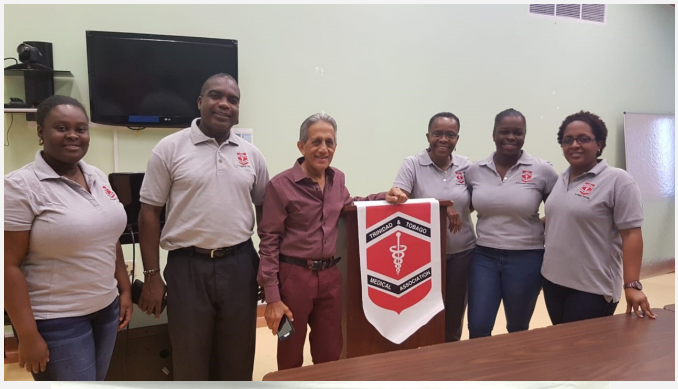
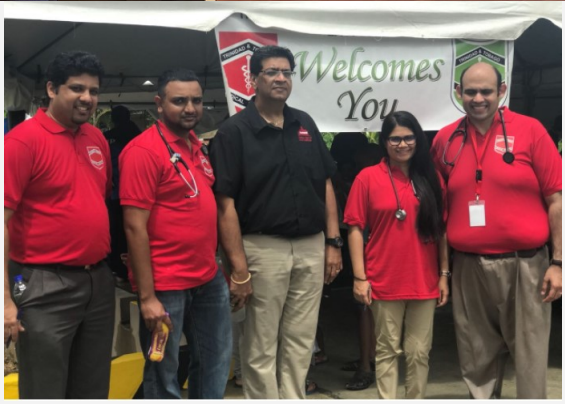
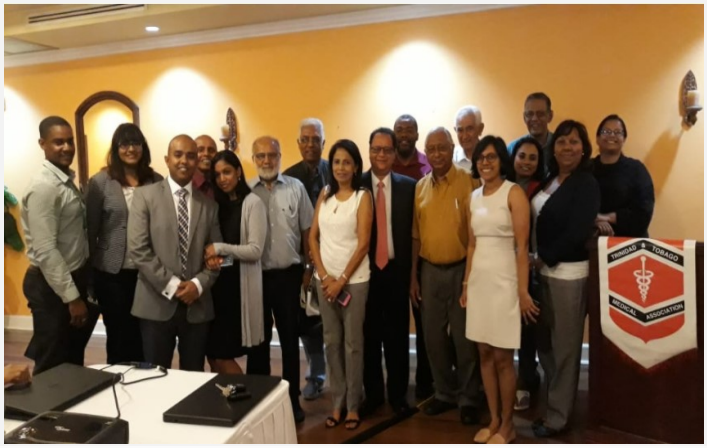
myT&TMA

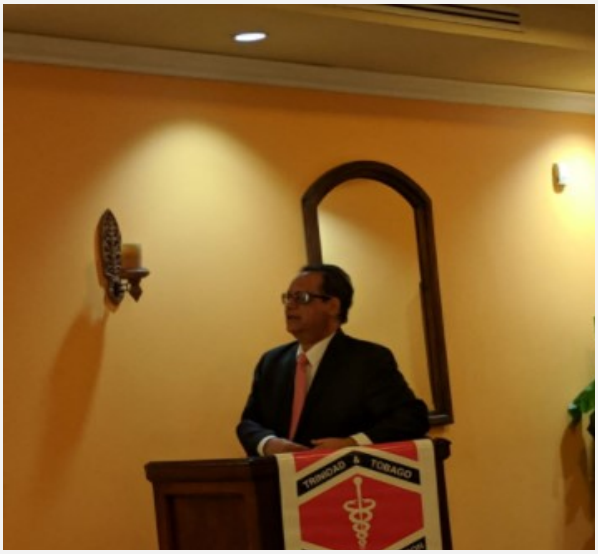
The official Newsletter of the Trinidad and Tobago Medical Association

