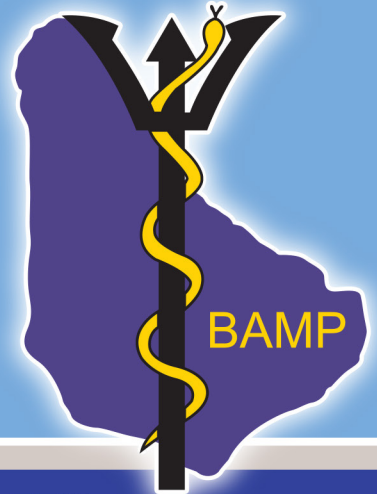


No 191 May-June 2017

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COVER PHOTO: Queen Elizabeth Hospital

Photographer : Anonymous

NOTES FROM THE EDITOR

Alternative Medicine

The scope of alternative medicine is broad, with widening use by the public of a seemingly unending list of treatments and practices such as acupuncture, homeopathy, relaxation techniques, and herbal remedies to name but a few. Many are well known, some do no harm while others are dangerous, a significant portion is proprietary and marketed commercially. On the local scene, there has been a steady increase in “industry-related” advertisements, in the print and broadcast media, aimed at an unsuspecting population of consumers who often feel powerless and vulnerable - making it is easy for coercive situations to arise offering ‘health care.’

Unfortunately, there is little evidence to confirm the safety or efficacy of most alternative therapies.

A proposed set of definitions that may be useful in discussing alternative therapies or treatments include “proven” products and services that have been scientifically tested and found to be both safe and effective for the specific condition for which their use is proposed. Much of the information currently known about these therapies makes it clear that many have not been shown to be efficacious.

“Experimental” therapies or products include those undergoing controlled trials to determine their proper application, dose, frequency of use, general safety, and efficacy.

“Untested” methods are those that have never been subjected to rigorous clinical testing or evaluation under standard protocols and controlled conditions. Many herbal, homeopathic, and dietary products fit this category.

“Folklore” remedies passed down through cultural tradition and oral history include many local home remedies such as bush-tea for colds, ginger-tea for “gas,” and honey and lime for sore throat.

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*EDITORIAL... cont'd**COMMENTARY*

Most folk medicine is not done for personal enrichment and is noncommercial, however, "quackery" on the other hand or health fraud involves commercial marketing or use of therapies, products, or procedures with no proven effectiveness. This has the potential to indirectly harm patients by delaying appropriate therapy or diverting care to unproven methods, and often includes financial fraud as well.

Promises of cure for cancer, human immuno-deficiency virus (HIV), and other conditions seem to attract desperate patients willing to try anything with anecdotal testimonials constituting the main basis for the "success" of these modalities.

The principle of non-maleficence requires that we do not intentionally create needless harm or injury to the patient, either through acts of commission or omission. In common language, it is considered negligence if one imposes a careless or unreasonable risk of harm upon another. Providing a proper standard of care that avoids or minimizes the risk of harm, is supported not only by our commonly held moral convictions, but by the laws of society as well. In all fairness then, the law should hold all alternative medicine practitioners to the same standard as those who are practicing conventional medicine.

PHYSIATRY- UNFAMILIAR, UNDER-VALUED AND UNDER-UTILISED



Dr. Shane Drakes
MBBS, DABPMR, FAAPMR

*Consultant Psychiatrist and Sports
Medicine Specialist*

What is a physiatrist? I will give you some answers which I have heard and read elsewhere:

- A "glorified" physical therapist (PT)
- A doctor who treats stroke patients
- A doctor who treats musculoskeletal (MSK) injuries
- Someone to deal with patients nobody knows how to or wants to manage
- A doctor without an identity

Options "b", "c" and "d" are true but it goes deeper than that. There is some procedural overlap with Orthopedics and Neurology so you may be tempted to answer "e" but I will show that's false. Answer "a" is just insulting!

A physiatrist is a medical doctor who has completed specialist training in Physical Medicine and Rehabilitation. We work

to improve or preserve the function of persons who have impaired function for varying reasons. We achieve this by:

- Evaluating the patient, including thorough history-taking and physical examination
- Making a diagnosis - medical condition and functional limitations
- Creating and implementing a customized treatment plan as a sole provider or as part of an inter-disciplinary team
- Reviewing the patient to evaluate progress, modify treatment if needed and manage any complications which arise

The specialty originated in the USA in the 1930s, expanded to assist injured war veterans returning home and was officially recognized by the American Board of Medical Specialties in 1947. Bahamas got a physiatrist 20 years ago, while Barbados has had one for over 10 years. In Barbados, we now have three physiatrists with varying practices and there are three others elsewhere in the CARICOM region. Around 9000 serve the 325 million residents of the USA and 12280 serve 30 countries in Europe. In our small region where information spreads rapidly, it is somewhat surprising and shameful that the field hasn't been promoted more.

Physiatrists can undertake subspecialty training in Brain Injury Medicine, Hospice and Palliative Medicine, Neuromuscular

COMMENTARY... *cont'd*

Medicine, Pain Medicine, Pediatric Rehabilitation Medicine, Spinal Cord Injury Medicine or Sports Medicine after completing residency.

There are many different patients who may benefit from the care of a physiatrist. Some of these include:

- Amputees
- Patients with arthropathy
- Patients with brain injury
- Cardiac patients with impaired quality of life
- Geriatric patients who may be at risk of falls
- Musculoskeletal pain
- Nerve conditions
- Pediatric patients with cerebral palsy and other disorders causing impaired development or impaired function
- Spinal cord injuries
- Sports injuries
- Work-related injuries
- Patients with spasticity
- All patients with impaired physical function for any reason

Procedures which physiatrists perform include:

- Nerve conduction studies and EMG
- Steroid injections
- Local spasticity treatments - Botox injections or alcohol nerve blocks
- Musculoskeletal ultrasound scanning
- Spinal procedures
- Injections of regenerative substances
- Minor surgery

Physiatrists work in inpatient settings as leaders of interdisciplinary teams or providing consultation services and in outpatient settings where almost all procedures are performed.

Key differences between physiatrists and orthopedic surgeons managing MSK conditions:

- Many physiatrists use ultrasound guided injections instead of landmark guided (blind) injections, the former being more accurate, more effective and possibly more cost effective¹
- Good physiatrists make sure the injection is not the only component of treatment
- No suspicion about the physiatrist having an incentive to recommend surgery

If you have a patient with a CNS problem that needs to be diagnosed/initially managed, send him to a neurologist. If

you suspect a peripheral nerve problem, the physiatrist is equally capable of diagnosing it using nerve conduction studies and electromyography performed with just as much competence as a neurologist. This holds true for local spasticity treatments with Botox injections. Botox is expensive and in suitable patients, a good physiatrist has the advantage (here in Barbados, definitely) with the ability to perform alcohol nerve blocks as well.

Physiatrists have been in the forefront of the revolution of using ultrasound imaging in MSK and neurological cases. Examples include:

- Using ultrasound to visualize nerve injury²
- Using ultrasound to guide successful radiofrequency treatment of an irritated nerve³

Some of my colleagues are also doing things which can only be described as minor surgery:

- Using ultrasound to guide successful fasciotomy⁴
- Performing the mild procedure which is an effective treatment for lumbar spinal stenosis⁵
- Successful bilateral greater trochanteroplasty in a multiple myeloma patient⁶

For my Family Medicine/GP colleagues, are you comfortable managing these cases?

- Middle-aged person with shoulder pain
- Young recreational footballer with ankle pain
- Person with numb fingers
- Elderly lady with osteoporosis and poor balance
- Stroke patient with shoulder pain
- Stroke patient with gradually worsening gait
- Patient with heart failure who is interested in starting an exercise program

You are the first persons most patients turn to with any problem. As good advocates for them, you must know when to use which specialty. What about a middle-aged motivated individual with joint pain interfering with quality of life who is struggling financially? Do you refer to PT although she can't afford it or is there another option? Referral to a good physiatrist should be considered for any person with impaired physical function.

I hope this information has increased your familiarity, improved your perception of the value and changed your mind-set about utilizing the great field of physiatry.

Dr Drakes operates from a private practice in Barbados.

COMMENTARY... cont'd

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COMMENTARY... *cont'd*

THE HISTORY OF HIV AWARENESS PROGRAMMES IN BARBADOS 1984 TO 2010 (PART 2)



Sylvan Spooner

(Continued from pg 21 Vol. 190).

TRAINING AND RESPONSE

As a result of these insufficiencies in the levels of education among health-care personnel, a number of seminars were held to fill gaps in knowledge and awareness. From February 1993 to September 1997, 33 seminars and workshops were conducted at the Queen Elizabeth Hospital involving a broad spectrum of the health care team. Nursing staff comprised 57 percent of participants. During these sessions, members of staff from the Accident and Emergency Department were given priority for training given the primary nature of their care. It is, however, important to note that in spite of the number of workshops on offer, physicians were least likely to attend. Particularly disturbing were the findings of a study conducted by a team led by Dr. Ernest Massiah and published in 2004 which found that between 1995 and 1999 only 53 percent of physicians attended some form of HIV training. In the light of research carried out by Dr. Peter Figueroa, which showed that in service training resulted in improved medical management of patients with HIV, their response to training has been unsatisfactory.

