No. 202 Aug-Sep 2020

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NOTES FROM
THE EDITOR'S DESK

COLORECTAL CANCER SCREENING

Twenty years ago, Barbados was shocked by the death of Malcolm Marshall due to colon cancer. Only 41 years old and widely regarded as one of the greatest cricketers ever, it was barely believable that he was cut down during the prime of his life. Fast forward to the present, we recently experienced similar emotions as Chadwick Boseman, the magnanimous star of Black Panther, succumbed to the same disease at the age of 43.

While, appropriately, there is a high level of awareness around prostate and breast cancer in Barbados, it seems that we (the medical community) have failed to bring the same level of attention to colorectal cancer. It is important that we do so for several reasons.

Firstly, screening reduces deaths due to colorectal cancer, is cost effective, and has adverse effects that are comparable with, if not smaller, than breast cancer screening.

Secondly, colorectal cancer is common in Barbados. It consistently ranks among the top 3 causes of cancer deaths among both men and women in Barbados.

What is perhaps most concerning, is that colorectal cancer screening remains poorly accessible for many Barbadians. Contributing factors can include the fact that physicians seldom recommend it, and patients often are unaware of it. Wait times for an appointment for a colonoscopy at the Queen Elizabeth Hospital are very long and the Gastroenterology Department is under-resourced.

The alternative option of seeking to have the investigation performed in the private sector, to reduce waiting time, can come with an estimated cost ranging varying between $1000 and $4000 in local currency and location. Realistically, this figure can be out of the budget range for a significant percentage of those in need of the investigation. Many health

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insurance policies do not provide any coverage for colorectal cancer screening. The result is that many individuals who are dependent on receiving care through the public sector, especially those of lower socioeconomic status, might not have the benefit of the much needed screening for colorectal cancer.

In the public sector, an outdated method of screening- the obsolete and unreliable faecal occult blood testing (FOBT) is rarely performed by Laboratories. The gold standard test for screening for colon cancer- the faecal immuno-chemical testing (FIT) is unavailable.

It is therefore essential for an accessible colorectal screening program to be established within the public sector. This would be no small feat, considering the economic hardships which the population has had to endure, however it is in the best interest of the public. It is highly recommend that government and QEH consider the following:

1. Establishment of a population-based screening program based on FIT, with referral for colonoscopy if a positive result is obtained. Prioritise access to colonoscopy for those with high risk for colorectal cancer and/or clinical features suggestive of colorectal pathology.

2. Capacity building is needed for oversubscribed existing GI service, through the employment of additional specialty trained staff and/or encouragement of existing personnel to pursue specialty training, to increase the throughput. This can enhance the much needed capacity for emergency, urgent and screening GI endoscopies.

3. A comprehensive campaign to educate both health professionals and the general public about colorectal cancer and the options for screening and prevention. Such screening tests ought to be covered by insurance companies.

It is strongly recommended that non-governmental organisations for example, the Barbados Cancer Society and Cancer Support Services can play an even greater role in promoting public education and awareness of colorectal cancer.

Both Malcolm Marshall and Chadwick Boseman leave rich legacies for us on which to reflect. It would be therefore fitting if we could harness the increased awareness of colorectal cancer, which their suffering has brought. There is a need to advocate for equitable and adequate access to screening for this often-preventable condition.

EDITORIAL... cont'd

PRESIDENT'S ADDRESS
BAMP AGM- JUNE 2020

Dr P Abdon DaSilva

Good afternoon colleagues. As advertised at last year's annual general meeting, this is my last hurrah as president of this august body.

Subsequent to that disclosure, an extensive study published in the New England Journal of Medicine found that the most productive age in human life is between 60-70 years. The second most productive is from 70-80. I believe therefore, that I chose wisely. And, in case you are wondering, the third most productive happens to be between 50 and 60.

I assumed this role four years ago, not with any arm wringing, but with what is perhaps better described as a great deal of persuasion by colleagues who shall remain anonymous. I wish at this time to thank them for having the confidence in me to lead this organisation, and for affording me the privilege to do so.

In my last address, I described the preceding year as a most arduous one. Yet, it pales in comparison to this one, and with the past six months, in particular.

I begin my address once more with "BAMP – the professional organisation."

Our current membership stands at two hundred and fourteen, representative of those in good financial standing, and exclusive of members who enjoy a non-paying status. A metric of our members points to a minority below age forty and a majority being older than fifty.

Notwithstanding the valiant, and sometimes not so valiant, efforts to recruit membership from among our younger population, the concept of collegiality continues to be elusive. More significantly is the association's need for members with a willingness to assume leadership roles and not just swell its numbers.

Our financial statement sadly currently reflects amounts receivable in excess of twenty thousand dollars with written-off membership fees of more than thirty-five thousand dollars, and whereas, I do not wish to encroach on the treasurer's territory, it would have been remiss of me to gloss over the issue.

In particular, our constitution speaks clearly to 're-eligibility' as follows: "No person who shall have been a member of the Association and ceased to be such shall be eligible for re-admission until he shall have paid arrears of subscription (if any) due from him to the Association as determined by the Council." We none the less, have been flippant in this regard over the years.

The fact that monies had to be borrowed from the CME account to meet our financial needs earlier this year, is a testimony to the fact, that this approach to receivable sums, must be addressed in earnest. This is an issue that should be brought to bear during the deliberations on any fee adjustment at this meeting.

Meetings with the QEH Board:

Previously scheduled quarterly meetings of members of Council with those of the Board of Management of the QEH, have whittled with time due to cancellations on their part. The last meeting is noteworthy, in that it was prompted on our part to seek clarity on the deployment of one of our members – a junior doctor at the Queen Elizabeth Hospital who had been required to work at the Paragon Facility that housed COVID-19 patients under quarantine. Only then were we made aware of an Amendment to the QEH Act which had taken place a few days earlier.

Under this amendment, the Board of Management of the hospital had annexed the facility at Paragon, the Blackman-Gollop Primary School, and the Harrison Point facility that was to be retrofitted, for use as isolation centres. In addition, a section of the Sparman Clinic had been earmarked for additional capacity on a needs-basis, and there was ongoing negotiation for use of the MD Alliance Surgery and Birthing Centre as an obstetric facility, as well as that of Premier Surgical Centre, for services. At the time, the Enmore facility was also being made operational to house Covid-19 patients who would require management in a tertiary level institution. The Board of Management had already been given a mandate to keep the Queen Elizabeth Hospital Covid-free as a dictate of national policy. Consequently, the Accident and Emergency Department was in the process of reconfiguring its triage system to separate patients with respiratory type symptoms from those presenting with other disorders. This gave rise to a satellite unit designated as the Clinical Decision Unit. This 24hr unit was designated to serve as a testing and holding site for patients who presented to the QEH and required screening for COVID-19.

More recently, members would have received a copy of correspondence from the QEH Board of Management with respect to its proposed Online Registration System for Patient Appointments. Your feedback on this important development is encouraged.

Covid-19:

On December 31, 2019 Chinese officials in Wuhan in China's central Hubei province confirmed dozens of cases of pneumonia from an unknown cause. On January 7, 2020 the outbreak was identified as a new coronavirus.

On February, 11 2020, WHO announced that the disease caused by the new coronavirus will be known by the official name of COVID-19.

On January 30, 2020, WHO declared the outbreak a global public health emergency and on March 11, 2020 declared COVID-19 a pandemic.

On March 17, 2020 the Minister of Health and Wellness announced "Barbados today confirmed its first two cases of Covid-19."

I have deliberately detailed the timeline, if only to inform you that BAMP had been requesting of the Minister of Health and Wellness to have a 'seat at the table' in preparation for the pandemic from its outset in January of this year.

When it became clear that BAMP's overtures were not likely to be met by the Ministry of Health and Wellness, BAMP's Council thought it appropriate and timely to communicate our disappointment at the exclusion of BAMP from the national effort to deal with the crisis.

A letter to the Honourable Prime Minister was met with success in securing a seat at the table of the Emergency Operations Committee (EOC) at the Ministry of Health and Wellness, and a call from the Director of Medical Services at the Queen Elizabeth Hospital requesting someone from BAMP to serve as a point-person between the Hospital and the Association. This was followed by a surprising and unexpected call from the Health Care Finance Commissioner of the Ministry of Health and Wellness, advising of the Ministry's willingness to assist BAMP members in securing PPEs.

To say I was dismayed by the response to my announcement of these developments to BAMP's Covid-19 Task Force, is putting it lightly.

The Task Force to which I refer was created as a sub-committee following an emergency meeting of BAMP's Council and its wider membership. The sub-committee currently comprises Drs Lynda Williams, Tanya Sargeant and Shari Goring as co-chairs, and its membership has grown in leaps and bounds over time. Additionally, Dr Williams serves as our sole representative on the EOC, from whom the Council has had no feedback.

We are all aware of the efforts of the Task Force, the Council has repeatedly commended the Task Force for its invaluable work to date, and I wish to do so once more today, on your behalf.

CME:

The BAMP/UWI CME Conference scheduled for May 16-17 and postponed due to Covid-19 social distancing protocols is presently being reformatted and will now take the form

EDITORIAL... cont'd

of several on line events during the remainder of the year. During all such CME events, Multiple Choice Questions (MCQs) will be posted and must be answered by each attendee to qualify, in order to receive his/her credits.

The requirement for at least five of the annual twenty credits to be a 'face to face' type event has been brought to the attention of the Barbados Medical Council, and whereas there has been no formal response to date, the suspension of that requirement for the remainder of the year is likely.