July/August 2019:2









In this Issue

A Publication of the Trinidad and Tobago Medical Association

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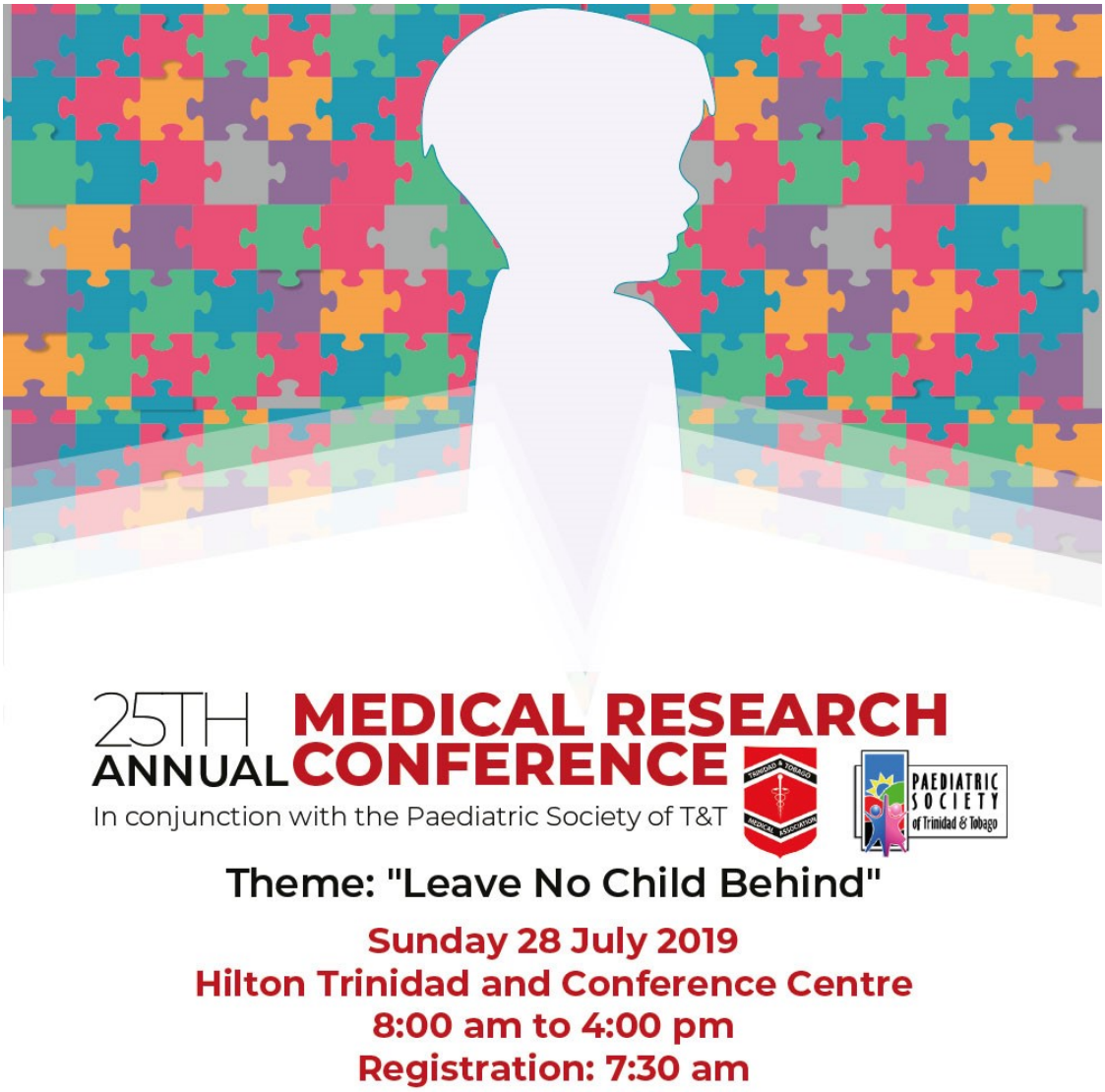
A Message from the Executive

After a brief absence and a focus on the Caribbean Medical Journal, the editorial team is happy to return with the July/August publication of the myT&TMA newsletter. Readers would be familiar with the format and are encouraged contact us with notes on events, notices and clinical issues. We welcome opinion pieces as well.

The myT&TMA newsletter welcomes aboard Dr Damion Basdeo who will be assuming the role of design editor. Please direct submissions to cmj.ttma@gmail.com addressed to him with any contributions.

We are please to announce the upcoming Medical Research Conference of the Trinidad and Tobago Medical Association, our hallmark event which brings together the best of research and academia in the region. We look forward to meeting with everyone in this 25th installment of the most prestigious conference in the Caribbean.



American Heart Association.