In 2004, a report, later known as the 'Waldron Report', made a number of controversial recommendations for the management of HIV and AIDS. Ranging from the decriminalization of homosexuality and prostitution, to the issuing of condoms in prison, it stimulated huge levels of public discussion. Unfortunately, the medical community

remained silent on these recommendations. Addressing the 2005 Annual General Meeting of the Barbados Association of Medical Practitioners (BAMP), Sir George Alleyne called for greater involvement:

I believe that as a group...we have a responsibility to address the issue of AIDS and not only from the point of view of the individual case. The situation locally is a serious one and good men and women and their associations cannot stand aside and watch. I may have missed it but I have yet to see the position your association has taken on this report.

This lecture addressed not only the absence of a cohesive medical response to Professor Waldron's call for the removal of discriminatory legislature but alluded to the malaise within the medical fraternity regarding its management of HIV and AIDS beyond the clinical arena.

MUSIC AND THEATRE AS METHODS OF AWARENESS

With its effect on public consciousness well established, music has across time been the vehicle through which numerous social concerns have been given voice. A number of Barbadian musicians have included awareness themes in their compositions. In 1986, Anthony 'Gabby' Carter stimulated immediate controversy with a recording titled 'De list' which in equal measure contained elements synonymous with both education awareness and stigma. A critical analysis of this recording is central to attaining a true grasp of its importance. In this recording, the artist chronicles the death bed confessions of a young HIV positive bisexual male who has compiled a 'list' of his sexual conquests. His death sent panic among his female partners who demanded to be shown the names on the list. It is here that the plot within this brilliant composition thickens with mention of a 'Nurse Babbalelou' who upon viewing the list realizes that she too had slept with one of the named individuals. The artiste states clearly that it was she who informs him that this 'list' includes the names of doctors, politicians, lawyers

COMMENTARY... *cont'd*

and a number of well-known persons. With a loud chorus proclaiming: 'Dis is de list, dis is de list, dis is de list wid de fellas that got de AIDS' this song created a firestorm and was immediately banned from all local playlists.

This recording both assisted and inhibited HIV awareness efforts at the time of its release and further analysis reveals why this was so. Not only did it fuel existing beliefs that an actual 'Aids list' existed, but it contributed considerably to the persistence of that rumor. However, of primary importance here is the reference to 'Nurse Babblelou' and her role in divulging the names of those persons mentioned in this fictitious list. Interestingly 'Nurse Babblelou' lends immediate comparison to the popular Barbadian literary character 'Lick Mouth Lou' who is notorious as the village gossip who cannot be trusted. Therefore, through her act of speaking to the calypsonian (or babbling) she divulges confidential patient information. Taken literally by some listeners, it is fair to suggest that this act by a fictitious nurse led persons infected with HIV to distrust members of the nursing profession. In so doing, it negated the efforts of nascent HIV awareness organizations which were advocating patient confidentiality.

Importantly, this song situated HIV/AIDS as a heterosexual disease at a time when all others were placing it at the feet of homosexuals. The young confessor, Gabby tells us, slept with both men and women, those wealthy as well as poor and through this it was made known that the disease does not discriminate. The character 'Nurse Babblelou' herself expresses surprise that the man whom she slept with was bisexual even though he was outwardly 'macho'. This verse purposefully informed the listener that the appearance of health was no indicator of the HIV status of an individual. Even though its release may not have been strictly for HIV awareness purposes but rather as satire, it was an important musical contribution to HIV/AIDS awareness which informed the public that the disease affects all facets of society. However, its abrasive chorus in large part overrode its lyrical content which required a level of analysis for full comprehension which may have been above the comprehension of the listening public. Other productions worthy of mention include Peter 'Ram' Wiggins 'AIDS', (1991) an initiative of the NACA, Mighty Whitey's 'White Glove', Brian 'Bumba' Payne's 'Awareness Music' (2001) and in 2004, Natasha Kya Williams' 'Condomize.'

THEATRE

Theater has also presented itself as an avenue through which HIV awareness can be disseminated. From Godfrey Sealy's 1988 'One of my sons is Missing', to the Idakeda Group of Trinidad's 'Shades of I-She' to the street dancers of Nepal whose performance warns of risks of HIV and migration, theater has been used as HIV awareness. One of the island's major theatrical productions was Winston Farrell's 2002 production 'Looking Back at Sodom'. With themes of betrayal, neglect and poverty, it explored the sexuality of three generations of women, and examined the relationship between transactional sex and HIV. Introducing 'Madame' a former prostitute, her daughter 'Paula' who immigrates abroad in order to avoid the fate of her mother, and her infant daughter 'Yasmine' who is left in the care of 'madame' it delved deeply into the social atmosphere which surrounded them. In subsequent scenes, Paula's return from abroad, a broken woman, unfulfilled ambitions and HIV positive, stand prominent. In her absence her daughter succumbed to prostitution in a repetitive cycle of sex, betrayal and poverty stemming from the sheer need to survive.

Another production, 'Secrets', commissioned by the Ministry of Tourism and screened at the Lloyd Erskine Sandiford Center in February 2009, was also HIV awareness themed. It relates story of 'Gina' who, although married to 'Richard' and together the parents of three children, finds herself in an adulterous relationship with 'Markus'. Weary of marriage and enjoying the excitement of a new lover, she soon learns that she had traded the sedateness of marriage for the excitement of an affair and HIV. Her infidelity and subsequent contracting of HIV led to social ostracism, marital dissolution and public shame, all lived experiences for persons infected with the disease. This production, unlike others which were restricted to theater, thereby limiting their exposure to public viewing, was one of very few HIV themed plays to be broadcast on national television.

THE ROLE OF THE MEDIA IN HIV/ AIDS AWARENESS
THE LOCAL PRESS

Throughout the first decade of HIV awareness both local newspapers contributed significantly to the climate of fear and discrimination which surrounded the disease. Though

COMMENTARY... *cont'd*

these would later temper their content to suit welcomed shifts in thought, during the first decade of HIV, irresponsible journalism did much to curtail the efforts of authorities. One story, written by Sharon Kellman and published in the Barbados Advocate of July 17th 1988, recounted the brutal 'rape' of a boy by someone believed to be HIV positive. In telling a story of rejection, a Deputy Principal disclosing the students' HIV status, his constant taunting at school and the child's desire to die, this story created a firestorm of public debate. It was also a lie. Despite its wide distribution, this story failed to withstand basic investigative scrutiny and each medical and legal institution cited denied any knowledge of the alleged incident. This story was the fanciful and careless creation of a journalist who cared little for the consequences of her actions. Matthew Farley then General Secretary of the Barbados Union of Teachers (BUT) writing at the time expressed shock that a journalist could 'fabricate a story using AIDS a theme, a student as the cast and the classroom as her stage.' The NACA meanwhile called for calm and asked that the story be investigated.

This incident did not occur in isolation and on Sunday February 14th 1993, the Sunday Sun ran a front page story which equated HIV with inevitable hopelessness and death. Entitled 'Careless Sex Brought on a Death Sentence' it was accompanied by a photograph depicting a young man claiming to be HIV positive who felt that he had nothing left to live for. With large portions of his face redacted, he is portrayed as a faceless victim, hopeless, and an object upon which the public is supposed to gaze and whose fate they are to avoid. Whether through imagery or renowned journalists such as Gladstone Holder proclaiming that HIV was transmitted via the bite of mosquitoes when no such risk existed, the response of journalists was sensationalist and meant to increase readership. In doing so, these dark depictions and blatant fabrications did much harm to existing forms of awareness and critically to public attitudes to the disease.

The Sunday Sun of March 17th 1996, in an article titled 'HIV infected group the butt of cruel jokes on a minibus', reported that residents of the Elroy Phillips Centre were verbally abused by passengers aboard a minibus and called for the bus to be disinfected. The use of the term "butt" in bold text indicates that notions of HIV's association with homosexuality remained present and furthermore hinted that members of the group returning to the center were homosexual. As late as January

12th 2009, a report on CBC TV-8 that a number of Nigerian nurses had died of AIDS created considerable controversy. This story and the furor which surrounded it, indicates that the links between HIV awareness groups and the media require constant reinforcement as they partner to fight stigma and discrimination.

POSTERS/OUTDOOR ADVERTISING AS AWARENESS MEDIUM

Posters have also been used by local advocacy groups to promote awareness. A review of the early advertising makes it clear that they were a reflection of the fear which existed during the period in which they were produced. Some, as evident in Figure 2, illustrated a collage of macabre imagery. Entitled 'Prevention is the only Cure' and commissioned by the NACA in 1988, it portrayed half skeletal forms, disease bodies and human faces contorted as if in eternal agony. In addition, various couples in sexually suggestive poses and in varying states of undress with warnings that 'casual sex kills' and that 'danger' lurks stand out prominently informing observers that this is a disease which is to be avoided. Situated at the corner of this collage is a list of ways - in notably smaller print- by which the viewer can avoid this fate. The message here is one of death and disease and it remains obvious that the aim of this poster was to instill a measure of fear within anyone who saw it.

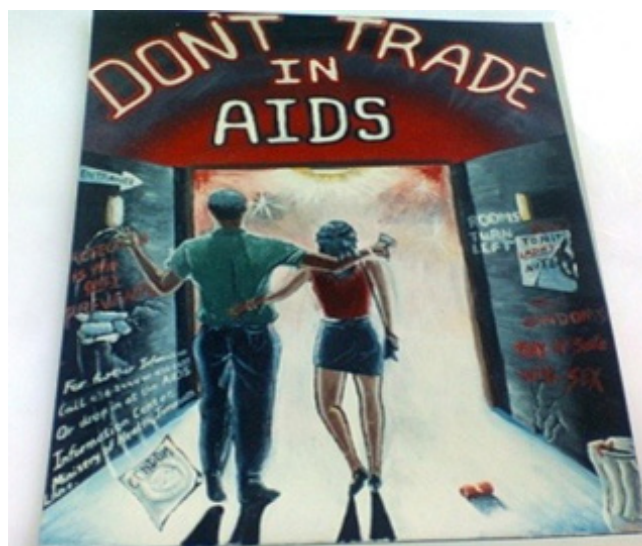


Figure 2. AIDS: Prevention is better than cure.

