Conclusions

The majority of medical students who participated in this study showed a positive attitude of 76.5 % towards people infected with HIV; however, several gaps in knowledge about HIV/AIDS have been identified in 16.9 % of students. In addition, 23.5 % of the participants showed a negative attitude towards people infected with HIV. Thus, students need to increase their knowledge of HIV/AIDS and pay attention to the management of patients who are infected with HIV.

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EVALUATION OF MOSTLY AFFECTED AGE GROUPS OF TUBERCULOSIS PATIENTS IN SRI LANKA

Introduction

Tuberculosis, it's an illness that mainly affect to lung. It caused by Mycobacterium tuberculosis (MTB) bacillus which is also known as Koch's bacillus. Tuberculosis bacillus is small, acid fast, aerobic, rod shape bacillus. It can spread stay person with the illness sneezing or coughing signs. TB easily spread where the people gather in crowds or where the people live in crowded condition. People with weaken immunity (ex: people with HIV/AIDS) have more prevalence to get TB than people with typical immune system. TB is present in all countries and any age groups [1].

In 2021, 10.6 million people fell ill with TB have estimated in world wild. 3.4 million of women, 6 million of men and 1.2 million children have found ill with TB. A total death from tuberculosis in 1.6 million. According to ICD 10 classification we can classify TB, respiratory TB bacteriologically and histologically confirmed, respiratory TB not confirmed bacteriologically or histologically, TB in nervous system, TB in other organs and miliary TB [2].

Generally, persons at high risk for developing TB disease fall into two categories; persons who have been recently infected with TB and persons with medical conditions that already weaken the immune system. Persons who have been recently infected with TB bacteria includes close contacts of a person with infectious TB disease, Persons who have immigrated from areas of the world with high rates of TB, children less than 5 years of age who have a positive TB test, such as homeless persons, injecting drug users and persons with HIV infection, persons who work or resides with people who are at high risk for TB in facilities or institutions such as hospitals, correctional facilities, groups with high rates of TB transmission, nursing homes and residential homes for those with HIV, homeless shelters. Persons with medical conditions that weaken the immune system includes people with HIV infection, substance abuse, silicosis, diabetes mellitus, low body weight, organ transplants, severe kidney disease, head and neck cancer, medical treatments such as corticosteroids or organ transplant, specialized treatment for Crohn's disease or rheumatoid arthritis [3].

There are several types of TB: it can mainly divide into active (symptomatic, contagious, positive blood and skin test) and latent (asymptomatic, non-contagious positive blood and skin test) TB. Latent TB can convert into active TB in 5 to 10 days.

Active TB can be pulmonary (primary tuberculosis pneumonia, tuberculosis pleurisy, cavitary TB, miliary TB and laryngeal TB) or extrapulmonary (ex: skeletal TB, genitourinary TB, liver TB, TB meningitis, TB peritonitis, gastrointestinal TB and cutaneous TB) [3].

According the annual data Sri Lanka consider as a middle burden country for tuberculosis. Sri Lanka has estimated incidence rate of TB is 64 cases per 100,000 population (2018) but actual incidence rate is 40 per 100,000 population. Every year around 8500 to 9000 cases were reported among them 250 to 300 cases child TB. But in these years reported TB cases have increased due to COVID-19. In recent years death rate from TB in Sri Lanka was 3.5 cases per 100,000 people. The rate of spreading of tuberculosis is higher in crowded areas, so it is specially found at a higher percentage in Western province including Colombo district, Gampaha district and Kalutara district [4].

Goal

Aims to evaluate mostly affected age groups of tuberculosis patients in Sri Lanka.

Material and Methods of research

Collecting and analyzing data within a time frame of 15.03.2022–20.03.2023 from 47 patients in the ages ranging from 10 years to 80 years ,who visited Base Hospital Kiribathgoda, Gampaha District, Sri Lanka. The laboratory data were retrieved from patients who had chronic cough for more than 2 weeks with other respiratory symptoms and had undergone sputum test for tuberculosis and the results were positive[positive AFB test].General examinations of the patients, past medical history and chest x ray examination results were also taken into consideration.

