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Editorial

Minimal Intervention Dentistry

Dr Albert MP Lee

Dental Bulletin

Ocular Complications after Inferior Alveolar Nerve Block

Dr. Chun-kei Lee

Aesthetic Dentistry and Orthodontics **CME**

Prof. A Bakr M Rabie

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Why There is a Need for Hospital Dental Services?

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Dr. Siu-fai Leung

Special Feature

Are You Ready for Court?

Dr. Edward Fan

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FEDERATION 2006 ANNUAL DINNER

See P.29

News from FMSHK Society News Medical Diary of August Calendar of Events

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Contents

Editorial

- Minimal Intervention Dentistry 2
Dr Albert MP Lee

Dental Bulletin

- Ocular Complications after Inferior Alveolar Nerve Block 4
Dr. Chun-kei Lee
- Aesthetic Dentistry and Orthodontics **CME** 7
Prof. A Bakr M Rabie
Dr. Ricky WK Wong
Prof. Nigel M King
- MCHK CME Programme Self-assessment Questions 10
- Why There is a Need for Hospital Dental Services? 11
Dr. Sai-kwing Chan

- Traumatic Dental Injuries to the Permanent Dentition 15
Dr. Siu-fai Leung

Special Feature

- Are You Ready for Court? 19
Dr. Edward Fan

Federation News 22

Society News 22

- News from Member Societies 22

Medical Diary of August 26

Calendar of Events

- Meetings 28
- Courses 28



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Minimal Intervention Dentistry

Dr. Albert MP Lee

Editor



Dr. Albert MP Lee

Dentists are used to be trained in a highly technical demanding skill in managing dental diseases like dental caries in order to restore the function of the teeth. In the past, once an incipient or early dental caries lesion is detected, invasive techniques like "cut, drill and fill" will be applied. With the current understanding of the nature of the disease and its process, the treatment philosophy is now changing to a more conservative approach and the concept of "minimal intervention" is gaining its popularity throughout the world in modern dentistry.

The current treatment philosophy is to prevent and detect dental diseases at the earliest stage in order to avoid invasive treatment. On the other hand, when surgical intervention is indicated, the least invasive techniques such as preventive resin restoration and minimal cavity preparation are utilised. Recent advances in technological innovation and dental materials science, allow dentists to have new armamentaria and tools to identify and heal early lesions by therapeutic means and measures such as surface protection and internal remineralisation. The introduction of fluoride in the oral environment plays an important role in modifying the disease pattern and progression. All these minimal intervention treatment techniques enable the preservation of dental tissue and the creation of an oral environment that will enhance the longevity of restorations and improve the life span of the diseased tooth in the oral cavity.

Apart from managing dental caries, the concept of minimal intervention could be applied to all other aspects of clinical dentistry in the maintenance of oral health for patients. Implementing invasive dental procedures are now weighted against long-term benefits of oral health and the well being of patients. Repeated invasive restorative procedures can further lead to the damage of sound tooth structures resulting in loss of tooth; inappropriate oral surgical procedures may lead to unpleasant complications or damage of surrounding vital tissues. If the treatment outcomes are not predictable, patients could be benefitted by a conservative approach or a non-invasive technique. Perhaps one day, the traditional practice of "cut and drill" by dentists could be replaced by "observe and preserve" with more evidence-based research in different disciplines of dentistry.

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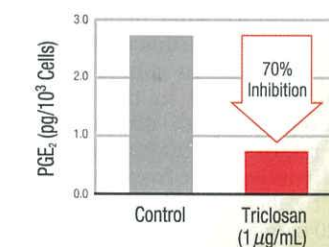
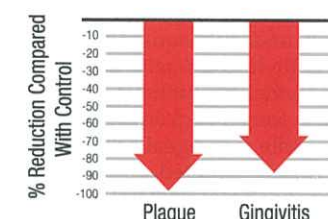
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Ocular Complications after Inferior Alveolar Nerve Block

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Dr. Chun-kei Lee

It has been more than 120 years since Carl Koller used cocaine as a local anaesthetic agent. Nowadays, administration of local anaesthetic is one of the commonest and most important procedures in dentistry. Although there may have some rare systemic complications after intra-oral local anaesthesia, most complications are local and temporary. These complications include haematoma formation, tissue blanching, pain due to nerve impingement or injection into muscle, trismus and facial nerve paralysis. A rare but serious complication, permanent damage of the inferior alveolar nerve and lingual nerve, may result from inferior alveolar nerve block (IANB) but the exact mechanism is still unknown.¹ Ocular complications after intra-oral dental anaesthesia are infrequently reported in the literature and these complications include strabismus, ptosis, diplopia, ophthalmoplegia and amaurosis (blindness).² Walsh (1957) described a case of permanent amaurosis after dental anaesthesia of upper teeth and he attributed this to the oily nature of the local anaesthetic solution containing procaine hydrochloride which resulted in the embolism of retinal artery.³ For the past 45 years, ocular complications after middle or posterior alveolar nerve block were reportedly twice more frequent than IANB.⁴ A literature review by the author of the present paper reveals more than 20 cases of ocular complications after IANB. About two third of cases had ocular complications of diplopia while one half of cases had amaurosis. Most cases had the complications disappeared within one to several hours. However, there were three cases in which the complications persisted after the local anaesthetic effect wore off. van der Bijl and Lamb (1996) reported that, after an IANB, a 14-year-old girl had blurred vision which lasted for 24 hours.⁵ O'Connor and Eustace (1983) described that a 61-year-old woman had diplopia, marked esotropia and dilated pupil immediately after IANB.⁶ An ophthalmic examination three days later revealed that the ocular movements were normal except that there was limitation of abduction of the affected eye with horizontal diplopia in dextroversion. Four weeks after the incident, the ocular movements returned to normal but the pupil remained dilated. A catastrophic accident happened to a 21-year-old woman who received an IANB for restoration of teeth.⁷ Immediately after IANB, the patient complained of complete hemifacial sensory and motor paralysis and an ophthalmic examination a few hours later revealed reduction in visual acuity. A six-month review showed that there was atrophy of the optic nerve.

Hypothesis of ocular complications

Hitherto, there is no agreement to the exact aetiology of ocular complications after IANB. However, it is generally agreed that the local anaesthetic solution reaches the orbit through vascular, neurological and lymphatic network.⁸

1. Arterial system

This hypothesis is supported by the presence of transient dizziness, blanching of the skin, and anaesthesia of the lateral parts of the upper and lower eyelids which are supplied by the lacrimal nerve that is dependent upon the lacrimal artery.⁹ The inferior alveolar artery runs posteriorly to the nerve and therefore, local anaesthetic solution may accidentally be injected into the artery. Although initial aspiration may show a negative finding, minor movement of the patient or the needle may cause the penetration of the arterial wall and subsequently the local anaesthetic solution will be injected into the arterial system. Since the local anaesthetic solution is injected under pressure, the solution is forced back into the maxillary artery. The origins of middle meningeal artery and inferior alveolar artery are closely situated and the solution may gain access to the middle meningeal artery which may enter the cranial cavity through the foramen spinosum and gives off many branches. The ophthalmic branch of the middle meningeal artery may anastomose with the lacrimal artery. The blood supply of the lateral rectus muscle derives from the lacrimal artery and from the lateral muscular trunk of the ophthalmic artery. Therefore, the intra-arterial injection of the local anaesthetics may reach and paralyse the lateral rectus muscle and cause diplopia. However, Fish and co-workers (1989) proposed that the accessory meningeal artery has intracranial terminal branches to the cavernous sinus and its content.¹⁰ Since the cranial nerves III, IV, and VI are in close proximity with the cavernous sinus, the authors explained that the complete paralysis of the right eye after a mandibular nerve block in a 29-year-old man using Gow-Gates technique was due to the temporary paralysis of cranial nerves III, IV, and VI. Singh and Dass (1960) studied 106 human orbits and found that the blood supply to the ophthalmic artery originated from the middle meningeal artery in six cases.¹¹ The central artery of the retina is a small branch of ophthalmic artery and the anaesthetic solution passing from the middle meningeal artery to the ophthalmic artery may then reach the eye, causing amaurosis (blindness) and loss of the pupillary



light reflex. In cases of permanent amaurosis, it was postulated that reflexive vasospasm of the central retinal artery resulted in ischaemia and necrosis of the retinal tissue.¹² Blaxter and Britten described three cases of transient ocular complication after mandibular nerve block.¹³ The first case involved a 16-year-old girl who was affected by blanching of skin lateral to the eye and above the eyebrow of the ipsilateral side, numbness of the face, loss of vision and diplopia. The second case had dilated pupil and loss of vision of the affected side while the third case had diplopia. The authors suggested that the different clinical manifestations were due to different degrees of the vascular anomaly.

2. Venous system

It has been suggested that the local anaesthetic solution, after an inadvertent entry into the venous system, will drain into the pterygoid venous plexus and thereby into the cavernous sinus through emissary veins traversing bony foramina.¹⁴ It will be more vulnerable when the patient is in the supine position. The abducens nerve may be more susceptible than other cranial nerves because it travels through the cavernous sinus. Therefore, it has been suggested that the venous spread of the local anaesthetic solution will explain the isolated ocular complications of diplopia resulting from the paralysis of lateral rectus muscle which is innervated by abducens nerve.

3. Sympathetic nervous system

Campbell and co-workers¹⁵ described a case with a Horner-like syndrome with ptosis, vascular dilatation of the conjunctiva, miosis and generalised rash over the left neck, face, shoulder and arm. They suggested the local anaesthetic misadventure resulted in a stellate ganglion block which explained the above symptoms and also the hoarseness of voice.

Management and prevention

Although it is rare to have ocular complications after IANB, the occurrence is alarming to both the dentist and patient. van der Bijl and Meyer⁸ suggested the following management guidelines:

1. Reassure patients as to the usually transient nature of these complications.
2. Cover the affected eye with a gauze dressing to protect the cornea for the duration of anaesthesia.
3. Functional monocular vision will be restored by covering the affected eye. The patient should be escorted home by a responsible adult, since monocular vision is devoid of distance-judging capability.
4. Should the ocular complications last longer than 6 hours, refer patients to an ophthalmologist for evaluation.

In order to prevent the ocular complications, injection into the vascular system must be avoided. It should not be overemphasised that the procedures of inferior alveolar block in children are different from adult and the craniofacial growth and the mandibular growth should be taken into consideration. The needle insertion

point should be higher in old age children. It has been suggested that the inferior nerve block should be administered 6mm above that the occlusal plane in 7 to 8 years old children but 10mm for 9 to 10 years old children.¹⁶ Moreover, it has been stated that aspiration of blood was significantly more common in patients aged 9-19 years old with 36% of 28 patients affected, than in patients of other age groups.¹⁷ In another study, there were 20% of positive aspirations in IANB in children of age group 7-12 years but only 10% in the age group of 15 to 16 years.¹⁸ Aspiration prior to injection and slow injections are mandatory. Frequent aspiration during the process of injection is encouraged. In the literature, only very few cases of ocular complications after IANB were reported in children. This may be due to the temporary effect of the complication and its rapid recovery without sequelae but it has been queried that these complications are under-reported.⁵ Moreover, it has been suggested that sudden monocular amaurosis may pass unnoticed by the patient and cases of visual disturbance following local anaesthesia in dentistry occur more often than are recognised.¹⁹ The author of the present paper had witnessed a case of ocular complications in a child who just cried suddenly after IANB but did not complain or even speak to the operator. It would be difficult to diagnose the ocular complications especially when the child was too young to comprehend and the child patient was wearing a sunglass during dental treatment. Therefore, the dentist treating child patients must be vigilant and beware of the ocular complications when performing IANB. More importantly, the clinicians should be able to diagnose and understand these rare complications and prepare to manage.

