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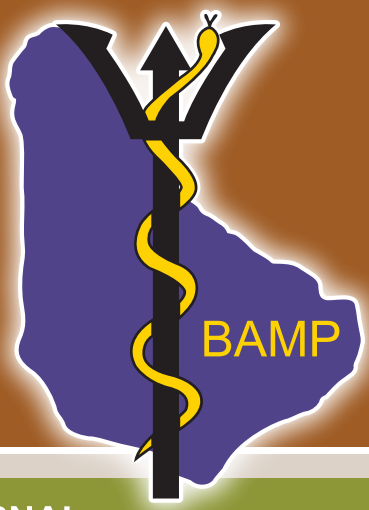

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THE EDITOR'S DESK

TO VAX OR NOT TO VAX

Within recent times, 2020 will go down in history as a most eventful year, and so too, will 2021 and perhaps beyond. These unusual and unprecedented circumstances will not only be remembered for a newly foisted vocabulary, but also for the unparalleled objection to the administration of Covid-19 vaccines.

Vaccines work by two broad mechanisms; they can block infections occurring entirely, or they can halt the progression to symptoms after infection occurs. The most direct pathway to population immunity is the first mechanism, also known as sterilizing immunity.

By now, it is clear that the Covid-19 vaccines are remarkably effective against progression to developing severe disease, and some preliminary findings have suggested the development of substantial protection against infection. A reduction of transmission by vaccination for population immunity will mandate high coverage rates in the entire population, independent of age, sex, or differences in ethnicity.

Although the precise value and even the possibility of herd immunity to SARS-CoV-2 is debatable, a significant percentage of epidemiologists appear to express the view that the threshold is about 70% protected by vaccination or previous infection.

In addition to directly protecting vaccinated individuals, COVID-19 vaccines provide a safe way of getting community transmission under control.

The term vaccine hesitancy, typically implies that individuals or communities are choosing not to take the vaccine on the grounds of low confidence or incorrect beliefs.

The challenge of low vaccine access and uptake by some groups is multidimensional. Whereas vaccine hesitancy is often implicated, this framing wrongly places the responsibility on minority groups to become less hesitant, rather than on public health systems to become more trustworthy and accessible. This framing also inadvertently discounts barriers to vaccine access that have been incompletely addressed for these populations.

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A part of the solution lies in sufficiently resourcing trusted, local personnel to take the time needed to listen to the concerns of the local community, address specific fears, counter misinformation, build trust with local communities, and in the hope of convincing people of the benefits of taking the vaccine.

An evidence-based understanding of, and response to, the unique needs of communities with low vaccine uptake, will allow policy makers to move beyond focusing on individual choices and to help to address the underlying causes of low vaccine uptake, including lack of confidence in vaccines and health-care services, and governments services more broadly, as well as issues related to convenience of access.

Although COVID-19 vaccine supply is currently limited, it is not too early to share clear, complete, and accurate messages, promote confidence in the decision to get vaccinated, and to engage the unvaccinated in plans to address potential barriers to accepting a vaccination.

Strong confidence in the vaccines leads to more people getting vaccinated, which leads to fewer COVID-19 illnesses, fewer hospitalizations, and fewer deaths.

COMMENTARY

SHOULD WE BE PROMOTING THE INFLUENZA ('FLU) VACCINE?

Dr. C.V. Alert
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Months ago, the World Health Organization (WHO) officials warned of a potential "twindemic," with spiking COVID-19 and influenza cases overwhelming health care systems. Experts also noted that the precautions taken to reduce the spread of COVID, such as hand-washing, social distancing and wearing of facial masks, can also reduce influenza spread. It could be a season with less influenza than usual. The Centre for Disease Control (CDC) in the USA urges everyone over 6 months of age to get a flu shot. Should we in the Caribbean follow that recommendation? While the 'flu shot does not protect us from COVID-19, the rationale for the 'flu shot includes reducing the stress on hospitals if the 'twindemic' does materialize. But what happens if your hospital system is already stressed out, as we have here?

The COVID-19 pandemic is teaching us an important lession. Scarce resources are being re-routed to prepare for anticipated (and in some countries actual) tsunami of covid-19 related activities, like testing, contact tracing and setting up quarantine centers. To date, this has led to the displacing of many essential health priorities. Some out-patient clinics were closed as staff was deployed elsewhere. Non-emergency surgeries were cancelled. Face-to-face visits were replaced by repeat prescriptions, with little/no assessment of current clinical status.

Many patients with chronic illnesses stayed away from hospitals and doctors' clinics because they were fearful of coming into contact with patients who may have had COVID-19 or their appointments were cancelled as preparations were being made for COVID-19 related activities. The national economic meltdown that accompanied COVID-19 disrupted clinical visits, especially for preventive activities, disrupted access to prescriptions or even medication purchases; many exercise and (semi)healthy eating patterns were forced to be abandoned.

The net result: our long suffering patients with the chronic non-communicable diseases (NCDs) are being pushed aside by a communicable disease called COVID-19. Without active intervention, our already high morbidity and mortality figures are likely to get even worse. "People are not going to doctors at the beginning and are they going to doctors (or the undertakers) at the end".

In the Caribbean, influenza occurs throughout the year but is rarely considered a serious or life-threatening disease. In the Northern Hemisphere, the influenza season typically starts in early fall, peaks in mid-February, and ends in the late spring of the following year. Duration and severity of influenza epidemics vary, however, depending on the virus subtype involved. As the colder months in the Northern Hemisphere approach, and we (hopefully) prepare for an influx of visitors, we are told to prepare for the 'twindemic' of influenza and COVID-19. We await with baiting breath, an 'affordable, acceptable and accessible' vaccine against the COVID-19, but in the interim we should take a closer look at the influenza ('flu') vaccine.

Several studies have reported influenza vaccine effectiveness in reducing illness severity in persons aged > 65 years,[1] and reducing in-hospital mortality and ICU admissions for those aged 18–49 years and > 65 years, compared to unvaccinated individuals.[2] At a time (i.e. now) when hospital beds are at a premium, any effort to reduce hospital admissions and reduce mortality and morbidity associated with the NCDs would be welcomed.

Within the Caribbean, a diagnosis of symptoms associated with any combination of 'fever, runny nose, congestion, headache, aches and pains and generalized malaise' rarely attempts to identify the virus. Influenza has traditionally been diagnosed on the basis of clinical criteria, and rapid diagnostic tests, which have a high degree of specificity but only moderate sensitivity, are only used in Barbados to a small degree and in other countries. In elderly or high-risk

patients with pulmonary symptoms, chest radiography should be performed to exclude pneumonia, a serious complication of 'the flu'.

Patients at high risk for complications from influenza include: pregnant women and those who have given birth within 2 weeks, [3] patients with extreme obesity (body mass index > 40 kg/m^2), [4,5] children younger than 5 years, particularly those younger than 2 years [6], those aged 65 years or older, [7] individuals with a weakened immune system as a result of disease or medication, patients with chronic medical conditions such as heart or lung disease, kidney, liver or metabolic disorders, and residents of nursing homes.

Persons with uncomplicated influenza typically experience acute onset of respiratory symptoms (cough, rhinorrhea, and congestion), myalgias and headache with or without fever. These symptoms are usually mild. Complications of influenza vary by age, underlying co-morbidities or high-risk conditions such as pregnancy, and immune function; of note elderly and immune compromised persons may not always manifest fever. Critically ill patients may be admitted with respiratory or multi-organ failure, exacerbation of an underlying condition such as chronic lung disease,[8] heart failure,[9] or other extra-pulmonary complications including: stroke, encephalopathy, or encephalitis.[10]

Prevention of influenza is the most effective management strategy, particularly if hospital admissions are to be minimized. In addition to vaccination, other public health measures are also effective in limiting influenza transmission. Enhanced surveillance with daily temperature taking and prompt reporting with isolation through home medical leave and segregation decrease the spread of influenza [11]. These are similar to the 3W's: wash your hands, wear your masks, and watch your (social) distance that are presently recommended to limit or stop the spread of COVID-19.

Specific antiviral therapy (perhaps except oseltamivir [sold under the brand name Tamiflu]) is not readily available in the Caribbean. In scenarios where the drug is available and given after the development of influenza, antiviral drugs can reduce the duration and severity of illness.

We know that every year we're going to have influenza and we need to improve how we prevent and control it through influenza vaccination, better diagnosis, and early antiviral treatment if available. Although the seasonal strains of influenza viruses that circulate in an annual cycle constitute a substantial public health concern, far more lethal influenza strains than these have emerged periodically. These deadly strains produced 3 global pandemics in the last century, the worst of which occurred in 1918. Named the Spanish flu (though cases appeared earlier in the United States and elsewhere in Europe), this pandemic killed an estimated 20-50 million persons worldwide, with 549,000 deaths in the United States alone. [12] At 240,000 deaths by mid-November 2020, COVID-19 is on pace to challenge these figures in the USA, the richest country in the world.

In centres where rapid diagnostic tests for influenza are performed, the lab can provide results within 30 minutes and can help confirm the diagnosis. It should be kept in mind, however, that these rapid tests have limited sensitivities and predictive values. False-negative results are common, especially when influenza activity is high, and false-positive results can also occur, especially when influenza activity is low [12]. Nevertheless, influenza virus testing may be considered if the results will change the clinical care of the patient (especially if the patient is hospitalized or has a high-risk condition) or influence care of other patients. [13]

Caribbean health officials have chosen to screen all visitors to our shores for COVID-19, as an important public health measure. Yet in populations with high prevalence of patients at high risk for the complications of influenza infections, and where there is limited hospital capacity, the influenza vaccine may be considered also as it offers an opportunity to 'flatten the curve' and reduce our inpatient populations to manageable levels. This can reduce the high morbidity and mortality figures that 'exist' in our populations, even before the uninvited COVID-19 came to town.