(Used with permission. From the private collection of Sir Errol Walrond)

COMMENTARY... cont'd

Another produced in 1989, (Fig.3) also utilized visual cues to convey a message of awareness. Less explicit than the poster mentioned previously, it depicts a young couple hand in hand approaching the entrance of a nightclub. The message that sex in on offer is presented in the form of graffiti stained walls proclaiming 'Rooms turn left,' and 'tonight is ladies nite.' Meanwhile, the awareness message, 'Condoms: Play it safe with sex' rather less than prominently. Labeled 'Don't Trade in Aids,' it sought to address not only transactional sex but called for condom use which ironically made the image of the young man, with cash in hand, and discarding an unused condom problematic.



Figure 3. Don't trade in AIDS.

(Used with permission. From the private collection of Sir Errol Walrond)

Since 2000, there has been significant transformation in the manner through which HIV awareness is presented through this medium. Previously dark with an apparent emphasis on awareness through fear, these have been replaced by highly sensualised imagery. In December 2004, the Barbados Defence Force (BDF), in collaboration with the National HIV/AIDS Commission (NHAC) launched its in-service HIV awareness campaign with a series of five Posters. One which read: 'I always protect my weapon in wet conditions' depicted a soldier standing knee deep water with a condom on tip of his rifle. In addition to outrage from women's groups which saw this depiction as associating sex with violence, a 2007 study by Market Research Inc. found that although soldiers found the messages favorable, 40.8% reported no change

in behavior. A 2009 survey carried out among soldiers revealed that little had changed in their attitudes to condom use. However, one particular concern was the inference that women were reservoirs of disease from which men must be sheltered as if within these 'wet conditions' lurks dangers from which men must protect themselves. Therefore, emphasis on the need for all players to protect themselves needed and still needs to be established.

SELECT GOVERNMENT POLICIES

A review of the Ministry of Health's proposed development plan for 1988-1993 reveals that it made no mention of HIV and AIDS. This glaring absence affords us an uncomfortable glimpse into lack of emphasis placed on the disease in regard to national policy during the decade following the first diagnosed case. One glaring absence was the provision of a safe space for ostracized persons who, as a result of the disease, were made homeless. In 1994, it was believed that this would change when the newly elected administration of Prime Minister Owen Arthur pledged to provide a safe haven for persons infected with the disease. However, with a local economy still in deep recession, financing became a considerable challenge.

In 1995, Canadian millionaire and philanthropist Peter Allard offered to construct an HIV/AIDS Hospice at no cost to government. This offer, although discussed with various stakeholders, was ultimately rejected by a new administration which showed so little interest, that representatives from Ministry of Health failed to attend meetings to discuss already advanced infrastructural plans. This incident highlighted the absence of an effective social partnership response to the disease as late as the mid-1990s. Having refused this offer for reasons which remain unknown, government embarked on its own HIV-related housing initiative. On July 7th 1995 the government of Barbados officially opened its hospice at Black Rock and suitably named it after Elroy Phillips who, as of 2010, remains one of few local individuals to make public their HIV positive status.

However, the decision to construct this hospice within the confines of the Lazaretto shed considerable light on how persons infected with HIV were viewed. Built in the 1850's, the choice of this former isolation facility for lepers suggests

COMMENTARY... *cont'd*

that the disease was considered equivalent to leprosy and that those infected were to be similarly cast aside. The choice of location and how HIV was viewed at the time went some distance toward reinforcing prevailing ideas that persons infected with HIV and AIDS were not fit to exist within the general population. Instead, it strongly infers that these persons were to be placed at the periphery of healthy society. Though well-meaning and a key introduction in the management of those affected, the association of the lazaretto with disease and decay would have certainly influenced public perceptions.

TREATMENT OPTIONS

Prior to the introduction of Antiretroviral Therapy (ART) treatment options for persons infected with HIV consisted primarily of the treatment of any number of symptoms which resulted from a weakened immune system. The introduction of Zidovudine (AZT) in 1995 provided a ray of hope for those infected with HIV. Approved by the United States Food and Drug Association (FDA) in March of 1987, at the time it was the most effective drug for combating the disease and the first anti-HIV drug approved for use in the United States. At the time of introduction, its use was restricted almost entirely to pregnant HIV- positive women with the sole objective of preventing mother to child transmission. Incidentally, the first child born with HIV reached adolescence just as AZT was made available locally. Unfortunately, due to the aforementioned policy, she was denied access to treatment. For Dr. Walrond, this incident, and the circumstances that surrounded it, was a bitter pill to swallow.

The opening of the Ladymeade Reference Unit (LRU) in June 2002 was another landmark treatment innovation. The provision of ARV therapy at no cost to the end user, contributed significantly to reductions in new AIDS cases from 131 in 2002 to 59 in 2010 and mortality from six to two percent over the corresponding period. As indicated within the Global Aids Response Report for 2010, by 2010 80.4% of persons eligible for Highly Active Antiretroviral Therapy (HAART) were receiving treatment. This was higher than figures for Guyana (71%), Trinidad and Tobago (75%) and Jamaica which had 57% of its HIV positive population receiving therapy. Although encouraging, this figure represents a marked decline from a high of 94.8%

in 2002. However, HAART made its greatest impact with the elimination of mother to child transmissions. From a MTCT rate of 27% in 1994 and 5.5% in 1999, by 2010, there had been no recorded new cases through mother-to child transmission since 2007. This remains the one true success story in relation to HIV awareness and prevention on the island.

The rates of new HIV infections in Barbados have remained relatively constant in spite of the Millennium mandate to reverse the trend of new infections by 2015. Table 1 highlights the total annual rates of infection from 1984 to 2009. In assessing the rates of new infections, data for two decades: 1990-1999 and 2000-2009 were examined. Figures for the decade 1990-1999 indicate 1535 new infections comprising of 992 males and 543 female with an average annual rate of new infections of 153.5 persons. By comparison the decade 2000-2009 saw 1559 new infections with 906 of those being male and 653 being female for an average annual rate of new infections of 155.9. Although this comparison gives statistical evidence to indicate that little has changed regarding new HIV/AIDS infections, of particular concern has been the increase in the rates of infection among women. These challenges have occurred in spite of increased spending, involving multidisciplinary initiatives.

Annual trends of new HIV cases, new AIDS cases and deaths of people with HIV 1984-2010

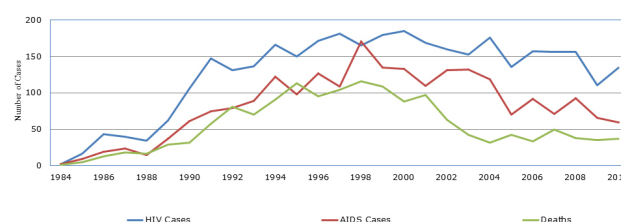


Figure 4: Source: Barbados HIV Surveillance Report

SUMMARY

HIV awareness programs between 1984 and 2010 were severely restricted by the culture of fear that accompanied the disease. In addition, the failure of a number of local institutions to call for tolerance set the tone for much of the discrimination which continues to affect awareness efforts. In

COMMENTARY... cont'd

addition, some within the medical community (as products of the larger society) have shown little regard for in-service HIV awareness programs vital to the conveyance of knowledge regarding attitudes and sexuality. The evolution of entertainment as a portal for awareness discourse would result in either its political censorship, or a message that is lost in translation amidst a plethora of secular recordings. The abrasive sexual texture of radio and television content and the youthful demographic to which it catered, proved counterproductive to HIV awareness. However it is the published figures for rates of new infections which ultimately provide a rubric against which we can statistically assess the results of HIV awareness programmes. Although much good has been done and the numbers of new cases for 2009 were the lowest since 1990, annual rates of infection had retained a worrying consistency in spite of a marginal decline. During the period 1984-2010, HIV awareness and prevention programmes, other than in PMTCT, were not wholly successful in either decreasing stigma or discrimination and had minimal reductions in rates of infection. Though to ascribe blame to Barbados' HIV awareness programmes would be a bridge too far and undeserving, much more needs to be done in the local fight against HIV and AIDS.

Sylvan Spooner is a Ph.D. student in the Faculty of Humanities and Education at the UWI Cave Hill Campus. His essay was part of his 2013 undergraduate thesis for which he was awarded the 2013 third year history prize.

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The Glebe Polyclinic , St George. Acknowledgement to Dr Carl Ward, Medical Officer, for supplying the photo.



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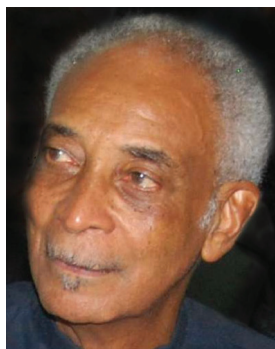
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FEATURED ARTICLE

INDEPENDENCE AND HEALTH – ‘THESE FIELDS AND HILLS’

**Sir Errol Walrond**

KA, FRCS, FCCOS.

Honourable Minister of Health Mr. John Boyce,
 Permanent Secretary in the Ministry of Health,
 Chief Medical Officer Dr. Joy St. John,
 Director of the Barbados Drug Service Mrs Maryam Hinds,
 Fellow Panellists,
 CEO's and Directors of Hospitals, Medical and Nursing
 Directors,
 Dean of the Faculty of Medical Sciences,
 Presidents of Health Professions Associations, Presidents of
 Non-Governmental Health Care Organisations,
 Knights, and Dames, Colleagues, Ladies and Gentlemen

Thank you Chair for your kind introduction.

