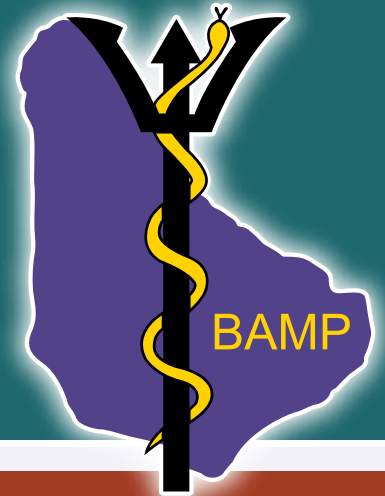


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UNIVERSAL HEALTH COVERAGE: A RIGHT OR PRIVILEGE?

In the UN's "Universal Declaration of Human Rights", the only mention of health is in Article 25.1 "Everyone has the right to a standard of living adequate for the health and well being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

Health is considered a public good. It often becomes a political issue as governments try to meet peoples' expectations, invariably making unrealistic promises to a captive audience from political platforms, and embedding hollow rhetoric in their party manifestos, perhaps oblivious to the author T.S. Elliot's "Between the idea and the reality falls the shadow."

Barbados has ratified and signed the International Covenant on Economic, Social and Cultural Rights which states under Article 12:

1. The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:
 - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child
 - (b) The improvement of all aspects of environmental and industrial hygiene;
 - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

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EDITORIAL... cont'd

Both WHO and the UN declaration on universal health coverage note the importance of locating universal health coverage in the context of action on social determinants of health. All people obtain the health services they need without suffering financial hardship to pay for them, a well run health system, a system for financing, access to essential medicines and technologies, and well trained health workers. Universal health coverage is a noble goal, but so too is action on social determinants to achieve health equity: the conditions in which people are born, grow, live, work, and age, and the inequities in power, money, and resources that give rise to them.

The United Nations Sustainable Development Goals that all UN Member States have agreed to try to achieve Universal Health Coverage by 2030 includes financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines.

All people, without discrimination due to race, gender, and socio-economic status, should have access

to essential quality health care services. To make this a reality, it is important to know the likely cost. The first step to universal coverage, therefore, is to ensure the availability of adequate funds and that funding increases consistently over ensuing years to enable the necessary scale-up.

Member States of the World Health Organization (WHO) committed in 2005 to develop their health financing systems so that all people have access to services and do not suffer financial hardship paying for them. In striving for this goal, governments face the fundamental question of how such a health system is to be financed and how to optimise use of available resources.

Regrettably, economic austerity is bad for health, not only because of its effects on funding of health services, but because of adverse effects on housing, income, and employment.

Where then, does that leave us as Barbadians?

ARE BARBADIANS ADDICTED TO SWEETENED BEVERAGES?



Dr. C.V. Alert
MB BS DM

Family Physician

Addiction is a chronic illness characterized by compulsive engagement in a particular behavior or set of behaviors, despite adverse consequences, whether these are potential or actually experienced. In this manner, persons addicted to nicotine continue to use cigarettes in spite of the long list of potential medical repercussion, while the money used to buy the cigarettes literally goes up in smoke. Persons addicted

to alcohol typically only give up the habit after they hit 'rock bottom', and generally with the need to be admitted to detoxification programs and enroll in long term behavior modification programs like Alcoholics Anonymous, AA. Likewise, persons addicted to cocaine are not deterred by the cost of supporting their addictions, and 'beg, borrow or steal' money to support the habit.

Against this background, do we have a 'sweetened beverage addiction' here in Barbados, and, if so, can this type of addiction be successfully treated merely by raising the taxes on the drinks? Is a sweetened beverage addiction different from other addictions?

A person's behavior generally does not follow 'logical' principles. Currently, when faced with a choice between pure water and sweetened beverage, the choice seems overwhelmingly in favor of the sweetened beverage, current

COMMENTARY... *cont'd*

consumption patterns seem to suggest. Supermarkets devote entire rows to sweetened beverages; such is their popularity. The 'Bottle Return' section outside of supermarkets seem to ignore their own signs limiting each customer to 120 bottles, and many people's weekly supermarket routine includes returning last week's empty bottles first.

The soft drink manufacturers clearly state that, whenever they attempt to introduce drinks containing less sugar, they are ignored in favor of the drinks with more sugar.

At least two local studies, namely the Adolescent Health and Fitness Study (AHFIT, 1997), and the Barbados arm of the Global school-based Student Health Survey (GSHS, 2011), have documented high consumption rates of sweetened beverages in our young people which alarmingly, is normally the time of life when addictions start. Of note, AHFIT, a study of 468 students attending one of four secondary schools, indicated that students consumed an average of more than 3 soft drinks per day during the normal school week. After which GSHS, a study of which questioned 1629 Barbadian students ranging from forms 3 and 4, highlighted that seventy three percent consumed carbonated soft drinks one or more times daily in the last 30 days.

In keeping with addiction characteristics, persons addicted to sweetened beverages are not deterred by the risk of becoming fat (if he/she is not there already), and thus may develop one or more of a large variety of weight related illnesses (if he/she has not been affected already). Furthermore, since many of these illnesses are 'silent', the consequences of the sweetened beverage consumption are often under-estimated. Individuals continue to consume sweetened beverages oblivious to the possible health consequences and therefore this fits the definition of an addiction.

One issue here is that few persons, in or out of the medical profession, take overweight and obesity seriously. In 1980 Dr. Frank Ramsay, then Director of the National Nutrition Unit at the time, noted that "measures for the prevention of obesity must be implemented urgently" however nothing happened. It was only in late 2012 that the American Medical Association (AMA) formally designated obesity as a disease, and put in place medical and insurance procedures to deal with obesity and its complications (co-morbidities). There are even University courses that deal specifically with Obesity, Obesity 101.

Nonetheless, we in the Caribbean have no similar procedures in place. In the 36 years since Dr. Ramsay's urgent plea was

made our obesity figures continue to spiral upwards, our obesity related co-morbidities continue to fill our hospitals and our cemeteries, and if we have a national anti-obesity program then it is one of the Ministry of Health's better-kept secrets. Against this background and without the link between obesity and disease being emphasized, would the general population perceive that overweight/obesity should be taken seriously?

There seems to be little doubt that sweetened beverages contribute to the consumption of excessive calories, leading to our 'large' obesity figures. Namely in the 2015 Health of the Nation study which targeted individuals 25 years and over, 75% of the women and 57% of the men were overweight or obese and there is overwhelming evidence that the disease profile in Barbados is dominated by the weight-related illnesses.

However it must be noted that not everyone who drinks a sweetened beverage will develop an addiction. The path to drug addiction begins with the voluntary act of taking a drug. Over time, a person's ability to choose or decline the drug becomes compromised. Young people, with less developed minds, are more vulnerable to becoming addicted than older individuals, and there is some evidence that the duration of exposure, e.g. starting at a very young age, increases the likelihood of becoming addicted. Seeking and taking the drug becomes compulsive. This is mostly due to the effects of long-term drug exposure on brain function. Addiction affects parts of the brain involved in reward and motivation, learning and memory, and control over behavior. Thus addiction is a disease that affects both the brain and behavior.

Can sweetened drinks addiction be treated?

Because addiction is a chronic disease, people can't simply stop using sweetened beverages for a few days and be cured: this does not happen in any other type of addiction. Most patients need long-term or repeated care to stop using completely and recover their lives. Perhaps like our current status in dealing with other chronic illnesses, we seem to lack the will and the resources to develop and implement sustainable programs that are likely to have long term-success. Attempting to increase the price of the 'drug' to reduce consumption has not worked for other addictions: it seems likely that additional measures would be needed if the sweetened beverage tax would eventually lead to reduced consumption of sweetened beverages.

COMMENTARY... cont'd

Addiction treatment must help the person do the following:

- stop using drugs
- maintain a drug-free state
- prevent relapses

This can be approached in a public health setting, since it is unlikely that the thousands of sweetened beverage consumers could be hospitalized for detoxification. In the UK, an approach has been suggested in which all manufacturers of sweetened beverages are simultaneously 'encouraged' (or legally mandated) to progressively reduce the quantity of sugar in sweetened beverages by 10% per year over a five year period, which overall, will gradually reduce the availability of sugar to the general population, including our young people. This gradually reduces the availability of the 'drug', reducing the available calories that contribute to obesity, while gradually resetting the brain's reward centre. With this intervention and over time, there would be reduced availability of the 'drug'.