Dr Kim Quimby has almost completed the task at hand, and I would like to thank her most sincerely for her hallmark dedication and commitment to the CME Conferences over the years. I wish also to thank the CME Committee for making this activity possible.

BAMP Bulletin:

Without fanfare, the last edition of the Bulletin signaled the significant milestone of being the two hundredth issue and the first virtual publication exclusive of a hard copy version. Coincidentally, with it came a suggestion from Professor Sir Henry Fraser for a renaming of the Bulletin to that of the BAMP Journal.

BAMPs Council has already approved the name change and the Bulletin Committee is in the exploratory phase of its progression to the status of a peer review journal.

Unfortunately, the emergence of a virtual publication still carries with it a recurrent expenditure of twenty-five hundred dollars in web design costs per edition, and the perennial challenge of meeting those costs through advertisements. I wish at this time to thank Professor Anne St. John for her diligent pursuits over the many years in seeking and obtaining the much desired and welcome funding.

I also wish to thank Dr Damian Best for his dedication in maintaining BAMP's virtual entity, as well as the members of the Bulletin Committee who willingly give of their time and expertise to the cause.

BAMP -The Trade Union:

This year marks the fortieth anniversary of BAMP as a trade union as it continues its affiliation with the Congress of Trade Unions and Staff Associations (CTUSAB). CTUSAB also celebrates its milestone of twenty-five years as a congress. It is noteworthy that BAMP is one of its founding members.

Regrettably we have been found wanting in our responses to requests from that organisation for input on issues such as the most recent Draft Flexible Working Arrangements Policy to which there was a singular response. Another important issue was Polygraph Testing in the Workplace that had previously generated only one response.

These issues are of national importance with far-reaching implications and deserve a more concerted effort and wider response from amongst our members.

In the fore-front of national discourse within recent times has been the Barbados Optional Saving Scheme under the acronym BOSS.

BAMP's membership within the Congress afforded members the opportunity to attend a meeting on June 2, 2020 at the Garfield Sobers Gymnasium in person, or via the Zoom platform.

I can only attest to the physical presence of a handful of members, and presume that others had a virtual connection, permission for attendance having been secured by BAMP for its members employed at the Queen Elizabeth Hospital, Psychiatric Hospital, Polyclinics and other health care facilities.

Members have since been provided with a copy of the recent legislation and should have wisely exercised their options by now.

Members would also have received a document from CTUSAB asking for members of the entire trade union movement to adhere to trade union procedures, practices and protocols as outlined therein. It is an important and timely reminder for us all.

Internationally, BAMP has etched its name on the pages of history in being part of an International Labour Organization and Public Services International pilot study on pay equity.

I wish to thank Dr Brian MacLachlan for his role in this landmark event.

Other matters:

On many occasions, members have been asked to provide feedback to Council on issues of national significance among which included input to the Joint Committee on the Medicinal Cannabis Bill 2019. In order to save face, BAMP's submission was made with the benefit of input from only a few of its members. None the less, I am pleased to report that some of its recommendations have been incorporated into the Bill. The Senate passed the Medicinal Cannabis Industry Bill at close to midnight on November 27th 2019, two weeks after it won approval in the House of Assembly. The law mandates the creation of the Barbados Medicinal Cannabis Licensing Authority, which will develop regulations to govern the industry.

The Barbados Medicinal Cannabis Licensing Authority has sought input on the proposed Bill that will provide for the regulation of the handling of medicinal cannabis in Barbados, the establishment of a Barbados Medicinal Cannabis Licensing Authority, a Barbados Medicinal Cannabis Licensing Board, and a Barbados Medicinal Cannabis License Appeals Tribunal, the issuing of licences for the handling of medicinal cannabis, and related matters. Regrettably, any further contribution on our part fell victim to the Covid-19 pandemic.

It is my understanding that the regulations are being drafted and a window of opportunity remains for input from the entire membership by way of a virtual meeting with the Authority has been proposed. This is likely to take place in the near future.

I must also refer to a request for input from members for submission to the Law Reform Commission. The Law Revision and Law Reform Act, 2017 made provision to repeal and replace the Law Revision Act to, inter-alia, make provision for the review and reform of the laws by a Law Reform Commission.

The Commission is expected to provide advice and information to ministries and departments of the government and other authorities which are concerned with proposals for the amendment or reform of any branch of law.

Unfortunately, the response from members once more fell disappointingly short of desirable. I am none the less reminded that "in all things it is better to hope than to despair" and urge you to add your voice while there is still time to do so.

Time does not however permit me to list all other missed opportunities for members to contribute to the national conversation. BAMP is not about its president, nor is it about its Council. Rather, it is a collective of its members. On a more positive note, BAMP was instrumental in ensuring that all members were able to register before the January 31st deadline through engagement with the Minister of Health and Wellness.

BAMP was also able to engage the Minister of Health and Wellness on the burgeoning demand on the consultant staff of the Psychiatric Hospital for evaluation of persons on remand prior to trial. The senior consultant has reliably informed BAMP that this is no longer an issue. Unfortunately, just when discussions on the timely payment of salaries and gratuities for our members at the Polyclinics and the Psychiatric Hospital were beginning to make headway, the Ministry of Health and Wellness became subsumed by the Covid-19 pandemic. In a similar vein, discussion on issues surrounding the functioning of the Barbados Medical Council became a victim of the crisis.

I am impressed by the seriousness with which the Minister has approached these issues and with his promise to a resolution. I encourage the incoming Council to pursue these matters as soon as the "Covid-storm" passes.

Finally, there are two important issues that are worthy of mention; the first is an ongoing effort to develop guidance on Driving Safely and Fitness to Drive. This initiative was the brainchild of Dr Dawn Grosvenor and has garnered the interest of the Barbados Licensing Authority. I wish to thank Dr Karen Springer and her subcommittee for undertaking this monumental task.

The second is the contentious issue surrounding bearer's notes. The pharmacists have deemed this practice, as one

EDITORIAL... cont'd

that is contrary to patient safety and are determined to bring it to an end. Physicians on the other hand, maintain that it serves as a cost-saving service to patients. At a recent meeting, the Minister of Health and Wellness seemed resolute on addressing the issue and has set up a subcommittee that includes the Director of the Barbados Drug Service, members of the Pharmacy Council, the Medical Council, members of the Pharmacy Owners Association and members of the Barbados Association of Medical Practitioners. The subcommittee has been given three weeks in which to come up with a pragmatic working solution to be presented to the Minister for furtherance to Cabinet.

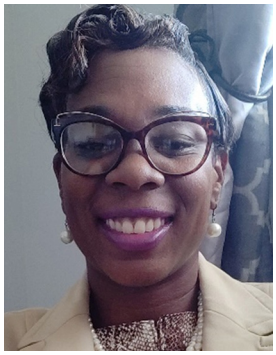
I humbly submit that the pervasive echo from members that 'BAMP does nothing for me' is an absolute falsehood.

In closing, I wish to thank my Council for its support through good and bad times and Ms. Phillips and Millar for skillfully managing the affairs of the Association, whilst appreciating that functioning in their jobs have not been the easiest at times.

I must acknowledge their willingness to keep the business of BAMP going during the time that other trade union offices were closed due to Covid-19 mandates, and for which no amount of gratitude can suffice.

I therefore wish the incoming Council and BAMP a bountiful success, and leave you with a few words from the Spanish painter Salvador Dali from which I draw comfort "do not be afraid of perfection – you will never attain it."
I thank you for listening.

MENTAL HEALTH AND COVID-19



Dr. Cheriann Catwell
MB.BS DM (UWI) Psychiatry

The coronavirus (Covid-19) pandemic has negatively affected the physical and mental health of many people worldwide, with long-term implications for public health. After the Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV-2) pandemic in 2003, there were documented increased levels of stress which persisted for up to two years[1]. This pandemic has created an additional stressor for persons already suffering from pre-existing mental disorders. Use of adaptive coping skills will be important for the preservation of good mental health during this time. Covid-19 risks affect people in a number of ways. In this article, we will discuss the impact of Covid-19 on the population, specific groups at risk of psychological distress, and the influence of resilience during this time, and useful coping skills anyone can implement.

Physically, Covid-19 generates uncertainty around the prognoses of coronavirus infection. Socially, the implementation of abrupt, unfamiliar public health measures that infringe on personal freedom can be provocative and difficult to enforce. Financially, many people have incurred significant losses.[2]. Politically, a paucity of resources for testing and management of the coronavirus is disconcerting, and inconsistent and conflicting advice from authorities is confusing for lay persons and health professionals alike. Psychologically, increased substance use and emotional distress (sadness, anxiety, irritability, feeling overwhelmed) are frequent sequalae.[3] It is clear that Covid-19 perpetuates psychological distress due to the multiplicity of influences in many domains of functioning. This thereby increases the risk of psychiatric illness associated with Covid-19 in persons with and without preexisting mental health disorders.