It is an honour to have been invited by to give this 50th Anniversary Lecture in the Barbados Drug Service lecture series. I say this because this service is in my opinion the best example of independent thought and action that has taken place in our health services during the last 50 years. But in order to understand where we are today we must recognise the Legacy from our Colonial past.

Prior to independence, Barbados' health services were directed from the Colonial Office and were largely manned by personnel recruited by that Office. Our state of health was described in the 1945 Report of the Moyne Commission in what we would now consider as rather hellish terms. Our phase of self-governance and the output from the University College of the West Indies, which started in 1948, had resulted in more locals from the Caribbean working in the health sector. At Independence most of the physical infrastructure we have today already existed. The century old General Hospital had already been replaced by the

Queen Elizabeth Hospital; the Mental Hospital, Jenkins to my generation, is still recognizable in every way in spite of a change of name. The Parish Alms houses have also been renamed but largely retain the same functions and stigma as they had at Independence. The Enmore, Speightstown and Six-Cross Roads Clinics would no longer be recognizable, but were the precursors of the polyclinics, one of the more verdant fields of health service provision that have developed during independence.

By independence near full immunization coverage against small pox, tuberculosis and polio along with the present day protection against measles, diphtheria, tetanus and whooping cough had been achieved.

Infant and childhood malnutrition had been well recognised in our colonial past and efforts by charitable ladies and official intervention in schools in the form of milk and biscuits had proven to be insufficient. For at the time of Independence the 2-year-old QEH, particularly around Xmas and during the Crop Season, would see the paediatric ward and its cots overcrowded with malnourished children, sometimes 2 to a cot.

Piped potable water was available to all at standpipes; and at independence considerable progress had been made to provide 50% of households with a piped water supply, but considerably less than that had water toilet facilities. It is with this mixed legacy that Barbados proudly entered Independence.

At the time of independence, I was asked to reflect on what Health and Freedom meant for us in the Barbados Independence Issue of the New World Magazine. I began my contribution by stating;

'In colonial territories the hospital has formed part of a system designed to look after the basic health needs of the poor. The public health need has been paramount, and the hospital service has remained relatively underdeveloped in relation to the size of their communities. It has provided a poor service for poor patients; whereas those patients who could afford to pay took their treatment in clinics at home and abroad'.

FEATURE ARTICLE... cont'd

On reflecting on our journey over the last fifty years, Barbados has kept pace with the health indices of more developed countries. There have been many developments in health provision in Barbados yet the statement rings true.

In these fields and hills, we can be proud of the polyclinics network, the expansion of specialist services, the modernisation of emergency services, the Barbados drug service and the contribution of the Faculty of Medical Sciences in both teaching and service.

But we should not be proud to have returned the St. Joseph's Hospital to the ravages of nature, or the rejection of the facilities of the Lion's Eye Care Centre just as it was about to be equipped and then to send people to Cuba for the removal of cataracts. Neither can we take pride in still using a garbage disposal site, long after its sell by date.

The state of Public Health in an independent Barbados is best reflected in how some basic indicators have changed over the period. We have one of the more densely populated countries in the world and our population growth has been kept under control, by the pre-and post independence efforts of the Family Planning Association, and the provision of primary and secondary education for all, and tertiary level education for many rather than the few. As a result fertility rates have dropped, and life expectancy at birth has increased from 69 years at independence to 75 years now, the ladies living rather longer than the men of course. This population dynamic is also reflected in a virtual doubling of the population over 65 years.

The country has become more prosperous as reflected in the per capita income, and per capita expenditures on health have doubled from 3.5 % to 7.5% of GDP. Government's expenditure on health, which represented 18% of the budget in 1966, has decreased in recent years to 11% in 2013, and was as low as 8% in 2009.

As regards the direct health indicators, the general mortality rate in Barbados has remained about the same in spite of an ageing population. This is reflected by improvements in infant and neonatal mortality, maternal mortality, as well as mortality from cardiovascular diseases, cancers and respiratory diseases. These improvements are largely due to improved services at the Queen Elizabeth Hospital. But that institution should not be proud of introducing the dismissive term 'Elderly for Care' whose intent is not hidden by using the acronym 'EFC'.

After all they are our only expanding demographic, in need of most care, and were the real investors in the services we enjoy today.

The Public Health of the nation is reflected in other indicators as well as the provision and maintenance of basic health services from the pre-independence period. For example, near universal childhood immunization levels have been maintained. The provision of potable water and sanitation services were spread to almost all households and affordable housing made available to a large proportion of the population. Unfortunately, the maintenance of the water distribution service has been allowed to lapse and today many households are without a reliable supply of clean water. Rusty water is not unusual in some areas, such as mine, and information is no longer made available to the public on the quality of the water being provided.

Sanitation services consisting of garbage disposal, sewage collection and treatment have developed at a snail's pace. The sewerage service is only available for parts of Bridgetown and the South Coast leaving out other heavily populated areas. The Bridgetown sewerage treatment plant, located in a densely populated area, at times produces a stench that is experienced by motorists on a nearby busy road, and the south coast plant has recently attracted attention in the press. On the brighter side, the discharge of effluent from hotels into the sea has been reduced.

An intermittent stench from the main land fill site affects nearby residents and those along the 'affluent' west coast where wealthy 'visitors' are encouraged to own or vacation in luxury villas. It can only be seen as an indictment on our progress that recycling and the more systematic collection and disposal of household garbage remains at the discussion level for the entire 50 years of our Independence.

On a more positive note, the monitoring of food handling practices in commercial businesses, including street vendors, has seen the elimination of major outbreaks of diseases such as typhoid. Tuberculosis, scarlet fever and personal hygiene problems such as head lice and crabs have been diminished by the increased provision of housing with less overcrowding. In fact, the tuberculosis wards at the QEH were converted to other uses by the end of the first decade of independence. It cannot be over-emphasised - the impact on health of education for all and employment for most.

FEATURE ARTICLE... *cont'd*

Fifty years ago infant and childhood malnutrition remained a fact of life, and we applaud the work of the late Sir Frank Ramsay in following this problem and championing better nutrition for those affected. Perhaps it is symbolic that the building that housed the Nutrition Centre cracked and had to be destroyed, for the pendulum has swung from childhood malnutrition to a widespread concern over obesity, and its companions of diabetes, hypertension and their offshoots of heart and kidney disease, strokes, lower limb amputations, expensive renal dialysis, as well as severe arthritis requiring joint replacement.

The public health threat of the chronic non-communicable diseases had been recognised for a long time. Its progress has been followed by research presented locally and at the regional medical research forum, CCMRC now CARPHA; the establishment of the Drug Service was in part a response to this problem, and within the UWI there is the development of the Chronic Disease Research Centre. Nevertheless, there is as yet no effective programme that has stemmed the tide of these problems. What has emerged are programmes to deal with the end results – intensive care units, renal dialysis and transplantation for failed kidneys, cardiac surgery for blocked arteries, a stroke unit and more recently the setting up of a National Commission on the Non-communicable diseases.

Advice for primary prevention include dietary changes and exercise that are repeated with little acknowledgement of the vast and confusing industry of weight loss programmes, all of them with difficulties for those who cannot afford to give effect to the recommendations in them. Fiscal policies that are intended to help the poor in getting adequate nutrition actually make the very items that produce obesity like sugar, flour and rice the most affordable options; the effect if any of the recent soda tax remains to be seen. The growth of profitable businesses that provide quick, tasty, affordable but poor choices for daily food intake has sky-rocketed during independence.

The government's own taste for taxes on the importation of motor vehicles has among other things systematically decimated the use of M2 – a term which would have been still recognisable at the start of independence, but I am sure is lost on most of you today. The use of this natural vehicle has been systematically reduced for our citizens by the growing number of fast moving vehicles on the road, whilst government's promotion of outdoor activity centres are aimed exclusively at the youth. The use of our beaches, once a popular activity for

all ages, has been largely cut off for those without vehicular access, and for those who have full time employment by the unaddressed security concerns of early morning or evening use.

Meanwhile, Barbados has been labelled as the amputation capital of the world with the end result of more major amputations being done as frightened patients are being referred too late for more conservative limb saving procedures. What is missing from that story is that at the time of that dramatic declaration, the 82 major limb amputations were 40 per cent less than 20 years earlier and had been reduced due to the untiring work of the surgical department in the QEH in trying to save those limbs. Unfortunately, 5 years after that championship was declared we were back to where we were 30 years earlier.

There are other health related issues that have changed significantly during the period, these include reduced tobacco smoking and motor vehicle accident fatalities. But there is increased drug use and gun shot wounds. Reduction in cigarette smoking was largely the work of community activists and I must applaud the nagging advocacy of Dr. Tony Gale in this regard. These efforts eventually led government to lead from behind and ban advertising and smoking in public places. The reduction in motor vehicle accident fatalities can be related to the rather late adoption of helmet and seat belt legislation. However, there has been a steady rise in motor vehicle accidents with our increasingly crowded roads and the failure to introduce any effective legislation related to reducing drinking and driving.

Another problem that appears to have been ignored as a public health matter is the rising toll of the illegal drug trade and its associated gun violence. Treating this problem as a purely criminal matter has clearly failed, and our governments have been loathe to even discuss decriminalisation of the trade as an alternative means to control the proliferation of guns and violence.

