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Enhancing Awareness of Eastern Cancer Care Hospice (Eascca) In Healthcare Education. A Descriptive Study and Framework for Palliative Care Engagement.

Vethini Ariyanayagam ^{1*}

^{1*} Faculty of Siddha Medicine, Trincomalee Campus, Eastern University, Sri Lanka.

*Corresponding author:

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ABSTRACT

Palliative care is a vital element of comprehensive cancer management; however, its integration into healthcare education remains limited in numerous low- and middle-income countries, including Sri Lanka. The aim of this study was to outline the Eastern Cancer Care Hospice (EASCCA) model, identify challenges to engaging healthcare students, and propose a framework to increase awareness for incorporating hospice-based palliative care into healthcare education.

A descriptive study Design was used, integrating experiential insights from the author's involvement in a two-day EASCCA training program with secondary data from institutional reports, World Health Organization (WHO) guidelines, and peer-reviewed literature. EASCCA offers comprehensive, community-focused palliative care that includes medical, psychological, spiritual, and social support. Key barriers to student participation included limited communication within institutions, low program visibility, geographic challenges, and the absence of formal curricular integration. A three-part awareness framework was created.

It is concluded that building awareness and establishing formal partnerships between EASCCA and healthcare education institutions can improve student engagement, enhance capacity building, and promote equitable access to high-quality palliative care in Sri Lanka.

Keywords: Palliative care education; Hospice model; Healthcare students; Community-based care; Sri Lanka

INTRODUCTION

Palliative care is recognized as a comprehensive approach aimed at enhancing the quality of life for patients suffering from life-threatening illnesses (Morrison & Meier, 2004). The spiritual, psychological, and social well-being of bereaved families are also regarded as integral components of palliative care. Accessing palliative care is a fundamental right of every individual affected by a life-threatening illness, and the provision of such care in accordance with individual needs is a collective responsibility, including healthcare professionals. Annually, an estimated 60 million individuals worldwide require palliative care, yet only approximately 14% of those in need currently receive it. The majority of these individuals reside in low- and middle-income countries (Kvale *et al.*, 2003).

Cancer is emerging as a global epidemic, with an upward trend. According to GLOBOCAN 2022, 19.9 million new cancer cases were diagnosed worldwide, and approximately 9.7 million individuals succumbed to the disease. The International Agency for Research on Cancer (IARC) forecasts that new cancer cases globally will increase from 19.3 million in 2020 to approximately 30 million by 2040, primarily due to aging populations and lifestyle modifications. There is an urgent necessity for concerted efforts to enhance awareness of cancer and to develop efficacious strategies to mitigate its escalating impact, with the aim of reducing disparities in cancer care.

Eastern Cancer Care Hospice, also known as EASCCA Hospice, was launched on February 4, 2020, to provide specialized care for patients with terminal cancer. Acknowledging that cancer is a leading global cause of death, EASCCA's goal is to provide compassionate support to patients and their families during difficult times.

Eastern Cancer Care & Hospice is a charitable palliative care institution located in Eravur, Batticaloa District, Sri Lanka. The hospice was established to provide comprehensive care and support for cancer patients, particularly those suffering from advanced-stage and terminal illnesses. The institution mainly focuses on improving the quality of life of patients through palliative and supportive care services, including pain management, psychological support, counselling, nutritional assistance, and spiritual care.

The hospice accommodates a significant patient population from Batticaloa and neighboring areas within the Eastern Province. Patients admitted to the facility receive ongoing nursing and medical care under the supervision of healthcare professionals and trained volunteers. Beyond inpatient services, the institution also offers outpatient department (OPD) services for individuals requiring routine consultations, symptom management, follow-up treatments, and

counseling. These OPD services assist both patients and caregivers by addressing the physical, emotional, and social challenges associated with cancer.

Furthermore, the hospice operates throughout the day to ensure uninterrupted patient care and emergency support. The availability of 24-hour care services demonstrates the institution's commitment to meeting the healthcare needs of vulnerable cancer patients within the community. Through its compassionate, multidisciplinary approach, the hospice plays a significant role in strengthening palliative cancer care services in Sri Lanka's Eastern region.

EASCCA Hospice adopts a community-based model with architecturally designed homes in a lush, serene environment. Registered with the Ministry of Health, it collaborates with Sri Lanka's National Cancer Control Programme and the Institute of Palliative Care Medicines to provide services that improve the quality of life for cancer patients.

Although Sri Lanka has made advances, it still faces challenges in incorporating structured palliative care into its healthcare education. The Eastern Cancer Care Hospice (EASCCA) operates on a community-based model, delivering accommodation, medical treatment, emotional support, and holistic services to patients with advanced cancer. In addition to patient care, EASCCA provides free training for healthcare students and professionals, helping to connect theoretical knowledge with practical experience.

There is limited awareness of EASCCA's training programs among healthcare students, which consequently constrains capacity-building opportunities and diminishes EASCCA's potential as a benchmark for multidisciplinary palliative care education in Sri Lanka. This study evaluates the EASCCA model, identifies obstacles to engagement, and proposes a practical framework to enhance awareness. A framework to increase awareness.

Sri Lanka, as a nation, is experiencing an increasing demand for palliative care due to the aging population and the rising burden of non-communicable diseases and other chronic illnesses, including cancers (Ratnasekera et al., 2026). Consequently, the 'Sri Lanka National Health Policy 2016-2025' has recognized that 'the mainstream health system should provide palliative care to all patients who need such care to ensure they can live and die with dignity.' Additionally, the 'National Strategic Framework for Palliative Care Development in Sri Lanka 2019-2023' (Ministry of Health, 2019) delineates strategic directions for the advancement of palliative care services within the country. Nevertheless, a considerable number of patients currently lack access to comprehensive palliative care services.

RESEARCH PROBLEM

While EASCCA provides unique experiential learning opportunities in palliative care, healthcare students' awareness of and involvement in EASCCA remain limited. Since EASCCA is not integrated into formal training programs, this valuable resource remains underused.