Top Ten Things to Know
2018 Guideline on the Management of Blood Cholesterol

1. In all individuals, emphasize a heart-healthy lifestyle across the life course.
2. In patients with clinical atherosclerotic cardiovascular disease (ASCVD), reduce low-density lipoprotein cholesterol (LDL-C) with high-intensity statin therapy or maximally tolerated statin therapy.
3. In very high-risk ASCVD, use an LDL-C threshold of 70 mg/dL (1.8 mmol/L) to consider addition of non-statins to statin therapy.
4. In patients with severe primary hypercholesterolemia (LDL-C level ≥190 mg/dL (≥4.9 mmol/L)), begin high-intensity statin therapy without calculating 10-year ASCVD risk.
5. In patients 40 to 75 years of age with diabetes mellitus and an LDL-C level of ≥70 mg/dL (≥1.8 mmol/L), start moderate-intensity statins without calculating 10-year ASCVD risk.
6. In adults 40 to 75 years of age evaluated for primary ASCVD prevention, have a clinician–patient risk discussion before starting statin therapy.
7. In adults 40 to 75 years of age without diabetes mellitus and with LDL-C levels ≥70 mg/dL (≥1.8 mmol/L), at a 10-year ASCVD risk of ≥7.5%, start a moderate-intensity statin if a discussion of treatment options favors statin therapy.
8. In adults 40 to 75 years of age without diabetes mellitus and 10-year risk of 7.5%-19.9%, risk-enhancing factors favor initiation of statin therapy.
9. In adults 40 to 75 years of age without diabetes mellitus and with LDL-C levels ≥70 mg/dL- 189 mg/dL (≥1.8-4.9 mmol/L), at a 10-year ASCVD risk of ≥7.5%- 19.9%, if a decision about statin therapy is uncertain, consider measuring coronary artery calcium (CAC).
10. Assess adherence and percentage response to LDL-C–lowering medications and lifestyle changes with repeat lipid measurement 4 to 12 weeks after statin initiation or dose adjustment, repeated every 3 to 12 months as needed.

Other highlights:

1. For secondary prevention, at mid- 2018 list prices PCSK9 inhibitors have a low-cost value [>$150,000 per QALY (quality-adjusted life-year)] compared to good cost value [<$50,000 per QALY]. The guideline provides a full discussion of the dynamic interaction of different prices and clinical benefit.
2. This guideline provides recommendations for children and adolescents with lipid abnormalities.
3. Substantial advances in estimation of risk with CAC scoring have been made in the past 5 years. One purpose of CAC scoring is to reclassify risk identification of patients who will potentially benefit from statin therapy. This is especially useful when the clinician and patient are uncertain whether to start a statin.

Grundy SM, Stone NJ, Bailey AL, Beam C, Birtcher KK, Blumenthal RS, et al. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA guideline on the management of blood cholesterol: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines [published online ahead of print November 10, 2018]. *Circulation*. DOI: 10.1161/CIR.0000000000000625.

American Heart Association (AHA). (2018). Retrieved from: https://healthmetrics.heart.org/wp-content/uploads/2018/11/Top-Ten-Things-to-Know-about-the-2018-Guideline-on-the-Management-of-Blood-Cholesterol.pdf

(AUTHOR'S OPINION)

The practice of "Jharay" and its relevance in modern medical practice

Jurawan R., Mahabir K., Verma S., Iswarawaka S., Maharaj R

Abstract

Deaths from liver disease in Trinidad and Tobago accounts for 1.2% of total deaths during 2017 according to the World Health Organization. The treatment of jaundice by traditional healers in communities and its medical relevance is not widely known. Jharay is one such method used by traditional healers. This method is still being practised by the Indo-Trinidadian ethnic descent population of Trinidad & Tobago, despite the lack of clinical trials. The objectives of this article are (1) to describe the origin of the practice of Jharay (2) explain the process and ingredients used in the practice of Jharay (3) compare and contrast the beliefs and practices of healers with clinicians and (4) to examine the possible integration of Jharay in clinical practice, especially with respect to palliative care. The authors postulate that the treatment of jaundice by healers extends beyond the intended medical effect in its clinical efficacy. They also wish to propose such treatments as part of many aspects of a 'Health-Belief-Model' in public health. The authors do feel that this may shed some light on why and how modalities such as Jharay continues to be an important dimension of overall patient satisfaction with respect to their healthcare.

Keywords - medical anthropology; traditional medicine; jaundice; Hindus and Indians; Trinidad and Tobago.