To date the requests for "Flu" vaccine, are confined to individuals who work in the hospitality industry, who come in contact every year with visitors when there is an influx (or a few who travel overseas on marketing missions). If sufficient persons get the influenza vaccine it may be possible to develop herd immunity in our populations, offering additional protection to everyone.

If our ambition is to lower morbidity and mortality in our populations, then we must embrace preventive medicine. We must promote vaccination. If we hope to 'flatten the curve' with respect to reducing the overpopulation of our hospitals, particularly with patients suffering from the NCDs, then we

COMMENTARY... cont'd

must consider measures that can help to promote this objective. Promoting influenza vaccination is one such measure. An ounce of prevention is better than a pound of cure.

Be wise: immunize.

References.

1. Casado I, Domínguez A, Toledo D, et al. Effect of influenza vaccination on the prognosis of hospitalized influenza patients. Expert Rev Vaccines. 2016;15(3):425–32.

2. Arriola C, Garg S, Anderson EJ, et al. Influenza vaccination modifies disease severity among community-dwelling adults hospitalized with influenza. Clin Infect Dis. 2017;65(8):1289–97.

3. Louie JK, Acosta M, Jamieson DJ, Honein MA, Group CPHNW. Severe 2009 H1N1 influenza in pregnant and postpartum women in California. N Engl J Med. 2010;362(1):27–35.

4. Webb SA, Pettilä V, Seppelt I, et al. Critical care services and 2009 H1N1 influenza in Australia and New Zealand. N Engl J Med. 2009;361(20):1925–34.

5. Domínguez-Cherit G, Lapinsky SE, Macias AE, et al. Critically ill patients with 2009 influenza A(H1N1) in Mexico. JAMA. 2009;302(17):1880–7.

6. Poehling KA, Edwards KM, Weinberg GA, et al. The underrecognized burden of influenza in young children. N Engl J Med. 2006;355(1):31–40.

7. Barker WH. Excess pneumonia and influenza associated hospitalization during influenza epidemics in the United States, 1970–78. Am J Public Health. 1986;76(7):761–5.

8. Biancardi E, Fennell M, Rawlinson W, Thomas PS. Viruses are frequently present as the infecting agent in acute exacerbations of chronic obstructive pulmonary disease in patients presenting to hospital. Intern Med J. 2016;46(10):1160–5.

9. Panhwar MS, Kalra A, Gupta T, Kolte D, Khera S, Bhatt DL, Ginwalla M. Effect of influenza on outcomes in patients with heart failure. JACC Heart Fail. 2019;7(2):112–7.

10. Randolph AG, Vaughn F, Sullivan R, et al. Critically ill children during the 2009–2010 influenza pandemic in the United States. Pediatrics. 2011;128(6):e1450–8.

11. Lee V, Yap J, Cook AR, et al. Effectiveness of public health measures in mitigating pandemic influenza spread: a prospective sero-epidemiological cohort study. J Infect Dis. 2010 Nov 1. 202 (9):1319-26.

12. Kilbourne ED. Influenza pandemics of the 20th century. Emerg Infect Dis. 2006 Jan. 12(1):9-14.

13. Seasonal Influenza (Flu): Guidance for Clinicians on the Use of RT-PCR and Other Molecular Assays for Diagnosis of Influenza Virus Infection. Centers for Disease Control and Prevention. http://www.cdc.gov/flu/professionals/diagnosis/molecular-assays.htm.

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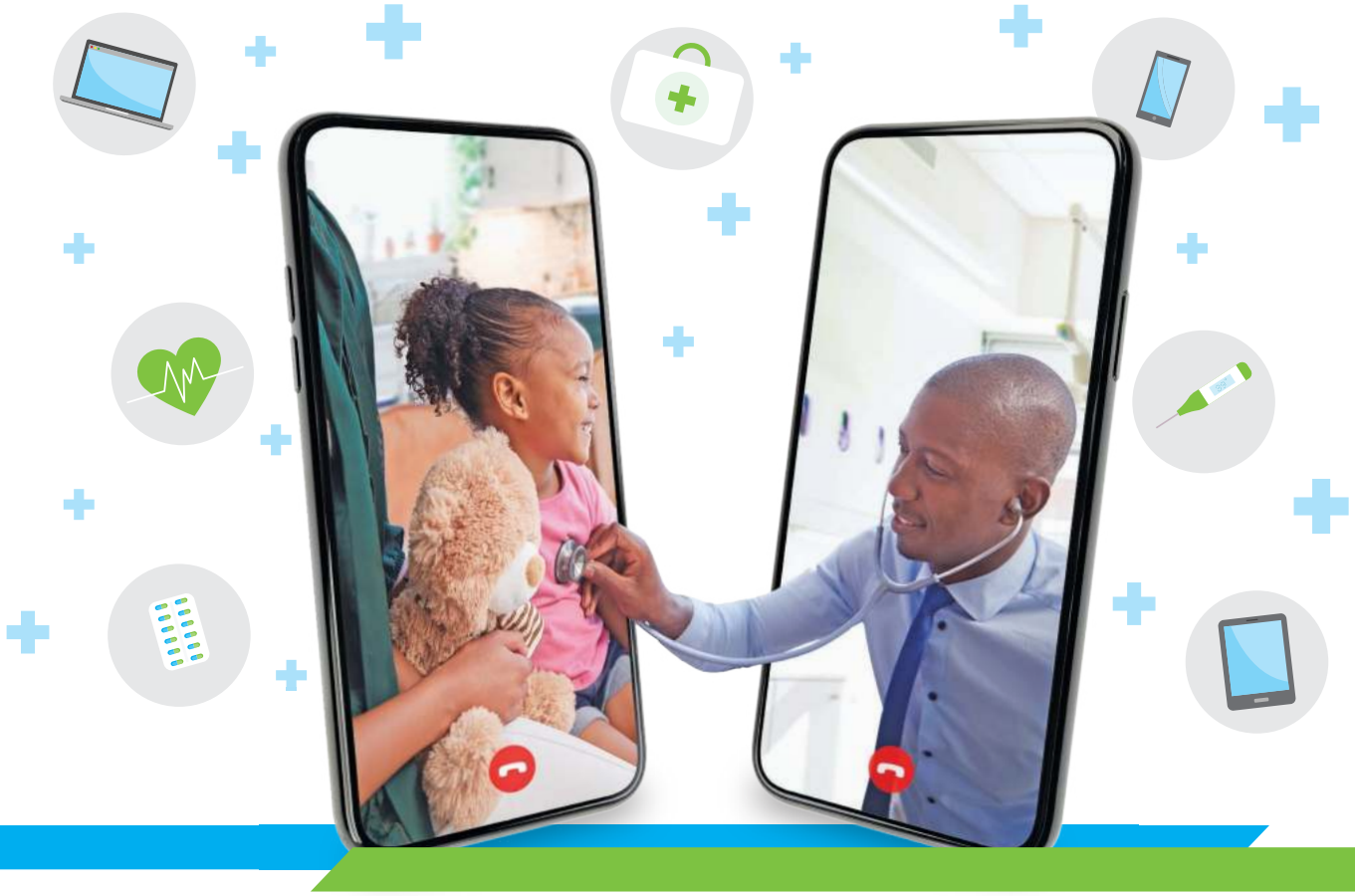

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COMMENTARY... cont'd

TELEHEALTH IS JUST AS EFFICIENT AS IN-PERSON HEALTH VISITS. THE FUTURE IS NOW!

Dr Tanisha Austin
Bat.Med Sc (Hons) MB. BS (UWI)

From a small island perspective, the advent of telehealth seemed futuristic but attainable and a not-too-distant prospect. Whilst many international health institutions have incorporated some aspect of telehealth, for Barbados, the widescale adoption of telehealth services remained uncertain up to this point. However, with the emergence of the COVID-19 pandemic in early 2020, many health institutions have quickly and unexpectedly made a shift towards telehealth or telemedicine.

Telemedicine and telehealth services have long been considered valuable to improving health care access by reducing some of the disparities between rural and urban health care[1]. According to the Federal Communications Commission, telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health and refers to medical services provided with the support of telecommunications technologies, such as diagnostic imaging. Telehealth is a rapidly growing field of medicine that utilises telecommunication and information technology to assist in the delivery of health care to patients at a distance from health care providers or medical institutions [2]. Telehealth can provide health care remotely by means of a variety of telecommunication tools, including telephones, smartphones, and mobile wireless devices, with or without a video connection [3]. Telehealth can encompass a broad variety of clinical and nonclinical remote health care services such as patient consultations, patient education and counselling [4], and it can be applied to various clinical settings for acute care as well as long term follow up for chronic diseases and feasibly be utilised in multiple subspecialties inclusive of paediatrics, internal medicine, surgical specialties, and emergency medicine to name a few.

Telehealth services can be classified into two different subtypes depending on the timing of the patient interaction as asynchronous and synchronous services. Synchronous services occur in real time and includes teleconsultation and videoconferencing between the physician and the patient. Conversely, asynchronous services do not involve real-time interaction and primarily involve data storage and the transfer of clinical information between two separate entities, for example, physician to physician data transfer and teleradiology services. Asynchronous methodologies allow the recipient to respond in their own time.

These services, or subspecialty consultation, can help to connect patients with health care providers to improve patient access to care. This is particularly crucial in countries where health care is not universally accessible for various reasons, geographic or otherwise. As telecommunications and computer technology have become increasingly reliable and easily accessible, the methods of communication have expanded from just telephone calls between patient and provider to include videoconferencing, the exchange of high-resolution image and video files, and the ability to remotely monitor patients via the Internet [2]. Telehealth also allows health care professionals to access subspecialist input which may not be readily available locally.