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Aesthetic Dentistry and Orthodontics

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This article has been selected by the Editorial Board of the Hong Kong Medical Diary for participants in the CME programme of the Medical Council of Hong Kong (MCHK) to complete the following self-assessment questions in order to be awarded one CME credit under the programme upon returning the completed answer sheet to the Federation Secretariat on or before 31 August 2006. One credit will be awarded for the Dental Council's CPD Program for Practising Dentists and one credit under the CDSHK CME Program (both subject to approval).

Aristotle said "Beauty is a greater recommendation than any letter of introduction". A statement that is true nowadays where attractive people have a much better chance of being successful. Dentists and orthodontists can greatly contribute to enhancing patient's smile, appearance, and subsequently self-confidence (Fig. 1).

Harmony between the dominant features of a face contributes to creating a beautiful face. The "Facial Dominant Features" are the smile with its components, teeth, gingiva and lips; eyes and facial frame.

Dentists and specialists in the dental profession are dealing with two out of the three dominant features of the face. They can greatly improve and alter the smile and greatly improve or alter the facial frame with orthodontics and/or orthognathic surgery (Fig. 2). In the following section we will review what constitutes a beautiful smile.

One begins to subconsciously analyse an object when one looks upon it, whether it is a face or a painting. Eyes are attracted first to a single location in the composition, most likely the most dominant, or bright, or moving part. In a face, the smile contains contrasts of bright teeth against red lips and is active in speech and expression. Thus, it is dominant and attracts one's attention first. Dentists can plan these visual channels in his/her composition using line, contrast and the size of objects by attending to the many details of a smile, including tooth position and the development of the smile to establish self-esteem, harmony and symmetry.

Malposed teeth, damaged by trauma or congenitally malformed teeth are in need of orthodontics and/or aesthetic reconstruction (Fig. 3). Therefore it is essential that the clinician has a comprehensive knowledge of the elements and basic principles of aesthetics and the specific characteristics of the individual's teeth.

The term aesthetic refers to an understanding of beauty. Therefore it is required to have an understanding of beauty and the artistic tools available to develop a beautiful smile.¹

"Golden Proportion" and "Beautiful Proportion"

demonstrate a desire to find a rational, physically measurable definition of beauty. "Beauty is that pleasant experience seen with subjective senses, interpreted by our associations, filtered by a philosophy of life, capturing our imagination through variety and distortion, and felt by intuition. The essence of beauty has been sought since the beginning of time".¹

Lombardi² defined 'dental aesthetics' by the way things were perceived visually. Visual perception could be divided into two categories: composition and proportion. Composition was the way colour, contour and texture are related to one another. Proportion was defined as balance, symmetry, parallel lines, curves and how they work together. The aesthetics of the face were said to encompass three views: the facial, the dentofacial and the dental views.³

The most important element is the facial composition. This composition influences most patients' concept of an aesthetic smile. From the normal distance at which one focuses on a person's face, the dentition appears white and straight. However, upon closer examination, the teeth are not straight they exhibit distinct proportions, characterisations and embrasures.

The second component in anterior dental aesthetics is the dentofacial composition (i.e., orofacial view). The constituents of the element are the oral orifice, the highly vascularised red lips, and the teeth, which act as a gate or entrance to the oral cavity.⁴

The dentofacial view involves the teeth and the surrounding structures of the gingivae and the lips. Rufenacht⁵ described this view as a coincidence of curves created by the contact points, incisal edges and the lower lip. It is important to evaluate the amount of teeth that are exposed when smiling and at rest.

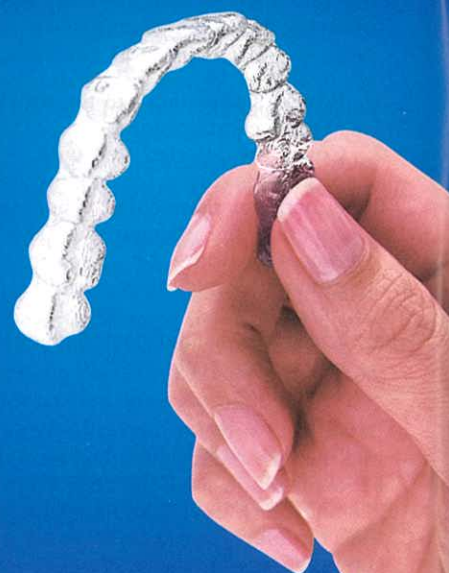
The smile line is an imaginary line that extends from the incisal edges of the maxillary incisors and is parallel to the curvature of the lower lip. It should not be confused with the lip line, which is the position of the upper lip during smile formation. It is the lip line that determines the display of teeth and gingiva. Proper placement of the incisal edges maintains the

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harmonious patterns that we see in natural smile lines.⁶ The anterior and lateral negative spaces act as a border to the dental elements, while the lips represent the frame.⁴

Tjan and Miller⁷ pointed out the average smile revealed 75% to 100% of the maxillary anterior teeth; the incisal curve of the teeth should be parallel to the lower lip and the incisal curve of the maxillary teeth should touch or just fail to touch the lower premolars. On average, women expose twice as much of their maxillary teeth as men (3.40mm vs. 1.91mm).³

To sum up, the perfect smile is aligned with the interpupillary line and centred on a perpendicular midline of the face.

The relationship from tooth-to-tooth is the next point that needs to be considered. It was the Greeks who tried to formulate beauty as an exact mathematical concept, they believed that beauty could be quantified and represented in a mathematical formula. This led Pythagoras to conceive the "Golden Proportion" ($1/1.618=0.618$), and Plato, the "Beautiful Proportion" ($1/1.733=0.577$), both concepts stated that a shape or object with specific proportion is perceived as having innate beauty. The most widely used concept in dentistry is that of the Golden Proportion, whose formula is as follows:

$$S/L=L/(S+L)=2/(1+\sqrt{5})=0.618$$

where S is the smaller and L the larger part. The uniqueness of this ratio is that when applied by three different methods of calculation (linear, geometric, and arithmetic), the proportional progression from the smaller to the larger to the whole part always produces the same results.^{8,9} Other researchers have indicated that in reality this Golden Proportion is not always evident, and variations are frequently apparent.¹⁰ If a clinician is to use the 0.75 ratio as a standard for determining the dimensions of a central incisor, then a progressive application of this ratio, from the central-lateral-mesial aspect of the canine tooth, will create an aesthetic composition.⁴

The single most impressive aspect of a face is the smile. The smile captures another person's attention, and its characteristics are critical to beauty (Fig. 4). There are repeating lines in a beautiful smile, the incisal edges of the upper teeth and the border of the lower lip form repeating lines that are referred to as the smile line. This repetition imparts harmony and unity to the smile, so too, does the repetition of vertical lines separating each tooth and the parallelism of the upper gingival line and lower border of the upper lip.¹

These elements are essential to dentists because they are common to virtually every conservative aesthetic dental procedure. Therefore, a basic knowledge and understanding of these artistic elements is required if a tooth or multiple teeth are to be restored in such a way as to attain an acceptable aesthetic result.

Tooth morphology, incisal edge position, emergence profile, contact points, incisal and cervical embrasures all play an important role in identifying and determining the aesthetic smile. These criteria must be evaluated during the planning and operative stages of aesthetic dentistry in order to achieve success with the final restorations.

To aesthetically restore a single anterior tooth is extremely difficult. By using a previsualised mock-up and knowledge of composite materials, the modifiers selected, and its shade and orientation, the definitive restoration can be visualised prior to completion. The transformation of this "vision" into an aesthetic creation that replicates natural variation constitutes the clinician's final challenge.¹¹

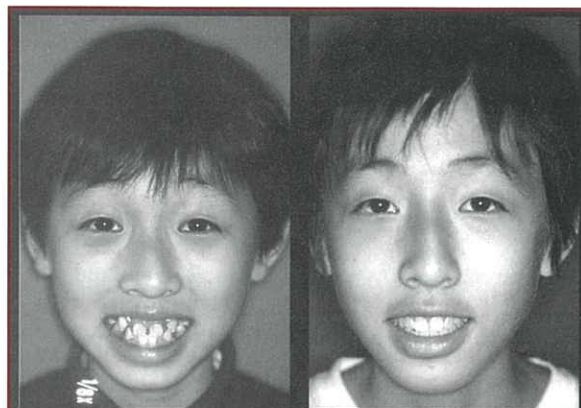


Fig 1. Patient with orthodontic treatment. Before (left) and after (right) treatment.

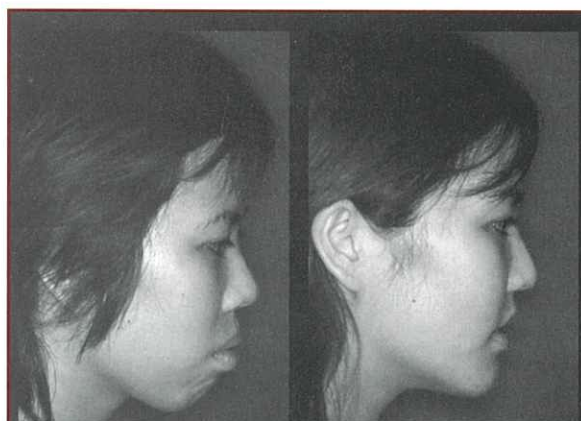


Fig 2. Patient with malocclusion needing combined surgical orthodontic treatment. Before (left) and after (right) treatment.

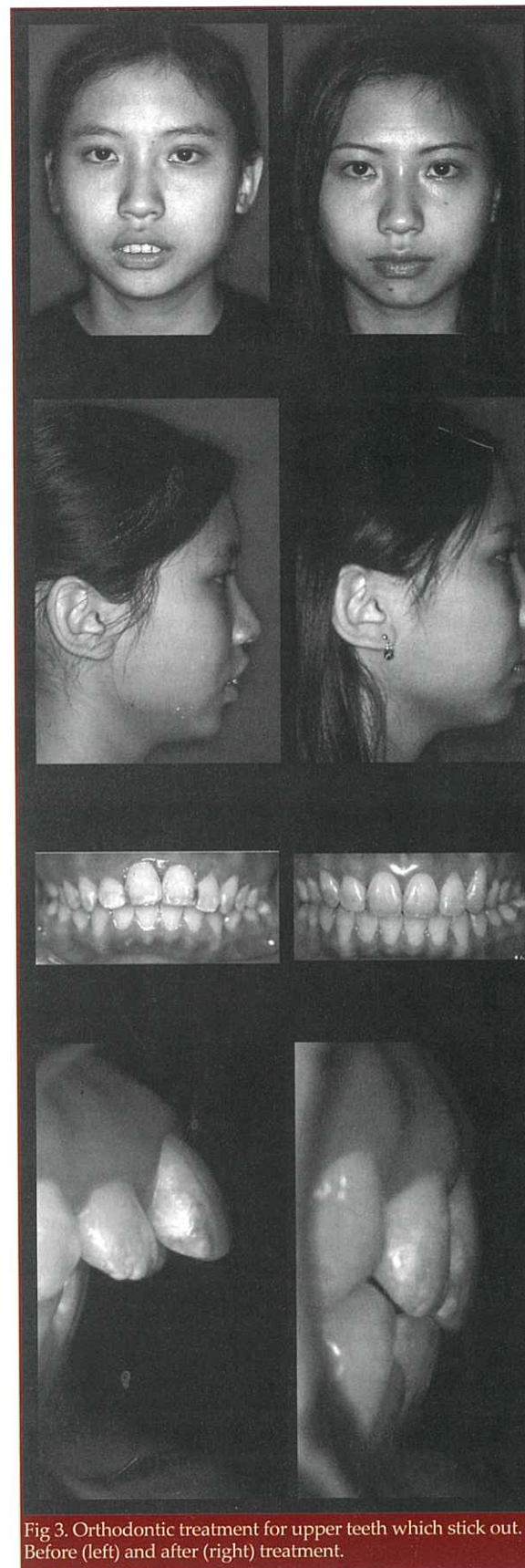


Fig 3. Orthodontic treatment for upper teeth which stick out. Before (left) and after (right) treatment.

