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# 香港醫訊



THE HONG KONG

# MEDICAL DIARY

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*Dr. Sammy CS Chiang*

## Medical Bulletin

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### ■ Recent Advances in Percutaneous Coronary Intervention (PCI)

**CME**

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### ■ Percutaneous Intervention in Adult Patients with Congenital Heart Disease- An Overview

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Editorial

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Dr. Sammy CS Chiang

Over the past few decades, advancement in Cardiology has been by leaps and bounds. The introduction of coronary angioplasty by Andreas Gruntzig in 1977, thrombolytic therapy in the treatment of patients with acute myocardial infarction, intracoronary stenting and later the use of drug eluting stents (DES), radiofrequency catheter ablation of cardiac arrhythmia, transcatheter therapy of congenital heart diseases, implantable cardioconverter defibrillator and cardiac resynchronisation therapy are just some of the more outstanding examples. This undoubtedly has cast new hopes in patients suffering from various kinds of cardiac disorders. For the Cardiology professionals, we find these new treatment modalities valuable in the management of our patients and in the relief of their sufferings.

In this issue of the Medical Diary, I have asked Dr. Michael Lee to write on the recent advances in percutaneous coronary intervention (PCI) and Dr. Boron Cheng to write on percutaneous intervention in adult patients with congenital heart diseases. I am sure most of us are aware of the advantages of DES in reducing in-stent restenosis. However, the recently published BASKET LATE trial and the Camenzind meta-analysis have raised some concerns on the long term safety of DES with suspected increased incidence of very late stent thrombosis. Dr. Lee has addressed this issue in his article together with other advances in the field of PCI. In Dr. Cheng's article, he has broadened our horizons on the large varieties of congenital heart diseases that can be successfully treated by the percutaneous approach.

Since our student days, we have been constantly reminded of the importance of antibiotic cover in patients suffering from congenital and valvular heart diseases. In this issue of the Medical Diary, I and Dr. Marc Cheng have summarised the latest guidelines for the prevention of infective endocarditis which we hope will be useful for the daily practice of our medical colleagues.

Sudden cardiac death is undoubtedly a condition most feared by the general public. It is also known that early defibrillation within minutes of cardiac arrest will greatly increase the success rate of resuscitation. The idea of the establishment of an Automated External Defibrillator (AED) programme has long been discussed in the Hong Kong College of Cardiology and we are most delighted to see its successful implementation in Hong Kong. The article by Dr. Kathy Lee has a detailed description of the AED programme in Hong Kong.

A passion for Chinese antiques is common amongst many doctors in Hong Kong. Amongst the cardiologists I know, Dr. Patrick Ko is undoubtedly an expert in this field. I have invited him to write an article on the history of ancient Chinese jade culture which I find interesting and educational.

I hope our readers will enjoy reading this issue of the Medical Diary and I would like to wish you all a happy and prosperous 2008.



## Update on the Latest Guidelines for the Prevention of Infective Endocarditis

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## Introduction

Infective endocarditis (IE) is an uncommon but potentially fatal condition. Despite the advances in its diagnosis, antibiotic treatment, surgical intervention and complication management, patients with this condition still have high morbidity and mortality. Over the decades authorities such as the American Heart Association (AHA), European Society of Cardiology (ESC) and the British Cardiac Society Clinical Practice Committee had drawn up guidelines for antibiotic prophylaxis for the prevention of endocarditis which were based largely upon the assumptions that dental procedures, invasive gastrointestinal and genitourinary tract procedures may cause IE in patients with underlying cardiac risk factors and that antibiotic prophylaxis is effective.

However, in recent years many authorities and societies as well as conclusions from published studies challenged the efficacy of antibiotic prophylaxis and urged these guidelines to be revised. In this article, we shall review the British (British Society for Antimicrobial Chemotherapy) as well as the American (AHA) guidelines published in 2006 and 2007 respectively while amalgamating their key messages that could form the basis of our local guidelines in the near future.

## Rationale for revising the previous guidelines

Guidelines on antibiotic prophylaxis that were published previously, in particularly that by the AHA which is now in its 10th iteration, had based their recommendations on a few case-control studies or expert opinions, clinical experiences and descriptive studies. Collectively, on the evidence-based grading system, these recommendations were categorised into Class IIbC level.

Secondly, the previous guidelines on the prevention of IE had been overtly complicated and ambiguous, making it difficult for clinicians as well as patients to interpret or remember their specific details.

Thirdly, current evidence supports that the vast majority of cases of IE caused by oral microflora most likely result from random bacteraemia caused by routine daily activities such as chewing food, tooth brushing, flossing, use of toothpicks and use of water irrigation devices.

Fourthly, cumulative evidence also suggests that, given the total number of cases of IE that occur annually, it is likely that an exceedingly small number are attributable to bacteraemia-producing dental procedures. Therefore, even if antibiotic prophylaxis were 100% effective, only a minute number of cases might be prevented.

Furthermore, the risks of antibiotic-associated adverse events outweigh the benefits based on the current evidence and that more 'liberal' use of antibiotic prophylaxis would inadvertently give rise to antibiotic resistant microorganisms especially the viridans groups of streptococci and enterococci.

## Which group of patients would benefit most from antibiotic prophylaxis?

In contrary to the previous guidelines which recommended antibiotic prophylaxis based mainly on conditions that had an increased lifetime risk of acquiring IE, the current guidelines focus more on individuals who have the highest risk of adverse outcome from IE.