OBJECTIVES

The EASCCA hospice model is a community-based palliative care service.

To identify barriers to healthcare students' engagement with EASCCA training programmes.

To propose an awareness framework for strengthening the integration of EASCCA within healthcare education.

To rising the global awareness of the importance of palliative care

To advocating for policy changes to support the integration of palliative care into healthcare education

To increasing access to care for vulnerable population who require specialized palliative care

To supporting by providing ongoing training programs to enhance the skills and knowledge of the dedicated work of palliative care professionals and volunteers.

THEORETICAL CONSIDERATIONS AND EMPIRICAL EVIDENCE

Global literature highlights the need to incorporate palliative care into healthcare education to boost patient outcomes and professional skills (Morrison & Meier, 2011). WHO guidelines recommend introducing early learning through both classroom and practical experiences to foster empathy, improve communication, and build confidence in end-of-life situations (WHO, 2018). Systematic reviews show that hospice-focused training decreases death anxiety and enhances communication skills among healthcare students (Lloyd-Williams & MacLeod, 2004).

The author's participation in EASCCA training reinforced these findings, highlighting the value of real-world exposure in developing holistic, patient-centered competencies. However, such opportunities remain insufficiently promoted within Sri Lankan healthcare education.

Integrating palliative care into healthcare curricula is widely acknowledged as vital to improving outcomes (Morrison & Meier, 2011). The WHO (2018) suggests introducing it early through classroom lessons and practical experiences. Hands-on training improves empathy, communication skills, and confidence in delivering end-of-life care (Lloyd-Williams & Macleod, 2004).

The author's involvement in the EASCCA training highlighted that real-world experience enhances skills beyond what is taught in the classroom. However, in Sri Lanka, such opportunities are seldom promoted, leaving healthcare students unaware of them.

Palliative care in Sri Lanka, the demand continues to grow due to the rising prevalence of non-communicable diseases and the ageing of the population.

Palliative care is extensively recognized and adequately resourced as a fundamental component of the healthcare system within Sri Lanka's national policy framework. It is incorporated into the National Strategic Framework for Palliative Care Development in Sri Lanka (2019-2023) and the National Strategic Plan for the Prevention and Control of Cancer in Sri Lanka (2020-2024). As an early initiative in palliative care education, a certificate course in Palliative Care for medical officers was organized by the Institute of Palliative Medicine, Calicut, India (a WHO Collaborating Centre in community-based palliative care and long-term care) in collaboration with the College of General Practitioners of Sri Lanka, the national cancer control program, the Ministry of Health, and the WHO country office in Sri Lanka.

Sri Lanka Medical Association formed a task force on palliative care and end-of-life care in 2017. The SLMA task force developed a manual and guidelines relating to end-of-life care and a manual relating to palliative care for the management of non-cancer patients.

Palliative Care Association of Sri Lanka was formed. The association also organized training programmes for health professionals and caregivers.

Postgraduate courses in palliative care were initiated at the Postgraduate Institute of Medicine (PGIM), the University of Colombo, in 2017.

The National Cancer Control Programme of the Ministry of Health issued guidelines in 2022 on palliative care for cancer patients in primary health care. The guidelines emphasize the importance of integrating various primary care disciplines to deliver high-quality palliative care services.

There are many hospital and community-based palliative care delivery points in the country.

1. Palliative care consult services in the country
2. Apeksha Cancer Institute, Maharagama
3. Teaching Hospital Ratnapura
4. Lady Ridgeway Hospital for Children, Colombo
5. Teaching Hospital Karapitiya
6. Colombo South Teaching Hospital, Kalubowila

In addition to these clinics, palliative care services are arranged through oncology clinics in all cancer treatment centres in the country. (Epidemiology unit, 2022)

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The following are some community-based hospices in the country mainly managed by NGOs

Organization	Institute
Sri Lanka Cancer Society	Shantha Sevana Hospice Care Maharagama
Cancer Care Association Sri Lanka	Hospice at Kurundankulama, Anuradhapura and Hospice at Matara.
Sathya Sai Association	Sathya Sai Cancer Hospice, Hanwella
Cancer Aid for North and East Sri Lanka (CANE)	Hospice at Chunnakum, Jaffna
Eastern Cancer Care Hospice (EASCCA)	Hospice at Eravur, Batticaloa
Palliative Care Association	Sahana Sevana, Abagahpura, Maharagama

METHODOLOGY

This study adopts a descriptive Design, combining:

Experimental Evidence: This study's experimental evidence was gathered through the author's direct participation in a two-day training programme at EASCCA Hospice in Eravur, Batticaloa. In addition to the author's observations, informal perspectives from approximately 8–10 participants, including programme coordinators, healthcare volunteers, and healthcare students, were considered during the training sessions. The service categories were identified through direct field observation of hospice activities and were supported by EASCCA institutional reports and WHO palliative care guidelines. These experiential insights informed understanding of the hospice model's strengths and helped identify barriers affecting student awareness and engagement in palliative care education.

RESULTS AND DISCUSSION

EASCCA Hospice Model

EASCCA offers comprehensive, community-focused palliative care services (see Table 1), in line with global hospice care standards. Training involved direct engagement, allowing students to experience multidisciplinary teamwork, communication with patients and families, and end-of-life care approaches.

EASCCA provides free hospice services with a holistic, community-centered approach, including accommodation, medical care, pain management, psychosocial support, and spiritual EASCCA offers comprehensive, community-focused palliative care services (see Table 1), in line with global hospice care standards. Training involved direct engagement, enabling students to experience multidisciplinary teamwork, communication with patients and families, and approaches to end-of-life care assistance. The author's training experience highlighted the importance of direct participation: students observed teamwork, improved their

communication skills for end-of-life care, and gained valuable insights into comprehensive patient management.