There are numerous advantages to adopting telehealth communication in clinical practice. Telehealth services increase patient's access to clinical care by delivering it when and where it is required by the patient. It allows us to overcome geographic barriers particularly in resource-limited settings where there may not be direct access to basic health services.or subspecialty consultations.

Providing a certain level of convenience for the patient or parents, telehealth also allows more flexibility around work schedules. It has been shown to improve patient adherence to follow up. Acting as a middle ground between face-to-face and telephone encounters telehealth ensures improved care over telephone encounters because of the enhanced ability of the consulting physician to visualise the patient.

Generally, telehealth is well suited for patients who have chronic medical conditions or who need an initial evaluation

of an acute illness. It has made frequent check-ins easier compared to in-person care which would improve the long-term management of chronic illnesses such as diabetes, asthma and epilepsy and can be as safe as or sometimes better than in-person care. Research has shown that using telehealth for minor injuries or ailments provides the same level of care as in-person medicine and reduces unnecessary ambulance rides and hospital visits.

Paediatric care has been shown to be particularly amenable to telehealth services. A telehealth model by McConnochie et al demonstrated that approximately 85% of acute visits to ambulatory paediatric clinics could be managed as telehealth encounters for reducing the social and economic burden imposed by common acute childhood illnesses [5]. Further studies have also demonstrated high levels of patient satisfaction with the use of telehealth services [6]. Telehealth services also allow better continuity of care and closer follow up by primary care physicians especially in the current setting of a pandemic where in-person visits are restricted. Thus, it has proven to be highly beneficial for both patient and the provider.

Telehealth services can be utilized to provide new and innovative ways for patient education and empowering patients in the management of chronic diseases. Interactive websites and videos can be produced to engage patients in learning about various chronic diseases such as asthma and can help reinforce management strategies previously taught. Telehealth technology is also crucial for continuing medical education for healthcare professionals and allows greater access to a wider pool of resources. Healthcare professionals can now attend international conferences presented by leading experts in various fields from the convenience of their home or office. Lectures can be delivered synchronously via videoconferencing and thus allowing providers to have discussions with other colleagues in real time. Such interactions with experts and subspecialists can help providers develop greater expertise to manage complex patients on their own and promote networking among medical professionals. Asynchronous methods can also be utilised for continuing medical education where the provider can review lectures series in their own time.

The ability to obtain specialist input on a patient can lead to early initiation of diagnostic testing and treatments by the primary care provider while the patient waits to be seen by the subspecialist, increasing the efficiency, saving time and cost of care delivery. Time and cost savings are also gained by the patients and not just the health care system. Health services that can offer patients or parents a means of obtaining medical care, without having to miss work, provide benefit for families and society in terms of increased earnings and productivity.

Telehealth can be used to improve health care quality and safety, although challenges exist in the successful implementation which must be overcome to help the field reach its full potential [7,8]. These include technological challenges, health care provider and patient concerns, financial barriers, and legal issues. Moreover, for telehealth to be practised successfully, infrastructure must be in place at the consulting site and the site requesting the consult. The technology platform utilised for telehealth consults should maintain sufficient connectivity and should offer prompt speeds for upload and download of data. Some providers may be hesitant towards telehealth due to unfamiliarity of software or perceived challenges with technology. Patients may be hesitant to utilise telehealth services for concerns with privacy, concerns about technology failures impacting on the experience of the patient visit as well as the loss of "in person" interactions which could have an impact on establishing the doctor-patient relationship.

One of the biggest barriers to the use of telehealth has been resistance on the part of providers to embrace this technology in caring for patients. For many providers, telehealth is not easily integrated into routine workflow, adds extra time to their already busy schedules, and is perceived as often adding little benefit beyond a traditional telephone call [9]. A common misconception is that you cannot be personable through telehealth, but you can still build rapport and keep the same bedside manner as you would with an in-person visit. Telehealth relies on patient observation and therefore the physical examination is limited, and providers must consider this when determining which consults are appropriate to be conducted virtually.

Several financial barriers can be associated with the provision of telehealth service. Firstly, institutions interested in engaging in telehealth must invest in the initial equipment or software to start a formal telehealth programme. There are also continued costs of equipment, maintenance, personnel training, and ongoing technical support. Perhaps the largest financial barrier is the lack of clear and consistent reimbursement for telehealth from insurance companies and

COMMENTARY... cont'd

lack of return on investment, therefore this may prove to be prohibitive for some persons seeking healthcare privately.

There are several legal issues raised by telehealth, which are of significant concern to many providers and organizations, particularly medicolegal liability. This is understandable, due to particular concerns about documentation, data storage or management and what might happen in the case of technology failure. It is therefore prudent that physicians maintain the standard of documentation in the patient medical records of all patient encounters, inclusive of telehealth consultations.

Another challenge of telehealth is the need to collect information that is normally obtained by directly touching or interacting with the patient to make diagnostic and treatment decisions. It is for this reason that synchronous interactions are important however this barrier is now beginning to be overcome by the use of technology embedded in many smart devices such as smartphones tablets and smart watches [10]. These smart devices have an array of sensors designed primarily for non-medical uses which can be utilised to augment the telehealth experience. These same sensors are now being used for clinical decision-making by a growing number of healthcare apps. These smart devices are equipped with heart rate monitors, pulse oximeters and newer devices offer small attachments which can record diagnostic pictures and even single lead electrocardiograms to name a few.

Use of telehealth services can help transform health care delivery, importantly addressing critical gaps in access to care locally and further afield particularly for patients with more complex health needs. The growth of patient interest in telehealth, along with improving telecommunication access with mobile devices, make the time perfect for using telehealth innovations and advances to help providers engage with their patients and other providers in new ways to deliver medical care outside the office [11].

This is a pivotal time for adoption of telehealth services especially in the setting of a pandemic which poses further additional challenges for continuity of care. To continue to care for patients with and without COVID-19 safely and effectively, many changes in practices were necessary, resulting in a rapid shift towards telehealth models in many settings (in both inpatient and outpatient areas), from basic telephone calls to videoconferencing [12]. In order to prevent and reduce the transmission of COVID-19, patients and providers had to quickly adapt to telehealth models and practices.

Telehealth was once limited to remote communities but is now increasingly used to expand the range and reach of health care services and improve access to patient care. Factors such as convenience, efficiency, communication, and comfort have been identified by patients as important in using telehealth [7]. Telehealth utilizes a range of practices and specialties and involves interactions among patients and providers through telephone, e-mail, video chats or conferences, the Internet, and remote devices. Health care professionals can potentially diagnose, monitor, and treat a multitude of acute and chronic conditions using telehealth modalities.

Of course, not all health care can be appropriately or safely done via telehealth, but research shows that in many cases, it is just as good as in-person care. With technological advances, approval and acceptance of telehealth are increasing because it is an efficient and effective tool for improving health care access and outcomes. There are several barriers to telehealth practice which need to be overcome but the future of telehealth is promising. The continued growth of telehealth in the future will have profound implications for medicine and health care delivery.

References

1. Nelson R. Telemedicine and Telehealth: The Potential to Improve Rural Access to Care. The American journal of nursing. 2017;117(6):17-8.

2. Utidjian L, Abramson E. Pediatric Telehealth: Opportunities and Challenges. Pediatric clinics of North America. 2016;63(2):367-78.

3. Dorsey ER, Topol EJ. State of Telehealth. The New England journal of medicine. 2016;375(2):154-61.

4. What is telehealth? How is telehealth different from telemedicine? 2019 [Available from: https://www.healthit.gov/faq/what-telehealth-how-telehealth-different-telemedicine.

5. Effectiveness of Telemedicine in Replacing In-Person

Evaluation for Acute Childhood Illness in Office Settings. Telemedicine and e-Health. 2006;12(3):308-16.

6. Mair F, Whitten P. Systematic review of studies of patient satisfaction with telemedicine. BMJ (Clinical research ed). 2000;320(7248):1517-20.

7. Gajarawala SN, Pelkowski JN. Telehealth Benefits and Barriers. The journal for nurse practitioners : JNP. 2021;17(2):218-21.

8. Olson CA, Thomas JF. Telehealth: No Longer an Idea for the Future. Advances in Pediatrics. 2017;64(1):347-70.

9. Uscher-Pines L, Kahn JM. Barriers and facilitators to pediatric emergency telemedicine in the United States. Telemedicine journal and e-health : the official journal of the American Telemedicine Association. 2014;20(11):990-6.

10. Voran D. Telemedicine and beyond. Mo Med. 2015;112(2):129-35.

11. Almathami HKY, Win KT, Vlahu-Gjorgievska E. Barriers and Facilitators That Influence Tele-medicine-Based, Real-Time, Online Consultation at Patients' Homes: Systematic Literature Review. J Med Internet Res. 2020;22(2):e16407.

12. Saiyed S, Nguyen A, Singh R. Physician Perspective and Key Satisfaction Indicators with Rapid Telehealth Adoption During the Coronavirus Disease 2019 Pandemic. Telemedicine journal and e-health : the official journal of the American Telemedicine Association. 2021.

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Surgical options in the treatment of kidney stones-a primer

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Kidney stones are relatively common and are estimated to affect around 5-10% of the general population in developed countries[1]. Several options exist for treatment including dietary modification and for certain ureteral stones, medical expulsive therapy is available. Unfortunately, surgical intervention is sometimes required for a significant number of patients; it is therefore essential that general practitioners have a working knowledge of the surgical options available for both kidney and ureteral stones. When intervention is required, the decision to match patient with treatment modality is nuanced, taking into consideration multiple factors such as stone location, density and size, patient anatomy and co-morbidities and importantly, patient preference. Fortunately, literature is replete with urolithiasis-related studies and these decisions are therefore largely data driven.