Typically, an individual coping with stress in a healthy way will make the community stronger. An individual's ability to respond to stress during this, and any significant world event depends on the individual's socio-economic background, social support system, and psychological health. Specific groups may be at particular risks of mental health concerns during this pandemic, given their everyday stressful reality. These groups of people include: those who are at increased risk for severe Covid-19 infection, those under 18 years, caregivers, frontline workers, who have existing mental illness, those with disabilities and anyone who contracts Covid-19 disease.[4] Prevention efforts may range from mental health screening, psycho-education, and psychosocial support for vulnerable groups, as they are at risk of adverse psychological outcomes. Despite this, it is perhaps comforting that research has found that most people are resilient and do not succumb to emotional distress after disasters.[5]

Many people are being forced to find new and more effective ways to cope. For example, with SARS-CoV-2, psychosocial support was far more effective when provided in the context of trusted pre-existing relationships.[6] Fostering individual resilience is important because it mitigates the distress associated with significant traumatic events.[7] Psychological First Aid (PFA) is an evidence-based approach to facilitating resilience immediately after trauma.[8]

Psychological First Aid employs the 'RAPID model'. The acronym represents five[5] principles: Reflective listening, Assessment of needs, Prioritisation, Intervention and Disposition. PFA has been found to be especially helpful in critical incidents including pandemics. The advantages of this model include: promoting personal and community resilience, mitigating acute distress and dysfunction, prioritising psychological/behavioral crisis reactions,[9] and differentiating benign, non-capacitating psychological behavioral crisis reactions from potentially more severe incapacitating crisis reactions.[10] Importantly, this model does not pathologise people who are stressed by extraordinary events. Instead, it assumes that those who are stressed are capable of resilience and are able to determine if they need or do not need further assistance.[11]

The Psychiatric Department of the Queen Elizabeth Hospital implemented this RAPID model to help frontline hospital workers to support others, and also to enhance their own individual resilience. Importantly, any healthcare worker can

learn PFA without any prior mental health education. Thus, PFA can help our communities to mitigate psychological distress.

What can you as an individual do to cope during the Covid-19 pandemic?

- Focus on things to reduce your personal risk by following recommendations from health authorities viz. physical distancing, use of a face mask, frequent handwashing.
- Stay connected especially, even though physically isolated. Talk to people you trust and who do not increase your fears. Contact your friends and family if you feel overwhelmed, or approach a mental health professional.
- Develop a new routine. Ensure you have adequate rest and exercise. Find a hobby.
- Stay well informed by listening to credible media sources but limit unnecessary media exposure to reduce anxiety levels.
- Be kind to yourself and others. Find ways of expressing compassion and kindness to others, such as helping persons in your community who may be vulnerable.
- Eat wholesome meals. Eat small portions of food frequently. Include fruits and vegetables and at least 2 litres of water daily.

What can you, as a healthcare professional, do to help your patients cope during the Covid-19 pandemic?

- Watch for psychological distress in your patients, especially those in high risk groups.
- Refer patients to a psychiatrist or psychologist if deemed necessary.
- Educate patients on the need to follow government protocols for social distancing and nose and mouth cover.
- Suggest ways to connect virtually with loved ones.

Conclusion

The Covid-19 pandemic, like the SARS-CoV-2 pandemic, has alarming implications for an individual's overall health and psychosocial wellbeing. Healthcare providers and governmental organisations involved in planning and advocating for resources for managing the Covid-19 virus must promote psychological support for the broad community, including patients, the general public and health care providers. We advocate building and maintaining resilience during the pandemic in order to min-imise psychological distress. This is especially important in groups at high risk. Historical experience has provided valuable lessons regarding what to expect and how we can best manage the community's overall psychosocial health. Therefore healthcare professionals have a critical role to play in order to (1) manage their own stress and (2) help patients and colleagues to manage their stress as well.

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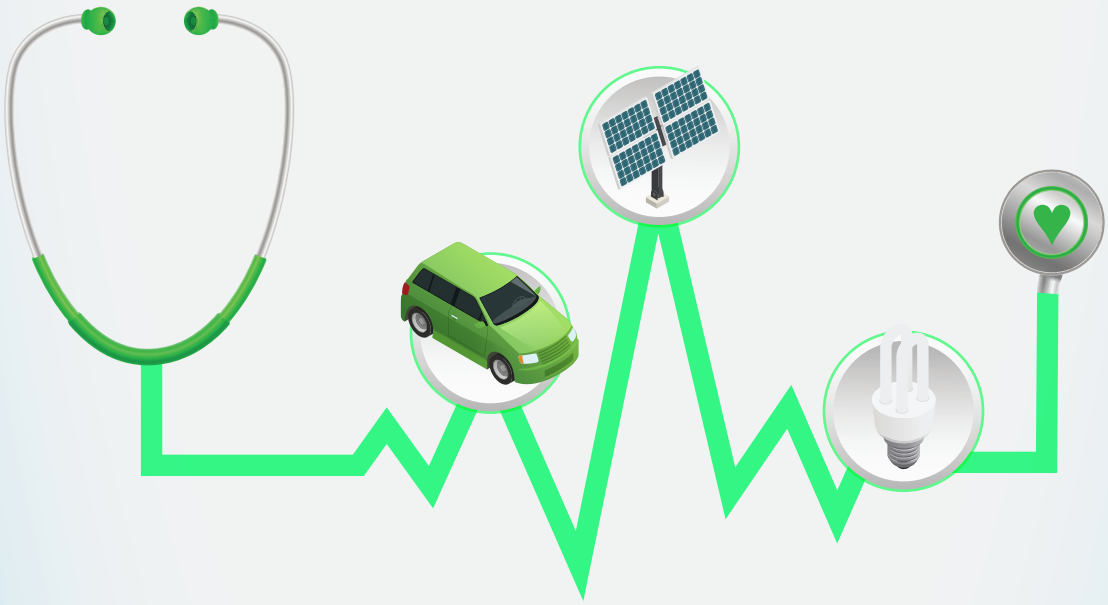

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COMMENTARY

QUARANTINE AFTER TRAVEL DURING THE COVID-19 PANDEMIC

Dr Joseph Herbert
MB. BS DM
Family Practice

The United States Centers for Disease Control and Prevention (CDC) recommends 14 days of quarantine and symptoms monitoring following travel from another country where COVID-19 transmission is high or increasing [1]. Several other countries, including Canada and Australia have this as a requirement [2,3] while others have closed their borders [4].

This 14-day period is based on the suspected incubation period of the virus, which includes the period of time between contracting the virus and becoming symptomatic. A systematic review and meta-analysis published in July 2020 found mean & median incubation to be 5.8 days (95% CI 5.0-6.7) and 5.1 days (95% CI 4.5-5.8) respectively, with 95% of persons demonstrating symptoms by 11.7 days (95% CI 9.7-14.2) after exposure [5]. A more recent study with a larger sample size, found the mean and median incubation period to be 8.3 days (95% CI 7.7-8.9) and 7.8 days (95% CI 7.0-8.5) respectively, with 90% of persons demonstrating symptoms by 14.3 days (95% CI 13.6-14.9) and 99% by 20.3 days (95% CI 19.2-21.3) after exposure [6].

Essentially, a 14-day period of quarantine after exposure allows for recognition of the large majority of symptomatic cases of COVID-19. In contrast, approximately half of cases which become symptomatic will be a high probability of being 'missed' if there is a quarantine period of 7 days, in the absence of the addition of reverse transcriptase PCR (RT-PCR) testing (Figures 1 & 2).

Furthermore, COVID-19 can be transmitted by asymptomatic persons (infected but never develops symptoms) and pre-symptomatic persons [7]. Current scientific evidence reveals that the peak period of infectivity of the virus is thought to occur prior to the onset of symptoms. However, there has been significant uncertainty regarding the degree to which these modes of transmission have contributed to the spread of the pandemic [8]. Transmission after 7-10 days of illness seems to be unlikely for immunocompetent patients with mild symptoms. [8].

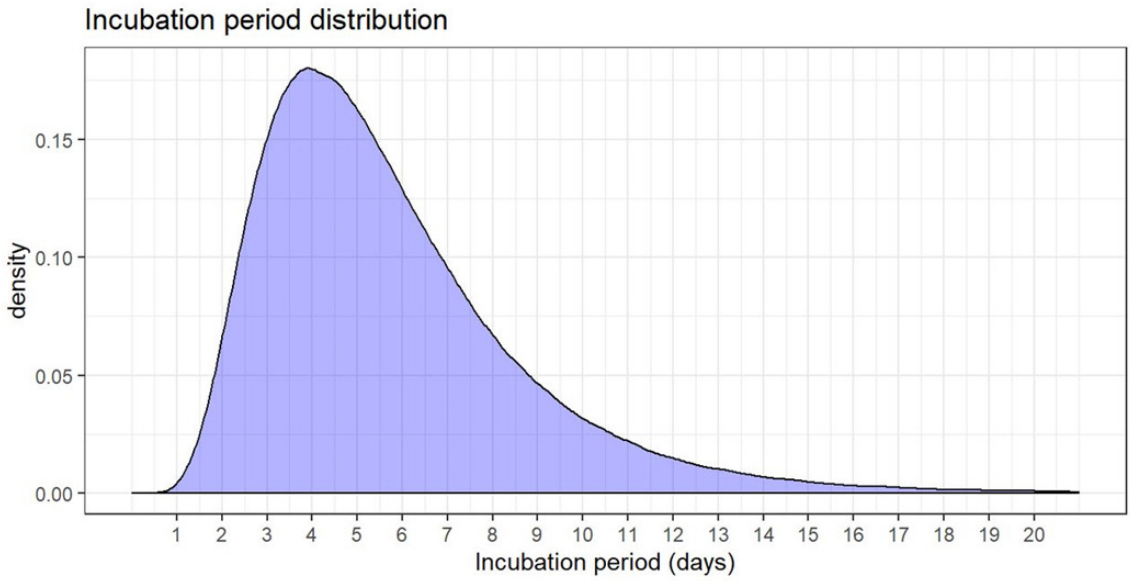

Figure 1: Probability density function of the pooled lognormal distribution of reported incubation period from meta-analysis by McAloon et al.[5]

