ganglia, which leads to the non-motor manifestations of the disease. The major categories are neuropsychiatric manifestations, autonomic dysfunction, sleep dysfunction and sensory abnormalities.

Non motor symptoms are quite common and most of them can precede the Parkinson's motor symptoms by decades. They are disabling and affects quality of life significantly. Most of the time non motor symptoms can be overlooked if not looked into carefully. Some symptoms can get aggravated with the Dopa therapy and can get masked with the disease itself e.g. depression.

They are difficult to treat but rewarding once treated as the quality of life of the patient directly depends on them.

Treatment should be individualized according to the presentation, severity of motor symptoms, age and the functional state. Levodopa therapy may aggravate some non-motor symptoms like orthostatic hypotension, psychosis and dry mouth, where cautious reduction of the dosage is necessary. Most of the symptoms would respond to non-pharmacological measures and few symptomatic drugs hence a multidisciplinary approach is warranted.

Appearance of some non-motor symptoms like dementia and psychosis indicate a poor prognosis and increased rate of hospital admissions.

Therefore, non-motor manifestations are equally important to diagnose and treat early, similar to the motor manifestations in Parkinson's disease, so as to improve the quality of life of the patient.

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Best Publication by a Physician –
Call for Applications

CALL FOR APPLICATIONS
BEST PUBLICATION BY A PHYSICIAN IN 2018

Eligibility criteria

- The applicant should be a Member or an Associate Member of the Ceylon College of Physicians.
- Study has to be based primarily in Sri Lanka
- The article should have been published in a peer reviewed journal during the year of 2018

Please send 5 hard copies of the article with a soft copy on a CD, a copy of your CV and a covering letter to reach us by 31st July 2019

The award will be presented at the
Anniversary Academic Sessions in September 2019

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Annual Academic Sessions 2019 at a Glance

52nd ANNIVERSARY ACADEMIC SESSIONS 2019

Ceylon College of Physicians

in collaboration with

Royal College of Physicians of Edinburgh

12th – 14th September 2019

Venue: Galadari Hotel, Colombo

Programme

Day 1	Thursday - Pre-Congress 12th September 2019		
8.00 – 9.00 am	Registration		
	Pre-congress symposia		
	Hall A	Hall B	Hall C
Session 1 9.00– 10.30 am	**Principles and Practice of Critical Care** **Daily goals: a holistic approach to individual patient care** Dr Graham Nimmo **Fluid management** Dr Susan Nimmo **Managing the patient who is difficult to ventilate/oxygenate** Dr Graham Nimmo	**Research for the Physicians** **Formulating research questions; guidance for beginners** Prof SAM Kularatne **Identifying research areas of local relevance** Prof Saroj Jayasinghe **The importance of study design** Prof A Pathmeswaran	**Palliative Care in the Community** **Role of the GP in Palliative care** Prof Scott Murray & Dr Mary Murray **Principles of symptom control and basic management of common symptoms** • **Pain** - Dr Udayangani Ramadasa • **Restlessness and agitation** - Dr Gamini Pathirana • **Breathlessness**- Dr Ravini Karunathilake • **Nausea and vomiting, constipation** - Dr Hasitha Wijewantha
10.30 – 11.00 am	Tea		
Session 2 11.00 am – 12.30 pm	**Analgesia in the critically ill** Dr Susan Nimmo **Sepsis** Dr Graham Nimmo **Clinical decision making** Dr Graham Nimmo	**Ethics, confidentiality and conflicts of interest** Dr Panduka Karunanayake	**Terminal care at home** Dr Shyamalee Samaranayke **Loss, grief and bereavement** Dr Mahesh Rajasuriya **Questions and discussion** All speakers and participants

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		How to write a good project proposal Prof Sarath Lekamwasam **How to write a good paper** Prof Janaka de Silva	
12.30 – 1.30 pm	Lunch		
Session 3 6.00 pm – 10 pm	**Inauguration Ceremony** **Chief Guest** – Dr SinhaRaja Tammita-Delgoda **Guest of Honour** – Prof Derek Bell *CCP Oration*		