Introduction

As all the countries in the world are becoming more racially and ethnically diverse, healthcare systems and providers need to take into consideration and respond to patient's varied knowledge, beliefs, behaviours, and attitudes regarding health conditions and traditional remedies inherent to their cultural belief systems. The emerging field of "Cultural Competence in Healthcare" is part of a strategy outlined by the Commonwealth Fund to tailor health delivery services to meet the needs of minority groups . When healthcare providers fail to understand sociocultural differences between themselves and their patients, the

communication and trust between them may suffer leading to patient dissatisfaction, poor adherence to medications and health promotion strategies, and poor health outcomes (Betancourt et al. 2002:5).

Dr. R Jurawan- Specialist Gastroenterologist at Port of Spain General Hospital, Trinidad and Tobago

Jaundice is one of the common diseases afflicting the Trinidadian population. It is crucial to examine how some patients understand and construct the experience of jaundice in accordance with their cultural beliefs in Trinidad. It has been reported that patients sometimes have different explanatory models about the meaning of symptoms and appropriate treatment and therefore, may have different understandings about their illness and appropriate expectations for treatment (Shimoji and Miyakawa 2000). Hence, it is important to study the evolution of such beliefs and expectations and try to explain them in modern scientific terms.

Background

We live in a society that highlights the need to respect and provide equitable health care to all persons regardless of their cultural background, social status, age, race, and gender. Thus, multiculturalism being the norm in the cosmopolitan island of Trinidad & Tobago, it is not only managing diversity is a challenge in general, but also this emphasizes the need to maintain cultural understanding with regards to provision of healthcare.
The islands of Trinidad and Tobago were encountered in Christopher Columbus' voyages in 1498 and was under Spanish rule until 1797, when British invasion made them British crown colony. During this time, the sugar industry dominated the country's economy and labourers were brought in mainly from Africa and India but also included some from China and Portugal to work on sugarcane plantations.

Today, Trinidad & Tobago's composition of multiple ethnicities owes its origins to slavery and indentured labour, long before independence from the British rule. Each ethnic group is recognized for its distinctive festivals, food, music, religion and traditional practices, which can all be linked to their respective ancestries. Hence, it is of no

surprise that there exists different perspectives, values and behaviours among the racial and ethnic groups which relate to sickness, health, and well-being. Healing the sick by 'prayer' and other so-called 'natural' means, form an integral part of both African and Indian traditional healing methods. These traditional practices have claimed to treat both physical and psychological illnesses of the individual.

Ayurveda is a system of ancient medicine, which was codified, documented and practised widely in the Indian sub-continent for many millennia. The origins of this system can be traced to as early as 6000 BCE. Many diseases have been described in the system with respect to their symptoms and signs as well as appropriate treatment options, which include both medical and surgical therapies.

Ayurveda considers every disease to be caused by one of the four factors described as a 'Dosha'. Thus Vadha, Pitta, Kapha and Sleshma are the four aetiological factors for most of the diseases. Specifically 'jaundice', which is known as 'Kaamala' is caused by the 'pitta' dosha and the system restricts a number of food items which might be responsible for causing the disease. Thus Ayurveda recommends that the patients suffering from jaundice should avoid the consumption of spicy foods like pepper and curry, as well as foods that are salted and sour. According to the theory, these foods might further flare up the already-vitiated 'pitta-dosha' and increase the severity of jaundice by corrupting the hepatobiliary system and spreading the obstructed bile into the bloodstream (Solumiks 2002).

In Trinidad & Tobago, it has been common for certain East Indian families suffering from jaundice to seek help from a traditional healer, usually a Hindu Pundit, who conducts healing by 'jharay phukay'. The origins of jharay-phukay are unclear but historically, Indians in Trinidad and Tobago can trace this practice back to the 'Hindi belt' region of northern India on the plains of the rivers of Ganga and Yamuna, which originate from the Himalayan mountain ranges. Many places on the banks of these rivers are still considered to be 'sacred' for the Hindus. It is noteworthy that a major proportion of Indian immigrants in Trinidad & Tobago had their ancestors coming from places that were located on the banks of these rivers.

The continuing practice of Jharay to this day shows the strong belief of the people of East Indian descent in Trinidad &Tobago, with regards to their cultural practices passed down from generation to generation.

With this background, this article attempts to describe the methodology adopted by the traditional healer in 'healing' jaundice and discusses its role in the modern scientific era of medical practice.