Various population-based studies have quantified the lifetime risk of IE acquisition for conditions such as rheumatic heart disease, mitral valve prolapse, congenital heart disease and prosthetic heart valve. Even though, these data provide useful ranges of risk in large populations. From a practical point of view, it is very difficult to utilise them to risk stratify individuals with a specific underlying cardiac risk factor, since each patient with valvular heart disease represents a broad spectrum of pathology ranging from minimal to severe and the risk of IE would undoubtedly be influenced by the underlying severity.

Both the British as well as the American guidelines have agreed that individuals with (1) previous endocarditis, (2) prosthetic heart valves, (3) surgically constructed systemic or pulmonary shunt or conduit, and (4) completely repaired congenital heart defect with prosthetic material or device during the first six months, constitute the group of patients with the highest risk of adverse outcome from IE.

To date, as no published data had yet demonstrated convincingly that the administration of prophylactic antibiotics prevents IE associated with bacteraemia from an invasive procedure, it is therefore not unreasonable to limit their use in those with the highest risk of



adverse outcome from IE who would gain the greatest benefit from IE prevention. Nevertheless, the switching of emphasis from those with increased lifetime risk to those with the highest risk of adverse outcome from IE would reduce the uncertainties amongst clinicians as well as patients as to who should receive prophylaxis.

### Prophylaxis for Dental procedure

Apart from the use of antibiotic prophylaxis in high risk individuals undergoing dental procedures, good oral hygiene is probably the most important factor in reducing the risk of endocarditis in susceptible individuals. Once an individual with a cardiac anomaly puts him or her at risk of developing IE, the patient should have his/her dental hygiene optimised. Accordingly, those with an intra-cardiac prosthesis should be referred for dental assessment. Interventions should be performed at least 14 days prior to surgery for mucosal healing to occur. As for those who require emergency valve replacement they should have a dental assessment as soon as practicable after surgery. The following table shows the regimens of antibiotic prophylaxis that should be used in high risk patients undergoing dento-gingival manipulation or endodontics.

Table 1. Antibiotic prophylaxis regimens for Dental procedures

Oral	Injection
Amoxicillin 2g	Ampicillin 2g or Cefazolin or Ceftriazone 1g
<b>If allergic to penicillin</b>	
Cephalexine* 2g or Clindamycin 600mg or Azithromycin/ Clarithromycin 500mg	Cefazolin* or Ceftriazone* 1g or Clindamycin 600mg or Vancomycin 1g

\* cephalosporins should not be used in an individual with a history of anaphylaxis, angioedema or urticaria with penicillin or ampicillin

### Prophylaxis for Non-dental procedures

Even though the American and the British guidelines share the consensus of offering antibiotic prophylaxis in patients who have a history of previous IE, who had cardiac heart valve replacement surgery and with a surgically constructed systemic or pulmonary shunt or conduit undergoing dental procedure, their opinions differ in prophylaxis in non-dental procedures (gastrointestinal or genitourinary tract).

The former no longer recommends antibiotic prophylaxis in non-dental procedures. This is based on the fact that the possible association between non-dental procedures and IE has not been studied as comprehensively as the possible association with dental procedures. The cases of IE temporally associated with non-dental procedures are mainly anecdotal either from a single or very small number of case reports. Besides, no published data to date had yet demonstrated a conclusive link between non-dental procedure and the development of IE. Further more, given the high prevalence of resistant strains of enterococci raises doubtful benefits of prophylactic therapy in these procedures.

On the other hand, the British guidelines adopt a more conservative and cautious approach. They base their recommendations on observational data, whether or not a non-dental procedure had been anecdotally linked to

cases of endocarditis in the past. The British guidelines advocate the use of antibiotic prophylaxis in procedures listed in Table 2, since these procedures had been associated with an increased prevalence of bacteraemia. Besides the conditions associated with the highest risk of adverse outcome mentioned previously, the list of conditions in which antibiotic prophylaxis should be offered in non-dental procedures extends to include individuals with complex congenital heart disease (except secundum atrial septal defect), complex LV outflow abnormality (including aortic stenosis and bicuspid aortic valve), acquired valvulopathy and mitral valve prolapse with echographic documentation of substantial leaflet pathology and regurgitation.

Table 2. Indications for antibiotic prophylaxis for Non-dental procedures

Antibiotics required	Antibiotics NOT required
<b>GI procedures</b>	
Oesophageal varices-sclerotherapy	Oesophageal varices-banding
Oesophageal stricture dilation	OGD
Oesophageal laser therapy	Sigmoidoscopy/colonoscopy
ERCP	PEG
Hepatic/ biliary operation	TEE
Gall stone-lithotripsy	Barium enema
Surgical operations involving intestinal mucosa	Proctoscopy
	Percutaneous liver biopsy
<b>GU procedures</b>	
Cystoscopy	Vasectomy
Urethral dilatation	Urethral catheterisation
TURP	Lithotripsy of renal stone
Trans-rectal prostatic biopsy	Circumcision
	Cosmetic piercing involving urethral mucosa
<b>O&amp;G procedures</b>	
	Uterine dilation and curettage
Vaginal hysterectomy	Therapeutic abortion
Caesarean section	Insertion and removal of IUD
	Sterilisation procedures
	Smears
	Vaginal delivery
<b>Respiratory tract procedures</b>	
Tonsillectomy/adenoidectomy	
Surgical procedure on upper respiration tract	Rigid bronchoscopy
Nasal packing and nasal intubation	Flexible bronchoscopy +/-biopsy
Cosmetic piercing of tongue or involving oral mucosa	Endotracheal intubation
	Tympanostomy tube insertion

### Conclusions

Given the growing trend of evidence-based medicine, the guidelines for antibiotic prophylaxis in dental and non-dental procedures have been radically changing in recent years. Ideally a prospective double-blind trial to evaluate benefits/risks of antibiotic prophylaxis should be carried out, but this is unlikely to take place due to the number of patients involved and that the current guidelines recommend prophylaxis. Having recognised that bacteraemia resulting from daily activities is much more likely to cause IE than bacteraemia associated with dental procedures, greater emphasis should now be placed on good oral hygiene as well as facilitation of access of dental care in susceptible individuals.