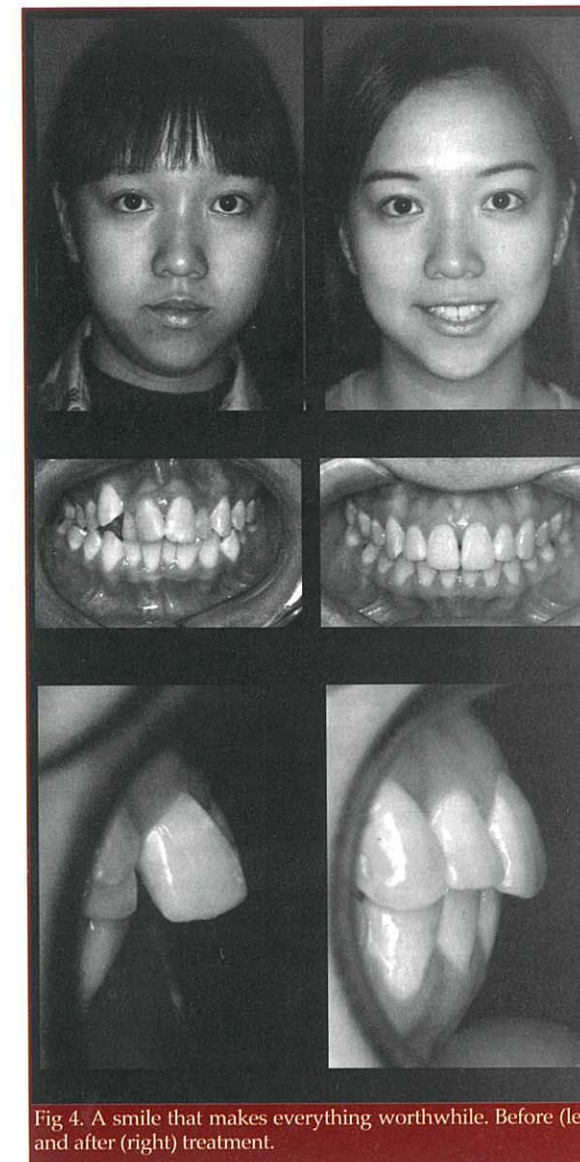


Fig 4. A smile that makes everything worthwhile. Before (left) and after (right) treatment.

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MCHK CME Programme Self-assessment Questions

Please read the article entitled "Aesthetic Dentistry and Orthodontics" by Prof. A Bakr M Rabie and complete the following self-assessment questions. Participants in the MCHK CME Programme will be awarded 1 CME credit under the Programme for returning completed answer sheet via fax (2865 0345) or by mail to the Federation Secretariat on or before 31 August 2006. One credit will be awarded for the Dental Council's CPD Program for Practising Dentists and one credit under the CDSHK CME Program (both subject to approval). Answers to questions will be provided in the next issue of The Hong Kong Medical Diary.

Questions 1-10: Please answer T (true) or F (false)

1. Eyes are attracted first to a single location in any composition, most likely the most dominant, or bright, or moving part.
2. Visual perception could be divided into two categories: composition and proportion.
3. The first component in anterior dental aesthetics is the dentofacial composition (i.e., orofacial view).
4. The smile line is an imaginary line that extends from the incisal edges of the maxillary incisors and is parallel to the curvature of the lower lip.
5. On average, women expose as much of their maxillary teeth as men.
6. It was the Romans who tried to formulate beauty as an exact mathematical concept. They believed that beauty could be quantified and represented in a mathematical formula.
7. The single most impressive aspect of a face is the smile.
8. The "Golden Proportion" is $1/1.733=0.577$
9. Tjan and Miller pointed out the average smile revealed 75% to 100% of the maxillary anterior teeth.
10. Aristotle said "Beauty is a greater recommendation than any letter of introduction".

ANSWER SHEET FOR AUGUST 2006

Please return the completed answer sheet to the Federation Secretariat on or before 31 August 2006 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions. One credit will be awarded for the Dental Council's CPD Program for Practising Dentists and one credit under the CDSHK CME Program (both subject to approval).

Aesthetic Dentistry and Orthodontics

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Orthodontics, Faculty of Dentistry, The University of Hong Kong, Prince Philip Dental Hospital

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Answers to July 2006 issue

Current guidelines in the treatment of hypertension

1. T 2. T 3. F 4. T 5. F 6. T 7. F 8. T 9. F 10. T



Why There is a Need for Hospital Dental Services?

Dr. Sai-kwing Chan BDS, FRACDS, FHKAM (Dental Surgery), FCDSHK (OMS)

*Consultant Oral & Maxillofacial Surgeon
Queen Elizabeth Hospital*



Dr. Sai-kwing Chan

Introduction

It has been said that the dentist too often looks at the mouth as if there were no man (or woman); and in the Hospital, too often is the man (or woman) looked at as if there were no mouth¹.

In Hong Kong, hospital dental services are provided in many but not all general hospitals. For public hospitals, services are provided by the dental departments in Pamela Youde Nethersole Eastern Hospital, Queen Mary Hospital, Caritas Medical Centre, Kwong Wah Hospital, Our Lady of Maryknoll Hospital, Queen Elizabeth Hospital, United Christian Hospital, Alice Ho Miu Ling Nethersole Hospital, North District Hospital, Princess Margaret Hospital, Prince of Wales Hospital and Tuen Mun Hospital. For private hospitals, dental services are provided in Canossa Hospital, Evangel Hospital, Hong Kong Adventist Hospital, Hong Kong Baptist Hospital, Hong Kong Sanatorium & Hospital, Matilda International Hospital, Precious Blood Hospital, St. Paul's Hospital, St. Teresa's Hospital, Tsuen Wan Adventist Hospital and Union Hospital².

Apart from Oral & Maxillofacial Surgery, which is a dental specialty in its own right and carries other scope of services, hospital dental services are nowadays commonly available to cover for the demand from an increasing number of patients with medically compromised conditions.

Several areas whereby the mouth interacts with the body are discussed here in this article.

Anticoagulants and Antiplatelet drugs

Therapeutic anticoagulation is administered to patients with prosthetic heart valves, cardiomyopathy, thrombotic cardiovascular problems such as arrhythmias, atrial fibrillation, supra-ventricular valve disease, and following coronary artery by-pass graft to prevent venous thrombosis, deep vein thrombosis and pulmonary embolism³.

The British Committee of Standards in Haematology advises that minor surgery can be performed with an International Normalized Ratio (INR) of up to 2.5⁴, in most instances, the INR is adjusted to fall below 1.5⁵. The drop in INR, on the other hand, may present a significant problem of thromboembolism with the rebound phenomenon⁶. So it is suggested that it may be safer not to stop the warfarin prior to simple dental procedures

(e.g. uncomplicated forceps extraction of 1 or 2 teeth with INR less than 3.5) provided appropriate local measures are taken, as the risk of excessive post-operative bleeding outweighs the risk of thromboembolism⁷. It further implies that patients can now undergo dental extractions on an ambulatory basis⁸. Still the need for dentists trained and experienced in the prevention and handling of post-extraction bleeding in such cases will warrant dental treatments to be undertaken in a hospital setting. For minor dental surgery (e.g. extraction of an impacted wisdom tooth), patients should be treated in hospital and the INR needs to be adjusted and monitored⁹.

Acetylsalicylic acid (ASA) is commonly used in the treatment and preventions of thrombotic diseases¹⁰. A daily dose of 100mg of ASA has little effect on intraoperative and postoperative bleeding from dental extractions¹¹. Thus patients need not stop taking ASA before dental surgery in general.

Ticlopidine and clopidogrel are anti-platelet drugs acting on the ADP receptors implicated in platelet aggregation¹². This effect is irreversible and lasts for the life of the platelet (7 to 10 days). It has been suggested that patients should stop taking them 7 to 10 days before elective surgery¹³. Dipyridamole is another antiplatelet drug that acts by inhibiting phosphodiesterase. Its antiplatelet activity is less than that of ASA and ADP receptor blockers and is wholly reversible in about 24 hours after the drug is discontinued. Dental procedures can thus be performed then.

Infective endocarditis

Infective endocarditis (IE) is a rare, potentially fatal disease where susceptible endocardium or a prosthetic heart valve is colonised by microorganisms such as streptococci, staphylococci and candida¹⁴.

As oral microflora are found in many cases of IE, it is postulated that certain dental procedures lead to bacteraemia¹⁵ which subsequently leads to IE. It is now known that even normal oral functions such as chewing and tooth-brushing can cause transient bacteraemia lasting up to 30 minutes after the cessation of the procedure¹⁵. Interestingly, a cohort study has found no definitive link between IE and dental procedures, even in patients with valvular abnormalities¹⁶.

Of all the different guidelines in use around the world, no one regime has proven superior to another. The most



commonly adopted guideline for antibiotic prophylaxis against IE is the 1997 recommendations of the American Heart Association (AHA)¹⁷. An oral dose of amoxicillin 2g taken one hour before the procedure is the standard regime for non-penicillin-allergic adults.

The British Society for Antimicrobial Chemotherapy (BSAC) has recently published their latest guidelines¹⁸. Good oral hygiene is recognised as the most important factor in reducing the risk of IE in susceptible individuals. The BSAC suggests that only three groups of patients are at risk: those who have had IE, those with valve replacements and those with surgically-constructed systemic or pulmonary shunts or conduits. Prophylaxis is indicated in all dental procedures involving dento-gingival manipulation. The new antibiotic regimes are still essentially based on 3g amoxicillin regime for non-penicillin-allergic adults and 600mg clindamycin regime for penicillin-allergic adults. So it is prudent that all patients undergoing valvular surgery should have their dental conditions thoroughly checked. The aim is not merely to cover the period of transient bacteraemia induced by procedural intervention, but to maintain an optimal level of oral hygiene life-long. Interventions ideally should be performed 14 days prior to surgery to allow mucosal healing. All elective dental procedures should ideally be delayed for at least 3 months post-surgery.

Ischaemic heart disease

There are no contraindications to elective dental treatment of patients with stable angina¹⁹. Stress reduction and adequate local anaesthesia are important to minimize any elevation in endogenous catecholamines.

Total joint replacement

As in case of IE, the risk of bacteraemia is far more substantial in a mouth with ongoing inflammation than in one that is healthy and using proper oral hygiene measures. It is suggested that the most critical period is up to two years after joint replacement²⁰.