The major ingredients used in Jharay for diagnosis and treatment
Hindu folk healers in Trinidad stir mustard oil and water in a brass plate known as 'Tharia', and recite a mantra, to diagnose and treat jaundice. If the liquids remain separate or thin after a few minutes of churning with a tiny grass-blade called 'dhub', the result is negative. If the liquids conjugate, the result of the diagnosis is that the patient - on whose head or body the tharia has been placed – is supposed to be afflicted by 'kaamala' (jaundice).

Both healers and their patients believe that the thick consistency of the mixture resembling the common Indian split-pea gravy known as dhaal is the evidence that jaundice is affecting the person. The healer confirms this by the foul odour of the mixture, and the burning sensation it emits on the healer's eyes. This ritual is administered as a 'treatment' for jaundice once or twice every session until the mixture no more becomes thick in consistency. The mustard oil and water mixture 'clears up', becomes thin and appears separated. This form of ritual therapy appears to be common in the folk medical culture of the Indian Diaspora, although there has been to no documentation in the published literature in ancestral India (in the traditional systems) that mustard oil could be used in this way.

The other ingredient which is used in the ritual is the 'dhub' grass, which is known as 'dharba' in Sanskrit. The botanical name is Desmotachya bipinnata ; and the stems and leaves of this dhub grass are bunched and tied like a tiny broom to cleanse the illness out of the infected patient. Hindu scriptures celebrate dhub because it is fed to sacred cows during drought and has saved people from famine in India. In India and the Diaspora, it is used in ritual worship as a purifier and a symbol of immortality (Mahabir 1991). Farmers in India traditionally apply crushed leaves to minor wounds as a styptic to stop bleeding, and discoloured leaves are used internally to treat liver complaints (Pankaj 2001). Again there has been no published literature mentioning dhub being useful as a ritual ingredient to treat jaundice.

Sunlight has traditionally been used for the treatment of neonatal hyperbilirubinaemia. It contains useful amounts of irradiance in the blue spectrum for treatment of jaundice. Paediatricians warn, however, that there are no appropriate controlled trials of the use of sunlight and therefore, it

should not be used as a substitute for phototherapy. Excessive exposure of the baby's body to sunlight may cause sunburn or dehydration and peeling of the skin. Newborn babies also have sensitive eyes that need to be protected by covering them, or by turning their face against the sun.

Procedure of Jharay

Basically, the Hindu pundits conduct healing by jharay-phukay (stroking and blowing) (Ramnath 1982; Vertovec 1992). The practice of jharay claims to deal with jaundice, fractures, dislocation/shifting of internal organs and renal stones. Interestingly, women form the vast majority of healers in the jharay tradition.

According to the healers, this might be because the 'ladies' are easily accessible at home as housewives anytime and any day, and that patients of both sexes feel more comfortable with a woman health-care provider (Mahabir 1997).

To perform jharay, a bunch of dhub grass is first tied like a broom in a tharia (brass plate) and filled with mustard oil and water. For adult patients, they are instructed to sit on a chair and place their fingernails in the mixture. For cases of neonatal jaundice, the heels of the neonate are placed in a yellow liquid. The process is repeated at sunrise and again at sunset, every day, for several days. Jharay for jaundice practiced by these healers, specifically involves a form of symbolic therapy. Healers and the patients perceive jaundice to be something 'bad' in the body that has to be drained, pulled or extracted. They place a tharia (brass plate) on the patient's head, and with appropriate chanting of mantra as part of their ritual therapy, they attempt to 'pull' the 'pitta' into the mustard oil and water mixture.

Healers, and some of their patients, claim that the sensation of When this is done in the presence of biomedical healthcare providers, some do tolerate the practice, while others dis

the pitta being filtered out of the body can be felt, and some patients may feel weak and dizzy during and after the treatment. Patients may be asked to place the tharia at their feet, or hold it with their hands, or dip their fingers into the concoction. The heels of infants are usually held to touch the liquids during the mantra recitation. Whatever the therapeutic protocol of the respective healer, the ritual symbolizes the procedure of extracting the pitta from the patient's blood and thus purifying it. Indeed, one healer said that when the used mixture is thrown and settles in the drain, it turns into the colour of blood.