Vector borne diseases, particularly dengue, chikungunya, and now zika, have been with us throughout the 50 years. The methods of control of the mosquito vector are well known yet little control is exercised until there is public concern about an epidemic, or the country is threatened with a travel warning to our tourist visitors. The public health inspectorate, that was so important in the elimination of malaria, and other infectious disease is not as proactive as they were in visiting, inspecting and advising households on vector control.

FEATURE ARTICLE... cont'd

However, AIDS, the greatest public health crisis in the period, was introduced and affected the population 20 years into independence, and remains a lingering threat for new HIV cases, which had risen steeply for the first ten years of the pandemic, have leveled off since then, at near peak yearly levels.

AIDS had produced panic among the general public and health professionals alike. It had emerged as a wasting, rapidly fatal disease among male homosexuals initially.

The stigmatization and hatred of those affected would be exploited by many in the community, including those quoting selected verses in the Bible, who sought to justify excluding AIDS sufferers and their families from all sectors of the community, even a peaceful burial was being denied. Scientific evidence of how the causative HIV virus was spread and behaved characterised it as a silent epidemic, for persons could be infected, healthy and capable of transmitting the virus for up to ten years before they became ill with AIDS. The fact that it was not spread by casual contacts, would be challenged by well-known newspaper columnists, and there was even an editorial calling for a list of affected persons to be published.

The health professions and the Ministry responded to the crisis, and the panic within the hospital was dissipated by putting in place a comprehensive education programme for all categories of staff. This alongside a multimedia, multimodal public education programme helped to control the public's fears of casual contact transmission. However, some safer sexual messages would be met with resistance, in particular from some faith-based groups and those responsible for the education of children. It remains today that educating children about safe sexual behaviour is the only area in education where children are largely left to their own devices, and ignorance is officially enlightening.

Local research and action into the prevention of mother-to-child transmission of HIV has been particularly successful, but was marked for many years by the provision of medication for this purpose only. Vigorous advocacy for all of the affected continued from the National Advisory Committee and the AIDS society. Barbados' representatives would play significant roles in the fight for HIV control regionally and internationally as members of the original WHO Global Programme on AIDS, and its successor the UN-AIDS programme.

HAART antiretroviral therapy for HIV emerged but was very expensive. Fortunately, international cooperation and the help of the Clinton Foundation allowed us to make this therapy available from 2003. This has resulted in a dramatic drop in the mortality from AIDS, but the newly diagnosed cases of HIV remain largely unabated.

Whilst the panic has settled, I must confess to being disappointed that there has been no legislative action to meet our commitments made at the United Nations that would mitigate against the continued stigma and discrimination in our society, or to impact on the sexual exploitation of children.

It is interesting that the leaders for this public health battle came from the hospital sector as well as the Primary Care sector. General practitioners have provided the bulk of the medical services in the island from the beginning of independence and throughout. At the time of independence this included a substantial proportion of the services in the hospital particularly in surgery, obstetrics and gynaecology, in 'Casualty' and in the then existing government clinics. The 'visiting specialist' general practitioners would be phased out from the hospital as more qualified staff positions became available.

At the end of the first ten years of independence, legislation was passed to introduce general practitioner services along the lines of the British National Health Service. The recently formed Barbados Association of Medical Practitioners pointed out that the number of GPs available was inadequate to properly service the population under the proposed programme. BAMP suggested that the service could start with the enrollment of the elderly into the scheme, the expansion of services in multipurpose clinics and the provision of free medication for the elderly, and for patients with diabetes and hypertension who had to take medication daily. The government, after public castigation of the profession's representatives, quietly dropped its proposal but set about to implement the proposal which is now called the Barbados Drug Service.

Furthermore, government supported the University's proposal for a specialist Family Medicine training unit by providing such a facility at the Edgar Cochrane polyclinic. The number of medical practitioners has quadrupled since independence with forty per cent of them now registered as specialists. However, I find the output of Specialist Family medicine practitioners

FEATURE ARTICLE... *cont'd*

disappointing and general practice remains a service of illness care on demand. The big difference in the primary care sector has been the establishment of the Barbados Drug Service.

As mentioned previously, the Barbados Drug Service was originally proposed in a limited form and was instituted out of the ashes of the proposed National Health Service. Unfortunately, the original director did not heed advice to computerize the service right from the start, in order to track the obvious temptation for abuse. A National Formulary was formulated and published yearly and became the template for other countries in the region. The service became so popular that the politicians could not resist one-upmanship and the extension of benefits. Inevitably there has been exploitation by both patients and the professionals with the running up of costs. Yet in my opinion it remains a Jewel in our health services – an expensive jewel, but one that is worn by those most in need in all sectors of the community.

Hospital beds for general, psychiatric and geriatric care essentially remain the same in proportion to the population as they were at the time of independence. Staffing at the junior and senior levels has expanded in both numbers and the variety of specialist expertise offered. However, in spite of the improvements in staffing, training, technology, new facilities and the provision of specialist services in most fields at the QEH, the aspirations and the assessment of our people remains as I assessed it in 1966.

Patients have to put up with long waits, overcrowded clinics and wards, missing notes, delayed results of investigations, and a shortage of essential supplies. Private patients fear better only in that they can pay to have a private room, but to get to those rooms has been made more difficult.

Facilities for private patients are now non-existent outside of the rooms, and when they are being admitted they have to go through more inconveniences than the public patient. The result is that in spite of providing the best care in the island for any difficult condition, and having to act as the institution of rescue for other private facilities, the QEH is not the preferred facility for those who are well to do and may be inclined to make major donations to the institution.

In addition, the rejection of the Lion's Eye Care Centre when it was already built and ready to be equipped sent a most damaging signal to the International donor community. A similar policy act returned a failing private hospital that was

acquired by government to nature as a ruin, and deprived the country of additional facilities, the need for which is now plainly apparent.

Placing the administration of the QEH under a Board of Governance has made no difference in bringing the public nearer to having an input into the institution. None of the hospitals have a Code of Conduct that all staff can be asked to live by and too often different categories of staff see themselves as rivals rather than as a team. In this 50th year of independence, all that the administration appears to speak about is how the hospital should be financed.

As I wrote in 1966 'No matter how much we regret it, a service that is going to spend as much money as the health service, must become involved in politics. But unlike other government services, the patients themselves can play a vital role in how good it is, if they are constantly on the lookout to improve it rather than to just take from it.'

In all of the talk about financing I never hear of an allocation for research or internal audit that can assess the cost-effectiveness of the services being provided. There is also no attempt to integrate the hospital services into the primary or secondary prevention of disease that is so important in allowing the hospital to be more effective by treating problems at an earlier stage.

As regards the role of the university, in 1966 I wrote - 'Perhaps the proposed extension of medical teaching of the University of the West Indies into Trinidad and Barbados, may provide the stimulus for integration of patient care, specialists services and nurses training'.

Teaching of final year students was indeed introduced in the first year of independence, and the University has played a crucial role in improving the standards of care at the hospital and at the GP unit attached to the Edgar Cochrane polyclinic. The teaching programmes have grown to a full undergraduate programme, as well as several postgraduate programmes, including the initiation of specialist training in Emergency Medicine in the region.

Most of the leading specialists in the island are UWI graduates, but there is still a paucity of specialist trained family medicine practitioners. Unfortunately, the initiative to get more community oriented practitioners through internship exposure has been abandoned. But the University

FEATURE ARTICLE... *cont'd*

has established the Chronic Diseases Research Centre, which has established registries for these diseases and hopefully will be able to influence preventive treatment strategies in the future. University staff also have full service roles, and were instrumental in developing thoracic surgery, and the Artificial Kidney Unit and renal transplantation by the late Professor Nicholson.

In closing, let me state unequivocally that we have had great advances in illness care during the 50 years of Independence. But the prevention of illness and the maintenance of health and healthy lifestyles have not been accorded the priority they deserve. The path being advocated of treating health

and illness as any other business as occurs in the USA, will in my opinion set the country on an unsustainable financial path. The country needs to change to an 'independent' path of development that encourages the adoption of healthy life styles by citizens of all ages, whilst maintaining the gains that have been made in illness care.

Sir Errol Walrond is Professor Emeritus, Faculty of Medical Sciences, UWI Cave Hill Campus.

His presentation commemorating the 50th anniversary of independence of Barbados, was delivered at the LESC and hosted by the Barbados Drug Service in collaboration with the Ministry of Health.

THE ROLE OF CLINICAL STAFF IN ANCILLARY IMMUNOCHEMISTRY TESTING IN BREAST CANCER.



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Ancillary immuno-histochemical (IHC) testing plays a pivotal adjunctive role in breast pathology. The primary use of IHC is to determine the oestrogen (ER) and progesterone (PR) hormone receptors and human epidermal growth factor receptor 2 (HER2) protein over-expression status of breast carcinomas. The results of these tests provide predictive and prognostic information for breast cancer patients. However, IHC testing is no longer synonymous with ER, PR, and HER2 biomarker testing. Secondary uses of IHC include the assistance with differentiation between: primary invasive and in situ carcinomas; primary and metastatic cancers; the types of in situ cancers; atypical ductal hyperplasia and benign intra-ductal lesions; and the identification of lymph vascular space invasion by tumour cells. Nonetheless,

because of the important role of ancillary testing in breast cancer management, this article focuses on the American Society of Clinical Oncology/College of American Pathology recommendations for ancillary immuno-histochemical testing in breast cancer, with an emphasis on the pre-laboratory, pre-analytic variables which are mainly controlled by clinicians.