The results of the research and their discussion

After analyzing the data of 47 patients who were involved in the case study, the following table is drawn representing number of patients obtained for each age range.

Table 1 – Number of tuberculosis patients for different age ranges

Age range	No. of patients	No. of patients(percentage)
10–20	2	4.26 %
21–30	4	8.51%
31–40	4	8.51 %
41–50	11	23.40 %
51–60	14	29.79 %
61–70	7	14.89 %
71–80	5	10.63 %

From the data collected from above table following graph is plotted.

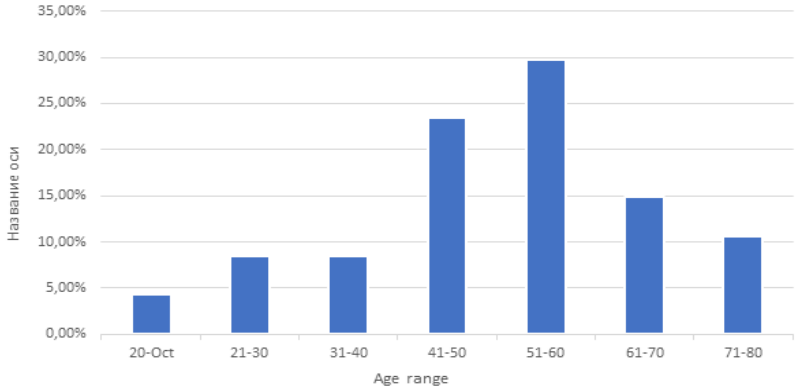

Figure 1 – Prevalence of risk factors of primary arterial hypertension

Conclusions

According to the research conducted and data collected (table 1 and figure 1) from 47 patients, the mostly affected age groups of tuberculosis patients in Sri Lanka from 15.03.2022 to 20.03.2023 are 51–60 (29.79 %), 41–50 (23.40 %) and 61–70 (14.89 %).

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MANAGEMENT OF DENGUE HEMORRHAGIC FEVER IN SRI LANKA

Introduction

Tropical island Sri Lanka, with largest outbreak of dengue in 2017 with 186,101 reported hospitalizations has a unique topography and seasonal monsoon cycles that influences epidemic and transmission the dynamics of dengue. In 2021, about 41,000 confirmed cases of dengue fever have already been registered, this exceeds the number of cases for the whole of last year.

Dengue fever is an acute transmissible viral disease. The viruses that cause dengue fever belong to arboviruses, Flaviviridae family of genus Flavivirus. Dengue is vector born, spread primarily by mosquito Aedes aegypti, it become infectious after a blood meal from an infected host and is able to transmit the acquired DENV [7]. Aedes can breed in both clean and organically rich stagnant waters and are primarily considered as contain breeders. Most patients remain asymptomatic while others acquire a febrile illness after an incubation period of 3 to14 days which may progress into Undifferentiated febrile illness, Dengue fever, Dengue hemorrhagic fever, Expanded dengue syndrome [6]. Most people with dengue fever have a mild form of the disease, but about 15 % of people admitted to hospitals develop hemorrhagic dengue fever, which causes severe bleeding and can lead to death. Hospital admission is carried out only for selected category of patients. It is impossible to predict in the early stages of infection whether someone will develop a severe form of dengue, which means that people should visit the hospital daily for blood tests to detect signs as early as possible. This is a huge burden on the healthcare system.

Main principle of treatment of dengue hemorrhagic treatment is fluid management by monitoring of infusion rates and urine output, thereby Sri Lanka was able to lower the mortality rate by 67.45 % from 2019 to 2022 [2].

Goal

To study the management of dengue hemorrhagic fever in a low socioeconomic country – Sri Lanka, highlighting the significance of early detection and fluid balance in critical phase.