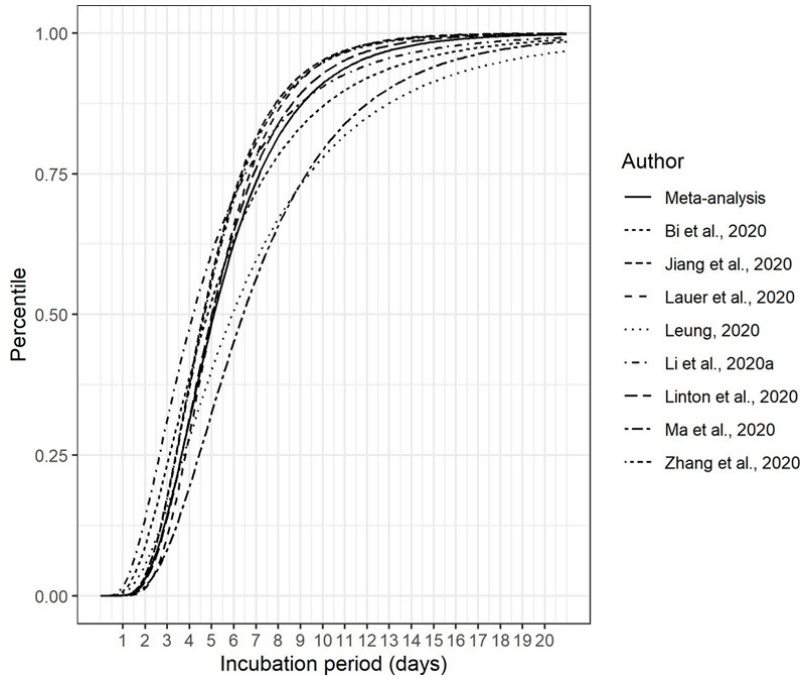

Figure 2. Cumulative distribution function of pooled lognormal distribution for incubation period and original input studies from meta-analysis by McAloon et al. [5]

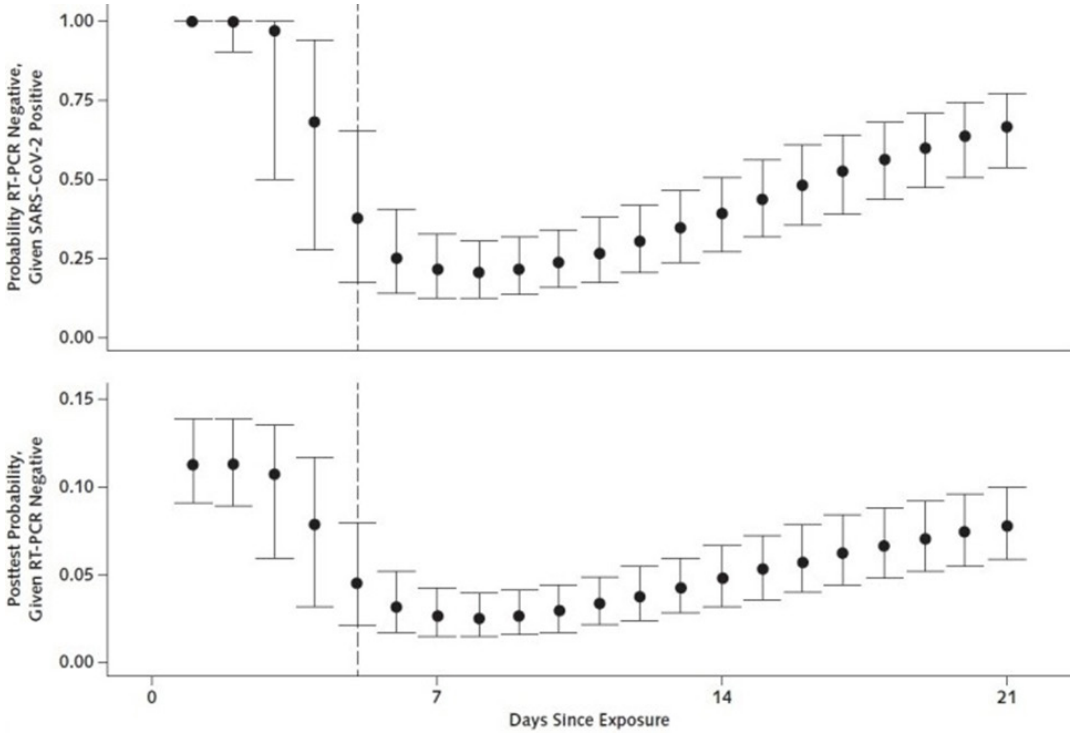

Figure 3. Probability of having a negative RT-PCR test result given SARS-CoV-2 infection (top) and of being infected with SARS-CoV-2 after a negative RT-PCR test result (bottom), by days since exposure [9]

SPECIAL ARTICLE... cont'd

In order to balance economic considerations with efforts at preventing local transmission of COVID-19, some countries, including Barbados, have implemented RT-PCR testing to allow a waiver or shortening of the quarantine period. The timing of such a test may be immediately prior to travel, on arrival, and at variable times after arrival. Some protocols utilise multiple tests.

It is important to recognise that there is a significant false negative rate associated with COVID-19 testing, even when using the gold-standard RT-PCR method as employed in Barbados. This false negative rate is 38% (CI 18% to 65%) at day 5 post-exposure, and lowest when testing at day 8 post-exposure (Figure 3) with an estimated false negative rate of 20% (CI 13% to 31%)[9].

A non-peer reviewed modelling study published by a team at the London School of Hygiene and Tropical Medicine examined the effectiveness of several permutations of quarantine and testing measures applied to travellers entering the United Kingdom[10]. The researchers found that a quarantine period of eight days on arrival with RT-PCR on day-7 (with a one day delay for test results) can reduce the number of infectious arrivals released into the community by approximately 94%, when compared with no quarantine or testing. This reduction is similar to the 99% reduction achieved by the 14-day quarantine period.

The findings also revealed that using a strategy in which travellers spend at least 5 days in quarantine, have a test on day 5 with release on day 6, resulted in a median 88% reduction in transmission potential. It follows that a strategy with any shorter quarantine and interval between arrival and testing, such as what is contained the current Barbados Travel Protocols, has the potential to result in a higher risk to those who can be exposed in the community.

The protocol published 24 September 2020, states that travellers from high risk countries will be allowed to leave quarantine on the basis of a negative test done 4-5 days after the last test accepted by the Ministry of Health and Wellness. This suggests that a person who was tested 72 hours before travel, who presents a negative test result on arrival, would be able to leave quarantine in as little as 1 to 2 days after arrival in Barbados.

It may be argued that a negative test performed 72 hours prior to travel may help to partially mitigate this risk. However, it must be recognised that among travellers within this cohort who contract COVID-19 in the 3 days before travel, at least 50% will remain asymptomatic at the end of their 1-2 day quarantine[5,6,] and 38% (CI, 18% to 65%) will have a false negative test [9]. The alarming implication is that 9-33% of these cases will be allowed to leave quarantine, and this is at a stage of the disease when they are most likely to be infectious[5-9]. These are precisely the cases which we cannot afford to miss!

Conclusion

It appears than the quarantine measures described in the September 24th edition of the Barbados Travel Protocols for passengers arriving from high risk countries with negative tests done 72 hours prior to travel, might well have the potential to fail to detect and contain a significant proportion of recently-infected pre-symptomatic cases of COVID-19.

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RESEARCH

DOCTOR OF MEDICINE IN INTERNAL MEDICINE AT THE UNIVERSITY OF THE WEST INDIES, CAVE HILL- 1988-2018

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Introduction

"The aim of the D.M. in Internal Medicine is to train doctors in the specialty of Internal Medicine to a level that allows them to provide clinical and academic leadership, and administrative support to their respective Medicine Departments. Successful D.M. candidates will practice at the level of consultants in General Internal Medicine." [1]

The quote above is taken from the post-graduate handbook of the Cave Hill campus[1] of the University of the West Indies (UWI). The Doctor of Medicine (DM) in Internal Medicine at Cave Hill is a 4-year residency programme divided into two parts. DM part 1 comprises the first 2-years during which the resident is expected to acquire the core knowledge and skills that would enable him/her to function as a medical registrar. The third year of the programme is the elective/research year, during which the resident can undertake an elective of up to 12 months and is expected to complete a research project. In the fourth and final year, the resident rotates through general internal medicine again and is expected to play a greater role in supervising junior residents, interns and teaching medical students. At the end of the fourth year, provided that a clinical research project has been completed and accepted, the resident is expected to sit the DM part 2 examination. Successful acceptance of the research project and passing of all compo-nents of the Part 2 examination is necessary for the awarding of DM degree in Internal Medicine.

Current DM regulations allow for two attempts at each part of the exam along with the requirement for withdrawal if any component is failed twice. Admission to the programme provides that the resident is a junior doctor post in the Department of Internal Medicine at the Queen Elizabeth Hospital, Barbados.

In 1971, the first candidate in the DM programme in Internal Medicine, entered the programme at the Cave Hill Campus. However, this attempt was short-lived, as the candidate transferred to the Mona campus. In 1994, the first candidates to graduated from the DM Internal Medicine programme at the Cave Hill Campus.

This paper will examine the programme at the Cave Hill campus from 1988 until 2018 and seek to explore whether or not the stated mandate has been met by posing the following questions:

1. How successful has the programme been in training doctors to the required level?

2. Are the doctors who have been trained providing clinical and academic leadership par-ticularly in service to the public?