Who requires treatment and what needs to be done for asymptomatic stones?

Absolute indications for surgical intervention in patients with upper tract stones include – renal insufficiency or infection in the presence of obstruction, obstruction in a solitary kidney, intractable pain and failure of passage. Frequent clinical scenarios involve the patient with asymptomatic kidney stones, I am frequently asked – how best do we counsel this group? Asymptomatic patients with staghorn calculi are a subset of this group. Staghorn calculi, which are usually due to recurrent urinary tract infection, have traditionally been treated surgically, as older studies suggest much worse outcomes with conservative treatment – mortality of 28% compared to 7.2% for those with surgical intervention[2,3]. While more contemporary evidence suggests that conservative management may not be as perilous as once perceived[4], the

American Urological Association (AUA) Stone Guidelines still recommend active management of these patients unless precluded by co-morbidities[5].

The patient with smaller symptomatic calyceal stones provides more of a dilemma. Koh and colleagues followed 50 patients with 85 stones over a period of 46 months, noting progression among 46% and a 7.1% rate of intervention[6]. In a cohort of 107 patients, Glowacki et al.[7] found a 48.5% 5-year cumulative risk of a symptomatic event - overall, 26.5% required surgical intervention. These data seem to suggest that a significant percentage of such patients will eventually develop symptoms although a smaller number will require some form of intervention. Stone size and location may influence rates of progression with larger stones (4-5mm or greater) and lower pole stones tending to fare worse. This notwithstanding, intervention should also be considered in patients with recurrent infections and those who have jobs which require them to be stone free such as airline pilots[8].

Ureteroscopy

Ureteroscopy involves passage of a thin ureteroscope into the ureter or kidney. Scopes may be semi-rigid or flexible with the latter utilizing both active and passive deflection to access stones in the calyceal system. Once the stone is visualized, lithotripsy is achieved via one of a number of energy sources such as laser, pneumatic or mechanical lithotripter. Lasers utilize a flexible fiber which facilitates the treatment of calyceal stones and are also associated with less stone retropulsion compared to other energy sources. Stones may be fragmented or dusted and a variety of basket devices exist to retrieve stone fragments.

For ureteric stones, ureteroscopy is a primary management option and success rates, while very good overall, vary with position – from 94% in the distal ureter to 85% for proximal ureteric stones[9]. The AUA's Stone Guidelines suggest ureteroscopy as a primary option for kidney stones less than 2cm and for lower pole stones less than 1cm[5]. For lower pole stones less than 1cm, shockwave lithotripsy is also an option; however, in a direct comparison, ureteroscopy was associated with higher stone-free rates although this did not attain statistical significance[10].

Patients with stones greater than 2 cm have traditionally been offered percutaneous nephrolithotomy which is associated with stone free rates of greater than 90%[11]. However, ureteroscopy may be an attractive alternative even in patients with larger stones. This is especially helpful in patients with co-morbidities or those who may be at increased risk of bleeding. Indeed, there are data to support this – a systematic review noted a stone free rate of 91% for stones among patients with an average stone size of 2.7cm[12]. It should also be noted however, that there may be a limit to which sized stones should be offered ureteroscopy as stones greater than 3cm were found to have a lower stone free rates (85% vs. 96%) compared to stones 2-3cm[13].

One should also be cognisant of the fact that the patients with larger stones may require two procedures in order to achieve these stone free-rates[14]. Ureteroscopy is the preferred treatment modality in obese patients, those with bleeding issues and in patients who develop stones during pregnancy. With respect to the latter, while urinary diversion with a urinary stent or nephrostomy tube was more common pregnant patients in the past, primary ureteroscopy among this group has emerged as a safe and effective option, with stone-free rates approaching 90%[15,16].

In general, ureteroscopy is a safe procedure with a rate of serious complications of <1%[17]. Patients should be aware that they may require a ureteral stent after the procedure. This might not be necessary after every case but is often at the discretion of the surgeon, and should certainly be considered after difficult cases. Many urologists have routinely placed stents prior to ureteroscopy; however this practice is now considered to be obsolete, and most cases do not require preliminary stenting unless indicated by infection or renal compromise.

Percutaneous Nephrolithotomy

Percutaneous nephrolithotomy (PCNL) was first described in 1976 and has become the preferred modality for larger stones. While a role will always exist for open surgery in resource-limited settings, these procedures have largely been supplanted by PCNL. PCNL involves image-guided cannulation of the kidney with a guidewire over which a tract is progressively dilated. A nephroscope is subsequently passed into the kidney and any one from a number of energy sources used to fragment the calculus (Fig. 1). The diameter of the tract is typically 24-30Fr (8-10mm) although the procedure has seen significant miniaturization in recent years with mini

(16-18Fr), ultra mini (11-14Fr) and micro (<10Fr) modifications described[18]. Traditionally, PCNL has been conducted in the prone position (tummy down) but more recently supine positioning has gained popularity for its advantages which include faster operative times, easier airway management, improved cardiorespiratory tolerance and the ability to conduct simultaneous ureteroscopy[19].

PCNL is not without risks, the most feared of which are major bleeding, sepsis and visceral injury, although these are thankfully rare[19]. Patients having this procedure should also be made aware that they may require multiple punctures and even adjunctive procedures in order to achieve stone-free status. Figure 1 illustrates the case of a complete staghorn stone in a morbidly obese patient where multiple punctures were required. Ninety-five percent of stone clearance was achieved via two incisions each less than 1cm and hospitalization less than 24hrs.

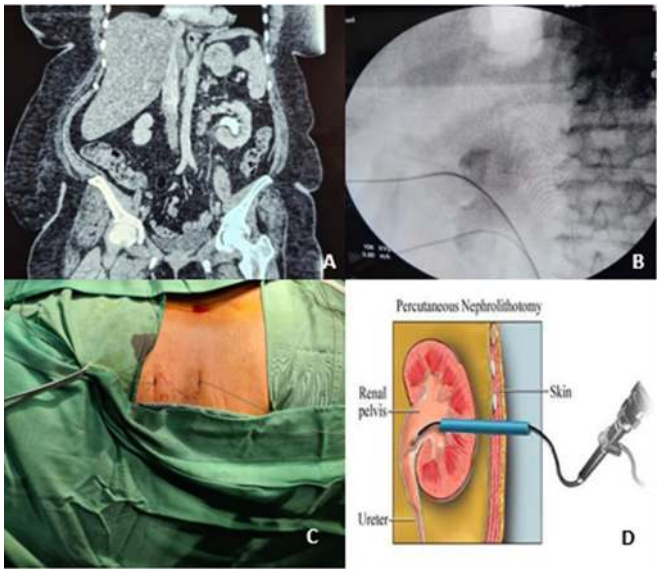

Figure 1. A-morbidly obese patient with a complete left staghorn stone on CT scan. B & C – Two guidewires are passed into the kidney under fluoroscopy. D – These tracts are subsequently dilated and instruments are then passed into the kidney.

Extracorporeal Shockwave Lithotripsy (ESWL)

Extracorporeal shockwave lithotripsy (ESWL) is a noninvasive treatment modality where a machine is coupled to the patient and generates shockwaves aimed at the stone in order to achieve fragmentation – the patient then passes tiny fragments in the urine. Several factors determine the success of ESWL; stone size, location composition and patient body habitus should all be kept in mind when selecting ESWL as a treatment modality.

Obese individuals with stone-to-skin distance of greater than 10cm, have a lower stone-free rate as do patients with stone densities greater than 1000 Hounsfield units[20,21]. In addition, stone location also influences outcomes with lower pole stones having lower stone-free rates.

The Lower Pole 1 Study randomized patients with lower pole stones with a mean diameter of 14mm to either ESWL or PCNL, noting higher stone-free rates among the group undergoing PCNL (95% vs 37%)[22]. The AUA guidelines panel therefore recommends that ESWL be offered to patients with kidney stones less than 2cm, and less than 1cm in the lower pole[12].

For ureteric stones, ESWL is a primary option along with ureteroscopy and while stone free-rates are lower with ureteroscopy, ESWL is carried out as a day case under sedation and has a lower side effect profile. Steinstrasse, a string of stone fragments blocking the ureter, may occur particularly after ESWL for larger stones but this does not usually require specific treatment unless it fails to resolve on its own[23].

Conclusion

As always, shared decision making is a central theme in helping patients to decide which surgical option is best. Procedures and complications should be discussed in as simple terms as possible. One should keep in mind stone size and location as well as patient body habitus and comorbidities when selecting optimal treatment modality. For example, the patient with a 1.5 cm obstructing kidney stone has all options open to him but was this patient anticoagulated he would probably be best treated by ureteroscopy given the potential risk of bleeding associated with PCNL or ESWL. A thin patient with a 1cm lower pole stone may be steered towards ESWL while a patient with a similar stone and a high BMI would be offered ureteroscopy instead, given the implications of an increased stone to skin distance on efficiency of ESWL. Similarly, a patient with a 1cm stone but whose stone is 1400HU may be offered ureteroscopy instead. These illustrate that, as is often the case, treatment should be individualized!

CME... cont'd

References

1. Croppi E, Cioppi F, Vitale C. The general practitioner and nephrolithiasis. Clinical Cases in Mineral and Bone Metabolism. 2008; 5: 145-8

2. Blandy JP, Singh M. The case for a more aggressive approach to staghorn stones. J Urol. 1976; 115: 505-6

3. Alsawi M, Amer T, Mariappan M, Nalagatla S, Ramsay A, Aboumarzouk O. Conservative management of staghorn stones. Annals of the Royal College of Surgeons of England. 2020; 102: 543-7

4. Morgan TN, Shahait M, Maganty A, Ost M, Jackman S, Averch T, et al. Conservative Management of Staghorn Calculi: When Is It Safe? J Endourol. 2018; 32: 541-5

5. Assimos D, Krambeck A, Miller NL, Monga M, Murad MH, Nelson CP, et al. Surgical Management of Stones: American Urological Association/Endourological Society Guideline, PART II. J Urol. 2016; 196: 1161–9.