The American Society of Clinical Oncology/College of American Pathology (ASCO/CAP) initially issued joint, evidence-based guidelines for ancillary HER2 testing in breast carcinomas in 2007.¹ Consensus guidelines for ER and PR testing followed in 2010.² The HER2 guidelines were updated in 2013.³ The guidelines were issued in order to ensure accurate biomarker testing. They encompass recommendations on the key variables in all phases of IHC testing- pre-analytic, analytic, and post-analytic, which have an impact on the results.

The reporting thresholds from the current American Society of Clinical Oncology/College of American Pathology (ASCO/CAP) guidelines using IHC testing are in tables 1 and 2.⁴ Assessment of tumour cell nuclei is performed for ER and PR, while assessment of membrane staining is performed for HER2.

SPECIAL ARTICLE... *cont'd*

It is recommended that hormone receptor and HER2 testing be performed on all primary invasive carcinomas as well as all recurrent and/or metastatic tumours.⁴ This change in the guidelines, from having one set of IHC testing, often on the primary tumour only, to multiple sets of IHC testing in a patient diagnosed with breast carcinoma, incorporates the finding of studies that have shown that there is a discordance between the immuno-histochemical profiles of breast tumours and metastatic/recurrent tumours.^{5,6}

The standardisation of as many factors as possible ensures the greater likelihood of reproducibility of results within a laboratory and between laboratories. In contrast to the pre analytic variables, the analytic and post analytic variables, are more easily managed, via standard laboratory operating protocols, the use of automated stainers, proficiency testing and keeping up to date with reporting protocols.

The pre-analytic phase refers to the steps the specimen goes through before IHC is performed. This phase is further subdivided into pre-laboratory handling, and intra-laboratory handling by pathologists and histo-technologists. Standardisation of these variables requires a team approach. Similar to the analytic and post analytic factors, the standardisation of intra-laboratory handling of specimens should be addressed via implementing laboratory standard operating procedures. The standardisation of pre-laboratory procedures is more difficult, because of the numerous players involved in submitting a specimen to the laboratory.

The latest version of the ASCO/CAP guidelines³ targets the three modifiable pre-analytic factors, cold ischaemic time, the type of fixative, and the duration of fixation. The documentation of these variables is a mandatory reporting requirement for ancillary testing for ER, PR and HER2. The documentation of the time the specimen was removed from the patient and the time the specimen was placed in fixative is an acceptable alternative to recording the cold ischaemic time.

The aims of the pre-laboratory handling of a specimen are to ensure that all specimens are fixed as soon as possible, and in an adequate volume of the correct type of fixative.

Warm ischaemic time is the time from the interruption of the blood supply to the tumour to the time of excision

by the surgeon; and the cold ischaemic time is the time of tumour excision to the initiation of fixation. There are multiple reports in the literature which delineate how increases of these times decrease the ex-pression of various macromolecules. Of note, Yildiz-Aktas et al⁷ demonstrated that significant reduction in IHC staining for ER, PR and HER2 usually occurs after four (4) hours for refrigerated samples and two (2) hours for non-refrigerated samples. The ASCO/CAP recommendation of a cold ischaemic time of less than or equal to one hour, errs on the side of caution. This time frame minimises degradation of clinically relevant targets for IHC; and the artifactual decrease of protein expression due to tissue handling.

In terms of the type of fixative, the ASCO/CAP recommended only one fixative for breast specimens, 10% neutral buffered formalin, and the pH must be between 7.0 and 7.4.^{3,4} No other concentrations, or any other variations, of neutral buffered formalin are acceptable. Non-formalin fixatives, acidic fixatives such as Bouin's and acidic, unbuffered formalin degrade ER and nucleic acids.^{2,4} Degradation of nucleic acids will result in a failure to obtain results in fluorescence in situ hybridisation (FISH).⁴ FISH is used for confirmatory testing of samples with equivocal HER2 results (score of 2+).

Adequate fixation is achieved when the volume of the fixative is 10 times the volume of the specimen.² Of note, breast specimens will float in fixative, because of the high percentage of adipose tissue and therefore have to be covered to ensure that the fixative surrounds the entire specimen. This needs to be communicated to all staff who may be involved in specimen handling. Unfortunately, most anatomical pathologists can cite instances where the breast specimen has assumed the shape of the container; breast specimens were not freely extracted from containers; or the specimen was floating in the fixative and no covering material was present. In some specimens where the material, usually gauze pads, which was supposed to cover the specimen, was present, it was beneath the specimen and often had sunk to the bottom of the container.

While the initiation of fixation is in the realm of the clinicians, the duration of fixation is in the hands of the laboratory staff. The latter should aim to ensure that the guidelines are not breached.

SPECIAL ARTICLE... cont'd

The ASCO/CAP guidelines¹⁻³ recommend that fixation should be for at least 6 hours in neutral buffered formalin. The upper limit of fixation for ER and PR is 72 hours, and 48 hours for HER2. Prolonged fixation, decreases immunoreactivity for ER, PR and HER2 and may lead to false negative results due to inadequate antigen retrieval during IHC analysis. There is debate in the literature about the minimum duration of extended overfixation required for a detrimental effect on the immuno-reactivity of biomarkers in breast carcinoma. Some studies⁸⁻¹⁰ have argued for that the upper limit for acceptable fixation be 96 hours. The 96 hours duration of fixation was investigated because it took into consideration specimens originating from remote sites and long weekends where routine surgical pathology laboratory handling is unavailable. However, the ASCO/CAP consensus guidelines¹⁻⁴ take a prudent approach to the maximum times allowed for fixation.

In conclusion, clinical staff members have an integral role in IHC testing for breast cancers, because non-laboratory staff members control variables such as the cold ischaemic time, and the type and the volume of fixative for specimens. Following the pre-laboratory, pre-analytic ASCO/CAP recommendations for ancillary immuno-histochemical testing may be challenging, but it should be done as part of the optimisation of care for breast cancer patients. Implementation of the guidelines require a coordinated, multidisciplinary effort, with buy in from clinical and laboratory staff.

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THINKING OUTSIDE OF THE BOX...OF PILLS: A FEW WORDS ON CONTRACEPTION.



Dr Tanya M. Evers
MD, MEd, FACOG

"This does not give you a license to have sex." How many mothers have uttered those words or others like them to their daughters as they embark on an important, but potentially frightening and confusing, journey into the world of contraception? Many adolescents and young women initiate usage of a contraceptive agent not for birth control, but for period control. About a third of teen OCP (oral contraceptive pill) users note usage for completely non-contraceptive reasons.^{1,2} These might include regulation or lightening of the menstrual cycle, relief of menstrual pain, or assistance with acne.³ Neither can we ignore the potential longer term benefits of hormonal contraceptives such as reduction in rates of ovarian and endometrial cancer.⁴ Over twenty years of age, 90% of OCP users do so for contraception, but still over half of these women report non-contraceptive benefits. These commonly prescribed medications serve a dual purpose for many. But, are people really happy with their selected contraceptive agent?

A study performed in St Louis, MO in the United States looked at satisfaction rates of various forms of contraception. A comparison of long acting reversible contraceptives (LARC) versus non-long acting forms, 66.9% were very satisfied versus 42.7%, respectively.⁵ When looking at the highest degrees of satisfaction with individual forms of contraception, over 70% were very satisfied with the levonorgestrel intrauterine system (LNG-IUS) compared to percentage rates in the 30s-40s for short acting combined contraceptive methods such as OCPs, ring, and patch, which then translated to a continuation rate of 87.5% for the LNG-IUS versus 49.1-55.1% for the aforementioned short acting contraceptives.⁶ Not surprisingly, women who were most satisfied with their

chosen form of contraception were more likely to continue with that same form of contraception.

Reflect on the adolescent/teenage patient, presenting for contraceptive counseling, with or without a confidant, advisor, and/or parent. She is introduced to the various forms of contraception. The least invasive and least intimidating option may seem like the pill, but what if she is able to familiarize herself with and accepts a LARC? She is most likely to be satisfied with that LARC and therefore continue its usage, which could affect her contraceptive decision making for a lifetime and therefore potentially the trajectory of her life. This may seem a rather melodramatic view of a patient selecting something as routine and simple to her physician as birth control. However, according to the World Health Organization, pregnancy and its complications are the second leading cause of death worldwide for 15-19 year old women, and about three million "unsafe" abortions occur in women in this same age range resulting in maternal morbidity and mortality.⁷

Consider that babies born to mothers less than 20 years of age have a 50% higher risk of stillbirth and neonatal death; also noted is a higher incidence of low birth weight babies and those long-term effects.⁷ Remaining mindful of those young women who may not be sexually active, yet request a contraceptive agent for non-contraceptive benefits, give special attention to the implant, a LARC that can be placed in the patients' arm and avoid the potentially anxiety inducing pelvic exam. The implant had an 83.3% continuation rate at twelve months in the aforementioned Piepert study, and over 75% of patients were very or somewhat satisfied.⁶

An important point that has yet to be discussed is efficacy of these various forms of contraception. Just because the patient may like it, doesn't mean it will be the most efficacious. However, one must acknowledge the importance of the patient's role in the usage of the prescribed contraceptive agent. As any provider can tell you, the more often a medication has to be remembered to be taken, the less likely said medication will actually be taken correctly. That is where we begin to review perfect versus typical usage.

CME... cont'd

If a woman who is not attempting to achieve pregnancy has unprotected intercourse each and every time she has intercourse there is an 85% chance of unintended pregnancy in the first year.² In this case typical and perfect usage rates would be the same.