Table 1: Services Provided by EASCCA Hospice

Category	Details
Medical Care	Pain and symptom management, palliative interventions
Psychological Support	Counselling for patients and families
Spiritual Care	Religious and cultural support based on patient needs
Accommodation & Meals	Free-of-charge stay with nutritious meals
Recreational Facilities	Green environment, relaxation spaces, and social interaction opportunities
Training Opportunities	Workshops and hands-on exposure for healthcare students.



Figure 1: The EASCCA Care Mode

Table 2: Barriers to Student Engagement with EASCCA

Barrier	Description
Limited Institutional Communication	Universities rarely promote EASCCA programmes
Low Visibility	Lack of awareness campaigns to inform students
Geographic Inaccessibility	The Eravur location is difficult for students from distant provinces to access.
Lack of Formal Integration	Not aligned with most healthcare curricula, thereby reducing incentives for participation.

Key barriers identified included limited institutional communication, low programme visibility, geographic inaccessibility, and lack of curricular integration. These challenges mirror those reported in other low-resource settings.

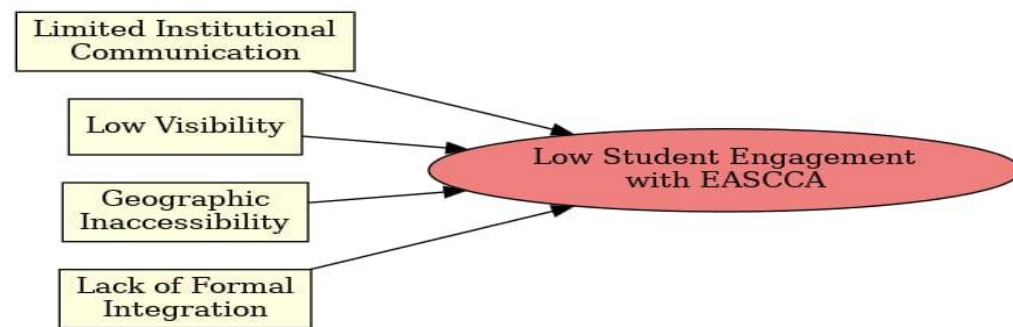


Figure 2: Challenges in Student Engagement with EASCCA

Table 3: Proposed Awareness Framework for EASCCA

Component	Proposed Action
University-EASCCA Partnerships	Formal MoUs and integration into healthcare curricula
Peer-led Promotion & Ambassadors	Student-led initiatives to spread awareness and encourage participation
Micro-credentialing & Certification	Certificates, digital badges, and credit recognition for students engaging in training

This framework is consistent with successful international models in the United Kingdom, India, and Africa, where collaborations between hospices and academic institutions have enhanced palliative care education (Kumar, 2007; Clark et al., 2018).

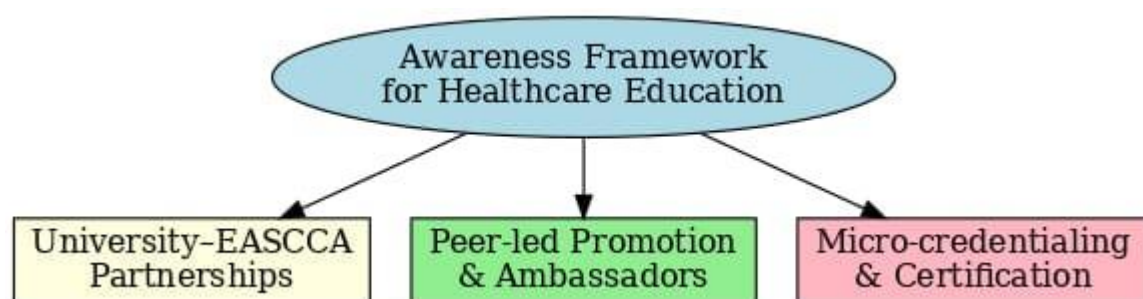


Figure 3: Awareness Framework for Healthcare Education

EASCCA Hospice offers comprehensive palliative care for cancer patients and serves as a training site for healthcare students. Although it adheres to international standards of holistic care (Saunders, 2001; WHO, 2018), its visibility and integration within Sri Lanka's healthcare education system remain limited. This demonstrates how local hospices can function both as service providers and academic collaborators.

Comparison with Global Models

Many countries worldwide have successfully integrated hospice and palliative care into healthcare education, often making them essential parts of training programs. For instance, in the UK, palliative care education is embedded throughout both undergraduate and postgraduate courses, with hospices serving as training sites where students gain hands-on experience in end-of-life care. This approach has been shown to boost clinical confidence and communication skills, while also reducing fears and stigmas surrounding death and dying (Lloyd-Williams & MacLeod, 2004).

In India, cancer diagnosis frequently occurs at advanced stages. Community hospice projects such as Karunashraya in Bangalore and Can Support in Delhi partner with medical colleges and nursing schools to offer rotations, certification programs, and volunteer opportunities, thereby increasing awareness of palliative care (Kumar, 2007). EASCCA's primary challenge is establishing official university partnerships to enhance its training efforts.

In Africa, the Hospice Africa Uganda model shows how embedding palliative care training in service delivery can scale nationally. It integrates into nursing and medical curricula, producing graduates capable of providing end-of-life care in resource-limited settings. This example demonstrates that even in low- and middle-income countries, collaboration between hospices and universities can develop trained professionals (Clark et al., 2018).

In Sri Lanka's case, through EASCCA, this aligns with the global trend: while service delivery remains robust, the integration of education and awareness efforts lags. Addressing this disparity is essential if Sri Lanka aspires to expand palliative care services beyond tertiary cancer centers and into community-based settings.

Findings in Light of Global Evidence

This study highlights barriers such as limited institutional communication, low visibility, geographic hurdles, and a lack of formal integration, which are similar to those found in other developing regions (Morrison & Meier, 2011). In India and Bangladesh, access to training is often hindered by geographic and awareness barriers, whereas high-income countries address these issues through curricular integration. Sri Lanka could consider adopting international approaches, such as digital learning combined with clinical placements at EASCCA, to overcome geographic constraints and promote university-hospice collaborations that normalize palliative care training. Elaborations that normalize palliative care training.