6. Koh LT, Ng FC, Ng KK. Outcomes of long-term follow-up of patients with conservative management of asymptomatic renal calculi. BJU Int. 2012; 109: 622-25

7. Glowacki LS, Beecroft ML, Cook RJ, Pahl D, Churchill DN. The natural history of asymptomatic urolithiasis. J Urol. 1992 Feb;147(2):319-21. doi: 10.1016/s0022-5347(17)37225-7. PMID: 1732583.

8. Assimos D, Krambeck A, Miller N. Kidney Stones: Surgical Management Guideline - American Urological Association. American Urological Association. 2016. Available at https://www.auanet.org/guidelines/guidelines/kidney-stones-surgical-management-guideline

9. Perez Castro E, Osther PJS, Jinga V, Razvi H, Stravodimos KG, Parikh K, et al. Differences in ureteroscopic stone treatment and outcomes for distal, mid-, proximal, or multiple ureteral locations: The clinical research office of the endourological society ureteroscopy global study. Eur Urol. 2014; 66: 102-9

10. Pearle MS, Lingeman JE, Leveillee R, Kuo R, Preminger GM, Nadler RB, et al. Prospective Randomized Trial Comparing Shock Wave Lithotripsy and Ureteroscopy for Lower Pole Caliceal Calculi 1 cm or Less. J Urol. 2008; 173: 2005-9

11. Ho A, Sarmah P, Bres-Niewada E, Somani BK. Ureteroscopy for stone disease: Expanding roles in the modern era. Central European Journal of Urology. 2017; 70: 175-8

12. Geraghty R, Abourmarzouk O, Rai B, Biyani CS, Rukin NJ, Somani BK. Evidence for Urete-rorenoscopy and Laser Fragmentation (URSL) for Large Renal Stones in the Modern Era. Current Urology Reports. 2015; 16: 54

A full listing of the references can be obtained on request through a communication with the BAMP secretariat.

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CME UPDATE

HORMONE REPLACEMENT THERAPY (HRT) IN THE MENOPAUSAL YEARS

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Transition into the menopausal years is associated with change in many aspects of lifestyle, physical and mental health. Menopause affects all women and refers to the biological stage when periods stop and the ovaries lose their reproductive function. It is a retrospective diagnosis and is deemed to have occurred when menstrual periods have stopped for twelve consecutive months. Usually this occurs between the ages of 45 and 55 years, but in some cases women may become menopausal in their 30's or even younger. When this occurs in a woman whose age is less than 40 years, the patient is diagnosed as having Premature Ovarian Insufficiency (POI).

Every woman experiences menopause differently. Symptoms can last from a few months to several years and up to 80% of women experience physical and/or emotional symptoms during this time. These can include hot flushes and night sweats, tiredness and insomnia, joint and muscle aches, heart palpitations, mood swings, anxiety and depression, forgetfulness or lack of concentration, vaginal dryness, vulval irritation and discomfort, dyspareunia, decreased libido and urinary symptoms such as frequency, urgency and recurrent urinary tract infections. The latter symptoms are referred to as the genito-urinary syndrome of menopause (GSM).

Development of menopausal symptoms and alteration of a person's health risk profile can lead to anxiety and significant reduction in their quality of life. To this end, it is imperative that consultations are conducted in such a way that women are actively involved, as education, self-awareness, and self-directed decision- making all contribute to improved health outcomes. [1]

The results of the placebo-controlled randomised Women's Health Initiative (WHI) trial and observational Women's study (Million Women's study) in 2002 and 2003 respectively caused great anxiety, both among the medical profession and the greater public. [2,3] Worldwide, hormone replacement therapy (HRT) prescriptions fell dramatically and have remained low primarily due to concerns that the associated increased risk of breast cancer diagnosis is unacceptably high.

In the years since these trials, our knowledge regarding identification of suitable candidates for HRT, dosing options, routes of administration and benefit/risk ratios has grown considerably. The key to HRT is an individualised clinical approach - identifying those women in whom benefits of HRT substantially outweigh risks. The goal of the initial consultation is to form an understanding of the woman's symptom complex, how bothered she is by her symptoms and the impact on her quality of life. Consideration also needs to be given to her overall health status including psychological symptoms and concurrent medical conditions.

Risk of breast cancer

The available evidence supports a causal relationship between HRT and breast cancer. On the other hand, short-term use of combined estrogen-progestin therapy (less than four years if no prior use of estrogen) appears not to increase the risk of breast cancer significantly, although it may make mammographic detection more difficult. [4,5]

Unopposed estrogen did not increase the risk of breast cancer in the randomised Women's Health Initiative (WHI) (median duration of use 5.9 years)[2]. However, observational studies suggest increased risk with longer-term use >10-year duration [6].

The attributable risks of breast cancer for women in their 50s, the group most likely to take hormone therapy for menopausal symptoms, are very low [4]. In the Endocrine Society Clinical Practice Guideline, the estimated additional risk of breast cancer, based upon WHI data, was three additional cases per 1000 women for five years of combined conjugated estrogen-medroxyprogesterone acetate (MPA)

use. For five years of unopposed conjugated estrogen use, the estimated risk was 2.5 fewer cases.

The type of progestin may affect breast cancer risk. A synthetic progestin, MPA, was used in the WHI trial and was associated with excess breast cancer risk. Limited observational data suggest that natural micronised progesterone may not be associated with additional risk. [8]

Window of opportunity

In general, the benefit of HRT would exceed the risk in symptomatic women aged 50-59 or less than ten years after onset of menopause who have no contraindications to HRT and acceptable risks for both breast cancer and cardiovascular disease. [4]

This "window of opportunity" theory arose out of a 2007 secondary analysis of the WHI trial. Women who initiated hormone therapy closer to the menopause tended to have reduced coronary heart disease (CHD) risk compared with the increase in CHD risk among women more distant from menopause. [4]

Contraindications to HRT include:

1. Estrogen dependent malignant tumors
2. Undiagnosed vaginal bleeding
3. Pregnancy
4. Active liver disease with abnormal liver function
5. Active thromboembolic disorder or acute phase myocardial infarction

Conditions in which precaution should be exercised when prescribing HRT include:

1. Fibroids
2. Hypertension
3. Epilepsy
4. Migraines
5. Endometriosis
6. Personal/family history of Venous thromboembolism (VTE)/stroke
7. History of heart disease or recent cardiovascular event
8. Starting HRT in the over 60's
9. Family history of breast cancer

Investigations

In healthy women with menopausal symptoms aged over 45 years, there is no need to conduct any specific investigations. Plasma follicle stimulating hormone (FSH) levels should only be used to diagnose menopause in women aged 40-45 with menopausal symptoms including a change to their menstrual cycle, and in women aged less than 40 in whom menopause is suspected. [4]

It can be difficult to diagnose menopause in women who are using the combined pill or high dose progesterone contraception. FSH levels should not be performed in these women as it is unhelpful.

For women who are not on hormonal contraception, perimenopause can be diagnosed based on presence of vasomotor symptoms and oligomenorrhea and menopause can be diagnosed if they have not had a period for at least 12 months. In women who have had a hysterectomy, menopause can be diagnosed based on symptoms alone. [4]

The following are indications for investigations prior to HRT use:

1. Unexplained vaginal bleeding
2. Undiagnosed breast lump
3. Personal or family history of VTE/stroke
4. History of estrogen dependent cancer
5. Active liver disease
6. History of cardiac disease or recent cardiovascular event
7. POI
8. Complex medical history
9. Long term use of HRT in the over 60's

Choice of therapy: continuous combined vs sequential combined vs estrogen only:

Once the decision has been made to commence therapy, the clinician must decide which HRT to use, which route is preferable and which regimen is needed. This is determined by several factors: age and menopausal status, severity of menopausal symptoms, medical/family and social history, risk/benefit profile, patient preference and of course cost of medication.

CME UPDATE... cont'd

Once a woman has an intact uterus, progesterone is required to protect the endometrium from the unopposed effects of estrogen - notably endometrial hyperplasia and cancer. Postmenopausal women or women 54 years and older should be prescribed a continuous combined regimen. Peri-menopausal women (< 12 months of amenorrhea) are prescribed sequential combined therapy in which progesterone is given along for 12-14 days of each cycle to achieve a monthly bleed. With the latter therapy, consideration should be given to changing to a continuous combined regimen after 5 years; this is to ensure adequate protection of the endometrium.

Women who have had a hysterectomy only require estrogen, with the following exception: women whose indication for hysterectomy was endometriosis should have concomitant progesterone prescribed. Caution should be exhibited in women who have had a sub-total hysterectomy and progesterone may be needed in some cases.

Systemic vs local therapy:

Systemic therapy will be required for women who present with a wide range of symptoms. Local therapy is needed to treat the symptoms of GSM and can be used as a stand-alone or as an adjunct to systemic therapy if symptoms not resolved by systemic therapy alone. Vaginal estrogens have the advantage of minimal systemic absorption and minimal endometrial stimulation, hence endometrial protection with progestogen is unnecessary. Local therapy is available in tablet form (vagifem), cream and a ring such as Estring. The rings are convenient as they need to be changed every three months.

Oral Estrogen vs: Non-oral:

Patches and gels have several advantages over oral estrogens. They avoid first pass metabolism in the liver, have less effect on clotting factors and reduces triglyceride levels. These attributes make them a more favourable option for patients with liver disease, diabetes, or family history VTE. The risk associated with transdermal HRT given at standard therapeutic doses is no greater than baseline popu-lation risks. [4]

Choosing the progesterone:

One of the main factors for reduced compliance with HRT is that of progestogen intolerance. Side effects include symptoms of fluid retention, androgenic effects such as acne and hirsutism, and pre-menstrual like symptoms. Progesterone is available as a tablet or patch (mostly already combined with estrogen), vaginal pessary and also the Mirena intrauterine system (IUS) can be used to provide the progestogenic arm of HRT.