Methods

Information on enrolment of DM candidates was obtained from records of the department of Internal Medicine at the Queen Elizabeth Hospital.

Inclusion criteria:

1. Individuals who enrolled in the DM Internal Medicine from July 1st 1988 until June 30th 2018 and

2. Whose predominant course of study was based at Cave Hill campus and

3. For whom a definite conclusion of outcome could be made

Exclusion criteria:

1. Individuals who were still enrolled in the programme on July 1st 2018

2. Individuals who were not expected to complete DM Internal Medicine having been required to take only part 1 as part of another programme (eg DM Haematology).

Outcomes are defined as:

1. Completed - individuals who have been awarded the degree of DM Internal Medicine from the Cave Hill campus.

2. Voluntary withdrawal - individuals who entered the programme, who were not required by regulations to withdraw but who could not be awarded the degree because of voluntary withdrawal.

3. Required to withdraw- individuals who were required by regulations to withdraw having not fulfilled the requirements either for progressing from part 1 to part 2, or for being awarded the degree.

Results

Fifty-four (54) physicians were enrolled between 1988 and 2018, 6 were enrolled on July 1st 2018, and 48 met the criteria for inclusion. Of the 48 included in the analysis, 26 (54%) were female and 22 (46%) were male). Twenty-six (26) persons (54% of those who enrolled) completed the programme, 17 (35%) voluntarily withdrew while 5 (11%) were required to withdraw (Figure1).

Of the 31 enrollees who did not withdraw voluntarily, 26 completed the programme, giving a pass rate of 84%.

Of the 26 who graduated from the programme 14 were female (54%) and 12 were male (46%). (Figure 2)

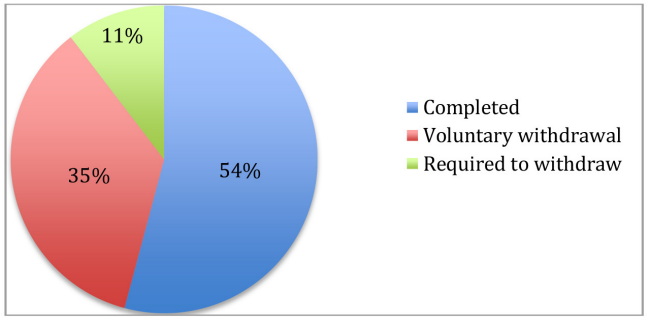


Figure 1- Outcome of enrolled candidates

Origins of enrollees and graduates

Of the 48 candidates who enrolled, 33 (69 %) were of Barbadian origin, 8 (17%) were from other Caribbean Islands, while 5 (10%) were from outside of the Caribbean region. Of the 26 persons who completed the programme, 19 (73%) were from Barbados, 4 (15%) were from other Caribbean islands, while 3 (12%) were from outside of the Caribbean (Figure 2).

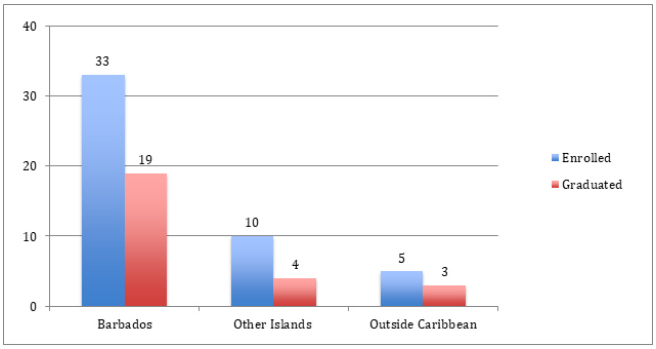


Figure 2: Origins of enrolled and graduates

Country/region of practice of graduates in 2018

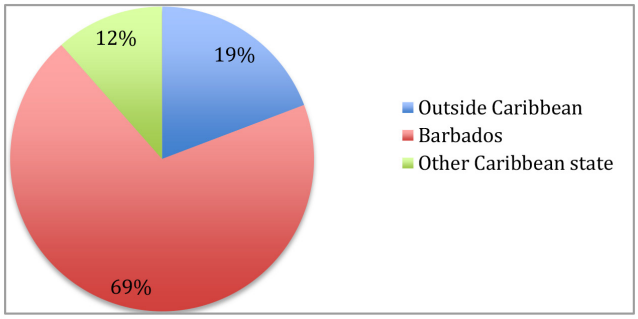


Figure 3: Country/region of practice

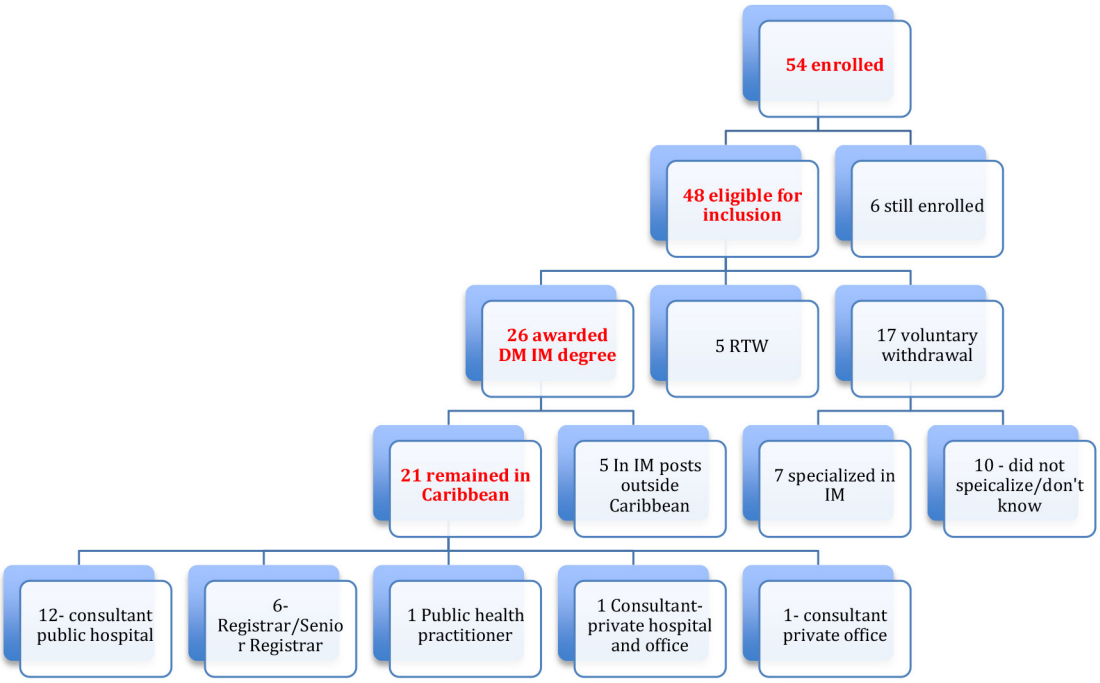
Twenty-one (21) out of 26 (81% of graduates) were practicing in the Caribbean- 18 out of the 26 (69% of graduates) were practicing in Barbados, while 3 out of 26 (12% of graduates) were prac-ticing in another Caribbean island, and 5 out of 26 (19%) were practicing outside of the region. (Figure 3).

Type of posts held by graduates working in Caribbean

18 out of 21 graduates who remained in the Caribbean were working in a public hospital. In the capacity of 12 being consultants, and 6 being senior registrars. One had completed a further qualification, and was a public health practitioner. Therefore, 19 out of the 21 were in some sort of public service post.

RESEARCH... cont'd

Overview



Discussion

This paper posed two main questions:

(i) how successful has the DM Internal Medicine programme at Cave Hill been and
(ii) to what extent were the graduates serving the Caribbean region.

Of the candidates who chose to remain in the programme (31) there was a pass rate of 84%. However, with the fairly high voluntary withdrawal rate of 35%, the overall completion rate was only 54%, which is disappointing. There were 16 out of 21 (76%) individuals who did not complete their training comprised and this was due to voluntary withdrawals. The reason behind these voluntary withdrawals could be instructive and is worthy of further analysis.

With respect to the second question, of the persons who did complete the programme, 81% have chosen to remain in the Caribbean. This retention rate is impressive and suggests that the mandate of providing specialist clinicians services for the Caribbean is being fulfilled. It is even more impressive that the vast majority is providing service in a public institution. A further look at this however, reveals that as many as 69% of graduates were working in Barbados with only 12% serving other Caribbean islands, whilst 19% were working outside the Caribbean region. This result is in itself not surprising, given that 69% of the persons who enrolled and 73% of the graduates were of Barbadian origin. Of the 21 who were practicing in the Caribbean, only 3 were practicing outside of Barbados. Whilst the majority of the graduates were practicing in Barbados, there were actually more graduates practicing outside the Caribbean region (5), than serving in other Caribbean islands (3).

The Cave Hill Campus has traditionally served Barbados and the Windward and Leeward Eastern Caribbean (EC) islands. The small representation of Eastern Caribbean (EC) graduates might therefore suggest an unmet need. One plausible explanation for this, lies in the requirement of the programme that the candidate secure a post at the Queen Elizabeth Hospital. Whilst this hospital functions as a teaching hospital for the Faculty of Medical Sciences at the Cave Hill Campus, it is not a university-owned hospital, and employment for physicians must follow Barbadian

employment regulations in Barbados, which requires that before a post can be given to a non-Barbadian, it must be proven that there is no suitable Barbadian to fill the post.