In 1997, the American Dental Association (ADA) and the American Academy of Orthopaedic Surgeons (AAOS) published their first Advisory Statement on Antibiotic Prophylaxis for Dental Patients with Prosthetic Joints. The Advisory Statement is further updated in 2003²¹. Essentially, for the first two years after a joint replacement, all patients may need antibiotics for all high-risk dental procedure. The recommended regime is based on 2g amoxicillin or 600mg clindamycin taken one hour before the procedure.

Radiation therapy for head and neck cancer

Most oral problems associated with radiation therapy can be prevented or minimised through optimal management. Patients planned for radiation therapy are now usually referred for a dental consultation before the commencement of therapy. There is no absolute rule for dental extractions before radiotherapy. Factors to be considered include the overall dental conditions (e.g.

caries, periapical status, periodontal conditions), previous dental care, current oral hygiene, the urgency of the cancer treatment, the radiation fields and dose, and the prognosis of the cancer²².

A period of healing after dental extraction before radiation therapy is considered essential. A consensus report in 1990 from the National Cancer Institute (NCI) recommended a minimum time of 2 weeks between extractions to the onset of radiation therapy²³.

Xerostomia is a symptom frequently encountered in radiation therapy. Functions of the salivary glands in the radiation field begin to be reduced by the second to third week of radiation treatment. The symptoms are progressive. The return of salivary function after radiation therapy is extremely variable and is related to the dose received.

Osteoradionecrosis (ORN) is the irreversible, progressive devitalisation of irradiated bone. Clinical manifestations of ORN may include pain, orofacial fistulas, exposed necrotic bone, pathological fracture and suppuration. About one-third of ORN develop spontaneously. Hyperbaric oxygen (HBO) therapy is considered an adjunctive treatment for ORN together with surgery.

Post-radiation dental extraction used to result in as high as 22% incidence of ORN²⁴. Dental extractions can nowadays be safely carried out with an atraumatic approach and follows a standard protocol to minimise ORN²⁵.

Obstructive sleep apnoea

Obstructive sleep apnoea (OSA) is defined as an apnoea/hypopnoea index (AHI) of 5 or more²⁶. This condition affects 2-4% of adults aged from 30 to 60 years²⁷. Nasal continuous positive airway pressure (CPAP) was introduced in 1981²⁸ and is the standard treatment modality. For patients who cannot tolerate CPAP, oral appliances provide the first-line non-invasive alternative to surgical treatment. By advancing the position of the mandible, the genioglossus muscle is pulled forward and the upper airway space posterior to the tongue base is increased. Oral appliances are found to be clinically effective in mild to moderate OSA²⁹. Such therapy requires close collaboration among the respiratory physicians, ENT surgeons and dentists. A hospital-based dental unit will be most convenient for the clinicians and patients.

Leukaemia

Initial signs and symptoms of leukaemia can appear in the mouth. Oral presentation such as spontaneous gum bleeding or gum swellings may be the reason for patients to seek dental care. Indeed, there are about two to three such cases attending our unit and later confirmed to be suffering from leukaemia. Mucosal pallor, mucosal purpura, lymphadenopathy, gingival bleeding, and petechiae are common oral manifestations³⁰.

Besides earlier detection, pretreatment dental care, in-patient care during period of chemotherapy, dental care during remission and long-term monitoring of the oral problems and dental development for child patients are essential. A protocol of oral care for children with acute

leukaemia³¹ has been developed and this has found to be most useful.

Lymphoma

Extradrinal lymphoma can arise in the jaw and presents with nonspecific signs and symptoms, such as painless swelling or pain in the mandible³². Burkitt's lymphoma can occur outside the African continent. There is at least one case in Hong Kong that is first presented as a jaw swelling and seen by a hospital dental unit³³.

Bone marrow transplantation

Bone marrow transplantation (BMT) is an accepted treatment for haematologic disorders such as leukaemia, lymphoma and multiple myeloma. A thorough dental examination is now normally undertaken for cases planned for BMT. Radiographic examination is required to detect occult dental disease³⁴. All potential or existing source of infection must be identified because patients are rendered agranulocytopenic before and after transplant³⁵.

Conclusion

Modern day dentists are trained and expected to handle the medically compromised. The examples of interactions quoted are by no means exhaustive. Mainly those common conditions that require in-patient hospital care are mentioned. The guidelines quoted are for reference only. The actual guidelines must be consulted in full context and clinical judgement applied for actual patient management.

In essence for all patients presented with oral or dental problems that may compromise their medical treatment, an optimal level of oral hygiene is the basis of whole patient care. Patients can be referred prior to various treatments to establish a pre-treatment optimal level of dental conditions. Same optimal level of the dental status should be maintained so as not to jeopardise the outcome of medical treatment procedures.

Hospital dental services, now widely available in various public and private hospitals, can provide all the supportive services in the delivery of proper patient care in collaboration with various specialties.

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Traumatic Dental Injuries to the Permanent Dentition

Dr. Siu-fai Leung BDS (HK), MSc (Endodontics) (Lond), FRACDS

Specialist in Endodontics



Dr. Siu-fai Leung

Introduction

Traumatic dental injuries (TDI) is a common cause of tooth damage and loss in the young and adolescent age group. As children start to attend school and engage in various physical activities, trauma to the teeth, especially anterior teeth, becomes common. However it has been shown that the correct knowledge to manage TDI is not adequate among local physical education teachers, who are likely to face such injuries on a daily basis (Chan et al 2001). Other causes of TDI are road traffic accident and violence, including child abuse. Proclined incisors predispose an individual to injuries.

TDI could be prevented by the use of mouth guards (Fig. 1) during physical exercise (Newsome et al 2001). These mouth guards are customary made from soft silicone and are readily available from private dentists and The Prince Philip Dental Hospital. Unfortunately they are mostly ignored except in some contact sports.

General management

Management of TDI could be divided into primary, secondary and tertiary phases. Primary care provides the urgent treatment required immediately after trauma. This can be divided into acute, sub-acute and delayed priorities. Acute priority deals with problems that time will affect the outcome, usually in the scale of minutes, like haemostasis, replanting avulsed (dislodged) teeth and fixing alveolar fractures. In case of avulsion it is recommended that the tooth be cleaned if soiled, with saline, milk or water, and reimplanted into the socket immediately on site, before seeing a dentist. (<http://www.aae.org/pressroom/releases/newsmilk.htm>).

Sub-acute priority could be executed within hours after injury, like treating various types of teeth luxations (displacement), complicated crown fractures, root fractures and removal of foreign bodies from the wound. Tetanus booster or antibiotic prophylaxis is also provided at this stage. Delayed priority includes the restoration of uncomplicated crown fractures. However, in view of the small size of Hong Kong and the almost immediate accessibility to dental treatment, this classification is more of an academic interest. More importantly rather, it is the willingness of the victim to attend for treatment, correct diagnosis and meticulous execution of treatment that determine the outcome of primary treatment.

The secondary phase of treatment usually starts two weeks after the primary phase. This includes monitoring of pulpal status and healing of soft and hard tissues, root canal treatment, periodontal surgery and orthodontic treatment. The tertiary phase of treatment commences a few months to years after injury, which includes the final restoration of missing teeth, orthodontic treatment and monitoring reimplanted teeth.

Type of trauma and management

TDI are usually a combination of trauma to the peri-oral soft tissues, teeth and their supporting tissues. These injuries and management are categorized individually for descriptive purpose only.

Soft tissue

The wound should be cleaned and haemostasis achieved. Any foreign body should be identified, by clinical and radiographic examinations, and removed. Lacerations should be sutured after removal of necrotic tissue.

Hard tissue

Uncomplicated crown fracture
Restoration of the fracture or bonding of the original fragment could be performed. The tooth may not respond to pulp test initially so vitality is checked periodically over a period of one year. Discolouration may occur. This could be due to transient hyperaemia, which is reversible, but it could also be due to pulpal necrosis or sclerosis.

Complicated crown fracture

Depend on the size of the exposure, pulp capping or high level pulpotomy could be performed. With the availability of mineral trioxide aggregate (MTA), treatment has become easier and more predictable (Fig. 2).

Root fractures

Root fracture could occur at the apical, middle or coronal one third of the tooth. The coronal fragment is usually displaced or dislodged. It is mobile and the fracture line could be revealed using multi-angle periapical radiographs (Fig. 3).

The dislodged fragment of a coronal root fracture should be discarded. Orthodontic extrusion of the root is carried out after root canal therapy. Alternatively extraction and dental prosthesis could be considered if age and other factors are favourable.

In case of mid root and apical root fracture, an attempt should be made to splint the teeth with semi-rigid splinting for 4 weeks. Kevlar (Ribbond) composite splint appears to give superior results compared with wire or cap splints (Andreasen et al 2004). In most cases of incompletely formed roots pulp vitality is maintained, whereas up to 30% of the coronal portion of mature roots undergo pulp necrosis. Root canal therapy of the coronal portion shall be treated as open apex with a MTA apical plug.

Antibiotic prophylaxis seems to be beneficial to the outcome of periodontal healing. A loading dose of 1g Amoxil followed by 500mg q.i.d. for four days is recommended (Andreasen et al 2004).

Tooth displacement

This ranges from concussion, subluxation, extrusive luxation, lateral luxation to intrusive luxation. In general there is periodontal bleeding and tooth displacement.

The incidence of pulpal necrosis depends on the mode of injury and stage of root formation, and ranges from 100% in intrusive luxation of mature roots to only 5% in concussion of immaturely formed roots. Concomitant root fracture should be excluded using multiple angle periapical radiographs.

Reduction of the tooth should be done with digital pressure or extraction forceps with gentle force under local anaesthesia. It is better to tolerate inadequate reduction than to force the tooth into position, risking further damage to the periodontal attachment. The occlusion is adjusted and the patient and parents informed. In mature roots suffering intrusive luxation, or when the tooth is locked too tightly, orthodontic extrusion is the treatment of choice. (<http://www.aae.org/pressroom/releases/newsluxation.htm>). A non-rigid splint should be used for 2-4 weeks depending on the extent of the displacement.

The pulpal and periodontal status should be checked periodically up to one year. Root canal treatment should be instituted for intrusive luxation cases, as pulpal necrosis is almost certain. Severe root resorption is usually not a major problem if root canal treatment is instituted timely.

Tooth Avulsion

Although not life threatening, tooth avulsion demands the most urgent management to prevent replacement resorption. With other factors being equal, successful replantation of an avulsed tooth depends solely on extra-oral drying time and the storage medium of the avulsed tooth.

Replantation - preservation of viable periodontal ligament cells on root

Any soiled material on the tooth surface should be rinsed off with HANKS's Balanced Salt Solution (HBSS) (Pohl 2005) or if not available, with saline, milk or water. The root surface should not be manipulated. The cleansed tooth is replanted back into the socket immediately. If this is not possible due to socket deformity or soft tissue injury, the tooth should be dispatched in the above mentioned

media (Trope 1992) to the dentist with the patient immediately. Water is not a good storage medium and carrying the tooth in the buccal cheek should be considered as a substitute.

Replantation in the dental office should be done under local anaesthesia. After the socket is flushed with normal saline to clean out large blood clots and foreign bodies, the tooth is inserted without undue force. The tooth should be splinted semi-rigidly for 2-4 weeks. There is a chance of pulpal revascularisation during the earlier stage of root formation. Root canal treatment will be required for mature root and this can be performed at the same time when the splint is removed. Calcium hydroxide inter-appointment dressing for one month is recommended. Failing that the necrotic pulp could lead to severe external inflammatory resorption (Fig. 4).