Since manufacturers would be required to add less sugar to their beverages, their input costs would have the potential of being reduced. This, in turn can certainly help in maintaining (or even improving) their 'bottom line'. This is the kind of co-operation in which manufacturers like to participate. The act of simply introducing a tax on a particular product has the possible effect of reducing the manufacturer's net profit.

After years of exposure to these 'hyper-sweetened' drinks, many Barbadians are likely to be addicted. The approach suggested by some to treating the sweetened beverage situation in Barbados by merely increasing the taxes seems not to take into account the possibility that significant numbers of Barbadians may be addicted to sweetened beverages. Raising the price of the 'drug' as a means of controlling addictive behavior has not worked for cigarettes, alcohol, marijuana, cocaine: indeed, in many cases as mentioned, individuals beg, borrow or steal' to support their addictive behaviors.

Taking the taxes from sweetened beverages and using them to subsidize healthy foods thereby lowering the cost of healthy foods, has been suggested as a possible complimentary option. However, in a land where available evidence suggests that locals already consume too many calories, and the hot climate (and global warming) mandates that individuals consume lots of liquids, cultivating a taste for lower calorie beverages is more likely to have long term success.

All this is to say that merely increasing the taxes is not likely to stop the epidemic of sweetened beverages. The Minister of Finance noted, one year after he introduced the 10% sweetened beverage tax in 2015, that consumption levels of the beverages had not changed. He then introduced, on top of the 10% tax, a 2% National Social Responsibility Levy. Others have suggested that the tax was too low in the first place, and calls for taxes ranging from 20-50% have been suggested instead.

However, as the Director of our National Nutrition Unit previously noted in 1980, we need to do something 'urgently' about obesity. Despite this plea, no anti-obesity measures were introduced. In the interim, the manufacturers saturated the market with sweetened beverages. A few local studies have highlighted the heavy consumption of sweetened beverages by our population, both the youth and adults, and suggest that these drinks are important contributors to our obesity epidemic. Yet, there is no evidence that we currently have any urgent or comprehensive response to the sweetened beverage epidemic, and the number of individuals who become addicted to these drinks, continues to rise.

Dr Alert is in private practice in Barbados and a Fellow of the Caribbean College of Family Physicians.

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HISTORY OF MEDICINE

THE EVOLUTION OF PRIMARY HEALTH CARE IN BARBADOS



Jamane Sargeant

The evolution of Primary Health Care (PHC) in Barbados has had an impact on the lives of many Barbadians. In the past, working class Barbadians dealt with poor health services including, severe overcrowding at hospitals and inadequate treatment from health care institutions and physicians. They suffered in silence as they dealt with preventable diseases related to malnutrition and unsanitary conditions. After Independence, to correct this historical injustice, the Barbados government adopted several comprehensive health policies, including the establishment of the polyclinic system. By the time the first polyclinic facility, Warrens Polyclinic (now the Eunice Gibson Polyclinic), was opened in 1976, Barbados was on its way to providing an affordable and accessible primary health care service for all Barbadians.

In addition to easing the burden at Barbados' main hospital, the Queen Elizabeth Hospital (QEH), the establishment of the polyclinic system was also in keeping with the 1978 World Health Organization's (WHO) Alma Ata declaration "Health for All". The primary health care system that we have today only existed after Independence. Before this time, health centres were established. Health centres were necessary to assist the working class in alleviating the public health issues of that period. According to Sylvan Spooner, "The Moyne Report was an unflattering indictment on the disregard for the health of the working class among whom malnutrition, venereal disease and high infant mortality were endemic."¹ It must be noted however, the Moyne Commission Report, which examined social and economic conditions across the

Caribbean in the 1930s, did not completely trace the modest development of primary health care prior to the 1937 labour rebellion in the colony. In 1921, one could see the first seeds of primary health care or community health being planted in Barbadian public health.

Muriel Hanschell, the first female member of the Legislative Council, played a vital role in this development. She assisted the widow of Dr. Sinclair Browne, Florence Browne, in establishing what can be considered the first Baby Welfare League. The clinic which was opened in Eagle Hall provided free cod liver oil, milk and medical care.² As time went by, other leagues were created to assist with the child and maternal health issues, but, it was not until Nora Stoute, who was the first Canadian Supervisor and Health Sister at the Barbados General Hospital, started the first health centre in 1943 that an effort was made for the development of a more comprehensive approach to primary health care. The St. Lawrence Church Health Centre, the first privately owned health centre cared for pregnant women and infants.³ It was not until the 1950's when the Pan American Health Organisation (PAHO) noted that "Barbados was considered a priority for the establishment of health centres," that other health centres started to be contemplated.

In 1953, the first state operated health centre, the Speightstown Health Centre came into being with financial assistance from PAHO.⁵ As a further initiative, the Public Health Act 1954 was created for the further establishment of health centres. Section V subsection 2 of the Public Health Act gave the Governor authority to establish health centres⁶ and Part IV subsection 10 made provisions for where these health centres are to be located.⁷ St. Michael Health Centre (which later became known as Enmore Health Centre) was established in 1955 and catered to the City of Bridgetown.⁸ Speightstown Health Centre established in 1953 catered to the north of the island⁹, and Six Roads Health Centre (now the St Philip Polyclinic) established in 1957 with equipment

HISTORY OF MEDICINE... cont'd

donated by UNICEF, catered to southern part of the island.¹⁰ There were special clinics at the health centres which treated individuals with specific health concerns. The Six Roads Health Centre provided clinics for those who suffered with syphilis, antenatal and postnatal treatment for women, child immunization, diabetes treatment, home visits, classes for midwives, and family planning sessions.¹¹ These along with other services were also provided in the other two health centres. The Enmore Health Centre had a lab, x-ray room, eye and chest clinic, whereas, the Speightstown Health Centre had an environmental health unit.¹²

Health centres improved public health care tremendously in Barbados. Within its two years of establishment, the Speightstown Health Centre immunized 2,552 children against diphtheria, tetanus and whooping cough.¹³ This meant more children were protected against easily preventable diseases. They also completed 294 home visits¹⁴ not excluding the burden of only having one vehicle¹⁵ and over 1,084 persons with syphilis received treatment.¹⁶ The Enmore Health centre was successful in stimulating persons' interest in their own health. The Chief Medical Officer of the Enmore Health Centre, Dr. Edgar Cochrane noted that 115 persons were interested in the state of their health to go through the burden in returning to the centre for a repeat venereal disease (VD) test,¹⁷ which suggests that there was effective counselling involved.

However, there were some major challenges with which the health centres had to contend. Attendance at the diabetic clinic at the Speightstown Health Centre was, for the most part "erratic and unsatisfactory and hardly any of them kept their instructions for regular attendance to avail themselves of the facilities for sugar test and their insulin injections."¹⁸ This was proven further in the medical report which stated that there was a considerable decrease in attendance over the previous year. There were only sixteen fewer diabetic cases, yet there was a decrease from 3,886 to 2,907.¹⁹

Another problem the health centres faced was in respect to venereal diseases. Although persons were returning for repeat testing at the Enmore Health Centre, sexually transmitted diseases (STDs) were still a major issue in Barbados.

SEXUAL TRANSMITTED DISEASES FOR THE YEARS 1956-1958				
Diseases	1956-1957		1957-1958	
	Male	Female	Male	Female
Syphilis	851	869	864	632
Gonorrhea	1471	705	1481	653
Other V.D	36	6	85	71

Table 1: Showing the increases of Sexual Transmitted Diseases at the Enmore Health Centre for the years 1956-1958.²⁰

As it relates to females, there was a decrease in syphilis and gonorrhoea cases which was commendable, however, in terms of other venereal diseases, there was a sharp increase which meant that the health authorities were having difficulty in monitoring patients. In 1957-1958, there were 607 cases for repeat V.D tests. Three hundred and fifteen persons returned and were positive, 78 returned and were tested negative, and, the remaining 214 cases did not return to be retested. In the medical report, there was no evidence to suggest how the education was spread or received, or that the health centres tried different approaches to make individuals serious about their health. There could even be the possibility that the health centres dealt with the disease and not the individual; that is to say health officials at the health centres did not take into consideration the person's environment, cultural and religious beliefs or other factors which play a role in a person's health.