In the future, our local guides in Hong Kong should at least adopt the British approach where antibiotic prophylaxis should be offered to individuals with highest risk of adverse outcome from IE while advocating the use of antibiotic prophylaxis in specified non-dental procedures that had been documented to cause IE.

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## Recent Advances in Percutaneous Coronary Intervention (PCI)

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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 January 2008.*

It has been 30 years since the introduction of coronary angioplasty by Andreas Gruntzig in 1977.<sup>1</sup> It started with only balloon angioplasty to dilate coronary artery narrowing and thus it was initially termed Percutaneous Transluminal Coronary Angioplasty (PTCA). In 1987, Sigwart and his colleagues first described the use of coronary stents to treat threatened vessel closure during balloon angioplasty,<sup>2</sup> with a view to scaffolding the intimal dissection flap and preventing the elastic recoil of the vessel. Percutaneous Coronary Intervention (PCI) encompasses balloon, stent and the assisted devices used in coronary angioplasty procedures. With the improvement in stent design and refinement of anti-platelet regimen, explosive use of coronary stents has been witnessed leading to markedly improved outcomes of PCI. Over the last 4 years, coronary stents have been used in 94% of PCI procedures done in HA hospitals in Hong Kong.<sup>3</sup>

### Drug-Eluting Stent (DES)

The escalating use of coronary stents is not without its problem. Repeat revascularisation still occurred in 15-20% of patients implanted with bare-metal stents (BMS).<sup>4</sup> In-stent restenosis (ISR) has long been regarded as the "Achilles' heel of PCI". The introduction of drug-eluting stents (DES) in 2001 has changed the landscape of interventional cardiology. This involves the delivery of anti-proliferative drugs via polymers coated on the stent surface locally to the diseased coronary artery to prevent restenosis by inhibiting the neointimal proliferation of the vessel wall. Compared to BMS, the absolute risk reduction of DES ranges from 10-50% in terms of reduction in restenosis and target lesion revascularisation across all lesion and patient subsets.<sup>5</sup> The 9-month angiographic restenosis rate of DES is in the range of 6-9%.

**Complex lesion subsets.** Most DES trials involved patients with single, short, de novo coronary artery stenosis. Extrapolation to the more complex, real world lesion subsets has not been supported with much evidence. In the multi-centred SCANDSTENT (Stenting Coronary Arteries in Non-Stress/Benestent Disease) trial,<sup>6</sup> 322 patients with complex coronary lesions (22% ostial, 34% bifurcation, 36% total occlusion) were randomised to receive either Sirolimus-Eluting Stent (SES) or BMS. The use of SES in these complex lesion

subsets was associated with significantly better outcome in terms of restenosis reduction (2.0% vs. 31.9%,  $p < 0.001$ ), Major Adverse Cardiac Events (MACE) reduction (4.3% vs. 29.3%,  $p < 0.001$ ) and a trend towards less stent thrombosis at 6 months (0.6% vs. 3.1%,  $p = 0.15$ ). Different stenting strategies have been suggested to tackle bifurcation lesions.<sup>7</sup> However, the two stents technique (one over the main vessel and one over the side-branch) has not been shown to have advantage over stenting of one vessel while performing balloon angioplasty of the other.<sup>8</sup> In fact, Colombo et al. have shown a 6-month restenosis rate of 28.0% for double stenting (main vessel and side-branch) as compared to 18.7% for provisional side-branch stenting (stenting the main vessel, balloon angioplasty to the side-branch and stenting only if necessary) with SES for bifurcation lesions.<sup>9</sup> The current consensus is to adopt a simple strategy of stenting the main vessel, ballooning the side-branch and finishing with a final "kissing balloons" technique (one balloon in the main vessel and one in the side-branch, inflating simultaneously). For unprotected left main coronary artery stenosis, there have been registry data showing a potential role of DES as an alternative to coronary artery bypass graft surgery (CABG)<sup>10,11</sup> and the ongoing randomised Synergy between Percutaneous Coronary Intervention with Taxus stent and Cardiac Surgery (SYNTAX) Study will further delineate the role of DES vs. CABG for left main disease.

**BMS in-stent restenosis.** The treatment of BMS in-stent restenosis (ISR) has always been unsatisfactory with balloon angioplasty and BMS-in-BMS technique. Vascular brachytherapy has brought some light to this area but its effectiveness is limited by the development of late stent thrombosis. In a meta-analysis by Dibra et al.<sup>12</sup> involving 4 randomised trials comparing DES vs. balloon angioplasty or vascular brachytherapy in 1,230 patients with BMS ISR, the angiographic restenosis rate was markedly lower in patients treated with DES. They suggested DES should be considered as the first-line treatment for patients with BMS in-stent restenosis.

