To the Editors:

# July 28 and 29, 1987 are unforgettable days

These are days I will never forget. On 28 July, the Ministry of Teaching Hospitals was burnt down. On 29 July, the day of the Indo-Sri Lanka Pact, I had great difficulty in getting an ambulance to Galle Face Green.

On 28 July there was mob violence in Pettah. It spread towards Fort. The Ministry of Teaching Hospitals was attacked with burning tyres. Once this wooden building started burning, we decided to run away. When we tried to escape we were prevented by the mob from taking our cars out. I ran away even without my briefcase, which contained my passport, identity card, and driving licence.

I walked from Fort to Kollupitya with Wilson my peon and went home by bus. In the evening we came with the Police. The building was razed to the ground. Many vehicles were burnt but my car was not.

A few days earlier, as the Director General of Teaching Hospitals, I was called to a top security meeting. Rajiv Gandhi was coming to Sri Lanka. He was to land on Galle Face Green on the morning of 29 July. I was asked to provide an ambulance with a doctor and a nurse at Galle Face Green. I agreed and came away.

I informed late Dr Donald Abeysundera, Director of General Hospital Colombo (now the National Hospital) to get an ambulance organised. He agreed.

On the 28 while we were in a daze after the burning of the Ministry, Donald informed me that no doctor or nurse was ready to come in the ambulance to Galle Face Green the next day. If I failed to get an ambulance to Galle Face Green I would be in real trouble. I telephoned doctors whom I knew and asked them a personal favour. After a few refusals I was lucky. Roshinara Gunaratna agreed but only on condition that I also come. I agreed. I told the Chief Nursing Officer of the GHC that she had to find one staff nurse out of about 800.

On 29 morning when I came to the GHC there was no staff nurse to go in the ambulance. I told the Chief Nursing Officer that she had to come. She wanted to go home and come. I sent her in my car to make sure that she came back.

The ambulance went with Dr Roshinara Gunaratna and the Chief Nursing Officer. I followed in my car. We were in Galle Face Green when Rajiv Gandhi landed by helicopter. He was whisked away to President's House. The ambulance was allowed to proceed towards President's House. I came away. Though the country was burning, I was a very relieved man.

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To the Editors:

# Examination of a driver alleged to have consumed alcohol

In Sri Lanka legal limit of drink driving is 80mg/100ml. Section 151 of Motor Traffic (amendment) Act No 40 of 1984 states that "when a police officer suspects that a driver of a motor vehicle on a highway has consumed alcohol he may require such person to submit himself immediately to a breath test for alcohol or an examination by a Government medical officer in order to ascertain whether such person has consumed alcohol".

A police officer can produce a suspected driver for a clinical examination at any time of the day on a Medico-Legal Examination Form (MLEF). The MLEF has special cages to be initialled by the doctor to indicate as to whether the examinee's breath smells of alcohol, he is under the influence of alcohol or has not consumed alcohol. Psychological, behavioural and clinical changes of alcohol intoxication are known to occur even in people who have not consumed alcohol. This led to the development of diagnostic criteria for alcohol intoxication [1]. The most recent diagnostic criteria developed by the American Psychiatric Association are:

- recent ingestion of an alcohol containing beverage
- clinically significant maladaptive behavioural or psychological changes (eg. inappropriate sexual or aggressive behaviour, mood lability, impaired

judgment, impaired social or occupational functioning) that have developed during or shortly after alcohol ingestion.

- One (or more) of the following signs, developing during or shortly after alcohol use:
  - o slurred speech
  - o incoordination
  - o unsteady gait
  - o nystagmus
  - o impairment in attention or memory
  - o stupor or coma
  - o the symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

The proof of "recent ingestion" of alcohol containing beverages can be done objectively by the history and investigations. Although there is no specific single clinical test to see whether a person is under the influence of alcohol, some tests are more specific than others [2]. The Standard Field Sobriety Tests are claimed to be validated in laboratory and roadside conditions, and are being used by the American police officers to decide whether a suspected individual has impairment in excess of a legal limit of 100mg/100ml [3].

Although estimation of blood alcohol level and clinical tests have their limitations, application of universal standards to all populations without mass scale research can create problems. For example, most Asian populations have smaller body mass than western populations. The advancement of genetic studies has shown that some populations (eg. Chinese) are less tolerant to alcohol than others; there is a sex bias too [4].