There was no general practice clinic at the health centres, which meant persons who could not afford the services of a private physician, had to attend the hospital. Hence, there was a serious state of overcrowding at the hospital. At least one informant reported that "The hospital used to be crowded and got to wait long,"²¹ because "patients with all sorts of things use to come ... you got a cough and a cold...a fracture... a stab wound... a headache."²² This created a situation where it was difficult for urgent cases to be seen in a timely manner.

HISTORY OF MEDICINE... cont'd

On the whole, health centres made a positive impact on the Barbadian public health system. One of their improvements is seen in the drop of the infant mortality rate. Before the health centres were established, Barbados had an infant mortality rate of 217 per 1000.²³ By 1975, the mortality rate was significantly reduced to 29.1 per 1000.²⁴

There was still limited access to quality health care. According to Dr. Elizabeth Ferdinand, "the only way that a person could be seen at the health centres is if they fell into the category of antenatal and postnatal in terms of women being pregnant and after pregnancy, child immunisation and sexual transmitted disease". If persons did not fall within this category they had to seek the services of the District Medical Officer which only came once or twice a week. Even before services were rendered, persons had to go through a means test which was facilitated by the social worker and only if the persons fall within this means test, would they be seen by the doctor.²⁵

The health centres failed to facilitate a full all round preventative comprehensive approach to public health and they also failed to address those who wanted to receive general medical attention which resulted in the QEH providing an even lower quality of health service. They were a major improvement for public health in Barbados, but their focus primarily on sexual transmitted diseases, child and maternal health; hampered their efforts in providing quality health care and also to prevent CNCDs. It was on this note that the government of Barbados tried to improve the health system by establishing polyclinics to provide quality care for everyone in Barbados.

The Alma-Ata Declaration of 1978 was an international conference on Primary Health Care by member countries of the WHO. It identified primary health care as the key to the attainment of the goal of Health for All. "The 1978 Alma Ata Declaration in Primary Health Care" to which Barbados is a signatory continues to be held as the backdrop for the development of health service of this country. In this context the government will continue to bring primary health care to all areas of the nation through the polyclinics"²⁶

The polyclinic system can be traced back to the intervention of Dame Nita Barrow. As Director of the Christian Medical

Commission of the World Council of Churches, she spearheaded many projects to promote the concept of comprehensive care.²⁷ It was an early initiative to get persons involved in their own health care. As Eleane Hunte, author of *The Unsung Nightingales: The Development of Nursing in Barbados 1844-2000* noted, "it was a combination of preventative and curative health care with emphasis on people's participation."²⁸ The reasoning behind the concept of total care, is that Barrow wanted to change the concept of nursing services from one that is divided into public health, hospital care and school health to a single coordinated unit.²⁹

The Warrens Polyclinic (now the Eunice Gibson Polyclinic) was opened in May of 1976.³⁰ In 1978, two more polyclinics were established. The Maurice Byer Polyclinic was opened in July 1978 which replaced the Speightstown Health Centre and the Black Rock Polyclinic (now Brandford Tait Polyclinic) opened in November of that same year.³¹ After signing on to the Alma Ata Declaration; "Health for all by 2000," (in which Barrow participated) more polyclinics were established during the 1980's. The Ladymeade Polyclinic, (later named the Winston Scott Polyclinic) located in Ladymeade Gardens, Bridgetown, St. Michael was established in 1984. Two more polyclinics were established in that same year; the Randall Phillips Polyclinic located in Oistins Christ Church, and the Edgar Cochrane Polyclinic located in Wildey, St. Michael.³² The St. Philip Polyclinic which was an extension to the Six Roads Health Centre, opened in 1987, while the Glebe Polyclinic in St. George, was established in 1987, and the David Thompson Health and Social Services Complex commonly referred to as the St. John Polyclinic opened in 2015; making a total of nine polyclinics on the island.

As stated earlier, the polyclinics were established for two main reasons: 1) to provide primary health care to all Barbadians which is in keeping with the Alma Ata Policy; and 2) to ease some of the burden placed on the QEH Accident and Emergency (A&E) department and to the QEH on a whole, thereby leaving the department solely to deal with serious emergencies.³³ Primary Health Care (PHC) according to the Alma Ata Policy includes: (1) Addressing the main health problems in the community; (2) providing promotive, preventive, curative and rehabilitative services accordingly; (3) education concerning prevailing health

HISTORY OF MEDICINE... *cont'd*

problems and the methods of preventing and controlling them; (4) promotion of food supply and proper nutrition; (5) an adequate supply of safe water and basic sanitation; (5) maternal and child health care, including family planning; immunization against the major infectious diseases; (6) prevention and control of locally endemic diseases; (7) appropriate treatment of common diseases and injuries; (8) and provision of essential drugs; (9) requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care. These arrangements made full use of local, national and other available resources; and to this end developed through appropriate education the ability of communities to participate; should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need; relies, at local and referral levels, on health workers,... suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.³⁴

The polyclinic fulfils these goals by providing many services which include education, treatment, and monitoring of diseases. The services which are provided by the polyclinic are: Dermatology, Nutrition Services, Environmental Health Services, Women's Reproductive Health and Family Planning, Dental services which are mainly provided for persons up to the age of sixteen years and extractions for adult individuals. Eye services are provided by the Winston Scott Polyclinic. This service is mainly provided for school children to monitor, educate and help in the maintenance of proper eye care.

A general practice clinic is designed to assist persons, who have serious medical conditions, and to monitor and educate persons who suffer with CNCDs. Blood tests are administered to monitor and investigate the health condition of ill persons. Pharmacy services provide patients with the necessary medication for the betterment and the control of their health. Podiatry educates and monitors foot care of diabetic persons. Mental health services help to monitor persons with mental illness. Pre- and post-natal checkups for women to monitor and educate, child health services for children to be immunised and the monitoring of their physical and psychological development.

There is also a Wound Care clinic for persons who suffer with chronic illness for the safe recovery of wounds and for persons who are in need of wound management, HIV/AIDS and other STI testing and counselling for persons who may or may not have the HIV/AIDS virus or STIs. There is also a functioning STI clinic at Winston Scott Polyclinic and social services for those who present at any polyclinic. The Glebe polyclinic has a functioning Asthma and Diabetic clinic for the monitoring and education of the respective diseases. There is also a men's health clinic which is held on the third Thursday of every month. There is also a hearing test clinic mainly provided to young children for prevention and monitoring of ear problems which may develop in young children and a social worker for those who present with social ills.

The opening hours for the polyclinics varies. The Maurice Byer Polyclinic and the Randall Phillips Polyclinic are from 8:30am to 8:30pm on weekdays. The Glebe, The St. Philip Polyclinic, The Eunice Gibson Polyclinic, The Edgar Cochrane Polyclinic, and the David Thompson Health and Social Services Complex opens from 8:30am to 4:30pm on weekdays. The Winston Scott Polyclinic; the general practice opens from 8:15am until 6:30pm on weekdays; and Saturdays are from 8:15am until 12:00pm. The Fast Track Clinic opens from 10:00am until 10:00pm on weekdays and from 9:00am until 4:00pm on Saturdays. The Brandford Taitt Polyclinic opens from 8:15am until 6:30pm on weekdays and Saturdays are from 8:15am until 12:00pm. No Polyclinics are opened on bank holidays.

The creation and the implementation of the polyclinic system in Barbados has made tremendous strides in the provision of quality health care for all its citizens given the limited resources that exist. However, with a more specific focus on primary health care in Barbados we cannot lose sight of the main aim of the polyclinic which is the prevention of diseases. With high rates of CNCD's, and the threat of sexual transmitted diseases like HIV/AIDS, the polyclinic system has its work cut out for itself. Although the formal health system can address policy-based remedies to health challenges, it is the duty of each and every citizen to take care of his or her own health and to prevent the abuse of health care services. It is also the duty of the Ministry of Health to promote healthy lifestyles, but this can only successfully work if all Barbadians and their health service agencies work together.