Day 2	Friday 13th September 2019		
7.00 – 8.00 am	**BC 1 - Numbness of hands and feet** Dr Umapathy N Thirugnanam		**BC 2 – Nephrology** Dr Kelum Wimalaratne
8.00 – 8.30 am	**Registration**		
	Plenaries - Hall A		
Session 4 8.30 – 9.00 am	**The Clinician and the Patient: re-defining the relationship** Prof Derek Bell President of the Royal College of Physicians of Edinburgh, UK		
Session 5 9.00 – 9.30 am	**How to evaluate an asymptomatic patient with raised liver enzymes** Prof Janaka de Silva Senior Professor of Medicine, University of Kelaniya and Director, PGIM		
Session 6 9.30 – 10.00 am	**Placebo and nocebo** Professor Ali Jaward Vice President (Global), Royal College of Physicians, London		
10.00 – 10.30 am	Tea		
	Symposia		
	Hall A	**Hall B**	**Hall C**
Session 7 10.30 – 12.00 pm	**Cardiology** **Risk Factors in Ischemic Heart disease- when to intervene** Prof Indira Samarawickrema **Speaker 2 – TBC** **Heart Failure with Preserved Ejection Fraction: a misunderstood disease in search of a therapy** Dr Naomali Amarasena	**Emerging infections** **Global perspective of Emerging Infections** Dr Nick Beeching **Meliodosis** Dr Enoka Corea **Leishmaniasis** Dr Nayani Madarasinghe	**Free Papers**

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Session 8 12.00 – 1.30 pm	**Maternal Medicine for Physicians** **Thyroid disorders in pregnancy** Dr Noel somasundaram **Acute Fatty liver in Pregnancy** Dr Manajala Senanayake **Thromboembolic disorders** Dr Lalindra Gooneratne	**Optimizing medicines use** **Interpreting evidence and its application to routine clinical practice** Dr Fraz Mir **Good practice in Prescribing for Older Adults** Dr Susan Pound **Medicines for the Differently Abled** Dr Chamari Weeraratne	
1.30 – 2.30 pm	Lunch		
Session 9 2.30 – 3.45 pm	**Palliative care** **Integrating palliative care into day to day practice in Sri Lanka** Dr Udayangani Ramadasa **Role of the interdisciplinary team in palliation** Prof Scott Murray **Decision making and ethical dilemmas in palliative care** Dr Dilhar Samaraweera	**Respiratory** **Pleural effusion – from pleural effusion to empyema** Dr Ed Nevil **Latent TB** Dr Jakki Faccenda **Obstructive Sleep Apnoea** Dr Chandimani Undugodage	
Session 10 3.45 – 4.30 pm	**Oration 2**		
4.30 – 5.00 pm	Tea		
5.00 – 6.00 pm	**EC 1 – Vertigo/syncope** Dr Daminda Domingoaracchi	**EC 2 – Assessment Backache** Prof Ali Jaward	
6.00 – 7.00 pm	**EC 3 – Cranial nerves and eye movements** Dr Umapathy Thirugnanam		

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Annual Academic Sessions 2019 at a Glance

Day 3 Saturday 14th September 2019			
7.00 – 8.00 am	**BC3 - Interpreting ECG** Dr Mevan Wijetunge		**BC 4 – Imaging: Case based discussion** Dr Lakmali Paranahewa
8.00 – 8.30 am	Registration		
Session 11 8.30 – 9.00 am	**Plenary 4 – Data sharing, confidentiality and autonomy - a series of oxymorons?** Dr Ed Nevil Palliative Care, Edinburgh, UK		
Session 12 9.00 – 9.30 am	**Plenary 5 – Acute illness in frail older patients** Dr Susan Pound Consultant in Geriatric Medicine Victoria Hospital, Kirkcaldy, UK		
Session 13 9.30 – 10.00 am	**Plenary 6 – Dying: different for different diseases and different cultures** Prof Scott Murray St Columba's Hospice Chair of Primary Palliative Care, Edinburgh, UK		
10.00 – 10.30 am	Tea		
	Symposia		
	Hall A	**Hall B**	**Hall C**
Session 14 10.30 – 12.00 pm	**Haemato-oncology** **Improving out comes haematological malignancies: a physician's perspective** Dr Saman Hewamanna **Chronic GVHD** Dr Lalindra Gooneratne **Myelomas** Prof Ray Powles	**Psychiatry** **Medically unexplained symptoms** Dr Lakmi Seneviratne **Delirium: a guide for the modern physician** Dr Sayuri Perera **Conversion and dissociation disorders** Dr Asiri Rodrigo **Psychiatry in epilepsy** Dr Chathurie Suraweera	**Free Papers**
Session 15 12.00 – 1.30 pm	**Medical Humanities** **A history of Western medicine in 20 minutes** Dr Panduka Karunanayake **Understanding Illness: Narrative Medicine** Dr Mevan Wijeyatunga	**Nephrology** **Post renal transplant issues** Prof Mohammad Ghnaimat Jordan **CKD** Dr Chula Herath **AKI – What's new?**	**Free Papers**