**Stent thrombosis.** Although DES is highly effective in reducing restenosis and future repeat revascularisation, it brings with it a potential complication of stent thrombosis even years after DES implantation. This might tilt the balance from a more benign stent restenosis in which the patients might present with increasing effort angina to a more sinister and fatal problem of stent





thrombosis in which the patient might develop acute vessel closure with large MI or death.<sup>13,14</sup> According to the Academic Research Consortium (ARC) definition<sup>15</sup>, stent thrombosis is further classified on the basis of timing (acute 0-24 hours after stent implantation, subacute >24 hours to 30 days, late >30 days to 1 year and very late >1 year) and certainty (definite, probable and possible). In comparing the incidence of stent thrombosis between 2,602 patients implanted with DES and 2,428 patients with BMS, no difference was observed in the overall (0.6% vs. 0.5%) and late (0.2% vs. 0.3%) incidence of stent thrombosis.<sup>16</sup> However, very late (>1 year) stent thrombosis is significantly more common in DES than BMS. In a meta-analysis on 14 contemporary clinical trials randomising 6,675 patients to DES or BMS with follow-up from 8 to 48 months, a significantly higher rate of very late stent thrombosis was observed in the DES group (0.5% vs. 0%) while no difference was observed in the overall incidence (0.1% vs. 0.07%).<sup>17</sup> In December 2006, the FDA has convened an Advisory Panel meeting on the issue of DES stent thrombosis and concluded that there seemed to be an excess of stent thrombosis with DES, especially with off-label use but they were uncertain about the magnitude of the problem.<sup>18</sup> They suggested future DES trials to look specifically at the incidence of stent thrombosis over a longer follow-up period and involving more patients. Discontinuation of anti-platelet therapy has emerged as one of the most important predictors of stent thrombosis.<sup>19</sup> Other contribution factors include stent malapposition (mismatch between the stent and the vessel), hypersensitivity, abnormal re-endothelialisation and resistance to aspirin or clopidogrel.<sup>15</sup> To prevent such catastrophic events, patients must be reminded to adhere to their regimen of dual anti-platelet therapy and, on completion, take aspirin monotherapy.<sup>20</sup> Patients with DES who require surgery, elective or otherwise, irrespective of the time since implantation, must continue to take aspirin perioperatively unless it is absolutely contraindicated.<sup>5</sup> Attention to PCI technical details may also improve DES outcomes. This includes avoidance of too many stents, especially overlapping stents, use the shortest stent length wherever possible, fully expand the stent over its entire length, particularly in calcified lesions, and residual dissections should be avoided.<sup>18</sup>

## Primary PCI for AMI

Patients presenting with acute myocardial infarction (AMI) carry a high mortality and morbidity. It has been shown that acute reperfusion therapy to restore coronary blood flow can improve the survival and decrease the long-term complications of AMI.<sup>21</sup> In the 1980s, fibrinolytic drugs have been the main modality of treatment for ST-elevation myocardial infarction (STEMI). However, numerous randomised trials and meta-analysis have shown that primary PCI (to open up an occluded coronary artery by PCI) for STEMI is associated with higher rate of reperfusion, lower risks of reocclusion and reinfarction and improved survival.<sup>22-26</sup>

The RIKS-HIA Registry is a large registry of 26,205 consecutive STEMI patients who received reperfusion therapy within 15 hours of symptom onset between 1999 and 2004.<sup>27</sup> 7,084 patients received primary PCI, 3,078 pre-hospital thrombolysis (PHT) and 16,043 in-hospital thrombolysis (IHT). After adjusting for age and

comorbidity, primary PCI was associated with lower mortality than PHT and IHT at 30 days (4.9% vs. 7.6% vs. 11.4%) and at 1 year (7.6% vs. 10.3% vs. 15.9%). The benefits of primary PCI persisted regardless of treatment delay and it was associated with shorter hospital stay and less reinfarction.

The routine practice of performing delayed PCI for persistently occluded coronary artery after STEMI has been questioned. In the Occluded Artery Trial (OAT),<sup>28</sup> 2,166 high-risk patients (with ejection fraction <50% or proximal occlusion) who had total occlusion of the infarct-related artery 3-28 days after MI were randomised to receive PCI or medical therapy. The median time to randomisation was 8 days. PCI did not reduce the occurrence of death, reinfarction or heart failure (17.2% vs. 15.6%,  $p=0.2$ ) and there was a trend towards non-fatal reinfarction in the PCI group (6.9% vs. 5.0%,  $p=0.08$ ). Thus, primary PCI should be done as early as possible after symptom onset and late restoration of coronary blood flow does not improve the left ventricular function, death, reinfarction or heart failure.

For STEMI, an invasive strategy with primary PCI is generally preferred if the door-to-balloon time can be achieved within 90 minutes or fibrinolysis is contraindicated.<sup>29</sup> Fibrinolysis is preferred if <3 hours have elapsed from symptom onset, there is an anticipated delay that decreases the potential advantage of PCI, or an invasive strategy is not an option (e.g. owing to vascular access difficulties or lack of access to a skilled PCI laboratory with skilled operators). To ensure timely primary PCI service involves the organisation of a cooperative network for STEMI. After such re-organisation in the Vienna STEMI Registry, there was a substantial increase in the use of primary PCI with significant decrease of in-hospital mortality from 16% to 9.5%.<sup>30</sup> More than 900 hospitals in the US have so far signed on to the D2B Alliance, representing more than 60% of US PCI hospitals. The aim is to reduce the door-to-balloon time for primary PCI to <90 minutes.

