To the Editors:

Selection of students for admission to a medical school in Sri Lanka [1]

The area of research is timely since selection of students for admission to medical schools has received much attention recently. Selection criteria need to be examined in relation to outcome, success in the medical course being one such outcome. The population for such an investigation has necessarily to be the total cohort (or better still, cohorts) of students who gain entry to all medical schools in a given year (or years). This is so because of the differential distribution of the different “quotas” and criteria for selection in medical schools.

It is noted that in the medical school selected for study, the variation observed in the independent variables (predictors) is very small. This is likely to be a function of the distribution of the “quotas” in the selected school, highlighting the need for studying those who are admitted to all six medical schools as one group. Absence of information on some important predictors such as proficiency in English language and the number of attempts at the Advanced Level examination adds to the difficulties of examining this relationship.

The above aspects are mentioned in passing in the discussion. However, the limitations in generalizing the results to all admissions to medical schools are not sufficiently dealt with and thus, the article is liable to misinterpretation. This would harm a meaningful debate on the appropriateness of current admission criteria, negating the intentions of the researchers.

Reference

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To the Editors:

In reply:

Intravenous magnesium sulphate in asthma: current recommendations

I appreciate the view of Dr. BJC Perera, Consultant Paediatrician on the above subject in his letter to the Editors in the CMJ 2004;49:103.

The column on “From the journals” usually includes summaries of journal articles. The references of the articles are included for readers who need details. This particular article on magnesium sulphate in asthma in the Drug and Therapeutics Bulletin has quoted 14 references, which include 3 meta-analysis and 4 randomised controlled trials. Two of the six references quoted in Dr. Perera’s letter (references 3 and 6) have also been considered in my article.

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To the Editors:

Good postgraduate trainers should be rewarded

Plans are underway for the postgraduate medical education (PGME) of Sri Lanka to move from the traditional apprenticeship style to an appraisal based training system. Several speciality Boards of the Postgraduate Institute of Medicine (PGIM) have already formulated necessary changes. Further changes in PGME in the form of quality assurance measures may be introduced in the near future [1]. Quite rightly, standards of training must be upheld and be shown to be upheld.

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Training is a partnership between the trainer and the trainee. Therefore, the role of a trainer in PGME should not be ignored. The new changes will fail to deliver improvements unless the trainers involved in PGME have confidence and commitment towards the process. Trainers should see it as a constructive opportunity rather than an irrelevant chore. If the changes are to be properly implemented, there must be advantages for the trainers too. Training should not be considered merely as a benign altruistic charity.

The trainers, especially the surgical ones, are under pressure from the two sides—providing service and training. When a trainer is taking a trainee through a procedure, it will almost always take much longer and the service suffers. While laudable and fairly successful attempts are made by surgical trainers to maintain a fair balance between service and training, further increases in commitment on training may make this adjustment increasingly hard to tolerate.

Teaching units with no access to computers, new books, journals and the internet are not appropriate teaching environments. Most of the trainers of the Department of Health do not have office space or secretarial assistance.

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References

To the Editors:

Couple characteristics and outcome of therapy in vaginismus

In the article titled, ‘Couple characteristics and outcome of therapy in vaginismus’ [1], Munasinghe and colleagues appear to have confused dyspareunia with vaginismus. Vaginismus is a classical psychosomatic disorder which usually results in complete apareunia and non-consummation of marriage. Milder forms of vaginismus can cause dyspareunia at coitarche and it may sometimes persist thereafter. Their reference to Rafla [2] with regard to avoidable causes of secondary vaginismus is incorrect. Rafla reported a case of bilateral vaginal tears occurring when an inexperienced person inserted a Cusco’s bivalve vaginal speculum into a sexually active nulliparous woman with vaginismus.

Vulvo-vaginal trauma results in scarring, and usually leads to secondary dyspareunia, but it may rarely lead to subsequent vaginismus due to fear of recurrence of the injury. Infection on the other hand causes dyspareunia, and when it is treated it should not lead to vaginismus. Vulvovaginal infection and trauma, as well as developmental abnormalities, pelvic inflammatory disease, pelvic endometriosis and atrophy of the vaginal epithelium cause dyspareunia. Antibiotics, surgery, vaginal dilatation, local analgesics and hormones are all accepted forms of therapy depending on the cause of dyspareunia. Before embarking on treatment in a woman having coital difficulties, it is essential to differentiate between vaginismus and other causes of dyspareunia by obtaining a detailed history and carrying out a complete gynaecological examination.

The therapy of vaginismus described by Munasinghe and colleagues is the method of gradual vaginal desensitisation, which is extremely laborious, time consuming and not quite satisfactory (80% success reported by them). The alternative is—the rapid vaginal desensitisation method [3]. This method involves insertion of a mould or large dilator into the vagina. No surgery is involved and the principle is simple desensitisation and not physical dilatation of the vagina. This method is easy, quick and rarely fails. However, it needs hospitalisation and a short general anesthetic. For this method to succeed, privacy and the presence of partner is essential for a minimum of 24 hours after the procedure. Therefore it is difficult to be carried out in a busy ward of a government hospital. The author has used this method with success in more than 60 patients during the last 17 years.