The awareness framework, including university partnerships, peer promotion, and certification, aligns with global practices. Certification and micro-credentials motivate students, as shown by success in India and Africa, where certificates boosted participation and employability (Kumar, 2007; Clark et al., 2018). The framework offers a feasible, adaptable pathway for Sri Lanka.

Broader Implications

Integrating EASCCA into healthcare education affects capacity building, the sustainability of training programs, and equity in cancer care. Equipping future healthcare professionals with palliative care skills aligns with the WHO's goal of ensuring universal access to palliative services.

Interpreting these findings through a global lens reveals three broader implications:

Capacity Building – Incorporating EASCCA into healthcare curricula can help address Sri Lanka's shortage of trained end-of-life care professionals and align with international initiatives to integrate palliative care.

Sustainability – Partnerships between universities and hospices create sustainable education-service ecosystems that reduce dependence on ad hoc volunteerism.

Equity in cancer care can be supported by expanding student engagement, which helps prepare future healthcare providers to deliver compassionate care in rural and underserved areas, aligning with WHO's goal of universal access to palliative care (WHO, 2018).

CONCLUSION

The Eastern Cancer Care Hospice (EASCCA) represents a pioneering model of community-based palliative care in Sri Lanka, providing both compassionate services for terminally ill cancer patients and valuable experiential learning opportunities for healthcare students. Despite its alignment with international standards of holistic hospice care, EASCCA remains underutilized as an educational resource due to limited awareness, weak institutional linkages, and a lack of formal curricular integration.

This study highlights the need for structured strategies to bridge the gap between service delivery and education. The proposed awareness framework, centered on university-hospice partnerships, peer-led promotion, and micro-credentialing, offers a feasible pathway for integrating hospice-based learning into healthcare education. Drawing on successful global models, embedding EASCCA within formal training programmes can strengthen student competencies, promote multidisciplinary collaboration, and contribute to more equitable cancer care across Sri Lanka.

Ethics Statement

Ethical approval was not required for this study as it was a descriptive analysis based on experiential learning and secondary data, without the use of patient identifiers or direct patient involvement.

Conflict of Interest

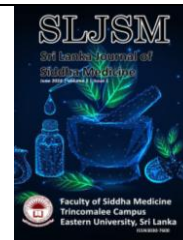
The author declares no conflict of interest.

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Anthropometric Measurement on Wrist and *Manikkadai Alavu* (Forearm Circumference) in *Gunmam* (Gastric Ulcer) Patients – A Comparative Study

Sugeevan R.^{1*}

^{1*} Senior Lecturer Gr II, Faculty of Siddha Medicine, University of Jaffna

*Corresponding author: r.rakulini@gmail.com

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ABSTRACT

Siddha Medicine is a system of traditional medicine originating in ancient Tamil Nadu in South India and Sri Lanka. Traditionally, it is taught that the *Siddhars* laid the foundation for this system of medicine. Siddha system has a unique diagnostic method to identify the diseases and their causes. *Manikkadai Nool* is one of the diagnostic tools. It is explained in the *Agasthiyar Soodamani Kajiru Soothiram* by Saint *Vedammamuni* in *Pathinen Siddhar Naadi Nool*. The aim of this study was to compare the wrist circumference and *Manikkadai alavu* (cm) in *gunmam* patients. It is an observational study. After identifying the eligible subjects, Data was collected by using the interview administrated questionnaire & relevant data was collected by measurement. Collected data were processed and statistically analyzed by a SPSS. The mean age of the subjects was 46.06 (SD±13.833). Majority of subjects in 14 (28%) were between 51 – 60 years of age. The majority of subjects in 30 (60%) were female. The average wrist circumference of the subjects was 16.3cm (SD ± 1.34) and 16.616cm (SD ± 1.24) and *Manikkadai alavu* was 18.10cm (SD ± 1.81) and 17.97cm (SD ± 1.82) in right and left hand. In group I, II and III, the mean value of right and left wrist circumferences was almost same. On the other hand, right and left *Manikkadai alavu* in cm was increase slightly. In the present study revealed that In Group I, II and III, the mean value of right and left wrist circumference.

was almost same. On the other hand, right and left *Manikkadai alavu* in cm was increase slightly. These slight differences may influence in the disease diagnosis by *Manikkadai Nool*.

Keywords: Diagnostic methods, *Gunmam*, *Manikkadai Nool*, Peptic ulcer, Siddha, Traditional Medicine.

INTRODUCTION

Gunmam is a gastrointestinal disorder. It is characterized by indigestion, epigastric pain, heartburn, nausea, vomiting, eructation, belching, body weakness, loss of body weight, flatulence and mental disturbances. Commonly it is classified into eight types. Various Siddha diagnostic methods are followed in Siddha system. *Manikkadai Nool* is one of the diagnostic tools. It is explained in the *Agasthiyar Soodamani Kajiru Soothiram* by Saint *Veadammamuni* in *Pathinen Siddhar Naadi Nool*. *Manikkadai Nool* measurement is the circumference of wrist which is measured four-finger breadth (fb) from the wrist. Wrist girth of the *Gunmam* is measuring by inelastic thread and expressing it in patient's own finger breadth units and interpreting a prognosis or diagnosis of diseases [3]. *Manikkadai Nool* measurement is a continuous ranging value from 4 to 11 fb with an interval of 0.25 fb between each value [3]. The method of measuring wrist circumference and the interpretation of different measurements are clearly mentioned in the text of *Pathinen Siddhar Naadi Nool*. So, I study, why measure the *Manikkadai alavu* four finger breath from the wrist which was studied in *gunmam* patients.