## Unstable Coronary Lesions - Vulnerable Plaque

Acute coronary syndrome and sudden cardiac death originates from rupture of a non-flow limiting coronary atherosclerosis with superimposed thrombus formation.<sup>31,32</sup> These vulnerable plaques consist of a thin fibrous cap and a large lipid core with abundant macrophage infiltration.<sup>33</sup> Proper identification of these plaques with appropriate treatment can theoretically prevent the catastrophic event of AMI or even sudden death.

Intravascular ultrasound (IVUS) has been used to identify coronary atherosclerotic plaque burden and assess vessel size. Spatial analysis of the IVUS signal (IVUS-Virtual Histology (VH)) can provide further details of the composition of the plaque, which can be categorised into necrotic, fibro-fatty, fibrous and calcified tissue.<sup>34</sup> By using IVUS-VH, Gaston et al. could identify a significantly higher prevalence of IVUS-derived thin-cap fibroatheroma (TCFA) in patients presenting as acute coronary syndrome, as compared to stable angina patients.<sup>35</sup> Ruptured TCFA



was the culprit for 60% of the coronary artery thrombi.

Kubo et al. evaluated the ability of optical coherence tomography (OCT) for assessment of the culprit lesion morphology in AMI as compared to IVUS and coronary angiography (CAS).<sup>36</sup> The incidence of plaque rupture observed by OCT was significantly higher than CAS and IVUS (73% vs. 47% vs. 40%). Fibrous cap erosion and intracoronary thrombus were also more readily identified by OCT. Further standardisation on OCT classification of plaque composition to minimise intra- and inter-observer variability will prove OCT to be a powerful tool for identification of vulnerable plaques.

Once a vulnerable plaque is identified, it is reasonable to cover the lesion and reinforce the cap by a stent which can also release pharmaceutical agents targeting to stabilise the necrotic core. Ongoing studies will provide more information on this mechanical treatment but aggressive medical therapy including anti-platelet and lipid-lowering agents will surely play an important role.

## Way Forward

The development of PCI has been moving in a fascinating speed. It has been estimated that more than 1 million PCI procedures are being performed in the United States and about 2 million worldwide every year. The introduction of DES has greatly reduced the incidence of in-stent restenosis but in return increases the incidence of very late stent thrombosis. Hopefully, the next generation DES with a biodegradable polymer, together with optimal pharmacological therapy can expand the scope to treat more complex patient and lesion subsets while keeping stent thrombosis and restenosis to the minimum. The mortality benefit of primary PCI for STEMI is beyond doubt. It might involve structural organisational changes for proper implementation of the programme. However, if vulnerable plaques can be detected early and appropriate treatment initiated, significant number of ACS and AMI can be prevented. This in turn will improve the overall health of the general population.

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## MCHK CME Programme Self-assessment Questions

Please read the article entitled "Recent Advances in Percutaneous Coronary Intervention (PCI)" by Dr. Michael KY Lee, 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 sheets via fax (2865 0345) or by mail to the Federation Secretariat on or before 31 January 2008. 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. Repeat revascularisation occurred in 40% of patients implanted with bare-metal stent?
2. Angiographic restenosis occurred in 6-9% of patients 9 months after implantation of a DES?
3. In the SCANDSTENT trial, the use of sirolimus-eluting stent to treat the more complex lesion subsets, significantly reduced restenosis and MACE?
4. In the treatment of bare-metal stent in-stent restenosis, vascular brachytherapy is more effective than DES to prevent further restenosis?
5. The use of DES is associated with significantly more very late (>1 year) stent thrombosis while the overall incidence of stent thrombosis is the same as BMS?
6. To prevent DES stent thrombosis, patients should be reminded to continue dual anti-platelet agents for the pre-specified period of time and then continue Aspirin as monotherapy for life.
7. Primary PCI cannot improve the survival of patients presenting as ST-elevation MI.
8. The goal of the door-to-balloon time for primary PCI for AMI should be <90 minutes?
9. IVUS-derived thin-cap fibroatheroma (TCFA) by using Virtual Histology is more prevalent in patients with stable angina than acute coronary syndrome?
10. Acute coronary syndrome originates from rupture of a non-flow limiting coronary vulnerable plaque?

## ANSWER SHEET FOR JANUARY 2008

Please return the completed answer sheet to the Federation Secretariat on or before 31 January 2008 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

## Recent Advances in Percutaneous Coronary Intervention (PCI)

**Dr. Michael KY Lee**

MBBS(HK), MRCP(UK), FRCP(Glasg), FHKCP, FHKAM(Medicine)

Specialist in Cardiology

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HKID No.: \_\_\_\_\_ - \_\_\_\_\_ X X (x) Other Membership No. (please indicate): \_\_\_\_\_

Contact TelNo.: \_\_\_\_\_

### Answers to December 2007 issue

Laboratory Diagnosis of Community-associated Methicillin-resistant *Staphylococcus aureus*

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

# Percutaneous Intervention in Adult Patients with Congenital Heart Disease- An Overview

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Dr. Boron CW Cheng

The field of interventional cardiology for adult congenital heart problems is evolving rapidly. Both native and postoperative lesions can be tackled with catheter interventional techniques. This overview will cover the most commonly encountered clinical problems.