Implantation - removal of periodontal ligament cells on root

If the root has been dried for more than twenty minutes, survival of the periodontal cells is not likely and replantation is not indicated. An implantation procedure, aiming to strength the root against replacement resorption after ankylosis, should be carried out. The root is cleaned of any attached soft tissue and immersed in 2% sodium fluoride for twenty minutes. It is then root filled extra-orally and replaced into the socket. This is followed by rigid splinting for six weeks.

Alveolar fracture

The alveolar segment together with teeth may appear mobile and shows displacement. The teeth may or may not be displaced in their sockets. The segment should be reduced under nerve block anaesthesia and splinted with a rigid splint for 4 weeks. The pulpal and periodontal status should be followed up to one year as more than 75% of one or more teeth could become non-vital.

If the dentist suspects more serious injuries are sustained, the patient should be transfer to an appropriate specialist after primary wound stabilization is performed.

Conclusion

A substantial amount of TDI could be prevented by the use of mouth guards. There is in general a lack of knowledge in the management of TDI among the lay population. This awareness could be raised by promotional campaigns (<http://www.hkda.org/Traumatic.htm>). The outcome of treatment depends on the extent of injury, the stage of root formation and correct execution of treatment (Andreasen 1995).

Dental treatment should be performed only after potential life threatening injuries such as neurological damage, bleeding or aspiration of foreign bodies/teeth, are treated or excluded. The only injury that requires immediate treatment is tooth avulsion. Readily available transporting media* could make a big difference in the outcome of replantation (Trope & Friedman 1992). Prophylactic antibiotic cover is useful in the following situations: Uncertain tetanus status, root fracture, replantation and excessive soft tissue contamination or laceration.



Fig 1. Silicone mouth guards (Courtesy of Dr. P.R.N. Newsome)



Fig 2 a

Fig 2 b



Fig 2 c

Fig 2

- Horizontal complicated crown fracture treated by high-level pulpotomy using MTA. The fragment is re-bonded with pin retention.
- Healing successful with completed root formation and normal periapical status. Tooth not responsive to pulp test.
- Orthodontic treatment to correct proclined incisors.



Fig 3 a

Fig 3 c



Fig 3 b

Fig 3

- Horizontal mid root fracture 21.
- Non-rigid splinting
- No complication following non-rigid splinting. Tooth remains responsive to pulp test.



Fig 4 a

Fig 4 b

Fig 4.

- Pulpal necrosis and external root resorption is evident in 11 two months following replantation without root canal treatment.
- Root canal treatment of 11, with orthodontic extrusion of 12 to expose fracture margin.

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*Tooth rescue box (Dentosafe®; Dentosafe GmbH, Iserlohn, Germany; EMT Tooth Saver, SmartPractice.com, Phoenix, AZ, USA.



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Are You Ready for Court?

Dr. Edward Fan LLB, MCI Arb, DIP LAMP, BDS, MGDSRCSEd, DIP F OD

*Barrister-at-law of Inner Temple, England and the Hong Kong Bar
Formerly Examiner of DGDP(UK) RCSEng and MGDS RCSEd*



Dr. Edward Fan

This presentation is intended to offer the doctors and dentists ("the practitioner") who have yet to make their debut as a witness in court, a brief introduction to the initial preparations in giving evidence in court. Legal procedural matters are not included as they should not be the concern of the practitioners. The practitioner should always consult his legal representatives for appropriate advice on his own case(s).

There are many reasons why a practitioner has to attend court in his professional capacity. For example, in personal injury cases, the practitioner may be the attending doctor of the injured person, who is the plaintiff in the litigation. In order to confirm the injuries sustained by the plaintiff, it would be necessary for the plaintiff to adduce the evidence from the practitioner. Under these circumstances, the practitioner is only a witness of fact as he is only informing the court his findings of the medical conditions of the plaintiff, and the treatment the practitioner rendered or intends to render to the plaintiff.

There are times the practitioner may be required to provide a report to court when he is not the attending doctor of the plaintiff. For example, in personal injury cases, if the injuries sustained by the plaintiff cause some long-term disability to the plaintiff, a claim for future loss of income or future medical expenses for follow up treatments may be included. A practitioner, who is not the treating doctor of the plaintiff, may be called upon by either or both parties, in the capacity of an expert in a particular field of medicine, to comment on the probable future medical conditions, the reasonableness and/or appropriateness of those future medical treatments of the plaintiff proposed by the attending doctor, and to recommend any alternative or additional future medical treatments as the practitioner may consider necessary. In these circumstances, the practitioner is acting as an expert witness in court.

Whether the practitioner appears in court as a witness of fact or as an expert, the practitioner is invariably required to produce a statement prior to his attendance in court. Generally speaking, if the statement is produced in the form of an affidavit or affirmation, i.e., a sworn statement, it is filed in court. Whether the statement is filed in court or not, it must be served on all the parties of the litigation prior to the trial if the content of the statement is intended to be adduced at the hearing as evidence. Accordingly, the maker of the

statement must ensure that the contents of the statement are the truth, the whole truth and nothing but the truth.

Witness of fact

When a witness gives evidence for a party of the litigation in court, he is likely to be cross-examined by the lawyers for the other parties. The cross examination by the lawyers for the other parties is primarily based on the statement of the witness. Theoretically, the provision of a statement of fact, albeit time consuming, should not have caused any problems to a practitioner. In reality, even with the help of the lawyers, some practitioners find the preparation of a statement daunting. This may be due to the lack of experience in statement provision, but it can also be caused by the attitude of the practitioner.

One of the fundamental problems in providing a good statement is due to the poor record keeping by the practitioner. For years, the medical negligence insurance agencies have incessantly reminded the practitioners about the importance of good record keeping. Unfortunately, that message appears to have fallen on some deaf ears.

The other problem is that some practitioners find it objectionable when their treatment rendered to the plaintiff or proposed treatment plan is being scrutinised.

Some practitioners may even have the misconception that the lawyers and judges know very little about medicine. They may even take the view that the lawyers and/or the court are unlikely to understand their evidence.

As a matter of fact, most lawyers handling personal injury and/or medical negligence cases are not new comers to the game. Some of the lawyers are even in possession of a medical or dental degree. As for the judges, most of them are experienced in dealing with medical evidence. In personal injury cases, there is a designated High Court judge in charge of the personal injury list. One therefore must not assume that the lawyers and the court are ignorant in medicine.

Expert witness

In civil litigations, the purpose in calling for the expert



report(s) by the parties is to either prove or disprove the claim. In producing an expert report, it is the duty of the expert to ensure that the court does understand its content fully.

The Hong Kong courts have adopted the duties and responsibilities of expert witnesses in civil cases stated by Cresswell J. in the *Ikarian Reefer* case, (*Ikarian Reefer* [1993] 2 Lloyds Rep. 68) as including:

1. Expert evidence presented to the Court should be, and should be seen to be, the independent product of the expert uninfluenced as to form or content by the exigencies of litigation.
2. An expert witness should provide independent assistance to the Court by way of objective unbiased opinion in relation to matters within his expertise. An expert witness in the High Court should never assume the role of an advocate.
3. An expert witness should state the facts or assumption upon which his opinion is based. He should not omit to consider material facts which could detract from his concluded opinion.
4. An expert witness should make it clear when a particular question or issue falls outside his expertise.
5. If an expert's opinion is not properly researched because he considers that insufficient data are available, this must be stated with an indication that the opinion is no more than a provisional one. In cases where an expert witness who has prepared a report could not assert that the report contained the truth, the whole truth and nothing but the truth without some qualification, that qualification should be stated in the report.
6. If, after exchange of reports, an expert witness changes his view on a material matter having read the other side's expert's report or for any other reason, such change of view should be communicated (through legal representatives) to the other side without delay and when appropriate to the Court.
7. Where expert evidence refers to photographs, plans, calculations, analyses, measurements, survey reports or other similar documents, these must be provided to the opposite party at the same time as the exchange of reports.

At present, there is no Practice Direction relating to experts and their reports to underline and define the obligations of experts. According to the Hong Kong Civil

Procedure 2006 (para. 38/4/4 at p. 622), it is advisable for the expert, whose report is to be adduced before the court, to state in his report that he recognises that it is his duty to help the court on matters within his expertise and that this duty overrides any obligations to the person from whom he has received instructions or by whom he is paid.

An expert's report should be addressed to the court and contain a statement as to his qualifications and experience, including any publications on matters within the area of his expertise. It is not necessary for the expert to supply personal details such as his marital status or family.

It is a pity that the above guidelines are not closely adhered to by some of the practitioners.

When I was a dental student in good old England many many years ago, most of my teachers shared the view that a general dental practitioner ("GDP") would come across no more than 3 cases of oral malignancy during his entire professional life. And the chances of a dental surgeon being sued by his patients in those days were much less than that of encountering a case of oral cancer in his surgery.

Times have changed. The chances of seeing a case of oral malignancy in a GDP's surgery may not have increased much these days. Judging from the ever increasing annual premium of medical negligence insurance, it is not hard to realise that a practitioner is much more vulnerable in being sued nowadays.

A more litigious society means the general public is more readily to sue whenever the occasion arises. Accordingly, a practitioner has to be constantly on guard when it comes to patient management.

A court appearance, even as an expert, may not be a pleasant experience especially when being under intense and detailed cross-examination by the other party. It is even worse when the practitioner is declared as an unreliable witness in the judgment. Some understanding in being a competent witness would at least assist the practitioner to deal with the situation more satisfactorily.

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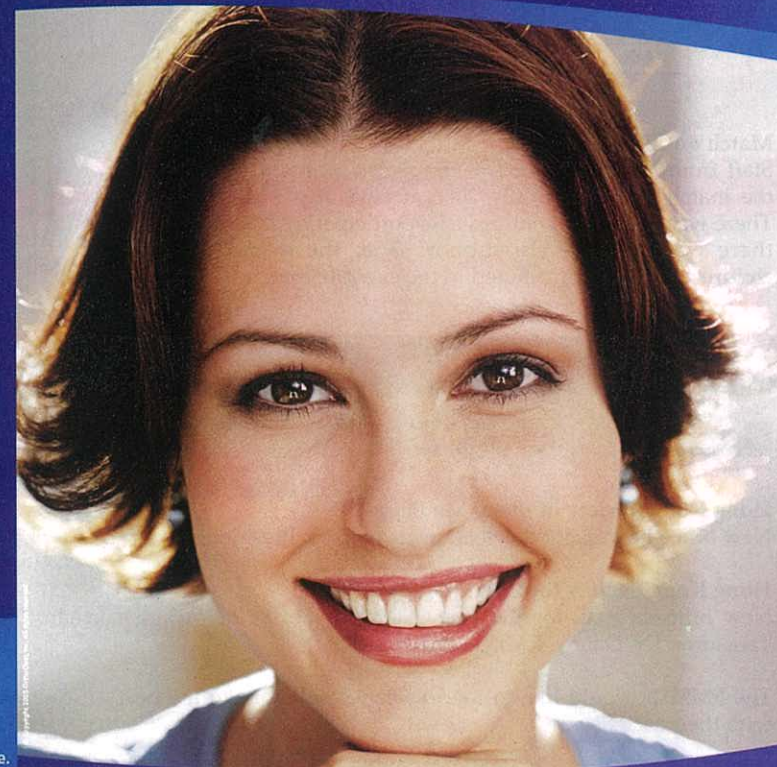
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The new FMSHK Team



Executive Assistant - Miss. Karen L.L. Chu



Accounting Officer - Miss Cora S.H. Tsang

Miss Karen Chu has been appointed as the Executive Assistant of FMSHK since June 2006, a role she comes to after 2 years experiences in manufacturing and 3 years experience in customer service. She is currently studying Business Management at RMIT University.