In Sri Lanka diagnosis of alcohol consumption and intoxication are done by clinical and breath tests only. However, a judgment given by the Court of Appeal in 1991 questioned the terms "intoxication" and "consumption of alcohol" in relation to blood alcohol level. That judgment highlighted the need to use blood alcohol levels with the clinical examinations [5]. At present, no academic body or the Ministry of Health has issued diagnostic criteria of alcohol intoxication in Sri Lanka. It is essential to issue such diagnostic criteria with an examination protocol for alleged drunken drivers. It should incorporate investigations of blood alcohol level and a special consent form to draw blood or take urine. This procedure will deliver a standard and equal service to all drivers who are alleged to have consumed alcohol.

## References


1. Rix KJB. "Alcohol intoxication" or "drunkenness": is there a difference? *Medical Science and Law* 1989; **29:** 100-6.
2. Gustafon R. Alcohol and vigilance performance: effects of small doses of alcohol on simple visual reaction time. *Perceptual and Motor skills* 1986; **62:** 951-5.
3. Burns M, Moskowitz H, Psychological tests for DWI arrest. Technical Report DOT-HS-5-101242, DOT-HS-806-724 National Highway Traffic Safety Administration, Washington DC 1977.
4. Lieber CS. Medical disorders of alcoholism. *New England Journal of Medicine* 1995; **333:** 1058 - 62.
5. Judgement of Sumanarathne vs O.I.C. Police Station, Borella and another in Court of Appeal, August 1991.


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To the Editors:

# Acalculous cholecystitis and dengue fever

Acalculous cholecystitis is rarely reported as a manifestation of dengue fever (DF). Even in the absence of cholecystitis, a thickened gallbladder wall on ultrasound examination is a constant finding in patients with DF. It favours the diagnosis of DF and predicts severity [1].

A 48-year old woman presented with fever, bleeding gums and skin bruising. Her platelet count was 34 000/uL, and dengue IgM and IgG antibodies were positive. She was treated with intravenous crystalloids. On day 4 she developed right upper quadrant pain. Liver aspartate transaminase was 101 IU/l, alanine transaminase 148 IU/l, and serum alkaline phosphatase 296 IU/l. Ultrasonography of the abdomen revealed a tender, distended gallbladder with a wall thickness of 5mm, and pericholecystic fluid. Gallstones were not identified. She recovered over the next three days.

Fever, right upper quadrant pain and tenderness, a thickened gallbladder wall without stones, presence of pericholecystic fluid and a positive sonographic Murphy's sign established the diagnosis of acalculous cholecystitis. In a North Indian series 14 out of 27 patients with DF were shown to have acalculous cholecystitis [2]. A series from China reported a lower incidence of 7.3% of acalculous cholecystitis among DF patients [3]. The pathogenesis of acalculous cholecystitis in DF is not clear. The pathophysiological changes in DF, increased vascular permeability, plasma leakage and serious effusions may lead to gallbladder wall oedema, increased bile viscosity and cholestasis [4]. The course of the acute cholecystitis in DF patients is usually self-limiting, and thickening of the gallbladder wall returns to normal in a few days [4]. The patient should be closely observed for diffuse peritonitis, which warrants surgical treatment.

Gallbladder wall thickness of more than 3mm is a constant finding in most sonographic studies of DF patients without cholecystitis [1]. A gallbladder wall thickness of >5 mm is a useful criterion for identifying high risk patients [1]. Acalculous cholecystitis should be suspected in patients with DF presenting with abdominal pain. Sonographic Murphy's sign and pericholecystic fluid collection are the sonographic features of acalculous cholecystitis in DF.

## References


1. Setiawan MW, Samsi TK, Wulur H, Sugianto D, Pool TN. Dengue heamorrhagic fever: ultrasound as an aid to predict the severity of the disease. *Paediatric Radiology* 1998; **28:** 1-4.
2. Sharma N, Mahi S, Bhalla A, Singh V, Varma S, Ratho RK. Dengue fever related acalculous cholecystitis in a North Indian tertiary care hospital. *Journal of Gastroenterology and Hepatology* 2006; **4:** 664-7.
3. Khor BS, Liu JW, Lee IK, Yang KD. Dengue hemorrhagic fever patients with acute abdomen: clinical experience of 14 cases. *American Journal of Tropical Medicine and Hygiene* 2006; **74:** 901-4.
4. Wu KL, Changchien CS, Kuo CM, Chuah SK, Lu SN, et al. Dengue fever with acute acalculous cholecystitis. *American Journal of Tropical Medicine and Hygiene* 2003; **68:** 657-60


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