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	Where there is love of art, there is love of medicine Dr Shehan Silva	Dr Kelum Wimalaratne	
1.30 – 2.30 pm	Lunch		
Session 16 2.30 – 3.45 pm	**Rheumatology** **Current and Future Use of Biologics in Rheumatology** Prof Suranjith Seneviratne **Systemic sclerosis - an update on a hard disease** Dr Voon Ong **Complementary and alternative therapy in Rheumatology** Prof Ali Jaward	**Endocrinology** **Diabesity: the modern pandemic** Dr Manilka Sumanathailaka **Interpreting discordant thyroid function tests - case based perspectives** Dr A G Unnikrishnan **Rational use of vitamin D therapy** Prof Sarath Lekamwasam	**Free Papers**
Session 17 3.45– 4.30 pm	**Oration 3**		
4.30 – 5.00 pm	Tea		
8.00 – 10.30 pm	**Conference dinner**		

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Most Innovative Outstation Physician Award 2019

CALL FOR APPLICATIONS

MOST INNOVATIVE OUTSTATION PHYSICIAN AWARD 2019

This award is open to fellows or members of our College working in the outstations,

in order to appreciate an innovative work already completed.

Application Process

- Any form of innovation relating to the professional work can be considered, but only one application is allowed for any one innovation.
- A written account of the work carried out should be sent.
- The name of a referee, who should be a senior person/ doctor, who knows about the innovative work carried out, should be provided.

All submissions will be assessed by a panel of judges appointed by the Council of the College. An award will be made only if the requisite standard has been achieved, and the award will be presented at the Anniversary Academic Sessions in September 2019.

Please send your application to,
Honorary Joint Secretaries
Ceylon College of Physicians
341/1, Kotte road,
Rajagiriya

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CALL FOR APPLICATIONS

FELLOWSHIP OF CEYLON COLLEGE OF PHYSICIANS

2019

Applications are called from suitably qualified Members of the Ceylon College of Physicians for the award of the prestigious Fellowship of the College. The Fellowship is awarded to those Members of at least 10 years' standing who are considered worthy of recognition for their distinguished service to the profession.

Eligibility Criteria

- Full Membership of the Ceylon College of Physicians for 10 years
- Should be proposed and seconded by two (2) Fellows of the college

Members who are interested are kindly requested to submit the following documents on or before the **30th of June 2019** to the **College Office**

- **A covering letter addressed to the President of the College, indicating the year in which you became a Member of the College. Specimen letter is available at https://ccp.lk/wp-content/uploads/2013/04/Fellowship-request-Cover-Letter-2019.docx**
- **An up-to-date curriculum vitae (CV).**
- **Copies of any postgraduate certificates that you may have obtained since becoming a Member of the College, in order to support your CV.**

Once the Council has approved the award of the fellowship, the fee to be paid will be informed.

Please contact the College Office for any clarifications

341/1, Kotte Road, Rajagiriya. | Phone: +94(0)11 2888 146/011 - 3094140 | E-mail: office@ccp.lk

or

Visit https://ccp.lk/membership-overview/

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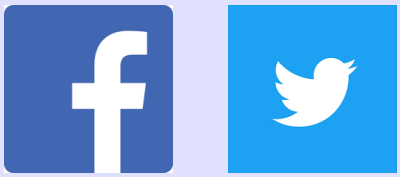
Forthcoming events

- 11th June – Young Physicians' Forum – Held at the Galle Medical Association, Auditorium, Karapitiya Teaching Hospital, Galle
- 12th June – Regional Meeting in collaboration with the Walawa Clinical Society. Held at the Hospital Auditorium, Embilipitiya District General Hospital
- 14th June – Council Meeting

Follow us now on 

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