The aim of the study was to compare the wrist circumference and *Manikkadai alavu* among patients diagnosed with *Gunmam*. The objectives of this study were to assess the socio-demographic pattern of the subjects and to study the wrist circumference and *Manikkadai alavu* among patients with *Gunmam*.

MATERIALS AND METHODS

Study design: This was an observational study.

Study setting: This study was carried out in OPD (Out Patient Department) & IP at Government Siddha Medical College, Palayamkottai.

Study duration: This study was carried out from April – August 2019

Study population

Inclusion criteria

Age above 20 and below 65

Both sexes

Loss of appetite

Nausea / Vomiting

Belching

Eructation

Pain in the abdomen

Flatulence

Abdominal distension

Indigestion

Generalized weakness

Exclusion criteria

Age below 19 to above 80

GIT disorders other than *Gunmam*

Sample size: According to the inclusion & exclusion criteria, 50 *Gunmam* subjects were selected for this study.

Data collection

Selection of the subjects: The selection was made for all suitable *Gunmam* subjects who was come to the OPD & IPD in the study period.

Sampling techniques and randomization process: The subjects were selected by simple random method.

Study instrument

Questionnaire: Questionnaire was prepared based on the specific objectives

Informed consent form: Informed concerned form was prepared by the researcher and written consent was obtained from selected subjects before the commencement of the study.

Study procedure

Subjects who were diagnosed as *Gunmam* was examined by researcher in the OPD & IPD. All relevant information was collected by interrogation & clinical examinations. In addition, diagnostic cards or earlier medical records was looked to get more information.

After identifying the eligible subjects, relevant information was collected by using the interview administrated questionnaire & relevant data was collected by measurement.

***Manikkadai alavu* (which are mentioned in Siddha literature) (Forearm Circumference)**

To measure the wrist circumference in finger breadth, the patient was asked to keep his left hand's four fingers on the wrist, then the doctor measured the circumference of the right wrist just below index fingers of the left hand of the patient using a inelastic twine, then the twine was removed from the wrist and placed on the patient's finger (above the metacarpal phalangeal joint on the palmar surface) and the measure the twine in finger breadth. Measure the wrist circumference of other hand likewise.

Anthropometric parameters

Wrist Circumference - Measure the wrist circumference with the help of measuring tape.

***Manikkadai alavu* in cm** - Measure the *Manikkadai alavu* in cm, four finger breath from the wrist by measuring tape.

Data analysis - Data was entered and *analyzed* with the usage of Microsoft Excel and SPSS. Collected literature review information also was compare with the results.

Quality assurance - The quality of the study was assured as the protocol of the study was submitted in peer review board and expert's opinions are taken. The whole study was done in supervision of faculties of the department and guide of the study.

RESULTS AND DISCUSSION

Distribution of Demographic Characteristics of study population

The mean age of the subjects was 46.06 (SD±13.833). Majority of subjects in 14 (28%) were between 51 – 60 years of age. The majority of subjects in 30 (60%) were female.

Table 1: Demographic characteristic of the study population

Characteristics	η = 50	
Gender	η	%
Male	20	40
Female	30	60
Age (Years):	η	%
21 - 30	13	26
31 - 40	3	6
41 - 50	13	26
51- 60	14	28
61 - 70	7	14
Mean age:	(Mean $\pm$ SD)	
Total	46.06 $\pm$ 13.833	
Male	45.50 $\pm$ 13.276	
Female	46.43 $\pm$ 14.405	

η : Frequency; %: Percentage; SD: Std. deviation

Table 2: Description of measurement of wrist circumference (WRC) and *Manikkadai alavu* (MA) (cm) in *gunmam* patients

	Mean
Rt WRC	16.300 ± 1.3439
Lt WRC	16.616 ± 1.2443
Rt MA (cm)	18.108 ± 1.8100
Lt MA (cm)	17.978 ± 1.82592

The mean Wrist circumference of the subjects was 16.3 (SD ± 1.3439) and *Manikkadai alavu* (cm) of the subjects was 18.108 (SD ± 1.8100) in right hand. The mean Wrist circumference of the subjects was 16.616 (SD ± 1.2443) and *Manikkadai alavu* (cm) of the subjects was 17.978 (SD ± 1.82592) in left hand.

Table 3: Description of measurement of *manikkadai alavu* by using traditional method in *gunmam* patients

		Mean
Rt Hand	Rt MA	9.3950 ± 0.7777
	Lt MA	9.3950 ± 0.7777
Lt Hand	Rt MA	9.3150 ± 0.77230
	Lt MA	9.3150 ± 0.77230

The mean Right *Manikkadai Alavu* of the subjects was 9.3950 (SD ± 0.7777) and Left *Manikkadai Alavu* of the subjects was 9.3950 (SD ± 0.7777) in right hand. The mean Right *Manikkadai Alavu* of the subjects was 9.3150 (SD ± 0.77230) and Left *Manikkadai Alavu* of the subjects was 9.3150 (SD ± 0.77230) for Left hand.

Table 4: Description of compare the measurement of right *Manikkadai alavu* with right and left *manikkadi alavu* and left *Manikkadai alavu* with right and left *manikkadi alavu* in *gunmam* patients

	Mean	t	Sig. (2-tailed)
Rt MA (cm)	18.108 ± 1.8100	68.787	0.000
Rt Hand/ Rt MA	9.3950 ± 0.7777	80.876	0.000
Lt Hand/ Lt MA	9.3950 ± 0.7777	80.876	0.000
Lt MA (cm)	17.9780 ± 1.82592	67.685	0.000
Rt Hand/ Rt MA	9.3150 ± 0.7723	80.708	0.000
Lt Hand/ Lt MA	9.3150 ± 0.7723	80.708	0.000

There were no significant differences observed between the measurement of right *Manikkadai alavu* (cm) with right and left *manikkadi alavu* and left *Manikkadai alavu* (cm) with right and left *manikkadi alavu* in *gunmam* patients.