Miss Cora Tsang has been appointed as the Accounting Officer of FMSHK since July 2006, a role she comes to after 12 years' experience in the Accounting Field and she obtained the LCC Higher Accounting Certificate in 1986. She studied a course of Computing and Information System in SPACE in 1996 to 1999.

Miss Chu and Miss Tsang are energetic and dedicated to serve the evolving needs of our member societies.

Soccer Five Tournament 2006

Match results for 24 June 2006

Janssen	5 : 1	Wyeth
Sanofi-Aventis	0 : 2	AVC
AstraZeneca	0 : 2	Eli Lilly
Schwarz	5 : 0	Abbott

Match on 24 June 2006

Staff from the Hong Kong Association of the Pharmaceutical Industries (HKAPI) helped in the registration and coordination of the match held on 24 June 2006 at Shek Kip Mei Sports Centre.

Match results for 16 July 2006

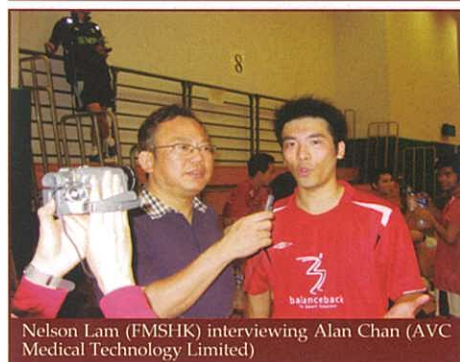
Schering-Plough	3 : 0	Pfizer
Boehringer Ingelheim	0 : 4	HKMA
P&G	0 : 2	GSK
IDS	2 : 1	Bayer

Match on 16 July 2006

Staff from FMSHK helped in the registration and coordination of the match held on 16 July 2006 at Shek Kip Mei Sports Centre. There was strong and enthusiastic participation from all teams and there were even lively support from the teams' friends and children. This all contributed to the eventful matches.



From left: Karen Lee (HKAPI), Idy Wong (HKAPI) and Mr. Nelson Lam (Organising Secretary, FMSHK)



Nelson Lam (FMSHK) interviewing Alan Chan (AVC Medical Technology Limited)



Society News

News from Member Societies

Hong Kong Society of Sleep Medicine

New office-bearers for the year are as follows: President: Prof. Yun-kwok Wing, Hon. Secretary: Prof. Albert M. Li.

Hong Kong Society for Immunology

New office-bearers for the year 2006-2007 are as follows: Chairman: Dr. Yong Xie, Secretary: Dr. Kin-Tak Chan, Treasurer: Dr. Danny T.M. Leung.

The FMSHK would like to send its congratulations to the new office-bearers and look forward to working together with their societies.



The Federation of Medical Societies of Hong Kong

30th August, 2006 (Wednesday)

Auditorium, 1/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong

New Trends in the Evaluation and Treatment of Dizziness And Balance Disorders

Chairman : Dr. Chi-kuen Chan, Education Committee

Speakers : Dr. Hui Yau MBBS, FRCSEd, FCSHK, FRCSEd (ORL), FHKAM (Surgery), FHKAM (Otorhinolaryngology), FHKCORL, FACS.

Specialist in ENT

Dr. Richard E. Gans, Ph.D. Founder of The American Institute of Balance

Programme : Meniere's disease – an update

Common Causes of Vestibular Disorders

Vestibular Function Assessment: Clinical Pathways

Non-Medical Treatment of Vestibular and Balance Disorders: Diagnosis Based Strategies

Registration Fee : FREE admission

Registration:

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Registration will be on first-come-first-serve basis.

CME/CPE accreditation applied for: Please refer to http://www.fmshk.org



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New Trends in the Evaluation and Treatment of Dizziness and Balance Disorders

30 August, 2006 (Wednesday, 6:15 p.m. – 9:15 p.m.)

1/F, Auditorium, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong

APPLICATION FORM

Name: Prof. / Dr. / Mr. / Ms. _____
(block letters please)

Position: _____

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Please tick as appropriate:

I will attend New Trends in the Evaluation and Treatment of Dizziness and Balance Disorders.

Signature _____

Date _____

Remarks: Please send registration form to The Federation of Medical Societies of Hong Kong at 4/F Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong. Registration will be on first-come-first-served basis.

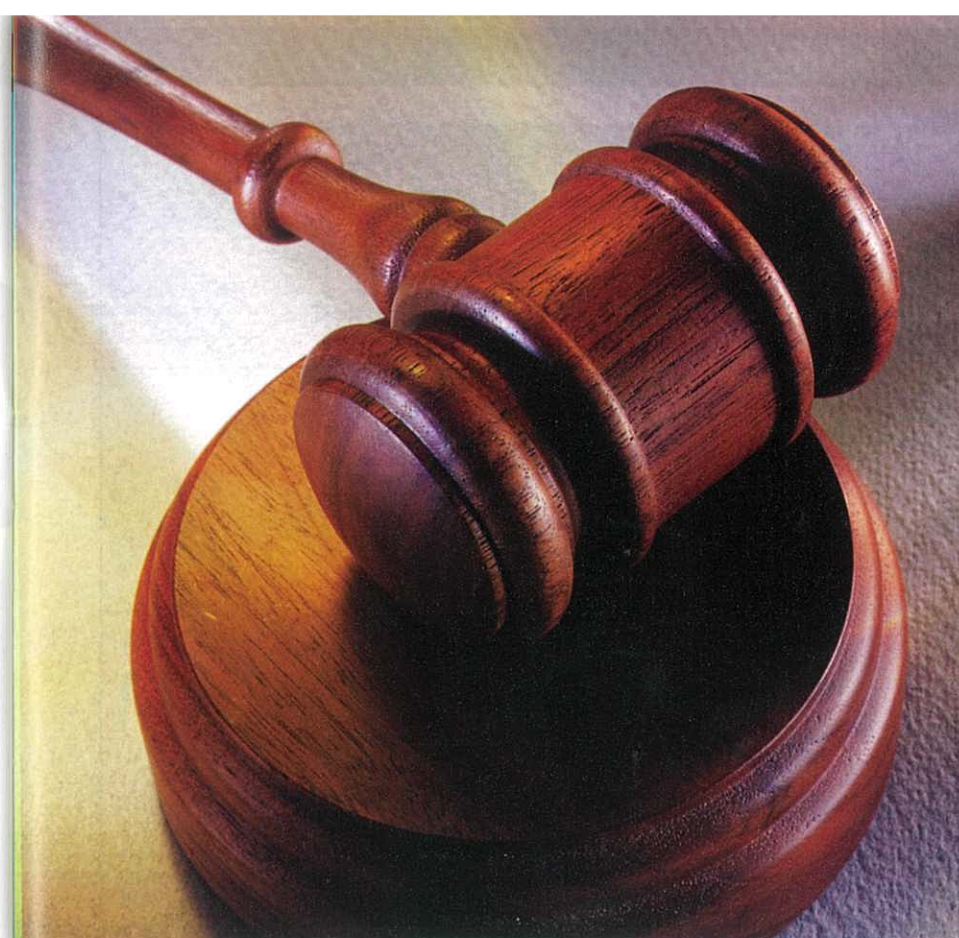
Enquiries: Please contact Ms Karen Chu at 2821 3515 or karen.chu@fmshk.com.hk.

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Day	1	2	3	4	5
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					



Date / Time	Function	Enquiry / Remarks
2 WED (9,16,23,30)	Post-Registration Certificate Course in Intensive Care Nursing Organised by: Department of Surgery, University of Hong Kong Medical Centre # Skills Development Centre, Department of Surgery, University of Hong Kong, Medical Centre, Queen Mary Hospital, Pokfulam, Hong Kong	Institute of Advanced Nursing Studies Tel: 2855 5836
3 THU 8:00pm	HKMA Council Meeting Organised by: The Hong Kong Medical Association # HKMA Headquarter Office, 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong	Ms. Christine WONG Tel: 2527 8285
6 SUN 2:00pm (7,8,9)	HKMA Structured CME Programme Year 06/07 (V) - Geriatrics Organised by: The Hong Kong Medical Association and Kwong Wah Hospital Chairman: Dr. TC SHIH Speaker: Various # Kwong Wah Hospital, Lecture Theatre, 10/F., Yu Chun Keung Medical Memorial Centre, Kwong Wah Hospital 11th Asian Oceanian Congress of Radiology Organised by: Asian Oceanian Society of Radiology & Hong Kong College of Radiologists # Hong Kong Convention and Exhibition Centre, Wanchai, Hong Kong	Miss Nina HUNG Tel: 2861 1979 (Registration fee is required) 3 CME points Tel: 3151 8822 Email: aocr2006@swiretravel.com
8 TUE 8:00pm	HKMA Newsletter Editorial Meeting Organised by: The Hong Kong Medical Association Chairman: Dr. HH TSE # HKMA Headquarter Office, 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong	Ms. Tammy TAM Tel: 2527 8941
9 WED 7:30am	Hong Kong Neurosurgical Society Monthly Academic Meeting - Cytogenetics in Neurosurgery: Its Clinical Implication Organised by: Hong Kong Neurosurgical Society Chairman: Dr. YUEN Shing Chau Speaker: Dr. MAK Wai Kit # Seminar Room, G/F, Block A, Queen Elizabeth Hospital	Dr. Y C PO Tel: 2990 3788 Fax: 2990 3789 2 CME points
7:00pm	Drospirenone in Fertility Control an Menopause Management Organised by: The Obstetrical and Gynaecological Society of Hong Kong Chairman: Dr. Dominic LI Speaker: Prof. Soo Keat KHOO & Prof. Macro GAMBACIANI # The Ballroom, 2/F, Langham Hotel, 8 Peking Road, Tsimshatsui, Kowloon	Ms. Loletta CHAN Tel: 2529 3078 1 CME point
10 THU 2:00pm	HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2006 (VIII) - Common Retinal and Macular Diseases Organised by: The Hong Kong Medical Association and Hong Kong Sanatorium & Hospital Chairman: Dr. TC SHIH Speaker: Dr. CHAN Wai Man # HKMA Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road C, Hong Kong	Miss Nina HUNG Tel: 2861 1979 (Registration fee is required) 1 CME point
13 SUN 8:00am	Trailwalker Practice Session Organised by: The Hong Kong Medical Association Chairman: Dr. C YU # Tsuen Wan MTR station (Hang Seng Bank)	Ms. Dora HO Tel: 2527 8285
2:00pm	HKMA Structured CME Program Year 06/07 (V) - O&G and X-ray Organised by: The Hong Kong Medical Association and Queen Elizabeth Hospital Chairman: Dr. TC SHIH Speaker: Various # Queen Elizabeth Hospital, Lecture Theatre, Block M, G/F., Queen Elizabeth Hospital	Miss Nina HUNG Tel: 2861 1979 (Registration fee is required) 3 CME points
15 TUE (16,17)	13th Hong Kong International Cancer Congress & 3rd Annual Meeting of Centre for Cancer Research Organised by: The Faculty of Medicine of The University of Hong Kong & The Cancer Centre of Queen Mary Hospital # Cheung Kung Hai Conference Centre, William MW Mong Block, Li Ka Shing Faculty of Medicine, The University of Hong Kong, 21 Sassoon Road, Pokfulam	Congress Secretariat Tel: 2855 4235 / 2818 0232 Fax: 2818 1186 Email: hkjcc06@hku.hk
18 FRI (25)	C105 Certificate Course on Orthoptics Organised by: The Federation of Medical Societies of Hong Kong & Hong Kong Orthoptists Association # Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai	Ms. Kitty LEUNG / Karen CHU Tel: 2527 8898 Fax: 2865 0345
19 SAT 12:00pm - 3:00pm	The Federation's Soccer Five Tournament 2006 Organised by: The Federation of Medical Societies of Hong Kong & The Hong Kong Association of the Pharmaceutical Industry Chairman: Dr. Godfrey CF CHAN # Shek Kip Mei Park Sports Centre, 290 Nam Cheong Street, Shek Kip Mei, Sham Shui Po	Ms. Karen CHU Tel: 2821 3515 Fax: 2865 0345
2:00pm	Co-organized CME Lecture with Hong Kong College of Family Physicians Organised by: The Hong Kong Medical Association and Hong Kong College of Family Physicians Chairman: Dr. SL CHAN & Dr. CM CHENG Speaker: Dr. CL YUEN, Dr. CH LI, Dr. K CHOI & Mr. A CHAN # Queen Elizabeth Hospital, Lecture Theatre, Block M, G/F., Queen Elizabeth Hospital	Miss Dorothy KWOK (NO Lunch will be provided for this lecture) Tel: 2527 8452 2.5 CME points
20 SUN 2:00pm	2nd Certificate Course in Recent Medical Advances for General Practitioners Jointly organized by the Family Medicine Unit, the University of Hong Kong and the Family Medicine Division, Hong Kong Sanatorium and Hospital Speakers: Various	Hospital Administration Department Tel: 2835 8800 Fax: 2835 8008 E-mail: hospadm@hksh.com Website: http://www.hksh.com/CME.pdf
23 WED (24)	Paediatric Dialysis & Transplantation Course Organised by: Hong Kong Paediatric Nephrology Society & Department of Paediatrics and Adolescent Medicine Princess Margaret Hospital Chairman: Prof. Bradley WARADY & Dr. CC MAN # Lecture Hall, 7/F, Block H	Dr. LAI Wai Ming Tel: 2990 3757 Fax: 2370 3466 12 CME points, 6 points per day
26 SAT 3:00pm	Trailwalker Practice Session Organised by: The Hong Kong Medical Association Chairman: Dr. C YU # Tai Po Road (the entrance of Kam Shan Road)	Ms. Dora HO Tel: 2527 8285
27 SUN 2:00pm	Joint Professional Tenpin Bowling Tournament Organised by: The Hong Kong Medical Association Chairman: Dr. KY HO & Dr. CF YEUNG # Super Fun Bowl Olympian City, Shop 148, 1/F, Olympian City, 18 Hoi Ting Road, West Kowloon	Ms. Dora HO Tel: 2527 8285
7:00pm - 10:00pm	The Federation's Soccer Five Tournament 2006 Organised by: The Federation of Medical Societies of Hong Kong & The Hong Kong Association of the Pharmaceutical Industry Chairman: Dr. Godfrey CF CHAN # Shek Kip Mei Park Sports Centre, 290 Nam Cheong Street, Shek Kip Mei, Sham Shui Po	Ms. Karen CHU Tel: 2821 3515 Fax: 2865 0345
28 MON (29,30,31)	Paediatric Advance Lift Support Provider Courses Organised by: Hong Kong College of Paediatricians & The Heart Institute for Children, Hope Children's Hospital Illinois, USA # Hong Kong Academy of Medicine HRT in Asian Women - where are we now? Tibolone Clinical Trials Programme Update Organised by: The Obstetrical and Gynaecological Society of Hong Kong Chairman: Dr. SK LAM Speaker: Prof. Christopher HAINES & Dr. Hans REKERS # The Ballroom, 2/F, Langham Hotel, 8 Peking Road, Tsim Sha Tsui	Dr. HUI Yim Wo Tel: 2990 1111 Fax: 2990 3481 Email: ywhui@netvigator.com 12 CME points (Cat A) Miss Pansy YU Tel: 2833 6380 1 CME point



