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A paradise for the travelling neurologist

Known as the pearl of the Indian Ocean, Sri Lanka is a small island, with a population of about 18 million, lying just below the southern tip of the Indian subcontinent. The island is a wonderful holiday destination and one of the many unfathomable mysteries of the island is how it manages to squeeze so many different landscapes and weather patterns into an area no larger than Ireland. Sri Lanka has been in the news in the recent past because of its cavalier cricketers and the unfortunate war that is going on between the government forces and the Tamil Tigers. This war, which is confined to the north of the country, has resulted in the collapse of the country's economy, though most of us living in the other parts of the country lead a normal life. With a new government elected in December 2001, a permanent settlement to the war is more than ever likely. Sri Lanka offers the traveller shimmering sunny beaches, tropical rain forests, wild life with elephants in abundance, green and misty hills and tea plantations and the chaotic bustle of cities like Colombo, Kandy and Galle. So what can Sri Lanka offer the travelling neurologist?

There are 15 neurologists and four neurosurgeons in the country. There are only three neurosurgical centres and patients frequently have to travel long distances to receive their services. Naturally the waiting lists are long and this is a speciality where delays can lead to irreversible consequences. Strokes, epilepsy, migraine and Parkinson's disease are common and are no different to in the west. There is only one stroke unit in the country and most strokes have to be managed without CT diagnosis. Rehabilitation services are almost non-existent. Multiple sclerosis is very rare and in the neurological differential diagnosis it is usually not considered.

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Although the literacy rate of Sri Lankans is the highest in the region, people in the rural areas still seek ayurvedic or other alternative medicines for hemiplegias and seizures. There is no state sector family practice service covering the whole of the country. All family practitioners are private and set up their practices wherever it suits them. Telephones are available to only about 25% of the population. Carrying out

population-based incidence studies is difficult for these reasons. There are six medical faculties in the country and the main teaching hospitals are situated around the faculties. In the main cities such as Colombo and Kandy, private sector hospitals are well developed and, sometimes, are better equipped than the state hospitals.

If the travelling neurologist were to do a ward round or a clinic, if he is lucky he would encounter the many exotic neurological cases that are particular to the country. Acute flaccid paralysis seen in a ward could very well be due to snakebite, or organophosphate poisoning. The incidence of snake bite in Sri Lanka is currently one of the highest in the world. The venom of the cobra,

the Russell's viper and the Sri Lankan krait is neurotoxic and results in muscle weakness varying from ophthalmoplegia to generalized paralysis with respiratory failure. Cobra and viper envenoming, in addition, causes severe local reactions and intravascular haemolysis. The krait has the habit of biting sleeping individuals in the night by creeping into the huts of rural farmers while they sleep on the floor, and causes only neurotoxicity with no reaction at the bite site. Patients present with generalized weakness and, if severely envenomed, neuromuscular respiratory failure.

Sri Lanka has a high incidence of suicide and deliberate self harm – about 40 per 1 000 000 population each year compared with 8 per 1 000 000 in the UK (Eddleston *et al.* 1998). Self poisoning with agricultural pesticides is seen everyday in parts of the country where pesticides are commonly used, and with natural

poisons such as oleander seeds in areas where the plant grows in the wild. Oleander seed poisoning causes cardiac toxicity and is popular amongst the young as a mode of attempting suicide after trivial conflicts such as broken love affairs or family disputes. Organophosphate ingestion causes a severe cholinergic crisis and has a mortality of around 10–15%. If treated promptly with atropine almost all recover fully from the acute crisis. Subsequently, after 3–5 days, some may develop a myasthenia-like syndrome, called the 'intermediate syndrome' (Senanayake & Karalliedde 1987). A smaller number go on to develop an axonal neuropathy after some weeks or months.

Leprosy, which is no longer considered endemic in the country, is another condition that may be seen in the outpatients clinic. Presentation can vary from a foot drop, an ulnar neuropathy, to a facial palsy. The clue to the diagnosis here is the palpable, thickened nerve. In patients presenting with a picture similar to that of chronic inflammatory polyradiculopathy, or progressive spastic paraparesis, spinal tuberculosis has to be excluded. Although TB is not so common, it is still seen in hospitals and clinics. Fortunately AIDS is not a problem in Sri Lanka, although it has reached epidemic proportions in the neighbouring India – an impending epidemic was predicted but there is no sign of it yet. This may be because of the cultural and religious influences on the majority of the population, who are Sinhala Buddhists.

Sri Lanka is certain to provide for the tired and weary traveller from overseas; a well-deserved break in a completely contrasting climate and unmatched tranquility. It would be an ideal place for a working holiday or for your sabbatical. Working in a busy and crowded hospital, seeing patients and collecting data during the day and relaxing in a beach resort in the evenings, and spending the weekends in the jungles of Yala or the chilly hills of Nuwara-eliya could be a dream come true.

References

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