Generally, once a Mirena IUS is placed after age 45, there is no need to adhere to the five-year limit and it can stay in situ longer. However, if the Mirena is providing the progestogen component of HRT, it is imperative that it be replaced in 5 years.

Micronised progesterone has a more selective effect on progesterone receptors and result in less interaction with androgenic and mineralocorticoid receptors compared with other progestogens. It appears to be the optimal progestogen in terms of cardiovascular effects, blood pressure, VTE and possibly stroke and breast cancer. [8]

Bio-identical hormones

The term "bioidentical" means the hormones are chemically identical to those your body produces. However, the hormones in bioidentical medications may not be any different from those in traditional hormone therapy. More importantly there is no evidence to support that these hormones are more efficacious or have a better safety profile when compared to traditional hormone therapy. [4]

Follow-up

Women are usually reviewed at 6 weeks to assess symptom control and side effects. Thereafter, reviews are every 3-6 months until therapy is settled. Subsequent visits are then on a yearly basis to assess the needs and risk/benefit profile.

Conclusion:

The initiation of HRT is a safe option in healthy, symptomatic women who are within 10 years of menopause or younger

than age 60 years and who do not have contraindications to HRT. Estrogen-Progestin therapy should be used for women with a uterus and unopposed estrogen for those who have had a hysterectomy. Estrogen is also indicated for the management of GSM, however low dose vaginal estrogen should be used as opposed to systemic estrogen.

Both NICE [4] and NAMS (North American Menopause Society) [9] recommend that individualisation with shared decision making remains key, with periodic re-evaluations to determine an individual woman's benefit-risk profile.

References

1. Hoffman AS, Volk RJ, Saarimaki A, et al. Delivering patient decision aids on the Internet: definitions, theories, current evidence, and emerging research areas. BMC Med Inform Decis Mak 2013; (13 Suppl 2): S13.

2. Writing Group for the Women's Health Initiative Investigators. Risks and benefits of estrogen plus progestin in healthy postmenopausal women. JAMA 2002: 288: 321-333

3. Million Women Study Collaborators. Breast cancer and hormone replacement therapy in the Million Women Study. Lancet 2003: 362: 419-427

4. National Institute for Health and Care Excellence. Menopause: Clinical guideline – methods, evidence and recommendations (NG 23), version 1.5, www.nice.org.uk/guidance/ng23/evidence/full-guideline-559549261 (12 November 2015)

5. McTiernan A, Martin CF, Peck JD, et al. Estrogen-plus-progestin use and mammographic density in postmenopausal women: Women's Health Initiative randomized trial. J Natl Cancer Inst 2005; 97:1366.

6 .Chen WY, Manson JE, Hankinson SE, et al. Unopposed estrogen therapy and the risk of invasive breast cancer. Arch Intern Med 2006; 166:1027.

7. Stuenkel CA, Davis SR, Gompel A, et al. Treatment of Symptoms of the Menopause: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab 2015; 100:3975.

8. Fournier A, Berrino F, Clavel-Chapelon F. Unequal risks for breast cancer associated with different hormone replacement therapies: results from the E3N cohort study. Breast Cancer Res Treat 2008; 107:103.

9. The 2017 Hormone Therapy Position Statement of The North American Menopause Society. Meno-pause 2017; 24: 728-753

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HISTORY OF MEDICINE

RACE-BASED EXPERIMENTATION HAS MADE NON-WHITE COMMUNITIES WARY IN CLINICAL TRIALS AND MASS VACCINATION PROGRAMMES

Melissa Griffith
BHSc - First Class Honours

The Tuskegee Syphilis Trial remains one of the most notorious raced-based experiments which has left unhealed scars in the memories of non-white populations, especially the African American population. For forty years, beginning in 1932, the U.S Public Health Service conducted its study of "Syphilis in the Untreated Negro Male", in Macon County, Alabama [1]. The study aimed to assess the progression of syphilis in untreated black men and it was hoped that the results from the study would confirm the racist belief that the manifestation of the disease was somehow different in blacks when compared to whites. Approximately 600 poor sharecroppers, of which 399 had been infected with syphilis while 201 were uninfected by the disease and formed the control group, were enticed by free medical exams, free meals and burial insurance in order to encourage their participation in the study after being told that they had "bad blood" [2].

The participants were under the impression that they were receiving treatment for their condition which was not even explained fully to them. However, unbeknownst to them, they were being studied and even when penicillin in the 1940s was found to be effective for treating the disease, it was not administered to them. The participants underwent regular spinal taps and were given vitamins, arsenic and mercury salve which was more iatrogenic than curative but helped encourage the participants' belief that they were being treated [1]. As a result of the lack of treatment and therefore progression of the disease, between 28 and 100 men died [3]. Each death of a participant was an opportunity for the researchers to perform autopsies in order to determine the extent of damage caused by the venereal disease as it was thought to be detrimental to the cardiovascular system of the black man [1]. The study was brought to an end in 1972 after word of this ethically unjustified experiment surfaced in news articles [2].

Having given a brief background of the Tuskegee Syphilis Trial, this article will provide an historical background of which Black people in particular, have been the subjects of other racially motivated medical research in order to explain the wariness of non-white minorities regarding some aspects of the medical field. The writer will then proceed, with the use of examples, to shed light on the view that although minorities are hesitant towards participation in medical research, including clinical trials and mass vaccinations, they are not opposed to participating in these ventures. The latter part of this article will focus on the disparities in the participation of ethnic minorities in medical research and will suggest that this injustice occurs as a result of racism which still persists in the current medical healthcare system.

The Tuskegee study, for very valid reasons, has led to the Blacks community's mistrust of the medical field, especially when white medical professionals have been involved. The study serves as just one example that said community has used to justify the fact that their lives are of no value to the white society. This has been observed in the conviction of some Black people that the Acquired Immunodeficiency Virus (AIDS) was a form of genocide against their people [4]. Of the 1056 Black church members who responded to a 1990 survey conducted by the Southern Christian Leadership Conference, 34% believed that AIDS was a manmade virus and 35% believed that AIDS was a form of genocide [4]. This belief may have stemmed from the perception that the Tuskegee Trial was also a form of genocide, as some Blacks were under the impression that the men who were a part of the study had been intentionally infected with syphilis by the white researchers [5]. While the facts of the Tuskegee study may not have been accurate in this case, the paranoia experienced by Black prople is relevant especially from a historical context.

The root of the Black community's fear of 'white medicine' predates the Tuskegee Syphilis Trial. There has been a long history of race-based experimentation where members of non-white communities have been used as 'guinea pigs' in studies conducted by Whites, in order to support the view that the white race was superior to every other race. For example, in the antebellum period, medical theory was used to justify the appropriateness of Africans as slaves [5]. It was believed that in comparison to Whites, Africans had thicker skin and thus would be able to fear the rays of the sun [5]. It was also said, and in this case correctly so according to Gamble, that Africans had an immunity to diseases such as yellow fever and malaria and therefore working in environments such as mosquito-ridden swamps would not bring any harm to them [5].

The enslaved themselves were often used without their consent as subjects of European experimentation. One instance of this involved a Georgian physician by the name of Dr. Thomas Hamilton and his victim, an enslaved individual named Fed. Dr. Hamilton conducted a series of brutal experiments on Fed to test remedies for heatstroke in order to make an allowance for slave masters to be able to force the slaved to work still longer hours on the hottest days [5]. In the experiment, Fed was made to strip naked and sit on a stool which had been placed on a platform in a pit that had been heated to a high temperature. Only Fed's head was above the ground. Fed was placed in the pit five or six times over a period of two to three weeks and was given different medications in order to determine which one allowed him to tolerate the heat best. According to Gamble, each of these trials ended when Fed fell unconscious and had to be revived [5].

Although this experiment may not be well known by the general public it tells a similar story of underlying abuse which has been perpetuated in more well-known experiments, which more or less help to explain the wariness of minorities towards medical research. However, it must be noted that wariness does not equal unwillingness to participate in medical research as seen in two studies which will now be discussed.

Ever since its occurrence, the grave injustice of the Tuskegee Syphilis Trial has been linked to the wariness/hesitancy of non-white communities in participating in clinical trials and mass vaccination programs specifically. A study conducted via telephone and mail surveys between January 1998 and March 1999 among 179 African Americans and white residents of the Detroit Primary Metropolitan Statistical Area (PMSA) sought to confirm the association between knowledge of the Tuskegee Syphilis Trial and subsequent willingness to participate in medical research studies [6]. Eighty-one percent of the African Americans confirmed that they were aware of the Tuskegee Syphilis Trial compared to 28% of Whites [6].

According to Shavers et al., knowledge of the Tuskegee Syphilis Trial seemed to have an impact on persons' willingness to trust medical researchers as knowledge of the Tuskegee Syphilis Trial resulted in less trust in researchers for 50% of African Americans and 17% of Whites. In addition, 46% of African Americans and 34% of Whites indicated that their knowledge of the study would affect their future research participation decisions, so much so that of these persons, 49% of African Americans and 17% of Whites admitted their unwillingness to participate in future medical research studies [6]. It was concluded that it was not knowledge of the Tuskegee study which directly impacted the willingness of African Americans to participate in the study, but rather it was the distrust resulting from knowledge of the unethical study which resulted in the wariness of American Americans towards participation in medical research studies. Similar conclusions have been drawn from other studies as well [7,8].