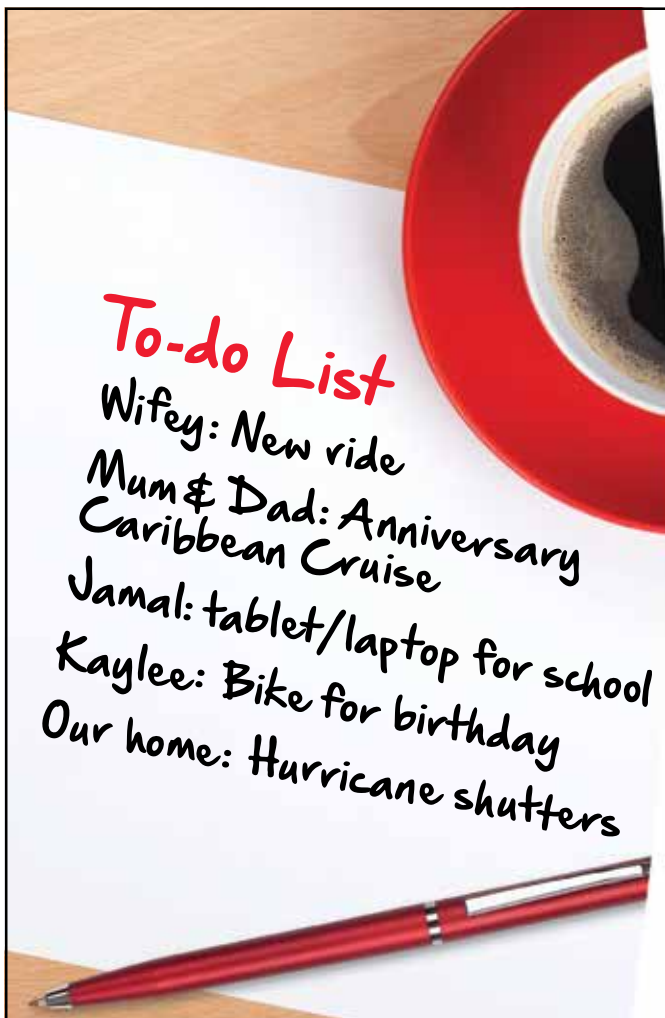
HISTORY OF MEDICINE... cont'd

Jamane Sargeant is a Graduate student in the Faculty of Humanities and Education at the UWI Cave Hill Campus. His essay was part of his 2011 undergraduate thesis for which he was awarded a Bachelors of History.

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HISTORY OF MEDICINE... *cont'd*ADVANCING PALLIATIVE CARE AND END-OF-LIFE
RESEARCH THROUGH THE USE OF A QUALITY
METHODOLOGY

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The need for palliative care and palliative care research in the Caribbean

The countries of the Caribbean have an increased morbidity and mortality associated with non-communicable diseases¹ NCDs. The region has the highest mortality rate from NCDs within the Americas, with most of these being categorised as premature deaths (occurring of in persons under 70 years old)². The leading causes of death include cardiovascular diseases, diabetes, and cancer², which have natural disease trajectories that would benefit from palliative care, from the point of diagnosis through to the end- of life phase^{3,4}. Based on palliative care needs assessment methodology it is expected that two-thirds (2/3) of persons who would have died in a given year from non-cancer illness and 100% of those who would have died from cancer could have palliative care needs during their last year of life^{5,6}.

From a policy perspective, the governments of the region have recognised this need for palliative care within the region and all of the countries of CARICOM are signatory to WHA resolution which speaks to incorporation of palliative care into the health care system through NCD care pathways⁷. However, this has not translated into development of palliative care national policies and or full integration of palliative care into the health systems of the region, partly because of a lack of regional research to inform the development process.

In the case of Barbados, there has been an epidemiology

based needs assessment to inform development of the services on the island, however across the region there remains a dearth of health services research in palliative care^{8,9}. While at a country level morbidity and mortality data can determine the expected burden of disease and maximum numbers of persons likely to benefiting from palliative care services, however, comprehensive health services research is needed to inform the development of accessible, affordable, and culturally acceptable models of palliative care.

In particular, research is needed which takes into consideration existing health system design as well as the felt needs, perceptions, and lived experiences of service providers and potential service users. This seems like a tall order and it is reasonable to ask how can this form of health services research be conducted in the Caribbean with respect to palliative care when:

- The term "Palliative Care" itself appears to be a poorly understood concept within the region;
- The potential service users/ research participants are likely to be classified as vulnerable research subjects,
- Sensitive, and deeply emotional experiences are likely to be explored.

The answers lies in going beyond the scope of quantitative

HISTORY OF MEDICINE... *cont'd*

methods and recognizing that formative health services research, like that needed to inform palliative care development can be achieved by using a qualitative research methodology.

Qualitative Research Methodology

Traditionally, research in medicine has hinged upon a numerically based view of reality obtained through using a quantitative methodology. In essence, gaining knowledge by quantifying the characteristics of a phenomenon under study, as a means of developing causal links or explanations¹⁰. However, the reality is that not all aspects of health services research lend themselves to quantitative study. As is with the case of palliative care a phenomenon may contain poorly defined or have significant unquantifiable aspects. In such cases a qualitative methodology is invaluable as it is specifically concerned with gaining knowledge by understanding the meaning of human action through the interpretation or construction of those difficult to quantify, or unquantifiable phenomenon of the social world¹¹.

Furthermore, it is applicable when:

1. A phenomenon is poorly understood and there is need for initial exploratory work to identify those factors that can be studied to identify/ establish causal links;
2. There is need to generate descriptive data that could develop theory- including descriptions of local context and service organization and delivery;
3. There is need to obtain the personal perceptions, experiences and social interactions of different persons regarding a health care process
4. A flexible research methodology is needed given the sensitivity of the research topic, or the vulnerability of some research participants

Given these characteristics, it therefore seems that a qualitative methodology is ideally suited to conduct of formative palliative care research. It is also worth noting

that although we now exist in a health research environment which increasingly values the role of qualitative methods and pragmatic mixed methods research⁽¹²⁻¹³⁾ to inform health services design and delivery, ultimately, choices of methodology and methods are driven by the nature of the phenomenon being studied, the nature of the research question(s) and ethical considerations. It is our view that areas of health services research related to palliative care development in the Caribbean that most urgently need to be explored to further development these are many and varied encompassing: user based service design (e.g. Preferred place of care and death for adult and pediatric populations), treatment (e.g. accessibility and cultural acceptability of opioid analgesics) to health services management (e.g. barriers and facilitators of coordinated community and hospital based palliative care).

Conclusion

While it has been agreed that palliative care has a place in the NCD care continuum, the reality is there is much work to be done to develop comprehensive integrated palliative care within the health care system of the Caribbean region. Efforts to assess and plan for the development of palliative care in the region should be informed by evidence, and in these formative stages, particularly evidence generated from qualitative research methods.

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A complete list of all references can be obtained for request from the office at BAMP.

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RESEARCH FORUM

REPORT FROM THE 62ND ANNUAL CARPHA HEALTH RESEARCH SCIENTIFIC CONFERENCE, 2017.



Professor M Anne St John
MB BS (UWI) FRCPC. FAAP

The 67th Annual CARPHA Research Conference was hosted by the Ministry of Health in Guyana during the dates of April 27th-29th, 2017, at the Marriott Hotel, Georgetown, Guyana.

There is usually a large attendance of distinguished researchers to participate in the presentation of both oral scientific papers and poster presentations which involve sharing of research which has resulted from studies conducted in the region and further afield.

This article highlights the research papers, submitted from researchers based in Barbados. The following abstracts were accepted as oral presentations at the scientific meeting.

Economic burden of cardiovascular disease in a small Island developing state.

AMC Rose, N Unwin, C Howitt, TA Samuels, EA Phillips, KS George, AJM Hennis, IR Hambleton

The objective of this study was to estimate the cost of hospitalised stroke and acute myocardial infarction, major causes of mortality in Barbados with known poor outcomes, to the Ministry of Health.