It is not surprising therefore that such a high percentage of enrollees and graduates are of Barbadian origin. However, when looking at those physicians enrolled, 5 were from outside the region. The fact that they were able to secure a post might suggest that at the time there were possibly no applicants or no suitable applicants from the EC Caribbean islands. Further analysis of the numbers of EC applicants who are unable to obtain places due to lack of posts would be instructive, in answering whether or not there is the need for additional training places. If that is the case, then solutions need to be found to solve this vexing issue.

In conclusion, the DM programme in Internal Medicine at Cave Hill seems to have a had moderate success, as reflected in a completion rate of 54%. A high percentage of graduates are in service to the Caribbean although this is mostly to Barbados. Further research is needed to explore whether or not the needs of the rest of the Eastern Caribbean are being met and if not, so-lutions need to be found to improve access to those underserved islands.

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HYPERTENSION: ARE WE STILL UNDER PRESSURE?

Dr. C.V. Alert
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Family Physician

"Do you know where you're going to?
Do you like the things that life is showing you?
Where are you going to, do you know?"

Diana Ross, the Theme from the motion picture - Mahogany.

In 1995, a study entitled the International Collaborative Study of Hypertension in Blacks (ICSHIB) was undertaken, using blood pressure cut-off measurement of 160/95 mmHg. A prevalence of over 21.5% was established for hypertension in adult Barbadians aged 25 years and above. Out of these, 58% of the patients receiving treatment were controlled[1].
Twenty years later, in 2015, another study called the Health of the Nation Study (HotN), of adult Barbadians aged 25 years and over, but this time as undertaken, notably using a cut-off measurement, this time of 140/90 mmHg, found the prevalence of hypertension was 42%. Of those who were on treatment, 58% were controlled .[2]

During a period of 20 years, the prevalence of hypertension in the Barbadian population had doubled. Can we afford to leave this trend to continue unchecked? If you are concerned about the health of our people, (as Diana Ross asks) "do you like the things that life is showing you"? Interestingly, the same percentage of patients with hypertension (58%) who achieved control of their blood pressure remained unchanged – by definition this is clinical inertia.

During the intervening years, the Faculty Medical Sciences Department, at the UWI Cave Hill Campus, was established in Barbados (in 2008), mandatory Continuous Medical Education (CME) was introduced for physicians (2012), the Caribbean Public Health Agency (CARPHA) introduced new guidelines for the "Primary Care Management of Hypertension in the Caribbean Community", and the Barbados National Formulary (BNF) list contained a fairly wide range of free anti-hypertensive drugs for patients.

Of note, this range was significantly reduced in 2018, as the Government's economic realities took priority over health

COMMENTARY... cont'd

considerations, so today, physicians have a shorter list of free antihypertensive drugs to offer to patients, and the system is interrupted by frequent shortages.

The Caribbean Public Health Agency (CARPHA), introduced new guidelines for the "Primary Care Management of Hypertension in the Caribbean Community " in 2005, with an announcement to upgrade them in 2014. Yet, in spite of these developments the data revealed that physicians are not doing any better in managing the blood pressure of their patients, while the number of patients needing care is increasing.

It is likely that similar trends have occurred in other Caribbean islands, as hypertension and the other non-communicable diseases (NCDs) remain unchecked in our populations.

Let us look at age standardised death rates from hypertension in selected Caribbean islands (Figure 1):

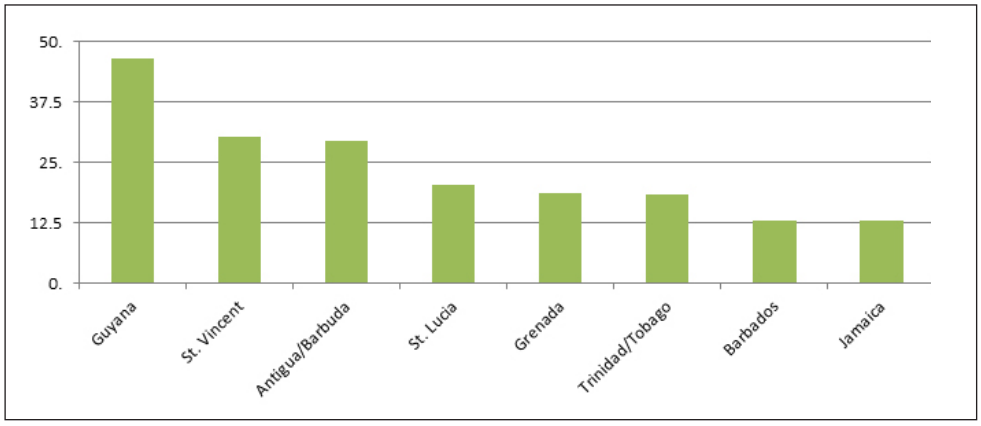

Figure 1. Age standardised Hypertension Death Rates, per 100,000 persons 3 .

There is almost a 4-fold difference in the age standardised death rates across the Caribbean , with Guyana (46.53, as the high point, and Jamaica 12.8) doing better than the other Caribbean countries. Since Caribbean decision makers usually choose particular statistics that 'suit-them' at any particular point in time, the health decision makers choose to hold on to data that suggests, that, the rates in Barbados are 'no worse' than other Caribbean islands. The findings of ICSHIB and HotN can easily be ignored. Therefore, there is no national plan to improve the outcome for patients living with hypertension in Barbados.

How do we compare internationally?

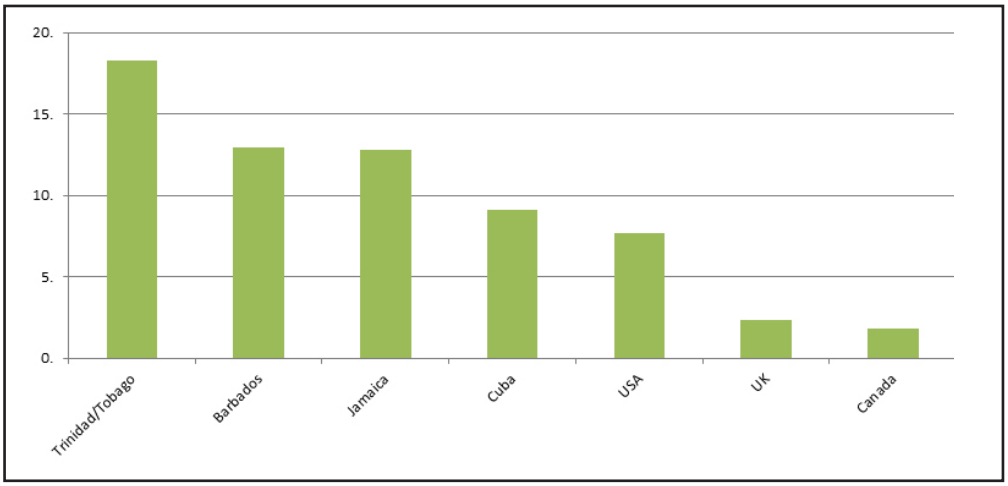

Figure 2: Standardised hypertension death rates, per 100000 persons 4.

BNF. Increasing numbers of NCD patients only places increased pressure on national budgets. Primary prevention of the NCDs also potentially reduces the number of patients who go on to develop the expensive complications of the NCDs, requiring a need of cardiac suites, stroke units, CT scans, MRIs, dialysis units and other expensive interventions, to keep them going, often at high taxpayer costs and with little evidence of cost effectiveness.

The Standardised Hypertension treatment protocol is in circulation in Barbados, and the subsequent introduction of the HEARTS technical package – is available for adoption.[8] The adoption has taken place within some polyclinics, but needs to be more widely disseminated. Suggested The old adage: "an ounce of prevention is better (and certainly cheaper) than a pound of cure" holds true here.

In the series of declarations that followed the 2007 conference "Uniting to stop the epidemic of the NCDs", Caribbean Heads of Government supported inter-sectoral collaboration, so Ministries of Education, Sport, Agriculture and Finance would join the Ministry of Health and Wellness in initiating programs for Caribbean people's 'wellness'. Whilst the annual "Caribbean Wellness Day" [September 8th] was one such initiative, we need much more collaboration and many more Ministries to participate in keeping our people healthy. We need this collaboration so primary prevention programs can be introduced as a matter of urgency.

Going forward, as Covid-19 threatens to dictate the physician-patient interactions, it has been suggested that tele-health and telemedicine can 'step up to the wicket'. Already a few patients have smart watches that can measure blood pressures, pulses, recognise abnormal cardiac rhythms, and even monitor calories consumed and calories burned on a daily basis. While computers, smart phones and other electronic devices are becoming more popular within our population, and there are sophisticated apps which can photograph retinas and scan urines, it is unknown what proportion of our patients, especially those who rely on free public health care, can actually utilise these features.

The source of training for patients and health care workers to utilise these specific features, also has to be identified. For some time we have been encouraging patients to do self-monitoring of blood glucose levels (SMBGs) and blood pressures (SMBPs). We will soon have to include waist circumferences (or other obesity measurements), and lipid profiles, as well as analysing urines. Meanwhile, our government officials will have to step up to the plate to pass appropriate laws to facilitate telemedicine, and our insurance companies have to come to the party to allow our few fee-paying patients to be reimbursed for their medical charges. The government would also be expected to set up the infrastructure in the free government clinics to facilitate telemedicine, all of this at a time when Covid-19 has both siphoned off significant portion of health resources, and is constricting the ability of our countries to affect quick economic turnarounds.