The Tuskegee Legacy Project which was conducted among 353 Blacks, 157 Hispanics and 623 non-white Hispanics between March 1999 and November 2000, found that there was no association between knowledge of the Tuskegee Syphilis Trial and willingness to participate in biomedical research [9]. The study was conducted in four city/county areas, one of which included Tuskegee, Macon County, Alabama - the same location of the Tuskegee Syphilis Trial. The other findings of the study also indicated that there was no difference between the ethnic groups in self-reported willingness to participate in biomedical research. However, it was found that Black people were twice as likely as Whites to have a higher fear of participation in biomedical research. The conclusion can be drawn therefore, that although Black people admit to having a higher fear of participation in comparison to Whites, they are equally as likely as Whites in some cases, to be willing to participate in medical research [9].

HISTORY OF MEDICINE... cont'd

This is also being currently observed in the mass vaccination programs for the COVID-19 pandemic. It is being said by politicians, journalists, and health officials that the Tuskegee study is the reason for Black Americans' hesitancy towards receiving the coronavirus vaccine [10]. The question can be asked- why after 49 years after it was ended, is the Tuskegee Syphilis Trial still solely being used to justify minorities' lack of participation in medical research, especially after so many other injustices against these non-white communities have been committed since?

It has been proposed that perhaps the Tuskegee study is being used by authorities as a scapegoat to mask the medical racism which still exists today. According to Karen Lincoln, a professor of social work at the University of Southern California (USC) and founder of Advocates for African American elders, Black people, especially Black seniors are not against receiving the COVID-19 vaccine 10. In fact, when Lincoln queried Black seniors in Los Angeles about their willingness to receive the vaccine, the Tuskegee trial was hardly mentioned as a reason for persons' wariness to take the vaccine. Instead, according to Dembosky, Lincoln posits that persons made mention of "contemporary racism and barriers to healthcare...while it seems to be mainly academics and officials who are preoccupied with the history of Tuskegee" [10].

This lack of access to the vaccine is being reflected in the COVID-19 vaccination statistics. In California for example, only three percent of the total number of persons who have received the vaccine are Black, despite the fact that the COVID-19 death rate for Black people is six percent higher than the statewide COVID-19 mortality rate [11,12].

The same disparity is noted for the other minority races. For example, 19.6% of vaccines have been administered to the Hispanics for whom the death rate is 22% higher than statewide death rates in California [11,12]. According to the Centre for Disease Control (CDC) as of March 28, 2021, across the United States and among persons who have received at least one dose of the COVID-19 vaccine, 4.8% include Asians, 9.2 % include Hispanics and 8.2% include Blacks, compared to 66% which include Whites [13].

According to a report published on May 6th, 2021 by the Kaiser Family Foundation (KFF), as part of the KFF COVID-19 Vaccination Monitor, 55% of unvaccinated Black adults and 64% of Hispanic adults compared to 41% of White adults reported fear of having to miss work as a result of the possible side effects, if they were to take the vaccine [14]. According to the same report, more Black and Hispanic adults expressed concerns of having challenges travelling to vaccination sites in comparison to White adults [14].

Data collected from a study conducted by the University of Pittsburg School of Pharmacy identified 23 urban counties in states such as Georgia, Mississippi and Alabama, among others, where Black residents endured longer driving distances to vaccination centers when compared to White residents [15]. The statistics are therefore indicative of the fact that these access-related barriers must be removed so that more persons will be comfortable and willing to become vaccinated as according to Dembosky, inaccessibility to the vaccine is what sows seeds of mistrust [10].

Although the memory of the Tuskegee study still persists in the minds of Black people especially, it is also a case where minorities' personal experiences in the contemporary healthcare system give rise to mistrust of medical professionals [10]. There is no doubt that persons of colour experience mistreatment in the healthcare system as a result of their race. This mistreatment often comes in the form of healthcare providers' dismissal of the concerns of minorities. This was recently reiterated by a 'Facebook Live' video of an African American woman Dr. Susan Moore, who happened to be a geriatrician and a family medicine physician from Indiana, in the U.S [10]. Dr. Moore unfortunately, had contracted COVID-19 and had to be admitted to the hospital. She recounted in the video that she had had to plead with her (white) physician to continue her course of Remdesivir, the drug which is supposed to accelerate recovery from the disease. Her physician was of the opinion that she did not need the medication because she was not short of breath, to which Dr. Moore insisted that she was. Dr. Moore also maintained in the video that had she been White, she would not have experienced that which she did. Unfortunately, she died two weeks later after publicly bringing her circumstance to light [10].

It is this same disregard for and stereotypes about the Black body that explains why a White doctor would assume a Black female patient to be sexually promiscuous and subsequently

diagnose her with pelvic inflammatory disease after she complained of excruciating abdominal pain [5]. These racist experiences of Black people clearly contribute to their hesitancy toward White medical professionals.

In the case of the Black community especially, a recent development suggests that it has become easier for researchers to blame the Tuskegee trial than it is for them to go the extra mile to ensure that this population is included in medical research [10]. Researchers have become so accustomed to assuming that Blacks would be reluctant to participate in medical research that they seem to not even bother to invite them or other minorities to participate. This has been confirmed by a study of cardiovascular disease, the Coronary Artery Surgery Study (CASS) which commenced in 1973 and ended in 1996.

The CASS study offered recruitment to a total of 2,095 people, and of this number, 2,065 persons were non-Hispanic whites while only 30 persons represented minority groups [16]. Even though non-Hispanic whites were and continue to be the dominant ethnic group in the U.S, it was reported that the study ought to have enrolled approximately 356 persons from minority groups based on the 17% proportion of the U.S population which was occupied by minority groups at the time [16]. Furthermore, African Americans and Hispanics, in comparison to non-Hispanic whites, are disproportionately affected by angina pectoris which was the cardiovascular disease at the center of the study.

It is also worthy of noting that 43.3 % of individuals who were willing to participate in the study were from minority groups while 37.1 % of those persons who indicated their willingness to participate were non-Hispanic whites [16]. The study not only dispels the view that minorities are unwilling to participate in medical research but highlights the saddening fact that minorities are often not even invited to participate in medical research, especially that which concerns diseases which disproportionately affects them.

In conclusion, it has been seen that the Tuskegee Syphilis Trial does contribute to the wariness of non-white communities towards participating in medical research such as clinical trials and mass vaccination programs. However, the Tuskegee trial is not the sole contributor to this hesitancy. In order to grasp this, it takes not only considering historical instances of mistreatment against minorities, other than the Tuskegee study, but rather, it takes moving beyond the past and examining how the same racism which fuelled those unethical acts, still perpetuates in the present. It is time for medical professionals to desist from hiding behind the mask of Tuskegee, to excuse the low rates of ethnic minority participation in medical research and start taking responsibility by inviting persons from minority groups to participate in medical research and ensure that access to care is fair, on all playing fields, while taking into account the different needs that minorities may require in order to access care and in order to participate in medical research.

It is critical to understand that underrepresentation of minorities in medical research can have detrimental impacts on the health of minorities, as they are often disproportionately affected by a plethora of diseases when compared to other races. Therefore, the medical profession must acknowledge their role in the perpetuation of racism and ought to make an effort to build the trust of minorities and seek to ease their wariness through education and empathy. Medical professionals must also resist settling into the mindset that 'all hope is lost' as despite the fear, evidence of the willingness of minorities to participate in medical research does exist.

References

1. Washington HA. Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present. Harlem Moon; 2006.

2. Tuskegee Study - Timeline - CDC - NCHHSTP. Published December 10, 2020. Accessed March 25, 2021. https://www.cdc.gov/tuskegee/timeline.htm

3. Gamble VN. A legacy of distrust: African Americans and medical research. Am J Prev Med. 1993;9(6 Suppl):35-38.

4. Thomas SB, Quinn SC. The Tuskegee Syphilis Study, 1932 to 1972: implications for HIV education and AIDS risk education programs in the black community. Am J Public Health. 1991;81(11):1498-1505. Accessed March 29, 2021. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1405662/

HISTORY OF MEDICINE... cont'd

5. Gamble VN. Under the shadow of Tuskegee: African Americans and health care. Am J Public Health. 1997;87(11):1773-1778. Accessed March 29, 2021. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1381160/

6. Shavers VL, Lynch CF, Burmeister LF. Knowledge of the Tuskegee study and its impact on the willingness to participate in medical research studies. J Natl Med Assoc. 2000;92(12):563-572.

7. Roberson NL. Clinical trial participation: Viewpoints from racial/ethnic groups. Cancer. 1994;74(S9):2687-2691. doi:https://doi.org/10.1002/1097-0142(19941101)74:9+<2687::AID-CNCR2820741817>3.0.CO;2-B

8. Scharff DP, Mathews KJ, Jackson P, et al. More than Tuskegee: Understanding Mistrust about Research Participation. J Health Care Poor Underserved. 2010;21(3):879-897. doi:10.1353/hpu.0.0323

9. Katz RV, Russell SL, Kegeles SS, et al. The Tuskegee Legacy Project: Willingness of Minorities to Participate in Biomedical Research. J Health Care Poor Underserved. 2006;17(4):698-715. doi:10.1353/hpu.2006.0126

10. Dembosky A. Stop Blaming Tuskegee, Critics Say. It's Not An "Excuse" For Current Medical Racism. NPR.org. Accessed March 29, 2021. https://www.npr.org/sections/health-shots/2021/03/23/974059870/stop-blaming-tuskegee-critics-say-its-not-an-excuse-for-current-medical-racism

11. State of California. California's commitment to health equity. Accessed March 29, 2021. https://covid19.ca.gov/equity/

12. State of California. Vaccines. Accessed March 29, 2021. https://covid19.ca.gov/vaccines/

Additional references can be made available upon request from the secretariat at BAMP (info@bamp.org.bb)

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BAMP RECOMMENDATION FOR PRIORITIZATION OF PFIZER AND SINOPHARM VACCINES

BAMP makes the following recommendations for equitable disbursement of Sinopharm and Pfizer vaccines in Barbados.