In a cost-of-illness study, healthcare costs for patients diagnosed in 2010–2011 were compared with those for a sample of the Barbadian population (≥ 25 years). Patient data on hospital stay, ward (intensive care vs other), surgical procedures and diagnostics were from the national cardiovascular disease (CVD) registry. Those who survived

to one year and the population sample were interviewed about these factors over the previous year. Propensity score matching was used to adjust for confounders. Costs were calculated in international dollars (US dollar purchasing power in the US for that year; Int \$2012).

Results revealed that the annual per person excess healthcare cost from CVD in 2012 was Int \$3949–5527 for emergencies and Int \$936–1734 in the post-emergency to one-year phase, totalling Int \$2.9–\$4.4 M (3% of the single public hospital's total annual expenditure).

Authors concluded that first year post-CVD per-patient cost in Barbados was lower than in European countries and the United States of America with these countries having lower in hospital stroke fatality ($< 20\%$) than Barbados ($> 30\%$), where less than 4% of the total hospital budget is spent on two of the island's major causes of mortality. They also concluded that the study provides baseline costs for future health economic assessments to investigate levels of spending needed to increase prevention and improve outcomes.

The Barbados tax on sugar sweetened beverages: an assessment of the political processes behind implementation and early effect on retail prices

M Alvarado, AM Thow, J Adams, N Unwin, MM Madhuvanti

With a background statement that in 2015, the Government of Barbados implemented a 10% tax on sugar-sweetened beverages (SSBs), the researchers explored factors that led to implementation, and assessed changes in retail prices following the tax.

They conducted 25+ key informant interviews, triangulated with a document review; analysis was informed by theories of the policy process, in particular Kingdon's Multiple Streams Approach. To explore whether retail prices changed, they used data from the largest supermarket chain in Barbados, with seven months of post-tax data. Linear regression was used to evaluate changes.

RESEARCH FORUM...cont'd

The results revealed that key factors in placing the tax on the policy agenda included: 1) the importance of "policy entrepreneurs," 2) interactions between the two "problems" the tax was seen to address, and 3) the unified resistance to international corporations. Early implementation has been characterized by: 1) pragmatic concerns around identifying SSBs, 2) limited resources to implement a health messaging campaign and 3) corporate strategies including possible reformulation and lobbying.

The authors concluded that health messaging campaigns may be important for other countries to consider in advance of introducing a similar policy. While the tax seems to be associated with a price change in SSBs, companies appear to be absorbing a portion of the tax.

Validating the annual monitoring of the 2007 CARICOM Heads of Government Summit Declaration on chronic non-communicable diseases.

TA Samuels, MM Murphy, N Unwin

With monitoring of national responses to the 2007 CARICOM Non-communicable Diseases Summit Declaration having occurred from 2008 to 2015, using a 26-indicator grid, completed annually by NCD Focal Points, the authors' study objective was to assess the validity of responses to the grid, compared to in-depth interview data and document reviews.

Seven national case studies on policy responses to the Declaration were undertaken, in early 2015, through interviews were conducted with stakeholders from multiple sectors, including Ministry of Health. Policy documents were identified and reviewed and findings were compared to responses to the 2014 NCD grid.

The findings from the grid and from cases studies agreed closely. Out of a total of 182 indicators (26 across 7 countries) there was a lack of agreement on nine (4.9%). All the disagreements arose from the difference between policy statements and implementation. For example, where two grid responses indicated the existence of a national NCD plan, stakeholder interviews found no evidence of implementation. Similarly, one grid response indicated an active NCD commission, whereas stakeholder responses indicated this was not the case.

For 17/26 indicators the self-reported grid data aligned exactly with the evidence collected in country from the stakeholders. The indicators for Surveillance and Treatment had 100% validation.

Authors concluded that "overall, the monitoring grid provided an accurate assessment of the national situation but with possible tendency to over report on some key areas. These findings have contributed to the design of a new monitoring grid, expanded to 50 explicitly defined indicators, and implemented in 2016."

Evaluating Implementation of the CARICOM Heads of Government Non-communicable Diseases Summit Declaration of 2007

TA Samuels, N Unwin

Non-communicable diseases (NCDs) are a threat to Caribbean social and economic development. In 2007, the Caribbean Community (CARICOM) Heads of Government held the first ever summit on NCDs, resulting in the Port-of-Spain NCD Declaration. This paper describes the evaluation, begun in 2014, with the overall objective to learn lessons that will accelerate further implementation of the declaration.

A mixed methods evaluation included: new analyses of disparities in NCD mortality, new quantitative and qualitative data collection to assess national and regional NCD policy responses, including seven in depth national case studies and economic modelling on tobacco and alcohol taxes.

Results revealed marked disparities in NCD mortality trends between CARICOM countries, with available data suggesting that only eight are on course to meet the 2025 World Health Organization (WHO) target of a 25% reduction in premature NCD mortality. No CARICOM member had fully implemented all the mandates from the Declaration, with 10 implementing less than half, and most lacking a well-functioning NCD Commission. Where good implementation was found, eg Caribbean Wellness day and STEPS surveys, active guidance from regional institutions was a key factor. Feasible national tobacco and alcohol tax increases could more than fund WHO NCD 'best buy' interventions.

Authors concluded that all-of-society and all-of-government responses at national and regional levels are weak and that

the disparities in trends in NCD mortality require further investigation to inform interventions. The core findings are being considered by multi-sectoral groups of CARICOM stakeholders, and recommendations for action will be considered by Heads of Governments in 2017.

Evaluating policy responses to upstream determinants of chronic, non-communicable diseases: supporting healthy diets and active living in seven Caribbean countries

MM Murphy, TA Samuels, N Unwin, C Guell

The objective of this study was to identify and assess in seven Caribbean countries, existing policies towards the prevention and control of chronic, non-communicable diseases (NCDs), gaps in policy responses, and the factors influencing successful policy development and implementation regarding unhealthy diets and physical inactivity.

Seventy-six semi structured interviews were conducted with relevant stakeholders in government, civil society and the private sector. All interviews were recorded and transcribed verbatim, and framework analysis was used. An analysis team undertook coding using the software Dedoose, after which two lead researchers synthesized the analyses.

Results showed that the most widely reported across the countries were policies and health promotion initiatives to support healthy eating in communities and schools, including the development of dietary guidelines. The promotion of physical activity also included policies for schools, and in addition initiating and supporting public participation sports events. However, the impact of these initiatives was reported to be limited by adverse upstream determinants. These include a reliance on food imports, which constrains more impactful fiscal and legislative action to support availability, quality and affordability of healthy foods. Similarly, there was little evidence of policy responses to create physical and social environments conducive to active living, such as those that support greater walking.

Authors concluded that the least well developed policy responses concern the macro, upstream determinants of unhealthy diets and physical inactivity. More political support, particularly across government ministries, including finance, trade, agriculture, transport and urban planning to

accelerate action for conducive environments for healthy eating and active living.

Prevalence and phenotype of diabetes and pre-diabetes using fasting glucose versus HbA1c in Barbados: implications for policy on diagnosis and prevention

N Unwin, C Howitt, AMC Rose, T A Samuels, AJM Hennis, I Hambleton

The objective of this study was to compare the prevalence and characteristics of adults identified as having diabetes and pre-diabetes by FPG and HbA1c.

A representative population based sample of 1234 Barbadian adults (> 25 years) was recruited. Fasting plasma glucose and HbA1c was measured on all. Those with previously diagnosed diabetes (n = 192) were excluded from the analyses. Diabetes was defined as: FPG > 7.0 mmol/L or HbA1c > 6.5%; pre-diabetes as: FPG > 5.6 – < 7 mmol/L or HbA1c > 5.7 – < 6.5%. Multiple linear regression was used to identify pre-dict.

The prevalence of undiagnosed diabetes by Hb A1c was 4.9% (95% CI 3.5 – 6.8–7.3) compared to FPG 3.5% (2.4–5.1). Overall 79 individuals had diabetes, but of these only 21 had diabetes on both HbA1c and FPG. Pre-diabetes prevalence was higher by HbA1c vs FPG: 41.7% (37.9– 45.6) vs 15.0% (12.8–17.5). Overall 558 individuals had pre-diabetes, but of these only 107 on both HbA1c and FPG.