Table 5: Description of compare the measurement of right wrist circumference with right *Manikkadai alavu* (cm) and Left wrist circumference with left *Manikkadai alavu* (cm) in *gunmam* patients

	Mean	t	Sig. (2-tailed)
Rt WRC	16.300 ± 1.3439	83.132	0.000
Rt MA (cm)	18.108 ± 1.8100	68.787	0.000
Lt WRC	16.616 ± 1.2443	91.583	0.000
Lt MA (cm)	17.9780 ± 1.82592	67.685	0.000

Anthropometric Measurement on Wrist and *Manikkadai Alavu* (Forearm Circumference) in *Gunmam* (Gastric Ulcer) Patients – A Comparative Study

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There were no significant differences observed between measurement of right wrist circumference with right *Manikkadai alavu* (cm) and Left wrist circumference with left *Manikkadai alavu* (cm) in *gunmam* patients.

Table 6: Description of measurement of wrist circumference and *Manikkadai alavu* in Group I, II & III subjects in *gunmam* patients

Group I : *Manikkadai Alavu* : 8 – 8.75

Group II : *Manikkadai Alavu* : 9 – 9.75

Group III: *Manikkadai Alavu*: 10 – 10.75

	Mean		
	Group I	Group II	Group III
Rt WRC	15.8500 ± .66858	16.173 ± .9377	16.575 ± 1.6697
Lt WRC	15.9167 ± .69402	16.060 ± .9797	16.362 ± 1.6053
Rt MA	16.0167 ± .62423	17.6733 ± 1.42902	18.5125 ± 1.73406
Lt MA	15.9000 ± .70427	17.587 ± 1.4870	18.238 ± 1.7695

The mean Right Wrist circumference of the subjects was 15.85 (SD ± 0.66858), Left Wrist circumference of the subjects was 15.9167 (SD ± 0.69402), Right *Manikkadai alavu* of the subjects was 16.0167 (SD ± 0.62423), Left *Manikkadai alavu* of the subjects was 15.9 (SD ± 0.70427) in Group I.

The mean Right Wrist circumference of the subjects was 16.173 (SD ± 0.9377), Left Wrist circumference of the subjects was 16.060 (SD ± 0.9797), Right *Manikkadai alavu* of the subjects was 17.6733 (SD ± 1.42902), Left *Manikkadai alavu* of the subjects was 17.587 (SD ± 1.4870) in Group II.

The mean Right Wrist circumference of the subjects was 16.575 (SD ± 1.6697), Left Wrist circumference of the subjects was 16.362 (SD ± 1.6053), Right *Manikkadai alavu* of the

subjects was 18.5125 (SD $\pm$ 1.73406), Left *Manikkadai alavu* of the subjects was 18.238 (SD $\pm$ 1.7695) in Group III.

In Group I, II and III, the mean value of Right and Left wrist circumferences was almost same. On the other hand, Right and Left *Manikkadai alavu* in cm was increase slightly.

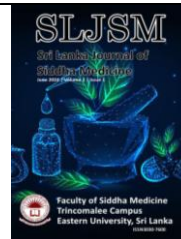
CONCLUSION

In the present study revealed that Majority of subjects in 14 (28%) were between 51 – 60 years of age and the majority of subjects in 30 (60%) were female. The average Wrist circumference of the subjects was 16.3cm (SD $\pm$ 1.34) and *Manikkadai alavu* of the subjects was 18.108cm (SD $\pm$ 1.81) in right hand. The average Wrist circumference of the subjects was 16.616cm (SD $\pm$ 1.24) and *Manikkadai alavu* of the subjects was 17.978cm (SD $\pm$ 1.82) in left hand. The average *Manikkadai alavu* of the *gunmam* subjects was 9 $\frac{1}{4}$. In Group I, II and III, the mean value of Right and Left wrist circumferences was almost same. On the other hand, Right and Left *Manikkadai alavu* in cm was increase slightly. These slight differences may influence in the disease diagnosis by *Manikkadai Nool*. There were no significant differences observed between *Manikkadai alavu* (cm) in right and left hands.

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Siddha Management of *Thol Thadippu* (Plantar Hyperkeratosis) Using *Sirattai Thailam*

K. Pavithra¹, V. Shomesh², S. Subaveena³, T. Soruban⁴ and V. Sathiyaseelan⁵

¹Medical Officer, Ceylon Hospital pvt, Ltd, Sri Lanka.

²Postgraduate student, University of Kelaniya, Sri Lanka

³Medical officer, Siddha Teaching Hospital, Kaithady, Sri Lanka.

⁴Senior Registrar, PGIIM, University of Colombo, Sri Lanka.

⁵Senior Lecturer, Faculty of Siddha Medicine, University of Jaffna, Sri Lanka

Corresponding author: sorruthiru@gmail.com, krishnanpavithra3@gmail.com

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ABSTRACT

Plantar hyperkeratosis, characterized by localized thickening of the skin on the plantar surface of the foot, is commonly caused by chronic friction and pressure, particularly in the heel and forefoot regions. It affects approximately 20–65% of adults aged above 65 years and around 18% of the working population, especially women. *Thol Thadippu* is not specifically mentioned under the 4,448 diseases described in Siddha medicine, it is referred as an indication in Siddha literature and generally means thickening of skin. Its clinical features may thus be related to plantar hyperkeratosis. This study aimed to evaluate the clinical efficacy of *Sirattai Thailam*, a traditional Siddha herbal oil preparation described in the Siddha Formulary of India (Part I). *Sirattai Thailam* is primarily composed of ripened coconut shells and prepared using the *Kuzhi Thailam* method (*Bhupuda Thailam*), traditionally used to treat thickened skin. A 19-year-old male with a 4-year history of plantar hyperkeratosis affecting the left heel and metatarsal regions (2nd - 4th) was selected for this study. After cleaning the affected areas with saline, *Sirattai Thailam* was applied on gauze and dressed daily for 8 weeks. Assessments included surface texture (imaging), hyperkeratosis size (ruler/tracing), quality of life using the

Foot Health Status Questionnaire (FHSQ), and patient satisfaction. Over the 8-week period, significant improvement was observed. The hyperkeratosis grade reduced from 3 to 1 on visual inspection. Heel lesion size improved from 4.8×5.8 cm to 3.5×5.8 cm, and the metatarsal area reduced from 3.8×3.4 cm to 3.2×3.0 cm. The FHSQ score improved from 75% to 91.15%. The participant reported high satisfaction and good compliance, with no adverse effects. *Sirattai Thailam* may be of interest as a potential non-invasive treatment for plantar hyperkeratosis, supporting its integration into dermatological care. Further controlled studies are warranted to confirm long-term efficacy and recurrence outcomes.