Compare that to typical versus perfect usage of the male condoms (15% unintended pregnancy in the first year vs 2% unintended pregnancy rate in the first year with reportedly perfect usage—that is to say consistently and correctly), OCPs (8% vs 0.3%), the contraceptive injection medroxyprogesterone acetate (MPA) (3% vs 0.3%), LNG-IUS (0.2% vs 0.2%), and the implant (0.05% vs 0.05%).² The more often one has to remember to use the agent, the less likely this will occur perfectly, thereby affecting the rates of unintended pregnancies in the first year. In the adolescent/teen patient with ever changing activities, schedules, and pressures on their time and attention, achieving the type of consistency needed for perfect usage could become problematic. Therefore, again, LARC usage in this population should be supported.

LARCs are a great option for the adolescent/teen population regardless of gravidity, and misconceptions must first be cleared from the mind of the provider so the patient in turn can benefit from this unencumbered viewpoint. While screening for sexually transmitted infections should be performed, intrauterine devices can be safely and routinely placed in the nulliparous teen without concern for inordinate rates of expulsion and without negatively affecting future fertility.¹ Both the LNG-IUS and the implant can cause changes to a woman's bleeding pattern, (including the potential for irregular bleeding) which needs to be thoroughly discussed, because as one might assume, incurring this risk and not having been aware of it could affect satisfaction with the device.¹ Also, the implant is not strongly associated with an increase in weight gain.¹ Every day patients are met with various barriers to care, regardless of the situation.

It may be that our patients are struggling with transportation, finances, childcare, and a multitude of other life circumstances making it a challenge for them to even make it to clinic. We may not be able to assist with all or perhaps any of those challenges. However, we must continually step back and consider how we as the provider may become a barrier to care. Regarding contraception, it is very easy to provide

the same information about each option to the patient and consider the task at hand complete⁷. However, one must remain mindful of personal biases and ensure a full-scale review of each option.

Clearly, evidence suggests that the benefits of LARCs outweigh the risks in most individuals, including young women. Armed with knowledge and conviction, one can meet the various barriers to care that may present themselves and work with the patient toward a thoughtful resolution to the timeless, yet at times frightfully daunting, question regarding contraceptive opportunities.

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ABNORMAL UTERINE BLEEDING: JUST A NORMAL FACT OF LIFE

Dr Tanya M. Evers

MD, MEd, FACOG

If one takes care of female patients, chances are one will be required to evaluate abnormal uterine bleeding (AUB) at some point. At times, the workup can be very straightforward and the results seemingly certain. Other times, the assessment and results appear ambiguous. An in-depth review of all possible causes of AUB across the lifespan of a female including pre-menarche and postmenopausal is outside the scope of this article. However, a general overview will be undertaken and specific points highlighted.

A complaint of vaginal bleeding in the pre-menarchal girl is luckily not something that one commonly sees. It can be a source of disconcertion for the patient, caregiver, and provider. In a world where media outlets seem only able to report the most horrible side of humans, it is easy to believe that all vaginal bleeding in young girls must be related to sexual abuse of some kind. While that may be the case for some and needs to be ruled out, consider other possibilities. In this relatively large 2016 study out of Sweden, the majority of vaginal bleeding (45.3%) in this pre-menarchal group of girls was due to trauma and notably, none of the trauma was due to sexual abuse.¹ The authors acknowledge that sexual abuse is not uncommon but was not uncovered in their study, perhaps because bleeding is minimal or nonexistent after abuse.⁵ One must also wonder where, when, and how often these abused children are brought to the attention of a medical provider.

The second most common cause of pre-menarchal vaginal bleeding was "unknown" (26.7%) with the presumption being that most were vulvovaginitis, followed by hormonal withdrawal bleeding in the newborn (10.3%).⁵ Any exam that takes place in this young, vulnerable population needs to occur in a calm, controlled environment. If even a somewhat invasive exam needs to occur, one must move to the operating room under general anesthesia. The authors of the previously mentioned study recommend that any vaginal bleeding of an "unknown cause" or suspected injury

"through or above the hymen" be examined under general anesthesia with colposcopy in the prepubertal patient.⁵ Vaginal bleeding in young girls may be uncommon, but one should have a plan as to how to take care of this patient to ensure that this young girl is afforded a thorough workup in a safe environment, sensitive to her needs physical and emotional needs.

Abnormal uterine bleeding in women of reproductive age is certainly a more common complaint and course of assessment for her provider. General categories to consider for this age group include pregnancy, structural, anovulation, exogenous, infection, and systemic.³ If a woman is of reproductive age, a pregnancy test must always be included in the workup and likely should be the first test performed in clinic. On that note, even if primary amenorrhea is the complaint being worked up, pregnancy should be ruled out first. In the immediate post-menarche age group, anovulatory bleeding should be considered months to even years after menarche occurs.¹ If the abnormal bleeding is of an acute nature, appropriate labs will likely be ordered and the acute bleeding controlled, followed by admission if needed. Regarding abnormal bleeding of a less severe, and more chronic nature, labs to consider include a blood count, thyroid tests, and STI screen (including gonorrhea/chlamydia testing); perhaps also coagulation studies, prolactin, and a pap test.³ In addition to always ruling out pregnancy, one must strive to avoid missing a cancer. Although cancer is less likely at age less than 35 years, and therefore, these women will need an evaluation of their endometrium if it is deemed that they have risk factors, which include obesity, low or nulliparity, unopposed estrogen, and Diabetes.^{2,8} About 5-30% of endometrial cancers/endometrial hyperplasia are in reproductive aged women.⁴ The link between obesity and endometrial cancer seems to be more closely related in the postmenopausal patient versus that of reproductive age.⁸ As women age, the decision to sample the endometrium becomes less of a question and one might say even more routine.

The goal of the workup in abnormal uterine bleeding is to rule out cancer and then to be followed by direct therapy

CME... cont'd

for conditions such as polyps and anovulatory bleeding.² Ultrasound investigation should be done so in a deliberate manner with timing of such immediately after bleeding ends in the cycling woman versus anytime in the non-cycling patient.² There is no set standard of endometrial thickness to predict risk of cancer in the reproductively aged woman and there are no biomarkers available that work.⁸ While Ultrasound may be one of multiple tests utilized in the woman of reproductive age, it may be the primary test in the postmenopausal patient with a complaint of vaginal bleeding. An endometrial thickness of 4mm or less in a postmenopausal patient has a negative predictive value of 99-100%.² One can be reassured with this result and the patient can avoid having an endometrial biopsy. However, if bleeding recurs, endometrial sampling will need to be performed; this recurrence can be expected in about 20% of patients with a median time to recurrence of less than a year in this study performed in the Netherlands.⁶

Other studies have found recurrence rates much higher. With endometrial cancer the most common gynecologic cancer in the western world, it is interesting to note that about 25% of the patients in a 2012 study were found to have endometrial cancer (median time to cancer ~6.7 years) even after a previous benign biopsy or D&C.⁷ The strongest risk factors were a presence of endometrial polyps, morbid obesity, and personal history of colorectal cancer; most protective was oral contraceptive pill use (with improved protection increasing with increased years of usage).⁷ With obesity seemingly ubiquitous and a notable risk factor for the most common gynecologic cancer in the female patient, a complaint of abnormal uterine bleeding needs to be taken seriously and a workup pursued. After the initial workup, vigilance needs to be stressed and the patient educated on her risks and plan for follow up.

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ECTOCARE foam dressings are created from a soft medical foam which carries a controlled dose of honey to allow exudate to pass through and be collected in the foam. The breathable bacterial barrier behind the foam helps to contain and manage exudate, while honey is dispersed into the wound treatment zone.



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BAMP AWARDEE

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**Professor Yasodananda
Kumar Areti**
MB.BS, MD, DA

I am sorry that my dad is physically unable to accept this award, but the knowledge that his hard work and contributions made such an impact, is an award in itself. I am so proud to say I am his daughter and hope that I live up to be even half the kind hearted, generous and knowledgeable person he is.

If a man is judged by his achievements and the lives he has touched, in the past 2 weeks I have been able to see his achievements in his world of work and friendships through a very different vantage point. To trust in the team of doctors whom he trained and worked so closely with, is my honor. I am grateful for all the prayers and support my family continues to receive from all regions of the world, from his schoolmates to graduate and post graduate colleagues, his teachers, students and several close friends.

One thing I have learnt (and debated several times) from my father, is that it is easy to point out the faults in any system and even easier to complain about them, but it is very difficult to stick it out through the ups and the downs. The key, however is to accept them and try to work with the faults to make it a better practice for the practitioners of tomorrow, with minimal compromise in the practice of ethics.

With this I give you his words of acceptance....

INTRODUCTION

ENDARO MAHANUBHAVULU - ANDARIKI VANDANAMULU
Salutations to all those great men in this world

CHANGING ETHICS IN MEDICAL PRACTICE

*Change is part of life so is change in ethics. The Hippocratic Oath (5th century BC) underwent several changes.
I will not be ashamed to say "I know not," nor will I fail to call*

in my colleagues when the skills of another are needed for a patient's recovery.

Modern: 1948 Declaration of Geneva - 1964 is the latest used in American texts

Does that all mean ethics keep changing with time!?

I often wonder whether these oaths and preachings of present day are genuine or the words of Hypocrites. (Hypocrisy is the contrivance of a false appearance of virtue or goodness, while concealing real character or inclinations)

GRATITUDE

In my long career of over 30 years in Barbados several medical practitioners touched my life. I would like to acknowledge a few of them who contributed to my success. My association with whom has touched my heart. Some of my students who make me feel proud. The list is by no means exhaustive.