The agreement between FPG and HbA1c defined hyperglycaemia is poor, and HbA1c gives a much higher prevalence of pre-diabetes.

Authors concluded that the routine use of HbA1c for screening and diagnosis would have major implications for clinical and public health policies and resources.

Does peak expiratory flow rate differ from that measured sitting differ from that measured standing?

JL Paul-Charles, K Mangera, EH Morris, OP Adams

The objective of this study was to determine whether in adults aged 18 to 60 years, is the peak expiratory flow rate (PEFR) measured sitting, different from that measured standing.

RESEARCH FORUM...cont'd

In a crossover (within-subjects) design study, adults 18 to 60 years of age attending four polyclinics in Barbados were recruited. Quota sampling by age, gender and clinic was done. An interviewer administered questionnaire collected demographic data. Peak expiratory flow rate sitting and standing was measured with a EU scale Mini-Wright meter. The highest of three readings done in each position was used and differences in means tested for significance by the paired sample t-test.

There were 199 participants with the following characteristics: 44% male, 96.5% African descent, mean age 37 years, 22% with a diagnosis of asthma, 23% current tobacco users and 22% current marijuana users.

Mean PEFR standing was 438 vs 430 L/min sitting, mean difference 8.7 (95% CI 3.6, 13.8, $p = 0.01$). For men mean PEFR standing was 519 vs 506 L/min sitting, mean difference 12.4 (95% CI 3.3, 21.5, $p = 0.008$). For women it was 375 standing vs 369 L/min sitting, mean difference 5.8 (95% CI 0.11, 11.5).

Authors concluded that the peak expiratory flow rate was significantly higher for both men and women in the standing compared to the sitting position. While several guidelines recommend that PEFR be measured standing, the basis of the recommendation is not clear, and published research is limited and inconclusive.

Sodium and potassium excretion in an adult Caribbean population of African descent with a high burden of cardiovascular disease

RM Harris, AMC Rose, IR Hambleton, C Howitt, NG Forouhi, AJM Hennis, TA Samuels, N Unwin

The objective of this study was to estimate sodium and potassium excretion, assess compliance with recommended intakes and to identify the main food sources of sodium in Barbadian adults aged 25–64 years, a single 24-hour urine sample was collected from each individual for the measurement of sodium and potassium excretion. Sodium-to-potassium ratio and proportions of participants meeting World Health Organization (WHO) recommended daily intakes of < 2000 mg sodium and > 3500 mg potassium were

calculated. Multiple linear regression was used to examine differences by age, gender and education. Two 24-hours recalls were used to identify the main dietary sources of sodium. All analyses were weighted for the survey design.

Among 364 participants, mean sodium excretion was 2656 (95% CI 2488, 2824) mg/day, with 67% (62, 73%) exceeding 2000 mg. Mean potassium excretion was 1469 (1395–1542) mg/d; only two individuals met recommended intake levels. Sodium excretion was greater by 428 mg/d (91.3, 764.6) in men compared to women. Sodium-to-potassium ratio was inversely and independently associated with age and education.

Main sources of sodium were rice and peas (6.0%), baked chicken (5.6%), macaroni pie (4.3%), white rice (4.2%) and coconut bread (3.8%).

Authors concluded that in this first nationally representative, objective assessment of sodium and potassium excretion in a Caribbean population in over 20 years, levels of sodium excretion were high, and potassium very low, with younger age and lower educational level being associated with the highest sodium-to-potassium ratio. These findings provide baseline metrics and identify potential targets for urgently required interventions.

The proportion of dementia in Barbados explained by common modifiable lifestyle factors

K Ashby-Mitchell, KJ Anstey

The objective of this study was to report on the proportion of dementia cases attributable to six modifiable lifestyle risk factors (mid-life obesity, physical inactivity, smoking, low educational attainment, diabetes mellitus, mid-life hypertension) in Barbados.

Methodology included Levin's attributable risk which assumes independence of risk factors was used to calculate the proportion of dementia attributable to the six risk factors under study. Using a recently published modified formula (Norton, Matthews, Barnes, Yaffe and Brayne, 2014) and survey data, a more realistic estimate which accounts for non-independence of risk factors was calculated. The effect

RESEARCH FORUM...cont'd

of a 5%–20% reduction in each risk factor per decade on future dementia prevalence was computed.

Assuming independence, the risk factors explained 58.7% of dementia cases in Barbados (1761 cases). Accounting for non-independence of risk factors researchers estimated the adjusted combined population attributable risk to be 50.9% (1526 cases). They noted that midlife hypertension was related to the greatest proportion of dementia cases when compared to the other risk factors under study (24.4%) and calculated that if each risk factor were to be reduced by between 5% and 20% every 10 years to 2050, dementia prevalence would be reduced by between 3.3% and 31.8% in Barbados.

Authors concluded that their findings present a case for greater investment in intervention programmes that target modifiable factors and that these risk factors have much in common. Any intervention that targets even one of them, can significantly reduce future dementia prevalence.

Quality of life after cardiovascular disease in a small island developing state

AMC Rose, N Unwin, C Howitt, EA Phillips, TA Samuels, IR Hambleton

The Objective of this study was to investigate the quality of life (QoL) in one- year survivors of cardiovascular disease (CVD: stroke and acute myocardial infarction) in Barbados. Quality of life was assessed in 265 one-year CVD survivors and a random selection of 1234 adult Barbadians ≥ 25 years. Data were collected on the previous year by interview using a health-related QoL (HR- QoL) instrument, the EuroQoL five dimensions questionnaire, covering physical (mobility, self-care, usual activities) and non-physical (pain/discomfort, anxiety/ depression) domains. Propensity score matching was used to adjust for confounders between CVD survivors and the general population.

Results revealed that at least one health-related problem was reported by most CVD survivors (79%; 95% CI 73, 84) vs half (51%; 95% CI 48, 54) of the general population. Eleven per cent of CVD survivors indicated problems in all five dimensions, vs < 1% of the population. More stroke

survivors (13%; 9– 19) had problems in all five dimensions than survivors of acute myocardial infarction (1%; 0–8%). Cardiovascular disease survivors (particularly stroke) had significantly greater prevalence of problems than the population group for the physically active dimensions, but more similar prevalence for the non-physical dimensions.

Authors concluded that in Barbados in 2011-2012, HR-QoL for one year CVD survivors (especially stroke) was significantly lower than for the general population. Mobility was the main QoL limitation. A UK study of minority ethnic groups found similar reductions in HR-QoL for persons with chronic disease, particularly heart failure and stroke. They stated that future work will investigate use of cardiac rehabilitation services and the impact of the introduction of a stroke unit in 2013.

Transgendered health in Barbados: Exploring the experiences and perceptions of transgender males and females when accessing healthcare services

FE Sargeant, MM Murphy

The aim of this study was to explore the experiences of transgender males and females, in accessing general and specialised healthcare services in Barbados, in order to sensitize healthcare workers when treating transgendered patients.

In depth one-on-one interview were conducted with eight male-to-female transgendered people. Audio files were transcribed and analysed with the help of Atlas.ti software. Data were coded and emerging themes were recorded based on a grounded theory approach.

The results revealed that transgender individuals experienced numerous challenges accessing healthcare as a general result of stigma and discrimination from public and private healthcare professionals. All participants sought services at private facilities, which they found to handle their needs with a higher level of confidentiality than at public facilities. Female doctors were perceived as being more open and comfortable with transgendered patients. Services such as hormone replacement and mental health specially tailored to the needs of transgendered patients are lacking.

RESEARCH FORUM...cont'd

The authors concluded that the issues surrounding healthcare access for transgender persons are complex. Staff sensitisation at all levels within public and private facilities has been recommended by the participants in order to meet their healthcare needs in a comfortable environment and that the right to healthcare will continue to be compromised if the identified challenges are not addressed especially in an environment that speaks to healthcare access for all.