Keywords: *Bhupuda thailam*, *Kuzhi thailam*, Siddha Traditional Medicine, *Sirattai thailam*, *Thol thadippu*

INTRODUCTION

Plantar hyperkeratosis refers to localized thickening of the skin on the plantar surface of the foot, most commonly affecting the heel and forefoot regions. It is primarily caused by chronic friction and pressure and may lead to pain, impaired foot function, and, in individuals with diabetes, an increased risk of ulceration¹. *Thol Thadippu* is not one of the 4448 diseases mentioned in Siddha medicine in particular. However, the condition is mentioned as an indication in Siddha literature and is generally understood to mean thickening of the skin. The clinical features of this condition are similar to plantar hyperkeratosis. So in the present study *Thol Thadippu* can be clinically correlated with plantar hyperkeratosis. Plantar hyperkeratosis is one of the most common dermatological conditions affecting the foot across all age groups. It is estimated to affect 20–65% of adults over 65 years of age and approximately 18% of the working population, with a higher prevalence among women². The gold standard treatment is scalpel debridement performed by a podiatrist. However, this procedure may be difficult for some patients to access or tolerate, highlighting the need for safe, effective, and non-invasive alternative therapies³. This study explores the potential effectiveness of external Siddha management using *Sirattai Thailam* in the treatment of chronic plantar hyperkeratosis, the selection of *sirattai Thailam* was based on its traditional siddha indication for *Thol Thadippu*, particularly in cases where internal medication is not preferred. *Sirattai Thailam* is a traditional Siddha herbal oil preparation described in classical Siddha literature, including the *Siddha Formulary of India (Part I)*, *Gunapadam – Mooligai Vaguppu (Muthal Pagam)* and

Pharmacopoeia of Hospital of Indian Medicine ⁴⁻⁶. The *Pharmacopoeia of Hospital of Indian Medicine* text highlights its important therapeutic applications for external use, particularly in conditions such as *Natpatta thol noi* (chronic skin diseases) and *Thol Thadippu* (skin thickening)⁶.

OBJECTIVES

The objective of this single case observational study was to observe the clinical changes in a patient with plantar hyperkeratosis, correlated with *Thol Thadippu*, during the treatment with *Sirattai Thailam*. Specifically, the study was designed to assess changes in lesion size and patient reported foot health throughout the treatment period using lesion measurements and digital imaging and the Foot Health Status Questionnaire (FHSQ).

CASE DETAILS

A 19-year-old male student from Thirunelvely, Sri Lanka, presented with a four-year history of plantar hyperkeratosis on the left heel and ball of the foot. The condition caused discomfort and mild pain, and the patient had previously sought treatment at Western hospitals without satisfactory results. The patient was subsequently received treatment at the Siddha Teaching Hospital, Kaithady, where scalpel debridement was initially performed. But no satisfactory improvement was obtained and hence external treatment with *Sirattai Thailam* was subsequently initiated.

On examination, the lesions were irregular in shape with clearly demarcated borders and yellowish discoloration due to dirt trapping, without hyperpigmentation or treatment associated lesions. The hyperkeratosis was asymmetrically distributed on the left heel and ball of the foot, and the surrounding skin appeared normal. The patient exhibited a flat foot deformity. Gait analysis showed normal pressure distribution, and the patient wore standard sandals. On palpation, the lesions were hard and of uniform thickness, with reduced temperature and monofilament sensation compared to normal skin. Mild tenderness was present, and the edges were well-defined but irregular, showing diffuse thickening. The measured size of the plantar hyperkeratosis was 4.8 × 5.8 cm on the heel and 3.8 × 3.4 cm on the ball of the foot

METHODOLOGY

This study is a single-case observational study at the Inpatient Division of Siddha Teaching Hospital, Kaithady. In this case, internal medications were not administered, as the patient preferred only external therapy.

The external treatment involved cleaning the affected areas of the left heel and ball of the foot with saline, followed by the application of *Sirattai Thailam* on gauze, which was then dressed over the lesions (Figure 2). Dressings were changed daily, with follow-ups on alternate days and weekly assessments, over a total duration of eight weeks. Outcome measures included evaluation of surface texture using digital imaging, measurement of hyperkeratosis size via ruler and tracing, assessment of quality of life using the Foot Health Status Questionnaire (FHSQ) assessed by physician, and documentation of patient satisfaction. Descriptive analysis was used to evaluate changes in lesion size, texture, and patient-reported outcomes throughout the treatment period.

Foot Health Status Questionnaire (FHSQ) Assessment

Patient-reported outcomes were evaluated using the FHSQ across four domains: Pain (Q1–Q4), Function (Q5–Q8), Footwear (Q10–Q12), and General Foot Health (Q9, Q13)^{8,9}. Scores were converted to percentages using the formula:

For Pain domain:

$$\text{Pain score (\%)} = [(5 - \text{Average of Q1 to Q4}) \div 4] \times 100$$

For other domains: (Function, Footwear, and General Foot Health)

$$\text{Domain score (\%)} = [(5 - \text{Average score of items in the domain}) \div 4] \times 100$$

RESULTS

Development and Composition of *Sirattai Thailam*:

Sirattai Thailam is prepared using ripened coconut shells (*Mutriya Tengai Sirattai Odugal*) in sufficient quantity. The drug is broken into small pieces and placed in an earthen pot, which has a small perforation at the bottom. The opening is fitted or connected to allow the distillate to collect in a receiving vessel. The mouth of the pot is then sealed using *Seelai* (a mixture of cloth and clay) to prevent vapor leakage.