Date / Time	Function	Enquiry / Remarks
29 TUE	C102 Certificate Course on Childhood Epilepsy Organised by: The Federation of Medical Societies of Hong Kong & Hong Kong Society of Child Neurology and Developmental Paediatrics # Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai	Ms. Kitty LEUNG / Karen CHU Tel: 2527 8898 Fax: 2865 0345
30 WED 6:15 - 9:30pm	New Trends in the Evaluation and Treatment of Dizziness and Balance Disorders Organised by: The Federation of Medical Societies of Hong Kong & AVC Medical Technology Ltd Chairman: Dr. Chi-kuen CHAN Speaker: Dr. HUI Yau & Dr. Richard E. GANS # Auditorium, 1/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai	Ms Karen CHU Tel: 2821 3515 Fax: 2865 0345 3 CME points



Calendar of Events

Meetings

24/9/2006	12th Annual Scientific Meeting Organised by: The Hong Kong Society of Rheumatology Chairman: Dr. HS TSUI & Dr. KW LEE Speaker: Various Enquiry: Ms. Teresa LEUNG Tel: 2599 8280 Fax: 2599 8998
5-9/11/2006	The 7th Asian Congress on Oral and Maxillofacial Surgery (ACOMS) Organised by: The Hong Kong Association of Oral and Maxillofacial Surgeons Enquiry: Ms. Justin NG & Mr. Daniel CHOK Tel: 2871 8896, 2871 8815 Fax: 2871 8898 Email: info@acom2006.org Website: http://www.acoms2006.org/
15, 16, 17/11/2006	13th Hong Kong International Cancer Congress & 3rd Annual Meeting of Centre for Cancer Research Organised by: The Faculty of Medicine of The University of Hong Kong and the Cancer Centre of Queen Mary Hospital # Cheung Kung Hai Conference Centre, William MW Mong Block, Li Ka Shing Faculty of Medicine, The University of Hong Kong Enquiry: Congress Secretariat Tel: 2855 4235, 2818 0232 Fax: 2818 1186 Email: hkicc06@hku.hk Website: www.hkicc.org
25,26,27/1/2007	International Colorectal Disease Symposium (ICDS) 2007 Organised by: Hong Kong Society for Coloproctology & Department of Surgery, Pamela Youde Nethersole Eastern Hospital Enquiry: Ms. Olivia HO Tel: 2595 6362 Fax: 2515 3195
13-17/6/2007	The 21st Congress of International Association of Paediatric Dentistry (IAPD) Organised by: Hong Kong Society of Paediatric Dentistry Enquiry: Ms. Justin NG or Mr. Daniel CHOK Tel: 2871 8896, 2871 8815 Fax: 2871 8898 Email: info@iapd2007.com Website: http://www.iapd2007.com

Courses

2,3/9/2006	Advanced Medical Life Support (AMLS) Provider Course Organised by: University of Hong Kong Medical Center Enquiry: Course Administrator Tel: 2855 4885, 2855 4886 Fax: 2819 3416 Email: qmhsdc@hkucc.hku.hk Website: http://www.hku.hk/surgery
9,17/9/2006 10,17/12/2006	Pre-hospital Trauma Life Support (PHTLS) Provider Course Organised by: Department of Surgery, University of Hong Kong and Hong Kong Chapter of the American College of Surgeons Enquiry: Course Secretariat, Department of Surgery, University of Hong Kong Medical Centre Tel: 2530 8016
4/10/2006	Post-Registration Certificate Course in Intensive Care Nursing Organised by: Institute of Advanced Nursing Studies Enquiry: Course Secretariat, Institute of Advanced Nursing Studies, Hospital Authority, Queen Mary Hospital Tel: 2855 5836
17/9/2006, 22/10/2006 12/11/2006, 17/12/2006 21/1/2007, 11/2/2007 18/3/2007, 22/4/2007 20/5/2007, 17/6/2007	2nd Certificate Course in Recent Medical Advances for General Practitioners Jointly organized by the Family Medicine Unit, the University of Hong Kong and the Family Medicine Division, Hong Kong Sanatorium and Hospital Speakers: Various, Enquiry: Hospital Administration Department Tel: 2835 8800, Fax: 2835 8008, E-mail:hospadm@hksh.com, Website: http://www.hksh.com/CME.pdf

Coming Certificate Courses of the Federation of Medical Societies of Hong Kong

Date	Course No	Course Name	Co-organiser	Target Participants
1 Sep 06 - 15 Dec 06 (Fri)	PTH06/01	初級醫學普通話課程		Medical & health professionals
11 Sep 06 - 23 Oct 06 (Mon)	C109	Certificate Course on Updates in Cervical Cancer Screening	The HK Society of Colposcopy & Cervical Pathology	Medical & health professionals
20 Sep 06 - 25 Oct 06 (Wed)	C100	Certificate Course for Clinic Nurses		Clinic Nurses
17 Oct 06 - 21 Nov 06 (Tue)	C97	Certificate Course in Ophthalmology	The Hong Kong Ophthalmological Society	Medical & health professionals
6 Nov 06 - 11 Dec 06 (Mon)	C106	Certificate Course on Sleep Health & Disorders	Hong Kong Society of Sleep Medicine	Public
8 Nov 06 - 13 Dec 06 (Wed)	C98	Certificate Course on the Diagnosis, Prevention and Management of Thalassaemia	Hong Kong Society for the Study of Thalassaemia	Medical & health professionals

Count Down & Go Go

Federation 2006 Annual Dinner 31st December 2006



Run Run Shaw Hall

The Hong Kong Academy of Medicine Jockey Club Building

99 Wong Chuk Hang Road, Aberdeen, Hong Kong

For further information and assistance please contact our secretariat, Ms Karen Chu at 2821 3515 or email to karen.chu@fmskhk.org



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2nd Certificate Course in Recent Medical Advances for General Practitioners



Jointly organized by the Family Medicine Unit, the University of Hong Kong
and the Family Medicine Division, Hong Kong Sanatorium and Hospital

20 August 2006 ENT and Sleep related problems 21 January 2007 Orthopaedics and Sport's Medicine

The advances in the assessment and management of sleep related breathing disorder
Dr Wong Lap Ching
Honorary Consultant in Otorhinolaryngology, Hong Kong Sanatorium & Hospital
Dr So Shun Yang
Honorary Consultant in Respiratory Medicine, Hong Kong Sanatorium & Hospital
Practical tips of management of common ENT problems
Dr Simon Wong
Honorary Consultant in Otorhinolaryngology, Hong Kong Sanatorium & Hospital

The practical management of common sports injuries
Dr Dan Hooley
Honorary Consultant in Orthopaedics and Traumatology, Hong Kong Sanatorium & Hospital
Advances in surgical treatment of common orthopaedic conditions
Dr Stephen Wu
Director of Orthopaedic and Sport Medicine Centre, Hong Kong Sanatorium & Hospital

17 September 2006 Cardiovascular

PTCA: an overview for GPs
Dr Tse Tak Fu
Honorary Consultant in Cardiology, Hong Kong Sanatorium & Hospital

The applications of vascular surgery
Prof Stephen Cheng
Honorary Consultant in General Surgery, Hong Kong Sanatorium & Hospital

11 February 2007 Paediatrics

Common developmental disorder in children
Dr Iris Lau
Honorary Consultant in Paediatrics, Hong Kong Sanatorium & Hospital
Paediatric surgery---an overview
Dr Yeung Chung Kwong
Honorary Consultant in Paediatric Surgery, Hong Kong Sanatorium & Hospital