I reiterate the words of Sr. George Alleyne in 2005, to the effect that we need an "urgent and sustained response" to deal with the alarming increase in chronic non-communicable diseases". Hypertension guidelines can help with improving the management of hypertension in individual patients. However, in the Caribbean, while a focus on the individual tree is important, we must bear in mind that we are also dealing with a forest. In the forest, we seem to be lost, or realistically speaking, do we know where we're going to?

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CME ARTICLE

A PHYSICIAN'S GUIDE TO COLORECTAL CANCER SCREENING IN BARBADOS

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Colorectal cancer is the second leading cause of cancer death for both men and women in Barbados.[1] However many of these deaths are preventable with screening. Based on our understanding of the adenoma-carcinoma sequence - a polyp takes an average of ten years to transform into a malignancy - there are a variety of cost-effective options for colorectal screening that not only allow for early detection of cancer, but also detection and excision of polyps prior to malignant transformation.[2] Preventative health expert bodies rank colorectal screening among the most impactful clinical interventions.[3]

In spite of this, Barbados has no national colorectal cancer screening program. Faecal immuno-chemical testing (FIT) is not available in the public sector. The wait time for routine screening colonoscopy at the QEH is approximately 12 months, and reflects an under-resourced gastroenterology service. The implication is that patients with suspicious symptoms, such as rectal bleeding, a positive FIT or faecal occult blood test (FOBT), or a change in bowel habit, are obliged to wait for similar period of time for an appointment, unless the GP makes direct contact with the gastroenterologist, to facilitate an earlier appointment or the patient presents to the hospital with an emergency.

Many local health insurance plans do not include colorectal screening as part of the preventative care coverage. Cost remains a major barrier for many in Barbados. For example, while locally available stool-based testing (FIT-M2PK or 3 consecutive FOBT) costs between $105-140 per year. If such screening tests are positive, a patient who is given a lengthy appointment for an colonoscopy, might have little alternative but to wait as health deteriorates or to find the funds ranging a thousand to four thousand dollars to access a colonoscopy in the private sector if the screening tests is positive.

There are also physician-related barriers. A recent cross sectional survey amongst local physicians, demonstrated that many of us are unlikely to discuss colorectal screening with patients, are more likely to prioritise other types of cancer screening such as mammography and PSA.[4] It appears that many physicians are unaware that the expert consensus is that colorectal screening is in fact, a more impactful screening intervention, with a more favourable balance of potential benefits versus harm.

The net result is that when the Barbadian public has very limited awareness or knowledge of colorectal cancer screening. Anecdotal evidence suggests that most eligible patients have either never heard of colorectal screening or that it has never been offered to them. Most are unaware of the various screening options. However, it is also our experience that once recommended, many will chose to be screened, in spite of the barriers described above.

Eligibility

For average risk patients, most expert bodies recommend routine screening between the ages of 50-75.[2] The screening interval for this patient group varies according to method.

The US Multisociety Task Force on Colorectal Cancer recommends that African-Americans commence screening at age 45.[5] There is no randomised controlled trial to support

this, but it is based on modelling data and a higher incidence of early-onset disease in the black population.[5]

In contrast, a more recent guideline for UK patients recommended estimating 15 year risk of colorectal cancer using the online QCancer tool, and only offering screening to those with risk >3%.6 African-Caribbean race is one of the parameters included in the calculator.

Most patients with a family history of colorectal cancer or high risk polyp in a first degree relative should start screening at age 40, or 10 years before the relative's age of diagnosis, whichever is earlier.[7] Colonoscopy is the preferred method in high risk patients, and is typically offered at a greater frequency than those of average risk.[7] However there are several genetic syndromes, such as Lynch Syndrome and Familial Adenomatous Polyposis that warrant even earlier and more frequent screening, as does Ulcerative Colitis.[2] Likewise, patients with a personal history of colorectal cancer or high-risk polyp require more frequent screening.[2]

Locally-available screening options

Colonoscopy: For an average-risk patient, this is performed every 10 years until age 75.[2,5] Sensitivity and specificity approach are near 100%. It is considered the gold-standard given its high sensitivity (95%) for both cancer and adenomatous polyps >1cm.[8] It allows tissue diagnosis at the same time as screening, and allows early detection and removal of pre-cancerous polyps. Disadvantages include high cost (several thousand dollars), the discomfort of bowel prep with polyethylene glycol starting the day prior, approximately 1:1000 chance of perforation or significant haemorrhage (risk varies according to patient characteristics such as age), and the risks and inconvenience associated with sedation.[8]

Sigmoidoscopy: For average risk patients, this may be performed every 5-10 years. Sedation is not required, risk of bowel injury is lower than colonoscopy, and bowel prep is less onerous (typically laxative or enema a few hours prior). Sensitivity is significantly lower than colonoscopy given that right-sided tumors are common and these will not be visualised.[8] To mitigate this, there is also the option of combining this method with FIT or high sensitivity guaic-based FOBT (gFOBT).[2,5]

FIT-M2PK: Though FIT is not available locally as a stand-alone test, one local private laboratory offers a novel combination of FIT with a test for dimeric M2PK, a pyruvate kinase isoenzyme which is over-expresseed by adenocarcinoma and high grade dysplasia within the colon. A walnut-sized stool sample should be collected and delivered to the lab within a day. The sample should not come into contact with the toilet bowel or water: initial collection into a clean plastic container or several sheets of newspaper stretched across the toilet bowl is suggested, with subsequent transfer into the typical blue-top sample bottles filled at least half-way.

Used alone, annual FIT is a well established strategy for colon screening with methods ranging in sensitivity from 73-88% (superior to gFOBT) & specificity from 90-96% (equivalent to gFOBT).[9] A 2012 metanalysis estimated that M2PK has a sensitivity of 80% and specificity of 95% for colorectal cancer, based on two published meta-analyses.[10,11] Referral for colonoscopy is recommended if either test is positive.

High Sensitivity gFOBT: This requires collection of samples from three consecutive bowel movements. Referral for colonoscopy is recommended if any sample is positive for blood.[2] Because the assay isn't specific for human haemoglobin, a patient may be asked to avoid red meat and vitamin C supplementation for three days prior to the first sample.[8] NSAIDs may also be held from seven days prior.

CT Colonography: This recently became available at Queen Elizabeth Hospital. This method is typically performed every 5 years, and requires preparation similar to colonoscopy but no sedation.[2,8] Sensitivity for cancer and high-risk adenomas approaches that for colonoscopy, though patients will require a follow up endoscopy for confirmation.[8]

Other approaches

Multi-target stool DNA testing (Cologuard FIT-DNA test) is another recognised screening method that is not available locally, but is recommended as either a first or second-line option in international guidelines. [2,8]

Although still used by some in Barbados, double-contrast barium enema is no longer recommended due to its limited sensitivity and specificity, and should be avoided as a screening tool given the availability of superior options.[8]

Carcinoembryonic antigen (CEA) is also not recommended as a screening tool, but rather functions as a marker used in follow up of patients following treatment of colorectal cancer.[8]

Summary of Recommendations for Physicians in Barbados

Primary care physicians should elicit a past medical history and family history from every new adult patient with the aim of determining risk for colorectal cancer. Patients who are deemed to be of average risk, should be offered screening between the ages of 50 and 75, although it is reasonable to offer Afro-Caribbean patients the option of starting at age 45. Appropriate locally-available options include colonoscopy every 10 years, or stool-based screening tests annually (Ie FIT-M2PK on a single stool sample). Screening strategies for high-risk patients differ and early specialist consultation is advised.

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CONTINUING MEDICAL EDUCTION (CME) DURING COVID-19

Dr Kim R Quimby
MBBS, PhD, Cert Medical Leadership.

During 2020, when preparations were in progress for the annual Continuing Medical Education (CME) Conference in May 2020, the CME Committee was cognisant of the fact that COVID-19 was marching across the globe and would inevitably reach the shoes of Barbados. It was obvious that similar measures, which had occurred in other countries who followed the World Health Organisation's (WHO) guidelines and restrictions which included a ban on mass gatherings, would be enforced on the island. This came into effect in Barbados on the 28th March 2020 when the government instituted a 'work from home' curfew for all non-essential services following the detection of first 2 cases of COVID-19 on the island, on the 17th of March.

Despite these restrictions, the CME committee was determined to continue its service because:

1) There was a tsunami of new information to share regarding COVID-19
(2) There were still educational needs outside of COVID-19, and we felt a responsibility to offer options
(3) There was no indication that the credit criteria for yearly re-registration would be lessened or nullified.

In working through this, several areas needed to be navigated:

1. Determination of which online platform was to be used such as:
   (a) TouchNet is a service administrated through the Bursary of The University of the West Indies (UWI). It allows for a seamlessly integrated system, as registration and payment are completed via a single online portal; and links to the webinars are sent by email immediately following payment. https://secure.touchnet.net/C24201_ustores/web/store_main.jsp?STOREID=3

   (b) Zoom Webinar which is managed by the Information Technology (IT) department at The UWI is the professional alternative to Zoom meetings. It provides differential access portals for speakers and delegates, which allows greater control over noise and camera interference while still allowing for adequate interchange of information and a robust question and answer segment.

2. **Determination of interest and availability:**
   A survey was circulated to investigate the preferred days and times for online activities and also the topics of interest. Feedback indicated that the majority of persons preferred the evenings on weekends. The committee determined that in the given senario, truncated 2hr blocks may be better than longer blocks. Offering shorter blocks offer a greater degree of flexibility and allow participants to pay for only those blocks in which they are interested. The blocks are short enough to facilitate persons to remain engaged.