Naturopathic doctors in India believe that recurrence of liver trouble in adults can be prevented with proper diet and lifestyle, regular exercise, adequate rest, fresh air, and frequent exposure to sunshine (HELP 2002). The therapeutic ritual of jharay for jaundice is sometimes performed on patients warded in the hospitals in Trinidad. When this is done in the presence of biomedical healthcare providers, some do tolerate the practice, while others dismiss this form of spiritual therapy as superstition. (Ross-Perot 1996).

It goes with saying that reliance on jharay alone as a form of diagnosis and therapy for jaundice cannot be even a suggestion, leave alone a recommendation. The authors wish to suggest that the ritual be included in a holistic treatment model, with alleviation of 'suffering' of patients, attributable to the hope it provides that the 'unwanted' pitta has been eliminated from their blood. One should consider suffering to be a multi-dimensional unpleasant experience involving physical, psychological and social components (Chapman CR, 1993).

Suffering would also entail psychological and spiritual distress which may be alleviated by the complete attention and personal interaction with the practitioner without providing cure to the underlying physical pathology. In the efforts to address the patient's overall suffering, the traditional practice can be considered an adjunct to standard medical care. This can be especially relevant in circumstances of end stage liver disease, where complete cure is impossible by modern medicine and the act of jharay provides some measure of comfort to the dying patient.

There has been a widespread notion in patients and their relatives that some physicians completely dismiss their cultural beliefs. If the practice of traditional treatments involve risks and clear harm to the patients, then there is justifiable reason to advise against the practice. However, the practice of jharay does not involve any major risk of side effects including Contact Dermatitis (Zawar, 2005). Hence the authors propose that there should not be any major objection to its integration as a palliative intervention especially in the face of serious illness.

In conclusion, the authors wish to propose non-harmful traditional treatment modalities such as jharay be integrated into the holistic practice of medicine, in an attempt to incorporate traditional perceptions and experiences. Cultural practices also have a role in influencing deep-rooted beliefs in various aspects including models of illnesses. Such practices have the potential of developing culturally-sensitive intervention strategies, especially for terminally ill patients who may want to hold to any straw that they believe may alleviate their suffering.

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Diabetes in Pregnancy

Healthy me…Healthy you…Healthy T&T.

Dr. Adesh Sirjusingh
Director of Women's Health, Ministry of Health

This article is related to Diabetes Mellitus (DM) and focuses on the term Hyperglycaemia in Pregnancy (HiP) which covers women who have pre-existing DM as well as those discovered for the first time in a current pregnancy. For those who are newly discovered, they may have DM or Gestational DM (GDM).

Before pregnancy

There is an alarming rate of potential Diabetes Mellitus in our country with high rates of obesity and even more worrying is that as many as one in five women may be entering pregnancy with impaired glucose tolerance levels. Afro-Caribbean and East Indian origins are at a higher risk for NCDs including DM. In fact, the traditional use of Body Mass index (BMI) must be re-defined as East Indians in particular are at higher risk at a lower BMI than the general population. All women should consider getting screened routinely. Based on this, it would be a good idea for women to have health checkups before planning a pregnancy including optimizing weight, start pre-pregnancy folic acid, check blood pressure, adjusting medications for chronic medical illness, and performing Pap Smear.

For patients living with DM, it is critical to be on contraception and plan your pregnancy well. The following are some issues to consider:

- Ophthalmology assessment
- Kidney function assessment
- Ensuring that vaccines are up to date
- Conversion to medication that is safer to use during pregnancy
- Folic acid, Calcium and Vitamin D supplementation
- Good control of blood sugars consistently and more blood testing and charting

Risks

High blood sugar, especially if you have pre-existing DM, increases the health risks faced by you and you baby during pregnancy. However, this does not mean that you will definitely have a complication.

These risks include:

- Maternal morbidity including caesarean deliveries
- Polyhydramnios (extra amniotic fluid)
- Shoulder dystocia (difficult delivery of baby's shoulders)
- Maternal birth trauma (bigger baby result in injury to the passages)
- Hypertensive disorders of pregnancy (including pre- eclampsia),
- Subsequent development of DM in the future for you and your baby
- Haemorrhage after delivery
- Increased possibility of a caesarean section delivery
- Preterm labour
- Fetal anomalies especially if the sugars are not well controlled in early pregnancy
- Stillbirths

Additionally, DM increases the possibility of the baby being admitted to the special care baby unit for a variety of problems including being preterm, low blood sugars, difficulty breathing, and jaundice.

During pregnancy

There are many "routine" antenatal care procedures that you will undergo that are not specific to Diabetes in Pregnancy (DIP). These are as recommended in the manual for Maternal and Child Health care from the Ministry of Health.