The most common interventional procedures for closure of intracardiac communications in adults are the closure of atrial septal defect (ASD) and patent foramen ovale (PFO). Other defects include muscular ventricular septal defect (mVSD), and perimembranous ventricular septal defect (pmVSD). Closure of postoperative intracardiac communications is included in this category. (e.g. interatrial communication in post-Fontan patients)

Other communications, which can be tackled with catheter interventional techniques includes patent ductus arteriosus (PDA) and coronary artery fistulae (CAF). Vessels or conduit narrowing, for example, coarctation of aorta (COA) and pulmonary artery stenosis, can also be tackled with interventional techniques.

## Atrial Septal Defect(ASD)

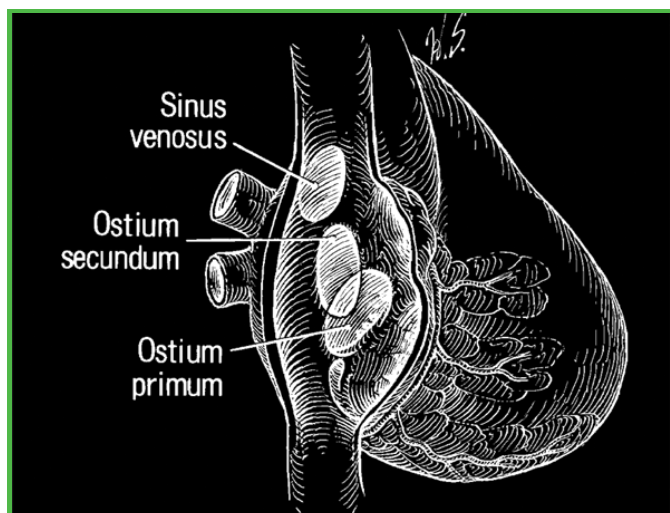


Fig. 1 Common types of Atrial Septal Defect

Early catheter closure in asymptomatic atrial septal defects with echocardiogram evidence of right ventricular enlargement is to reduce the risk of atrial arrhythmias, development of right ventricular failure symptoms and pulmonary vascular disease. If enlargement of the right ventricle is present, closure is indicated regardless of the presence or absence of symptoms. In the presence of raised pulmonary arterial pressure and left ventricular dysfunction, balloon test occlusion is advisable before definitive closure.

Percutaneous catheter closure of ASD is feasible in secundum type defects less than 40mm. Device closure is not feasible in sinus venosus defects, atrioventricular septal defects and secundum ASDs greater than 40mm.

The most widely used device nowadays is the Amplatzer septal occluder (AGA Medical, Golden Valley, Minnesota, USA). This is a double disk, self-centering design constructed from a meshwork of nitinol wire with a loose polyester fill. One disk is positioned in each atrium and they are joined by a waist that is sized to the defect stretched diameter and positioned across the defect. The size of the device is determined by the diameter of the waist, available from 4 to 40mm in diameter.

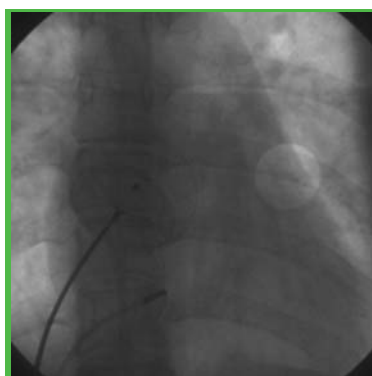


Fig 2. An Amplatzer Septal Occluder

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## Atrial Septal Defect(ASD)

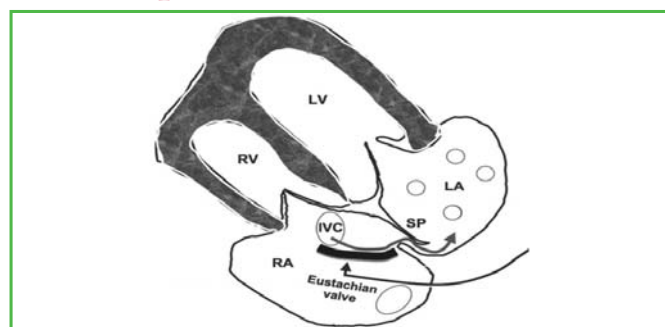


Fig3. Diagram showing the preferential of blood from IVC towards the fossa ovale. (Meier et al. Circulation 2003)



### Cryptogenic stroke

A patent foramen is present in 27% of the population and has been implicated in young patients with cryptogenic stroke by allowing paradoxical embolisation of the clot that has developed either in the systemic veins or in the foramen tunnel itself. Under normal situations, the left atrial pressure exceeds that of the right atrium, thereby compressing the flap of the septum primum across the oval foramen in the left atrium. For a venous thrombosis to cross a patent foramen ovale, the pressure in the right atrium must be greater than that in the left atrium. Such changes occur transiently during Valsalva Manourvres in daily life. It is therefore anticipated that closing a patent oval foramen will reduce the risk of recurrent embolic strokes. The diagnosis is usually made as the result of investigation of a stroke or transient ischaemic attack using echocardiography or transcranial Doppler.

### Platypnea Orthodeoxia syndrome

This uncommon syndrome occurs when intracardiac shunting is present in the upright position leading to oxygen desaturation and breathlessness. This may occur in post-right ventricular infarct, thoracic aortic aneurysm or decrease in right atrial compliance secondary to aging. In this situation desaturated blood flows from the inferior vena cava across the foramen ovale into the left atrium, most commonly when the patient assumes a standing position. This uncommon condition can be resolved effectively by device closure.