Erectile dysfunction and depression in a Barbadian male population

AR Greenidge, AP Browne, KR Quimby, IR Hambleton, RC Landis

The objective of this study was to report on the characterisation of erectile dysfunction (ED) and depression in a Barbadian male population with diabetes using the IIEF-5 and BDI-II questionnaires.

Sixty-four male participants were administered questionnaires on erectile dysfunction and depression. The participants were assigned to either the case group (current non-healing foot ulcer) or the control group (no current ulcer and no history of foot ulceration). The answers were scored and the scores categorized according to the keys of the respective instruments. Categories for ED were: severe ED, moderate ED, mild to moderate ED, mild ED and no ED. Categories for depression were low, moderate and significant. Results were compiled and analysis performed using STATA SE 12.1 (Stata Corporation).

The mean age of the cases was 58.25 (\pm 9.03 SD) years and the controls was 59.33 (\pm 14.90 SD). The mean diabetes duration was 15.88 (\pm 10.20 SD) years in cases and 15.13 (\pm 15.16) years in controls. Forty per cent of cases and 25% of controls had some form of ED. Only 17.5% of cases and 29.2% of controls had moderate or significant depression. Fifty per cent or more of participants reported no sexual activity for four weeks prior to the study.

Authors concluded that men with diabetes and foot ulcers have greater levels of ED than those without foot ulcers, but those with foot ulcers have less depression than those without foot ulcers. Depression is positively associated with ED but not at levels of statistical significance in this study population size.

Nutritional analysis of the planned menu in two district hospitals in Barbados

S Whittaker, N Sobers-Grannum

The objectives of this study were to analyse the two-week planned menus at two district hospitals in Barbados and determine the menus' quality by comparing them to the food-based dietary guidelines for Barbados (FBDGs), the Caribbean six food groups daily recommended servings, and the dietary reference intake (DRI) for an older adult.

Results revealed that the menus failed to meet four of the seven FBDGs, but met two of the food groups of the CSFGs recommending daily servings. However, fruits, vegetables, legumes and nuts failed to meet mean average with ≤ 1 servings; and fats and oils servings varied between the institutions. Fourteen DRI targets were analysed in the study. Mean levels for calories was 1237 kcal or 77% and 69% for females and males estimated energy requirements (EER) at one institution, and 1056 kcal or 66% and 59% for female and males at the other. Dietary reference intake targets for macronutrients were met as well as Vitamin B12 and iron, however, the menus still failed to meet more than 50% of the DRI targets.

Authors concluded that menus at both institutions failed to meet most of the dietary standards and targets. Scheduled menu analysis is recommended for promoting and enhancing the dietary needs of the elderly in district hospitals in Barbados.

Reference.

CARPHA Public Health Agency 62nd Annual Scientific Meeting. West Indian Medical Journal Supplement West Indian Med J 2017; 66 (Suppl.1) 2017.

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ANTIBIOTIC STEWARDSHIP IN THE MANAGEMENT OF ACUTE URTIS



Dr Joseph Herbert
MB BS DM

Family Medicine

Antimicrobial resistance has been described as a slowly evolving public health disaster, one largely created by the misuse of antibiotics. Multi-drug resistant infections kill as many people every year in the United States as prostate cancer, and organisations such as the CDC and WHO have declared that we are on the cusp of the “post-antibiotic era”^{1,2}.

Despite the alarm, **it is estimated that 50% of antibiotics prescribed in the outpatient setting are either unnecessary or the inappropriate class, dose or duration**³. It is therefore imperative that primary care physicians familiarise themselves with clinical guidelines (see references) for the management of common acute infections such as upper respiratory tract infections (URTIs). This article attempts to outline an evidence-based approach, which can be summarised by applying the following questions to the clinical scenario:

- Is antibiotic therapy indicated based on the available evidence/guidelines? If so, would a period of watchful waiting – a trial of only symptomatic treatment – be appropriate? The aim is to avoid antibiotic use when the benefit is small or nil.
- If antibiotics are indicated, what is the appropriate class, dose and duration based on the available evidence/guidelines?

The Common Cold and Acute Rhino-sinusitis

The common cold is characterised by rhinorrhea, nasal congestion, sore throat, cough, malaise, and occasionally a low-grade fever. In contrast, patients with acute rhino-

sinusitis are usually characterised by some of the following additional features: fever, anosmia, facial pain/tenderness (worse on leaning forward), maxillary tooth discomfort, and features of Eustachian Tube dysfunction. This clinical distinction is important. **Clinicians should not prescribe antibiotics for the common cold**, since it is caused by viruses predominantly, and the course is brief and self-limiting⁴. With the common cold, combinations of oral antihistamine and decongestants have been found to be the most effective, although symptomatic treatment.

The vast majority of cases of acute rhino-sinusitis are also viral and require symptomatic treatment only – NSAIDs/paracetamol, saline irrigation and intranasal steroid (particularly in those with allergic rhinitis) are recommended while decongestants and oral antihistamines are not⁵.

Acute bacterial rhino-sinusitis (ABRS) should only be suspected, and **antibiotics should only be prescribed in patients with acute rhino-sinusitis who fall into one of the following categories 4,5:**

- **severe symptoms/signs at onset (fever >39°C PLUS purulent discharge or facial pain) persisting for at least 3 days**
- **clinical worsening after 5 days**
- **no improvement after 10 days**

Evidence suggests that the benefit of antibiotics in adults is modest: 14 patients with ABRS must be treated to shorten the duration of illness by one day in one patient! It is therefore reasonable to offer ‘watchful waiting’ to adult patients with mild-moderate ABRS, provided there is no evidence of complications, immunosuppression, or risk of poor follow up⁶. Locally, available outpatient treatment options are summarised in Table 1, with a recommended duration of 5-7 days in adults and 10-14 days in children⁵. Treatment failure is defined by clinical worsening or lack of improvement after 3 days. Urgent referral is indicated if there is suspicion of complications such as neurological involvement or spread to the surrounding bone or soft tissues.

CME /ARTICLE...cont'd

Symptomatic Treatment
Analgesia (NSAID, paracetamol) Saline Nasal Lavage Intranasal steroid
1st Line Antibiotic
Amoxy-Clav. acid 1g BD or 625mg TDS (45-90/kg/day of amox. component in two doses for children, with higher dose for severe infection)
2nd Line Antibiotic
Doxycycline 500mg OD (adults) Levofloxacin 500mg OD (10-20mg/kg/day for children)

**Table 1: Treatment of Acute Rhino-sinusitis
Acute Tonsillo-pharyngitis**

The vast majority of patients with this condition have a self-limiting condition, which are caused by viruses predominantly, which requires symptomatic treatment only: oral analgesia with paracetamol or NSAIDs and/or topical therapies such as lozenges and sprays. In addition, the physician must assess for evidence of group A streptococcal (GAS) infection, and other conditions that require special management such as infectious mononucleosis, peritonsillar abscess/cellulitis, and primary HIV infections.

Many patients have GAS colonisation, which poses no significant threat to life. Therefore, **a throat swab culture (or rapid antigen testing, if available) should only be performed when there is reasonable suspicion of GAS pharyngitis based on a Centor criteria score of >2** (see Table 2). The result should be followed up within 48hrs and **antibiotics should only be prescribed once the presence of GAS is confirmed**, the purpose of which is to prevent complications such as acute glomerulonephritis and rheumatic fever^{4,5}. Recommended effective regimens include ⁵:

- penicillin V 500mg (or 250mg for children 27kg) po bd x 10 days
- amoxicillin 500mg (or 25mg/kg for children) po bd x 10 days

- cefadroxil 500mg (or 30mg/kg for children) po bd x 10 days
- If allergic to B-lactams: azithromycin 500mg (or 12mg/kg for children) x 5 days

Centor Criteria (score 1 point for each)
Tonsillar exudates Tender anterior cervical lymphadenopathy Fever by history Absence of a cough

**Table 2: Centor Criteria
Acute Bronchitis**

An acute cough, often preceded by the common cold or pharyngitis, is the hallmark of acute bronchitis. Purulent sputum and mild wheezing is common, and the median duration of the cough is 2-3 weeks – many patients become concerned by these things, and need to be reassured that they are not indicative of pneumonia or a need for antibiotics. In fact, the vast majority of cases are viral, while the remaining 5-10% of cases are *caused by B. pertussis, M. pneumonia and S. pneumonia*. It is a self-limiting condition and therefore, with the exception of pertussis, **physicians should not perform testing or initiate antibiotics in patients with acute bronchitis unless pneumonia is suspected** ⁴. Pneumonia should be suspected in the presence of significant dyspnoea, confusion, abnormal vital signs, or evidence of consolidation on chest exam – a chest X-ray should be obtained to differentiate ⁴.