The preparation is carried out using the *Kuzhi Pudam* method (destructive distillation). A pit is made in the ground, and a collecting vessel is placed at the center. The drug-filled earthen pot is positioned above this collecting vessel in such a way that the distillate can drip down into it. The setup is then covered properly and subjected to heat by arranging and igniting cow dung cakes (*Varatti*) around and over the pot.

On heating, the coconut shells undergo destructive distillation, and the medicated oil (*Sirattai Thailam*) is released in vapor form, which condenses and collects in the receiving vessel (Figure 1). The collected oil is then used for external application, either alone or mixed with an equal quantity of coconut oil or *Amirta Vennai*.

Plantar Hyperkeratosis Measurement

The size of the plantar hyperkeratosis was measured weekly using a tracing method. Table 1 summarizes the reduction in lesion size over the 8-week treatment period. The heel lesion decreased by 1.3 cm in length, and the ball of the foot decreased by 0.6 cm in length and 0.4 cm in width over 8 weeks, showing progressive reduction in hyperkeratosis size.

Foot Health Status Questionnaire (FHSQ) Assessment.

Table 2 shows the patient's Foot Health Status Questionnaire (FHSQ) scores before and after eight weeks of treatment with *Sirattai Thailam*. Scores were converted to percentages using the formula. Before treatment, the overall FHSQ score was 75%, reflecting mild pain, slight functional limitations, and moderate foot discomfort. After treatment, the overall score improved to 91.15% with notable reductions in pain (93.75%), improved function (87.5%),

better footwear comfort (83.33%), and excellent general foot health (100%). These results indicate significant improvement in the patient's foot health and quality of life.

Visual Grading of Hyperkeratosis

The severity of plantar hyperkeratosis was assessed using a simple visual grading scale (Figure 3). Grade 1 represents mild thickening of the skin that is smooth and painless. Grade 2 indicates moderate thickening with some discomfort, while Grade 3 describes severe thickening accompanied by pain and the potential for cracks or fissures in the skin. Baseline hyperkeratosis was graded as Grade 3 with significant thickening and discomfort. After the eight weeks of treatment with *Sirattai Thailam*, the lesion showed clinically progressive improvement. After the treatment period, hyperkeratosis was graded as Grade 1, with mild residual thickening and no pain reported. This gain was consistent with the observed decrease in lesion thickness and related discomfort.

DISCUSSION

This case suggests a possible role of *Sirattai Thailam*, a Siddha external preparation in the management of plantar hyperkeratosis. There was progressive clinical improvement during the eight-week treatment period, with evidence of reduction in skin thickening and lesion size and improvement in foot surface appearance documented by digital imaging. Improvements in Foot Health Status Questionnaire (FHSQ) scores were also observed, particularly in domains related to foot health and comfort.

The findings are in agreement with the traditional Siddha use of *Sirattai Thailam* in skin thickening conditions and chronic skin disorders. The slow clinical improvement over the treatment period with no adverse effects reported suggests that further investigation of this external therapy is warranted. The observed improvement, however, cannot be certainly attributed to the intervention because this report is based on a single patient. Further controlled studies with larger sample sizes and longer follow-up periods are needed to evaluate its efficacy, safety and recurrence outcomes.

CONCLUSION

In this case, treatment with *Sirattai Thailam* was associated with improvement in plantar hyperkeratosis, including a reduction in lesion severity and improvement in patient-reported foot health and comfort. These results suggest that *Sirattai Thailam* can be considered as a complementary or alternative approach to conventional treatments for plantar hyperkeratosis. Further controlled studies are warranted to confirm its long-term efficacy and assess recurrence outcomes.

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CONFLICT OF INTEREST

The authors reported that there were no competing interests.

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Tables

Table 1: Weekly Measurement of Plantar Hyperkeratosis (cm)

Date	Left heel length	Left heel width	Ball of foot length	Ball of foot width
2025 FEB 28	4.8	5.8	3.8	3.4
2025 MAR 07	4.4	5.8	3.8	3.4
2025 MAR 14	4.2	5.8	3.7	3.4
2025 MAR 21	4.0	5.8	3.7	3.3
2025 MAR 28	3.8	5.8	3.6	3.3
2025 APR 04	3.7	5.8	3.4	3.3
2025 APR 11	3.6	5.8	3.3	3.1
2025 APR 18	3.5	5.8	3.2	3.0

Table 2: FHSQ Scores Before and After Treatment (%)

Domain	Before Treatment	After Treatment
Pain (Q1–Q4)	75.00	93.75
Function (Q5–Q8)	75.00	87.50
Footwear (Q10–Q12)	75.00	83.33
General Foot Health (Q9, Q13)	75.00	100.00
Overall	75.00	91.15

Figures

Figure 1: End product *Sirattai Thailam*



Figure 2: External treatment procedures with *Sirattai thailam*



Figure 3: Images of *Sirattai Thailam* management



AUTHORS GUIDELINES

Aims and scope

Sri Lanka Journal of Siddha Medicine (SLJSM) is published by the Faculty of Siddha Medicine, Trincomalee Campus, Eastern University, Sri Lanka. It is a refereed journal that publishes original articles, reviews, and case study relevant to the Health related disciplines and Allied Sciences

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Submission of a manuscript to the Editor involves the assurance that it is original and that no similar paper, other than an abstract or an oral or poster presentation, has been or will be submitted for publication elsewhere without the consent of the Editorial Board. The language of publication is English. Papers are edited to increase clarity and ease of communication.

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Acknowledgements

- Sources of funding should be listed
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Tables

- Tables follow the literature cited section
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