Specific issues related to DIP may include more frequent visits, more consultations with other members of the team including the dietitian, blood glucose testing, ultrasound examinations, and admissions on occasion to the antenatal ward. You may also be managed with medication if your blood glucose remains high (Metformin, Insulin).

Often, the delivery is planned as we do not recommend that our patients deliver beyond the given due date. This may involve what is called induction of labour. Sometimes if the baby is too large or if you had shoulder dystocia before, the team may recommend a planned caesarean section delivery.

After delivery

The blood glucose level gets easier to control and you will be weaned off medication especially if it was gestational diabetes. It is a good idea to discuss contraception, continued diet and exercise, pap smear and long term follow up as you have a higher chance of developing diabetes mellitus.

The Team Approach

The team approach to providing healthcare to a patient must be highlighted. Although the Nurses, Midwives and Obstetricians are often the persons who clients interact with the most, there are many other members of the team who work behind the scenes and without whom little can be achieved.

Other key members of the team include the Pharmacist, Dietitian, Laboratory personnel and the Diabetes Educator. A holistic approach is often necessary including: medication and instructions on taking medication the right way (e.g. Insulin before meals), exercise, compliance with dietary needs, home blood glucose monitoring and charting. Other clinicians may be involved including the Endocrinologist, the Ophthalmologist and the Renal Specialist.

New Ministry of Health policy changes

The Ministry of Health has started a new policy directive of universal screening for diabetes for all our pregnant population. This means that all pregnant patients will now be screened for Diabetes. Traditionally screening was only done based on a selective approach. This would have possibly missed 50% of women with gestational diabetes.

Another change in policy was to adopt universal screening at the patient's first visit with a public healthcare professional, instead of screening at 24-28 weeks. Again, it is possible that many women may be entering pregnancy with abnormal blood glucose levels and, with earlier diagnosis, it is possible to start treatment and management interventions sooner.

We have also adopted a standardized national clinical guideline on the management of Diabetes in Pregnancy. This includes the above recommendations, adopts recommended World Health Organization's criteria for diagnosis, and a standardized management protocol for antenatal care, labour, delivery and postpartum care.

New recommendations have also been added for the target blood glucose levels during pregnancy.

The Ministry of Health has developed a national 2017-2021 Strategic Plan to address Non-Communicable Diseases (NCDs) including major health programmes which focus on research and strengthening of care for our diabetic population and NCDs. The new policy on the sale of sugary drinks in school cafeterias and the School Nutrition Programme has already started. This is also to be implemented in our public health facilities.

This is in keeping with the United Nations Development Programme -Sustainable Development Goals (SDGs) and our 2030 Agenda. The Sustainable Development Goals (SDGs), otherwise known as the Global Goals, are a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity. These SDGs are consistent with the theme of the World Diabetes Day (WDD) 2017 'Women and Diabetes: Our Right To A Healthy Future'.
The key messages guiding the campaign are:

- All women with diabetes require affordable and equitable access to care and education to better manage their diabetes and improve their health outcomes
- Pregnant women require improved access to screening, care and education to achieve positive health outcomes for mother and child
- Women and girls are key agents in the adoption of healthy lifestyles to improve the health and wellbeing

These are exciting times for the country, but we need everyone on board. We recognize that your health can only improve if each individual accepts personal responsibility for their care by being compliant with treatment recommendations. This includes lifestyle modification (diet, exercise, making right personal choices for health), keeping appointments to the antenatal clinics and health appointments, using medication as prescribed and communicating with your health providers.

The Directorate of Women's Health is a newly created unit at the Ministry of Health, charged with the responsibility of implementing policies that specifically target and bring about improvement to women's healthcare issues. This series of articles is penned by Dr. Adesh Sirjusingh, Director of Women's Health, and is based on frequently asked questions and comments from women throughout Trinidad and Tobago.

The information contained in these articles is not meant to replace advice from your healthcare provider. When it comes to personalized health information, your qualified healthcare professional is the best person to consult, rather than self-diagnosis and recommendations from the Internet. Medical research, treatment and technology are always evolving and every effort was taken to provide up-to-date advice at the time of preparing this article.