In the absence of pneumonia, only supportive treatment is warranted ⁴. There is little evidence to support the efficacy of the plethora of over-the-counter medications for acute bronchitis, though some argue that offering these reduce patient requests for unnecessary antibiotics. Beta agonists should be reserved for those with evidence of bronchospasm or chronic lung disease.

An exception to the rule is if influenza is diagnosed, being associated with significant morbidity and mortality in certain

patient groups. When influenza is suspected, patients with severe disease or risk factors for this (age >64, pregnancy, resident of long term care facility, BMI >40, underlying chronic diseases), should be prescribed a preferred antiviral agent (eg. Oseltamivir) promptly ⁵.

Shared Decision-making & Patient Education

Many patients expect antibiotics for URTIs, making it more difficult for physicians to navigate these consultations. Patient education and consultation techniques that employ shared decision-making have been shown to reduce antibiotic misuse (7). Key elements of these techniques include:

- Using open ended questions to explore the patient's expectations, concerns and understanding of the cause of their illness.
- Providing information to fill the gaps in knowledge, specifically discussing pros and cons of anti-biotic therapy versus other conservative therapeutic options. Sharing pamphlets or online resources that reinforce this information is likely to be helpful.
- Involving the patient in the selection of the treatment, based on the preceding discussion.

Consultation models such as the Four Habits Model and Patient-Centered Clinical Method, provide a more detailed framework for enhancing shared decision-making, improving patient satisfaction and strengthening the doctor-patient relationship.

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CASE REPORT

A MISSED DIAGNOSIS OF ECTOPIC PREGNANCY



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Introduction

An ectopic pregnancy is defined as any pregnancy implanted outside of the endometrial cavity¹. In the UK, this occurs in approximately 11/1000 pregnancies¹. In Barbados, there appears to be a peak incidence of 33.2/1000 in the 35 to 39 year age group². The diagnosis is important, due to the risk of women dying from ectopic pregnancy. The case fatality rate (about 0.2 per 1000 estimated pregnancies)³ has decreased in recent years, suggesting that earlier diagnosis and treatment may have made an impact¹.

Risk factors for ectopic pregnancy include tubal damage following surgery or infection, smoking, and in vitro fertilization (IVF), although the majority of affected women appear to have no identifiable risk factors¹. Classic presenting symptoms include abdominal or pelvic pain, amenorrhoea (or a missed period) and vaginal bleeding³, while common signs include pelvic, adnexal and/or abdominal tenderness³. However, UK guidance warns that practitioners should "be aware that atypical presentation for ectopic pregnancy is common"³.

Case report

A 33-year-old G2P0+1 lady, whose last menstrual period had taken place 17 weeks prior to her presentation, was referred for consultation at the Queen Elizabeth Hospital (QEH), with a presumptive diagnosis of a missed miscarriage, by her general practitioner. She had been in attendance for antenatal care since eight weeks of pregnancy, and had been examined on the day of referral, and no fetal heart could be auscultated. She had been referred for an ultrasound examination, which was performed trans-abdominally by a private radiologist.

What was reported was "a 15-week-and-3-day-sized fetus

with hydropic features, including intra-abdominal and pericardial fluid, and an absence of a heart beat". No other abnormal findings were noted, and the overall impression given was "hydrops with fetal demise".

On the gynaecology unit, the patient's history was noted as being benign, with no chronic illnesses or history of serious medical problems, and no prior surgery. Her periods were regular, she had not been on contraception at the time of pregnancy occurrence, and had conceived naturally. She had no history or symptomatology of any sexually transmitted infections, and had not experienced pain nor vaginal bleeding. Her clinical examination was unremarkable, with normal vital signs, and an abdominal mass arising from the pelvis, which was of equivalent size to a 16-week pregnancy was palpated. Her cervix was long and closed, with no bleeding demonstrated.

On the basis of the clinical findings and the ultrasound report, the patient was managed as a missed miscarriage (an intrauterine pregnancy with an absence of heartbeat). Vaginal misoprostol was administered. Misoprostol is a prostaglandin tablet used to effect pregnancy termination, and the patient received 800 micrograms vaginally three times a day for the next two days, with no effect.

On the third day, to evaluate matters further prior to planning further treatment, the gynaecology team performed an ultrasound of their own (Figure 1). The uterus was visualized, and was normal in size, with a smooth endometrium. Anterior and to the left of the uterus was an extra-uterine gestational sac with containing a demised fetus. The patient underwent a low-transverse laparotomy, during which a 10cm left tubal ectopic pregnancy was found (Figure 2) and excised (salpingectomy).

CASE REPORT...cont'd

The patient recovered well, with no untoward effect of either misoprostol administration or surgery.

Discussion

This case illustrates that atypical presentations for ectopic pregnancy can, and do, occur. The patient, having reached the second trimester, was presumed to have an intrauterine pregnancy. In a retrospective review of 693 ectopic pregnancies in Canadian university hospital ⁴, Saxon et al reported that the average gestation at the time surgery for a ruptured tubal pregnancy was 7.2 ± 2.2 weeks, with a mean ultrasound tubal diameter of 4.1 ± 1.9 cm. Conventional wisdom suggests that the fallopian tubes are not constructed for an expanding pregnancy, and thus are prone to rupture at a relatively early gestation. However, this did not hold true on this occasion.

The original ultrasound confirmed fetal demise, but we note that it was never explicitly stated whether the pregnancy was thought to have been intrauterine to begin with. It may again have been presumed by all involved that the size of the fetus could only have been so great with an intrauterine gestation. The normal-sized uterus might have been more easily visualized, had a transvaginal ultrasound also been done. Perhaps a protocol for obstetric scanning inclusive of reporting on all gynaecological organs, and a policy of routine scanning for patients upon admission to the gynaecology ward, might have resulted in an early recourse to surgery, with less patient time spent in hospital, and less hypothetical risk of tubal rupture during the lag time prior to surgery.

An Australian case series⁵ found a 12% (31 of 255) rate of undiagnosed ectopic pregnancy at Flinders Medical Centre. The delay from initial presentation to surgical treatment in that report varied from 2 to 29 days (mean 8 days), consistent with the 3-day delay seen in our index case. Undue reliance upon an ultrasound report was a factor in 5 cases (16%)⁵. Failure to consider ectopic pregnancy in the differential diagnosis of pelvic symptoms, was also reported as a contributing factor to missed diagnosis.

Our case bears some similarity to a case report from Curaçao in 2009⁶, which described a 32 year old woman presenting with an unwanted pregnancy, but who had a six-week size uterus and no ultrasound performed. She too was administered misoprostol 800 mcg, but on a single occasion, and after two weeks of bleeding and a persistently positive pregnancy test, a ultrasound revealed an empty uterus, despite a high β hCG of 9260 iu/l. A transvaginal ultrasound subsequently performed, confirmed an extrauterine pregnancy, which was

subsequently operated on, with no adverse outcome. With a clearly visible, advanced pregnancy in our case, no β hCG was necessary as the diagnosis was clear.

Conclusion and Learning Points

Ectopic pregnancy is a potentially life-threatening condition with typical features, but missed diagnoses can occur, as happened in this case, and as reported in earlier literature. Careful examination of all pelvic organs at the point of obstetric and gynaecology ultrasound examination, and a policy of admission ultrasound, might reduce the chance of misdiagnosis, minimise inappropriate treatment, and result in cost savings, due to a shorter duration of hospitalisation.

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INSTRUCTIONS TO AUTHORS

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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.

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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.*

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1. Abbasi K, Smith R. No more free lunches. BMJ 2003;326:1155-6.
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