There are many devices available for closure of PFO. The most common examples are the CardioSEAL septal occluder and the Amplatzer PFO occluder. Other newer devices include the Premere device.

### Ventricular septal defect (VSD)

Device closure may be considered for highly selected cases of perimembranous and muscular VSD. Closure of VSD is indicated in patients with large intracardiac shunting, history of bacterial endocarditis and development of aortic regurgitation. A perimembranous VSD may be regarded as suitable for device closure if the distance from the superior edge of the defect to the insertion of the right coronary aortic valve leaflet is adequate. For Amplatzer perimembranous VSD device, the distance required is no less than 3mm. A muscular VSD may be closed with both the Amplatzer family device or the CardioSEAL occluder. Indications for closure of muscular VSD are similar to perimembranous VSD except for the development of aortic regurgitation.

### Patent ductus arteriosus (PDA)

The rationale for closure of a PDA is the prevention of haemodynamic deterioration and elimination of the ductus as a substrate for bacterial endocarditis. Current recommendations are that any clinically apparent PDA should be closed.

At present, the most frequently used device for PDA closure in adults is the Amplatzer PDA occluder. It is particularly suitable for large diameter PDAs (>3mm).

For small ductus in adults or in patients with a small residual leak after a previous surgical or device closure, coils may be considered as an alternative option.

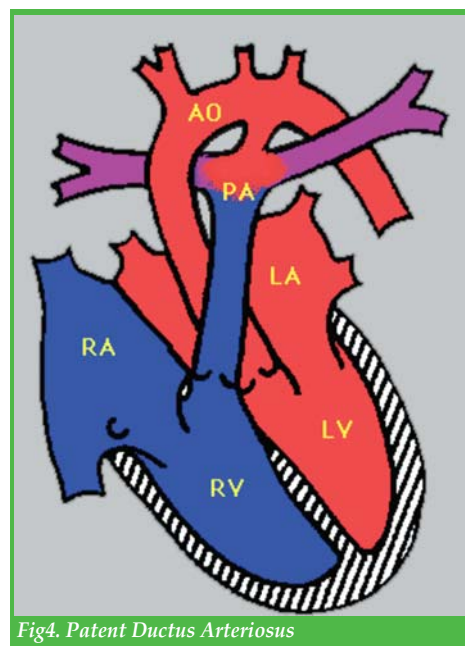


Fig4. Patent Ductus Arteriosus

### Coronary artery fistula (CAF)

Small coronary arteriovenous communications are not uncommonly observed during selective coronary arteriography in adults. These small communications are usually not significant, cause no haemodynamic sequelae, and hence may be ignored. In a few patients, there is a large communication between a coronary artery and a cardiac chamber, coronary sinus or pulmonary trunk. These coronary artery fistulae are characterised by enlargement of the coronary artery giving rise to the fistulous connection. The right coronary artery is the site of origin in more than 50% of cases, and the common sites into which the fistulae feeds are a cardiac vein, the right atrium and the right ventricle. Bilateral fistulae are present in up to 5% of cases. Run-off through a large fistula may lower intracoronary diastolic pressure and produce myocardial ischaemia by a steal phenomenon. Significant shunting from the left to the right may be present, resulting in chamber enlargement secondary to volume overload. Giant fistulae are at risk of rupture.

Multiple occlusion techniques including vascular plugs, coils and balloons, have resulted in complete occlusion in the majority of patients.

### Coarctation of aorta (COA)

The mean survival of patients with untreated COA is 35 years, with a mortality rate of 75% by 50 years of age. Death in unrepaired patients is usually due to heart failure, coronary artery disease, aortic rupture or dissection, concomitant aortic valve disease, infective endocarditis or cerebral haemorrhage. COA is considered significant if the gradient is greater than 20mmHg between the arm and the leg with or without proximal systemic hypertension, or in the presence of upper extremity hypertension accompanied by echocardiographic or angiographic evidence of aortic obstruction.

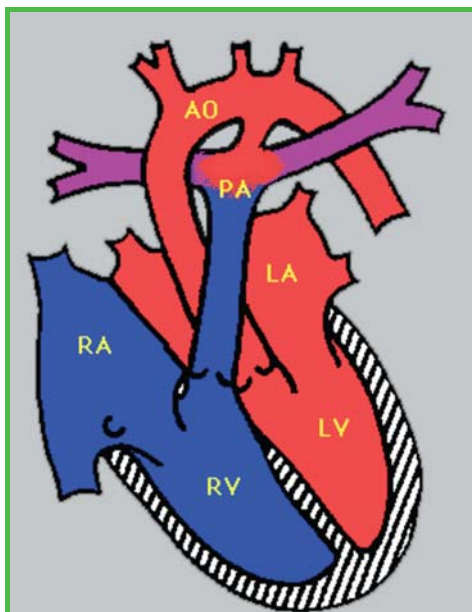


Fig4. Coarctation of Aorta

Catheter intervention is based on the use of balloon-tipped catheters and stents. There are advantages to the primary implantation of balloon expandable endovascular stents over simple balloon angioplasty for COA in adult patients. Elastic recoil of the abnormal segment may limit success of balloon angioplasty alone, a problem that can be overcome by the rigidity of the stent. The outstanding advantage of these stents is the radial strength, which prevents elastic recoil. The use of

stents may also reduce the incidence of aneurysm formation by limiting the amount of dilatation required and thus reducing the degree of traumatic injury to the aortic wall.