22 October 2006 Urology

Advances in management of BPH and prostatic cancer
Dr Richard Lo
Honorary Consultant in Urology, Hong Kong Sanatorium & Hospital
Assessment and management of urological presentations commonly encountered in general practice
Dr John Ngan
Honorary Consultant in Urology, Hong Kong Sanatorium & Hospital

18 March 2007 Obstetrics and Gynaecology

Advances in management of subfertility
Dr Milton Leong
Honorary Consultant in Obstetrics & Gynaecology, Hong Kong Sanatorium & Hospital
Dysmenorrhoea: a practical approach
Dr Joseph Chan
Director of Department of Women's Health, Hong Kong Sanatorium & Hospital

11 November 2006 Oncology

Breast Cancer---from diagnosis to management
Dr Polly Cheung
Honorary Consultant in General Surgery, Hong Kong Sanatorium & Hospital
Prof Richard J. Epstein
Director of Comprehensive Oncology Centre, Hong Kong Sanatorium & Hospital

Advances in treatment of lung cancer
Dr Jonathan Sham
Honorary Consultant in Oncology, Hong Kong Sanatorium & Hospital

22 April 2007 Ophthalmology

Laser treatment of various eye diseases
Dr Alvin Kwok
Honorary Consultant in Ophthalmology, Hong Kong Sanatorium & Hospital
Common eye problems encountered by family physicians
Dr Ivan Chen
Director of Cataract Surgery Centre, Hong Kong Sanatorium & Hospital

20 May 2007 Endocrinology

An overview of obesity management
Dr Lo Kwok Wing
Co-Director, Endocrine & Diabetes Centre, Hong Kong Sanatorium & Hospital
Ms Flavia U
Dietitian of Department of Health Assessment, Hong Kong Sanatorium & Hospital
Practical tips in the management of diabetes mellitus
Dr Elaine Tsui
Co-Director, Endocrine & Diabetes Centre, Hong Kong Sanatorium & Hospital

17 December 2006 Investigations

Clinical application of molecular diagnostic tests
Dr Edmond Ma
Director of Clinical Pathology Laboratory, Hong Kong Sanatorium & Hospital
Advances in imaging for GP
Dr John Chan
Honorary Consultant in Radiology, Hong Kong Sanatorium & Hospital

17 June 2007 Dermatology and Plastic Surgery

Skin cancer management
Dr Tung Man Kwong
Associate Director of Plastic & Reconstructive Surgery Centre, Hong Kong Sanatorium & Hospital
Clinical dermatology + case discussion
Dr Alec Fung
Honorary Consultant in Dermatology, Hong Kong Sanatorium & Hospital

Venue : Auditorium, 4/F, Hong Kong Sanatorium and Hospital, 2 Village Road, Happy Valley, Hong Kong
Date : 20 August 2006 to 17 June 2007 (Sundays)
Time : 1:00 - 2:00pm (Lunch), 2:00 - 5:00pm (Lecture)
Certificate : Awarded to participants with a minimum attendance of 80%
Fee : HK\$300 for the whole course, HK\$50 per lecture
Enquiries : 28358800 (Tel), 28358008 (Fax), hospadm@hksh.com (Email)
Registration Form : Download from HKSH website: <http://www.hksh.com/CME.pdf>
Registration : Please return the completed registration form with a cheque of appropriate amount made payable to "Hong Kong Sanatorium & Hospital, Ltd." to The Administration, Hong Kong Sanatorium and Hospital, 2 Village Road, Hong Kong

3 CME points per session

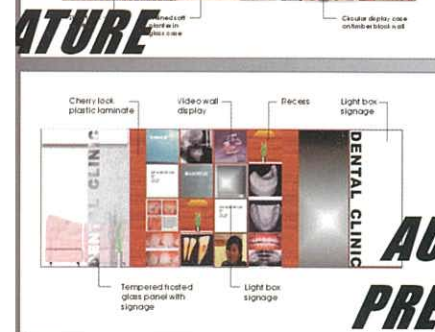
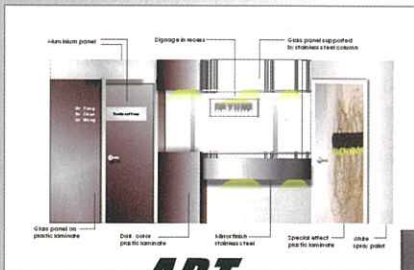
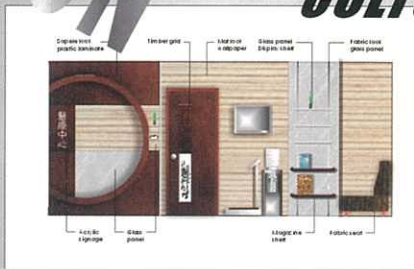
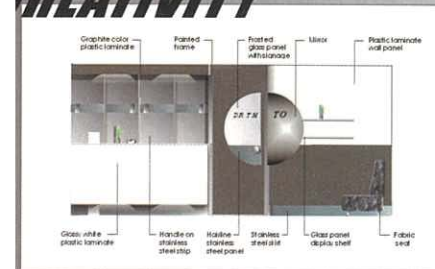
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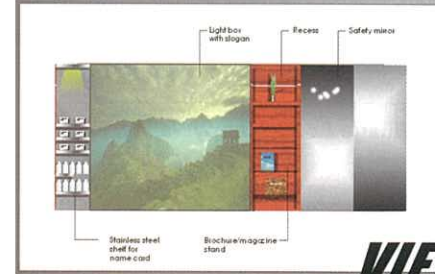
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Commencement of Practice

Dr. Cheng Pik Shun
鄭碧純醫生

Specialist in Paediatrics
MBChB (CUHK)
MRCP (UK)
MRCPCH
FHKCPaed.
FHKAM (Paed)

wishes to announce the commencement of her practice
as from 3rd July 2006 at

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Division of Qualigenics Diabetes Centre

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Email: ps.cheng@qualigenics.com

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Certificate Course on Orthoptics

視覺矯正證書課程

(Course no. C105)



Jointly organized by



The Federation of Medical Societies of Hong Kong
香港醫學組織聯會

Hong Kong Orthoptists Association
香港視覺矯正師協會

Date	Topic	Lecturer
18 August 2006	Introduction to Orthoptics 認識視覺矯正 Visual development 視覺功能發展	Mr. Kwok Shing Chin 郭勝千先生 Ms. Chong Sze Lok, Gabriela 莊師樂小姐
25 August 2006	Binocular Function 共視功能 How to diagnose strabismus and amblyopia 如何診斷斜視與弱視	Ms. Chong Sze Lok, Gabriela 莊師樂小姐, Mr. Chia Chi Keung 謝志強先生
1 September 2006	Esodeviation 內斜視 Exodeviation 外斜視	Ms. Tsang Chi Shan 曾志珊小姐 Ms. Fong Mei Yan, Betty 方美茵小姐
8 September 2006	Muscles Palsies 眼外肌麻痺	Mr. Kwok Shing Chin 郭勝千先生 Ms. Chiu Wai Ling 趙惠玲小姐
15 September 2006	Management of Strabismus 斜視的處理方法	Ms. Chiu Wai Ling 趙惠玲小姐 Ms. Fong Mei Yan, Betty 方美茵小姐
22 September 2006	Amblyopia 弱視的診斷與治療	Ms. Wong Wai Yin, Lisa 黃惠賢小姐 Mr. Leung Cheuk Wa 梁卓華先生

Date : 18 August 2006 to 22 September 2006 (Every Friday)
Time : 7:00 p.m. - 8:30 p.m.
Venue : Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong
Course Fee : HK\$960 (6 Sessions)
Language : English (Supplemented with Cantonese)
Certificate : Awarded to participants with a minimum attendance of 70%
Enquiry : The Secretariat of the Federation of Medical Societies of Hong Kong
Tel. : 2527 8898 Fax: 2865 0345 Email: info@fmshk.org

CME/ CPE Accreditation applied for
For downloading the application form, please refer to our website:
<http://www.fmshk.org>

Certificate Course on Childhood Epilepsy

兒童癲癇症證書課程

(Course no. C102)



Jointly organized by



The Federation of Medical Societies of Hong Kong
香港醫學組織聯會

The Hong Kong Society of Child Neurology & Developmental Paediatrics
香港兒童腦科及體智發展學會

Date	Topic	Lecturer
29 August 2006	What is Epilepsy? 甚麼是癲癇症?	Dr. Chok-wan Chan 陳作耘醫生
5 September 2006	Non-medical Treatment for Epilepsy 癲癇症的非藥物治療方法	Dr. Ada Yung 楊穎欣醫生
12 September 2006	Management of Acute Seizure and Status Epilepticus 癲癇發作及癲癇連續狀態的處理	Dr Sharon Cherk 卓蘊樺醫生
19 September 2006	Medical Treatment for Epilepsy 癲癇症的藥物治療	Dr. Ngai-chuen Sin 冼藝泉醫生
26 September 2006	What are the Co-morbidities of Epilepsy? 癲癇症有什麼相關病症	Kwing-wan Tsui 徐炯環醫生
3 October 2006	Social Aspects & Parenting of Children with Epilepsy 我的兒女患了癲癇症, 怎麼辦?	Dr. Shun-ping Wu 胡信平醫生

Date : 29 August 2006 - 3 October 2006 (Every Tuesday)
Time : 7:15 pm - 8:45 pm
Venue : 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, HK
Course Fee : HK\$960.00 (6 Sessions)
Language : Cantonese (supplemented with English)
Certificate : Awarded to participants with a minimum attendance of 70%
Enquiry : The Secretariat of the Federation of Medical Societies of Hong Kong
Tel. : 2527 8898 Fax: 2865 0345 Email: info@fmshk.org

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THE FEDERATION OF MEDICAL SOCIETIES OF HONG KONG

香港醫學組織聯會

初級醫學普通話課程

隨著香港與內地日益密切的經濟、文化交流，香港的醫院迫切需要有強健的普通話聽、說能力來擴展業務，提供優質服務。在與內地醫生，官員的學術，業務交流活動中，除了學術報告用英文外，也是需要普通話的。

先到先得，額滿即止，報名從速！

課程內容

本課程是一個由淺入深的醫學普通話課程。像其他專業語言一樣，首先還是基礎普通話，日常生活用語。我們非常重視發音，保證每一位學員正音的機會。同時，按照實際看病過程學習症狀學、門診和病房的詞匯，語法。

這樣做，是為避免目前社會上許多普通話課程的弊病 ----- 以時間短，價格低為號召，而實際上流於形式，不按語言學習的科學規律辦事，學過十幾個，二十幾個小時並不能達到比較準確，流利的普通話水平。

而每位醫生都明白，醫生與病人之間互相準確，深刻的理解，溝通，這對於保證診治效果，增強病人對醫生的信心，對治病的信心是何等重要啊！

本課程會採取互動方式，不斷通過各種方式了解學員的狀況，想法，要求，引導學員達到非常實用的醫學普通話水平。

導師

孫鐵山，北京籍。畢業於北京大學醫學院。1980年來港定居，曾做過中醫，針灸，醫療儀器銷售，教普通話等工作。近十年主要從事包括醫學普通話在內的普通話教學工作。現主要在浸會大學中醫藥學院教授西醫課程，在香港中文大學校外進修學院教授普通話，持有中國國家語言文字工作委員會一級證書。

日期

PTH06/01 2006年9月1日至2006年12月15日(星期五)

下午7時至9時 30分 共16課 每次2小時 30分

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