1. Allow individual doctors' practices and group practices that want to give Sinopharm vaccinations, to be screened and approved by the Ministry of Health and Wellness (MHW) for participation in the national vaccine program

2. Persons who have non communicable disease and were registered previously for the initial vaccination programme or the home vaccination programme and did not yet receive a call should be offered Sinopharm or Pfizer vaccine first

3. Healthcare workers, particularly those in institutions, should be strongly encouraged to be vaccinated with their choice of vaccines or may be required to do so if this becomes national policy

4. Home caregivers for the elderly should be strongly encouraged to be vaccinated with their choice of vaccine

5. In accordance with the recommendations from our paediatricians, children between 12-18 years of age should be offered the Pfizer-BioNTech with the following prioritization of conditions:

    a. those who have chronic immunosuppression due to chemotherapy, diabetes mellitus, autoimmune diseases, primary immunodeficiency, HIV and immunosuppressive medication e.g long term steroid therapy

    b) those with other chronic illnesses: chronic lung diseases such as asthma and cystic fibrosis, hemoglobinopathies such as sickle cell disease, chronic kidney disease, genetic illnesses

    c. those living with adults that need to be shielded and are unable to take vaccines themselves

    d. those who have disabilities e.g. paralysis, hearing or sight impaired, mental disability, particularly those in day care or long-term care facilities

    e. those in correctional facilities should be offered the vaccine

    f. those attending university or schools overseas or are a part of sports teams who are traveling

    g. those entering tertiary educational institutions in Barbados (UWI, BCC etc.)

    h. all other children in this age group , at the discretion of the pediatric cohort of the medical community

6. Pregnant females and breastfeeding mothers, particularly those who are frontline workers may now be offered Pfizer-BionNTech vaccine.

BAMP Covid-19 Task Force
August 15, 2021

LETTER TO THE EDITOR

COVID-19 UPDATE AND THE NEED FOR VACCINATION

Dear Editor

This letter is written with the intention of making a special appeal to my colleagues. With the raging "co-epidemic" of vaccine hesitancy, vaccine fear, anti-vaccine conspiracy theories and fake news, I have been asked to present an update and evidence-based advice on the absolute necessity of getting vaccinated to prevent Covid from spreading, affecting our patients, our family and partners and everyone we care about as well as ourselves, and completely ruining the Bajan economy and social well being.

I am told that there are still a few hesitant doctors and a very distressingly large number of nurses at the QEH who have not been vaccinated. This is both surprising and frightening. So please, bear with me as I summarise a few facts, and if you HAVE been vaccinated, please discuss the facts with colleagues who are still a bit hesitant.

The facts

Did you know that breakthrough COVID-19 infections are rare in fully vaccinated people, and far less than the initial large trials suggested, now that they've been given to so many millions of people? In fact, more than 3.5 billion doses of Covid-19 vaccines have been given around the world, with more than 80 % in developed countries, where tracking has been most effective. The trials and post-development monitoring are the largest ever in modern therapeutic development.

Vaccines are highly effective at preventing infection, although none are 100% protective. Even when a rare break-through occurs, the vaccine is still overwhelmingly effective, preventing severe illness, and protecting people from needing to be hospitalized, or ventilated or dying.

What is very disturbing is that I'm told half of our QEH nurses haven't been vaccinated and not all of our doctors. This is surprising and dangerous, given the proven efficacy and only very, very rare possible serious side effects of the vaccine, not to mention the risks to health care workers, patients and families if not fully vaccinated. The Houston Methodist Hospital in Texas was the first to require staff to be vaccinated against Covid and 99 % of 26,000 health workers received their jabs. Other hospitals are following in droves, to protect health care workers AND patients. The French and British hospital trusts, care homes and others are following this lead.

Hospital leaders say it's not illegal for health-care institutions to mandate immunization. "As health-care workers, it's our sacred obligation to do whatever we can to protect our patients, who are the most vulnerable," the CEO of Houston Methodist told The Washington Post. "We proudly stand by our employees AND our mission to protect our patients."

The precedent for mandatory vaccination (especially for health workers) is the Massachussetts' Law of 1905, mandating vaccination for small pox, or payment of a substantial fine. The law was clear– the public good and the public health took precedence over the individual's "right to choose". With our slow take up of vaccines, with only a quarter of adults fully vaccinated, we're far, far away from the numbers needed to achieve herd immunity and emerge from the pandemic. With thousands of visitors now coming in, with the variants, we're in grave danger (pun intended)!

The much-hyped up clots (thrombi) have occurred at a rate of just over 300 in over 30 million Astra Zeneca vaccines, or one in a hundred thousand! The usual frequency of clots or thrombi in the adult population is a hundred times that, while the death rate from Covid is 3,000 in a hundred thousand or 3,000 times the theoretical, possible risk of a clot!

Meanwhile chronic or "Long Covid" affects more than one in ten patients with Covid, including those with mild symptoms. Long Covid patients suffer for three to six months or longer, with symptoms including severe long-lasting fatigue and malaise, brain fog, depression and suicidal thoughts, muscle and joint pains, sleep disturbances, migraines, chest pain, skin rashes, panic attacks and lasting damage to the heart, lungs and brain. Incapacitating fatigue may last six months or more.

So why would anyone risk not being vaccinated?

In Barbados immunisation in childhood and infancy eliminated all major infectious disease and saved thousands of lives, since the 1950s because more than 99 % of all Barbadians under 55 are fully immunised. How did this come

about? The wise public health doctors Sir Maurice Byer and Sir Frank Ramsey introduced mandatory immunisation of children for entry into primary school. The schedule is a complete one, starting with the DPT (for diphtheria, pertussis and tetanus) in infants at two months.

Diphtheria was a killer, but since the vaccine it virtually disappeared in short order, although it has recurred in unvaccinated children in South America. Pertussis or whooping cough was horribly infectious and debilitating. Schools often closed, as with Covid lockdown. Tetanus killed almost every victim. Tetanus toxoid was introduced a century ago, and virtually eliminated tetanus in the USA, except for a few cases in the unvaccinated. When I came home in '77 we had a desperately ill patient or a death almost every month, in older people not immunised. This no longer occurs.

Today our children are also protected from polio (which disabled Caribbean children in 1951), haemophilus, pneumococcus, measles, mumps, rubella, chicken pox and HPV, all of which conditions can be fatal. Measles was eliminated in the Caribbean, the first region in the world to achieve this. Outbreaks are recurring in unvaccinated children in the USA and South America. Rubella causes severe problems in unborn infants but it's now a threat of the past.

Our children are blessed by the multiple miracles of vaccination. So why are people playing Russian roulette with Covid? One of the many lies of anti-vaccinators is that the mortality rate is less than that of 'flu, and some lay people believe it. In fact, Covid's mortality rate is about 40 times greater than 'flu, much more in countries with poor health care; and 'flu rarely kills anyone but the very elderly. It's our role as health care professionals to explain the difference and counsel the public.

The word is also put out by strange or wicked people that the vaccine is a world plot to kill millions; or that it's a computer chip for "them" to control us! These propaganda, delusions or fixed false beliefs can only be held if there's a vacuum of information. To protect ourselves, our patients, our contacts, our partners and our family, save lives, save ourselves and long-term illness ("Long Covid"), we must all seek vaccination soonest, and urge our loved ones to. Follow the advice of Mavis Brathwaite on TV to Idalia, and don't let a "lil pain from a needle stop yuh from doin' the sensible thing".

Given the amazing success of all immunisations, including COVID-19, all health professionals should be leading the battle against Covid. The illogical, somewhat weird excuses "for waiting" include:

"Vaccination is a plot to kill millions."

"It's been developed too fast", non - scientists say, when thousands of scientists in scores of centres have worked all out with billions of dollars on a technology being worked with from many years already–a mammoth effort.

"It's really a chip to control you" say the deluded, and "It will alter your DNA and change you."

"It's not safe." Often repeated fake news, after a few score possible deaths from clots, compared to the ten-thousand-fold greater death rate from Covid!

"It's not properly tested and I'm not going to be a guinea pig", in spite of trials bigger than any other medical intervention in history, 3.5 billion doses given safely, and more than 40 million of the Astra Zeneca brand. Numerous experts have blasted claims that the vaccines are experimental, and emphasised that they are overwhelmingly safe. And with 75 years work with 15 plus vaccines, they simply don't produce long term problems!

And there's the simply unjustified: "It's my choice not to have it".

Clearly health workers who won't take the vaccine are not thinking seriously enough about patients' and families' safety. They can prolong the pandemic, the economic disaster, the suffering and the deaths indefinitely. We could be in the same place, with more lock downs, if we don't all play our part.

It's up to you!

The above letter was submitted as an open letter to all health care professionals, from Professor Emeritus Sir Henry Fraser

Bamp Council – 2020 - 2021

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CALENDAR OF EVENTS / NOTICES

BAMP CONTINIING MEDIAL EDUCATION SERIES

The BAMP will be hosting a series of CME presentations virtually
Commencing Saturday June 19th - October 16th, 2021
from 4:30 - 6pm

Register to obtain CME credits. More information to follow.

Instructions To Authors

The BAMP Journal is a publication of the Barbados Association of Medical Practitioners (BAMP). It is now effectively approaching its fifth decade of publication, having replaced the initial Newsletter of the Association, whose publication commenced in 1976.

The Editor is assisted by members of an Editorial Committee, chaired by the Public Relations Officer of BAMP Council, and is comprised of 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 Journal, 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 Journal, with appropriate reference.

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

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