1. Dr Bhavani S Kodali, a friend since 1971 is responsible to have brought me here.
2. Prof. HSL Moseley recognized my worth very early in my stay in Barbados. He has constantly encouraged me to success
3. Mr. Frank Ward is a gentleman and I worked with him for several decades. He is the only surgeon who could discuss physiology with our department. Even now he reviews his anatomy every year. Though he is worked slowly his surgical techniques were excellent. He is very clear in dissection and one can see the anatomy very clearly.
4. Dr. David Deane is the brightest obstetrician and gynaecologist. We have great mutual respect. A teacher is very happy when his students are successful and more so when the student is better than himself.
5. Dr. Tamara Greaves is one of my students, about whom I am very proud
6. Professor Hariharan Seetharaman exceeded me and became a professor in Trinidad long before I was made a professor. I am really proud of his achievements.

MY FAILURES

1. Acute Perioperative and Chronic Pain Services
2. Obstetric analgesia

Life is a long journey and in the course of life and career, one has to face many ups and downs. One can meet several troubles and obstacles on the way of life but should not be

BAMP AWARDEE... cont'd

disheartened on these situations. Sometimes one gets a success and sometimes failure. Failures give a better point of view through which we can march our way onto success.

Though it is said that failures are the stepping stones to success, the above areas went beyond a point of irretrievability. Whenever I was about to throw in the towel, I was reminded that in doing so you never know really how close you are to success. I did come very close but still could not achieve the above goals. Hope someone will achieve these above in future and wish that person is my student.

CONCLUSION

I interact with members of BAMP who keep stating that BAMP is useless. I will never associate myself with incompetent people, I have always said that BAMP is not about its President or The council. The success or failure of BAMP depends on its members, YOU. The failure of BAMP can only be attributed to you being useless or incompetent and not due to its President or Council. Remember the famous quotes of JFK :

"My fellow Americans, ask not what your country can do for

you, ask what you can do for your country."
Forgive your enemies, but never forget their names.

Change is the law of life. And those who look only to the past or present are certain to miss the future.

Ask yourself what is your contribution to BAMP and how you can make it a force to reckon with.

I conclude by acknowledging the love and constant support of my family, particularly my wife who has looked after me for over 34 years.

THANK YOU

The above response was read by Dr. Archana Areti MB.BS, MD, FUGRA, daughter of Professor Areti, following the award of the BAMP Award of Excellence to her father, Professor of Anaesthetics, Faculty of Medical Sciences, UWI Cave Hill Campus, and a Honorary Consultant, Department of Anaesthetics at the QEH.

RECENT AWARDEES



BAMP has recently received information on positive career advancements for some of its members as:

1. Fellow of the American Academy of Neurology (FAAN) - Professor David Corbin, Consultant Neurologist at the QEH (2016) and Dr Sean Marquez, Consultant neurologist and Senior Associate Lecturer (UWI) ,were elected as a Fellow of the American Academy of Neurology (FAAN).
2. Fellow of the American College of Physicians (FACP) - Dr Cindy Flower - Consultant Rheumatologist (QEH) and Associate Lecturer (UWI) and Dr Wayne Clarke - Consultant Internist (QEH) and Associate Lecturer (UWI). Dr Kenneth Connell, Governor of the ACP Caribbean Chapter attended and marched with the new FACP's, for the first time as a new Chapter of the College, at the Convocation in San Diego, California in April 2017.

The singular honors are afforded as a mark of recognition of excellence and leadership in their respective specialties.

Congratulations to the awardees!

LETTERS TO THE EDITOR

TEENAGE KICKS – YUTE GYM PROGRAMME



Fiona Anthony

*CEO, Heart and Stroke
Foundation of Barbados*

The Teenage Kicks YUTE Gym was launched in September 2015 as a Pilot Project, to improve the health and well-being of youth between the ages of 8 and 19 years old targeting in particular children who are overweight or obese children. Exercise by prescription. The aim of the programme is to offer a safe, age appropriate environment to exercise for through the monthly monitoring of weights, BMI's and blood pressures. The programme was developed to contribute to improving the health of the children registered in the programme and reduce the risk of non-communicable diseases (NCD's) in this age group. In conjunction with the exercise component the programme also orientates the children on how to recognise healthy behaviours, addressing areas such food security issues such as health and nutrition, food preparation and purchase.

Participants

The participants in the programme are children who suffer from being overweight/obesity or any child who would benefit from intervention to prevent/reduce the risk of NCD's. The children can be referred by their paediatrician, GP, school teacher or any concerned health care professional. The current age range for registration is currently from 8 to 18 years of age. There are currently >50 students who are registered in the programme.

Structure

Presently the programme runs from 9:00am to 10:30am on a Saturday morning and within this session the children are divided into two groups depending on their age for certain aspects and routines of the programme. The programme is a run by a trained fitness instructor with the support of a nursing assistant and volunteers from our Volunteer Programme. Consultant services and mentorship are offered by a paediatric consultant, Professor Anne St John, also one of

the Directors of the Heart and Stroke Foundation of Barbados. Healthy snacks are provided at classes. Nutrition counselling, from visiting overseas is provided for students and relatives, from dietetic students on rotation. Activity classes are also provided for upstairs of the gym hall for parents/ guardians who remain on site during class time, but is subject to availability of manpower.

Future

We continuously look for ways in which our Teenage Kicks YUTE Gym Programme can be improved. Although we currently rely on dietetic students from McGill University to provide the nutritional education for the children, we are incorporating a registered nutritionist into the programme to provide on-going advice and support for the participants. We are also in discussion with other partners to increase the capacity of human resource for strengthen the programme, by way of the increasing numbers of students who are being registered. The current programme is also currently being revised with the assistance of a senior fitness instructor who has expressed a keen interest in working with this programme.

Outcomes

The aim at present is to restructure the programme in time for the commencement of the new school year in September. With this we are developing the concept of a rolling programme as we endeavour to meet the demands of increasing numbers of referrals.

Conclusion

The Heart & Stroke Foundation of Barbados is committed to providing an effective, enjoyable and sustainable programme for overweight/obese children to improve their health and live by our mission "to keep people heart healthy and reduce suffering and death from heart disease and stroke."

The above information was submitted from the Heart and Stroke Foundation of Barbados, an NGO.

Editor's comment: This positive significant development demonstrates progress related to the long awaited, and much needed implementation of an exercise by prescription programme, for our youth. Its momentum and sustainability merits being supported, through utilisation in the fight against NCDs.

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CALENDAR OF EVENTS**Registration for Caribbean Cytometry and Analytical Society (CCAS) expert summit**

From care to cure - shifting the HIV Paradigm
 August 27th-31st, 2017
 Almond Beach Resort, Barbados.

Register go to www.ccas2017.org | info@ccas2017.org

Mailing address : info@ccas2017.org

Cancer Support Services 6th Annual Conference

Saturday June 24, 2017
 Accra Beach Hotel & Spa, Rockley, Christ Church.

Theme : "It's Not a Sprint, It's a Marathon".

More information -call Cancer Support Services at 228-7081.

INSTRUCTIONS TO AUTHORS

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BAMP Bulletin is the journal of the Barbados Association of Medical Practitioners (BAMP). It is now effectively approaching its fourth decade of publication, having replaced the initial Newsletter of the Association, begun in 1976.

The Editor is assisted by members of an Editorial Committee, chaired by the Public Relations Officer of BAMP Council, and comprising a cross section of BAMP membership, from Professor Emeritus to medical resident. There is also an Advisory Board of seven senior members of the profession and since the beginning of 2011, with the publication of the new Bulletin, submitted papers are peer reviewed, usually by members of the Advisory Board or other local specialists in the relevant area. Expansion of the Advisory Board and of our reviewers to include international experts is planned.

Manuscripts should be clear, concise, accurate, and where appropriate, evidence based, but written, in the words of the Royal College of Physicians, "with a style that retains the warmth, excitement and colour of clinical and medical sciences". Content may range from letters to the editor and clinical case reports to short Commentary articles, clinical or epidemiological studies, CME review articles or historical articles. Good items of medical humour are accepted, and quality photographs or paintings may be submitted to adorn the cover, which will have the new, dramatic masthead above a photograph or painting. Historic photos, are welcome.

Authors are asked to indicate with their submission any competing interest, including any funding for a study. They are asked to submit in Word, to edit their work carefully, and to provide full name and qualifications, address (email address optional), a word count, a portrait photograph.

References should be indicated in the text with an Arabic numeral in superscript and not bracketed e.g. ¹ or ^{6,7},

numbered in order of appearance and listed at the end, using the style of "Uniform Requirements" in the New England Journal of Medicine and as referenced here: (New Engl J Med 1997; 336: 309-15).

They should give the names of up to four authors. If more than four, they should give the first three followed by et al. The title should be followed by the journal title (abbreviated as in Index Medicus), year of publication, volume number, first and last pages. References to books should give the names of authors (&/or editors), title, place of publication and publisher, and year of publication. *References should be not more than 10 in number.*

Other examples, taken from the instructions in the Journal of the Royal College of Physicians, are:

1. Abbasi K, Smith R. No more free lunches. BMJ 2003;326:1155-6.
2. Hewitt P. Trust, assurance and safety - the regulation of health professionals in the 21st century. London: Stationery Office, 2007. www.officialdocuments.gov.uk/document/cm70/7013/7013.pdf.

Accuracy of references is the responsibility of the author.

Photographs and illustrations should be submitted as separate attachments and not embedded in the text.

Submission of an article implies that it represents original work or writing and is not submitted elsewhere. Relevant articles of interest that have been published elsewhere may be accepted if clearance is obtained from the first journal and republication is stated, or may be abstracted for airing in the BAMP Bulletin, with appropriate reference.

Articles, letters and all items should be submitted to BAMP Office (info@bamp.org.bb).



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