   A variety of topics were submitted and during the following weeks, the committee organised these topics into blocks and reached out to local, regional and international colleagues to fill the Faculty spots (see the programme) for presentations.

3. **Allocation of CME credits:**
   During the meeting with the Barbados Medical Council representatives, and it was determined that the same 1 CME credit per hour would be offered for attendance in Online sessions, similar to what was offered for attendance in previous face to face meetings.

To date, 6 blocks have been completed. Feedback indicates that these sessions were well organised and were useful for clinical practice.

CME ARTICLE... cont'd

As the CME Committee looks towards the future, we have to reconsider the format of the forthcoming that CMEs will take.

Are persons more amenable to online education?

Can this format support the camaraderie, social interactions and spontaneity that is evoked by in-person events?

In keeping with a similar vein to other organisations, CME can be offered as a hybrid approach with online meetings for more instructional sessions and small group in-person meetings for practical sessions. The Committee looks forward to colleagues' input on this.

It is hoped that the CME Committee has fulfilled its task of delivering a high-calibre online experience for medical practicioners during the COVID-19 era, and the the CME committee members look forward to in the expected role of continuing to provide service in the future.

Table: CME schedule for 2020

Sunday 19th June	**Special Considerations: during COVID-19**
4:00 p.m.	COVID complications and ICU management
4:30 p.m	Rx of acute Asthma without nebulisation
5:00 p.m.	Office safety
5:30 p.m.	CPR
Sunday 2nd August	**Mental Health**
4:00 p.m.	Peri-partum mental health
4:30 p.m.	Menopause and Mental Health
5:00 p.m.	Always on: working during crisis
5:30 p.m.	Psychosocial effects on physicians and patients during COVID (inc stigma in recovered patients?
Saturday 15th August	**Substance use and misuse**
4:30 p.m.	Drugs in sports
5:00 p.m.	Cannabis and Mental Health
5:30 p.m.	Management options in substance abuse disorders
6:00 p.m.	Vaping
Saturday 29th August	**In the General Practice Office**
4:30 p.m.	Practical exercises in interpreting ECGs
5:00 p.m.	GP case #1
5:30 p.m.	Vitamins, minerals and herbal supplements
6:00 p.m.	GP case #2
Sunday 13th Sept.	**Neurology**
4:00 p.m.	Neuropathic pain
4:30 p.m.	Alzheimer's
5:00 p.m.	Parkinson's
5:30 p.m.	EEG, EMGs and other neurological investigations

Sunday 27th Sept.	**Gynaecology**
4:00 p.m.	Management of the infertile couple
4:30 p.m.	Traditional management of menopause
5:00 p.m.	Alternative management of menopause
5:30 p.m.	Cx cancers: HPV, vaccination, interpreting PAP smears
Saturday 10th Oct.	**In the OPD**
4:30 p.m.	Rheumatology Case
5:00 p.m.	Surgery case
5:30 p.m.	Gynaecology case
6:00 p.m.	ENT case
Saturday 24th Oct.	**Diet & Nutrition**
4:30 p.m.	Failure to thrive
5:00 p.m.	In cancer patients
5:30 p.m.	Diet fads
6:00 p.m.	Targets in overweight and obesity
Sunday 8th Nov.	**Virology**
4:00 p.m.	Thrombo-embolic complications of COVID
4:30 p.m.	Ethical issues in HIV
5:00 p.m.	Endemic haemorrhagic illnesses in Caribbean
5:30 p.m.	HIV guidelines
Sunday 22nd Nov.	**Haem-Path**
4:00 p.m.	Challenges with breathalyser
4:30 p.m.	Anticoagulation management in patients with COVID-19
5:00 p.m.	Death Certification
5:30 p.m.	Update on cancer markers
Saturday 5th Dec.	**Surgery and Radiology**
4:30 p.m.	Management of the diabetic foot
5:00 p.m.	Investigating an abdominal mass
5:30 p.m.	Colorectal cancer
6:00 p.m.	Breast mass

Dr Quimby is the Chairperson of the UWI / BAMP CME Committee.

LETTER TO THE EDITOR

AN OPEN LETTER TO THE BAMP EXECUTIVE

Dear Editor

My congratulations to the BAMP Executive. Perhaps this letter will highlight some of the challenges you face from a historical perspective.

I would like to make a few comments about BAMP, an organisation to which I have been paying annual subscriptions since 1987 till date (32 years), and in which I have served as the Editor of the BAMP bulletin for 9 years, roughly between 1992 and 2001. When I was invited to 'revive' the Bulletin, no Bulletin had been published since the previous 18 months. In my last 3 years as editor, and if I may add, I was the main contributor of articles to the Bulletin as well, there were 6, 6, and 5 bulletins produced annually. There was a specific 'challenge' with the production of the 6th bulletin in my final year, resulting in my resignation as the Editor of the Bulletin.

During my period as Editor, I offered my resignation every time a new BAMP executive was sworn in and each time I was invited to continue as the Editor of the Bulletin.

Because the Editor of the Bulletin was not a member of the BAMP Executive, I invited the Executive repeatedly to provide a written Editorial for each edition of the Bulletin, representing the views of the BAMP Executive. Unfortunately, this rarely happened, and the Editorial offerings generally represented my personal views, and not those of the BAMP Executive. Finally, when my (BAMPs) Editorial was critical of the BAMPs Executive and I was asked to change it, I finally resigned to allow the Executive to express their own views.

During the last series of BAMP 2020 AGM meetings, a point was made about BAMP losing 143 members over the last two years, and seemingly not attracting many (or any) new members. A variety of financial reasons were offered for this, but the difficulty BAMP was/is facing in attracting new members is not new.

During my period as Editor for over 3 or 4 years, I wrote a series of articles, about the then existing BAMP AGM who usually showed up. This was possible during that era when all meetings were face-to-face, and 'zoom' meant you had to get somewhere fast. I used a definition of 10 years or less post-graduation to define a young doctor. My amateur analyses of the BAMP AGM attendance lists back in those days showed that less than 20% of (i) young doctors, or (ii) doctors attached to the QEH, which employed about one half of the working doctors on the island, or (iii) doctors attached to the polyclinics, were attending the AGMs.

This infered to me, and I also tried to make the point repeatedly to different BAMP executive committees over the years, that there was limited communication between BAMP and a majority of doctors working in Barbados. This was especially so since the main formal meeting of doctors was the AGM, even though an annual dinner was also on the agenda in those days.and it was necessary to actively explore channels to improve this; after all if these doctors knew little of BAMP, why should they be interested in joining. What additionally surprised me was that BAMP, primarily a trade union to 'serve' doctors who were employed by the Ministry of Health, was not able to attract a vast majority of doctors who were employees of the Ministry of Health.

The BAMP Executives over the years have failed to develop an effective communication channel with a majority of doctors who work here.

My personal philosophy in my years as Editor of the BAMP bulletin and as a frequent contributor of articles to the BAMP Bulletin, was to (attempt to) highlight what is happening here. I had little interest on topics such as an article on Diabetes that highlighted recent conference information from the American Diabetic Association, but bore no connection to the situation with diabetes here. I still maintain that, if only in part, the BAMP Bulletin (or the newly renamed BAMP Journal) should offer information about what is happening here, and this can serve as a channel of communication between doctors. I hope that the name change does not limit it to pure scientific articles, excluding local content. In this regard, the most recent edition of the bulletin, Feb/Mar 2020 has more 'Barbados-specific' articles than usual, including "Interim Guidance for Primary Care physicians for Covid-19 in Barbados". Hopefully, this trend will continue.

In a previous article submitted to BAMP Bulletin on "Mandatory CME in Barbados" I noticed that that CME's

introduction seemed to separate physicians more than bring them together. Doctors who work in the polyclinics (presumably) go to one set of CME activity, hospital doctors (presumably) go to another set (or sets, depending on their areas of specialty), whilst doctors who work in private practice, attend yet another set. So, doctors from these various sets rarely interact. It is not surprising that referrals in or out of hospital or polyclinics, cause so much friction.

The 'combative' atmosphere that surrounded BAMPs AGM was just a 'boiling over' of a situation that had been simmering for a long time, where different groups of doctors had no history of intra-group communication. Mis-trust and mis-understanding thrive in the circumstances. The new BAMP executive have to devote appropriate enthusiasm and resources not only to heal some recent wounds, but also to initiate appropriate programs to bring the profession back together.

Dr. C. V. Alert MB BS. DM Family Physician.

Bamp Council – 2020 - 2021

NAME	TITLE
Dr Lynda Williams	President
Dr Adanna Grandison	1st Vice President
Dr Geoffrey Lafond	2nd Vice President
Dr Ingrid Durrant	General Secretary
Dr Dawn Grosvenor	Assistant General Secretary
Dr Vikash Chatrani	Assistant Treasurer
Dr Gregory Walton	Treasurer
Dr Sandra Reece	Public Relations Officer
Dr Corinthia Dupuis	1st Floor Member
Dr Adrian Waterman	2nd Floor Member
Dr Manohar Singh	3rd Floor Member
Dr Ingrid Burrowes	4th Floor Member

Instructions To Authors

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

The Editor is assisted by members of an Editorial Committee, chaired by the Public Relations Officer of BAMP Council, and comprising a cross section of BAMP membership, from Professor Emeritus to medical resident. There is also an Advisory Board of seven senior members of the profession and since the beginning of 2011, with the publication of the new 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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