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- *Members must take note that wherever is says "Employee", we mean T&TMA Member.*
- *Emp.+1 means a T&TMA Member and one family member (a spouse OR one child).*
- *EMPLOYMENT INFORMATION and BASIC GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT info are NOT required at this time.*
- *On completion, PRINT & SIGN the completed form and RETURN to T&TMA Office for compilation and collection.*
- *Members need to be reminded that, any Member with a pre-existing condition, SHOULD join the T&TMA Group Health Plan at this time as there are NO medical requirements at Initial Enrolment period.*

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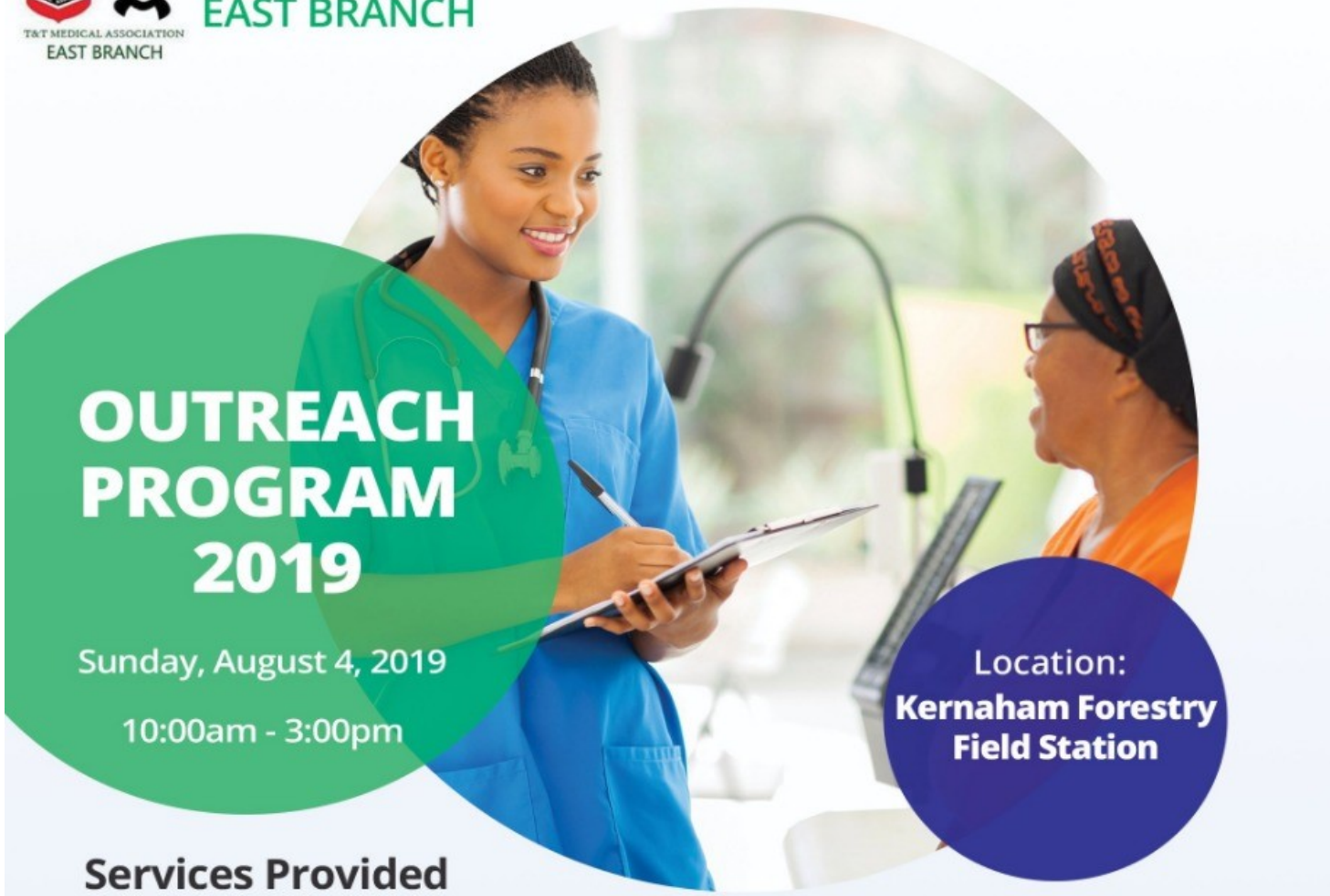
EAST BRANCH



OUTREACH PROGRAM 2019

Sunday, August 4, 2019

10:00am - 3:00pm

Location:
Kernaham Forestry Field Station

Services Provided

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