### Pulmonary artery stenosis

The goals of intervention include a reduction of right ventricular pressure load, maintenance of right ventricular function, reduction in the amount of regurgitation through an abnormal pulmonary valve and increase in pulmonary perfusion in the affected lung. The most common site of pulmonary artery stenosis is found at the point of bifurcation of the main pulmonary artery. Branch pulmonary artery stenoses may reflect intrinsic abnormalities of the pulmonary arteries or may be the result of previous surgery such as systemic to pulmonary artery shunts.

Catheter intervention is again based on balloon and stent dilatation of the stenotic segment.

### Conclusions:

The number of patients treated with interventional catheter techniques in the adult congenital cardiac clinic continues to grow. Many of these techniques have the benefit of avoiding surgical procedures involving sternotomy or thoracotomy. In experienced hands, most catheter interventional procedures have good safety profiles and high success rates.

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MIC-01-2007-01



# The Hong Kong College of Cardiology Automated External Defibrillator (AED) Programme

**Dr. Kathy Lee**

MBBS, FRCP (Edin), FHKCP, FHKAM (Med), Specialist in Cardiology  
Hong Kong College of Cardiology



Dr. Kathy Lee

## Sudden Deaths Occur Every Day in Hong Kong

In Hong Kong, more than one thousand people lose their lives suddenly and unexpectedly every year. Many cases are due to ventricular fibrillation causing sudden cardiac arrest. If a normal heart rhythm is not restored promptly, sudden death is inevitable within 10-15 minutes. Normal heart rhythm can often be restored immediately with an electrical shock from a defibrillator. The sooner defibrillation is given, the better the chance of survival.

## Time is Paramount in the Rescue of Cardiac Arrest

Survival rate of sudden cardiac arrest drops by 7-10 % for every minute if normal rhythm is not restored. In Hong Kong, the mortality of out-of-hospital cardiac arrest is 97 -99 %. The poor survival is partly due to the time delay in restoration of normal rhythm and circulation. Although in most instances, an ambulance with ambulance officers and a defibrillator can reach the location of cardiac arrest within 12 minutes after a 999 call, the time spent waiting for rescue may be too long for cardiac arrest victims. Scientific studies show that if effective defibrillation is achieved within 3 minutes, 75 % of victims with ventricular fibrillation can be revived. Since the 1990s, all emergency ambulances in Hong Kong are equipped with an automated external defibrillator (AED). However, public-access AEDs are popular among other countries including the US and Japan but not Hong Kong.

## What is an AED and Who Can Use It

AED is a small electronic device designed to be used by the responder at the scene in case someone collapses. An AED tells the user what to do step by step using a voice command. The AED analyses the ECG and determines if it is necessary to deliver a shock. The AED will only give a shock if it is appropriate. It will not deliver a shock if the heart rhythm is normal when the collapse is due to other conditions. An AED is simple to use. Inexperienced laypersons and even school children can follow the voice instructions and use them correctly. Public-access AED has been proven in clinical trials that it saved 50% more lives from out-of-hospital cardiac arrest. Many local cardiologists see

the need to have more public-access AEDs in Hong Kong.

## The Hong Kong College of Cardiology AED Programme

We believe having an AED nearby may help to save a life in the future. Our goals are to increase public awareness, promote layperson training in basic life support skill, and coordinate AED installation in suitable locations. The cost-effectiveness of AED is closely linked to the estimated chance of having a cardiac arrest and the volume of people flowing through. The Hong Kong College of Cardiology (HKCC) donated the first public-access AED to Lan Kwai Fong as it is a popular public entertainment area with a high volume and density of people travelling around. The HKCC AED programme launched in March this year attracted intense interest from the media and the public. The HKCC is planning to continue the programme in other potential locations like public sports facilities and MTR stations.

## Other Initiatives and Collaborations

The need for increasing the survival rate of sudden death calls for the "Hong Kong - Heart-Safe Place" Programme (攜手共建「安心坊」) as more lives may be saved after the widespread installation of AED. This programme is targeted to coordinate community efforts towards improving sudden death survival in Hong Kong by increasing public access to AED. The objective of the programme is to encourage organisations and public facilities to deploy AED and be involved in early defibrillation and resuscitation of sudden death victims. Under this programme, HKCC offers professional consultation to community organisations on AED installation and emergency response programme.

To be qualified as a "Heart-Safe Place", three criteria must be met when HKCC carries out an assessment on an individual site:

- 1) The AED must be accessible by the community;
- 2) A designated on-site response team with AED and CPR training must be present;
- 3) A follow-up plan including AED maintenance and drill must be in place.

Lan Kwai Fong became the first "Heart-Safe Place" since HKCC set up an AED and an emergency response system there in March 2007. Since then, more than





Lan Kwai Fong became the first "Heart-Safe Place" since HKCC set up an AED and an emergency response system there in March 2007. Since then, more than a hundred AEDs have been deployed in different locations throughout Hong Kong. Currently, many corporations and organisations have been awarded as a "Heart-Safe Place" by the HKCC. They include the Disneyland Resort, Island School, shopping malls and housing estates under the management of the Sun Hung Kai Properties, Henderson Properties, MTR Properties, Shun Tak Properties and many more.

In collaboration with the Ruttonjee/ Tang Shiu Kin Accident and Emergency Training Centre, the HKCC has coordinated training courses on Basic Life Support and AED for hundreds of lay public. Under the auspices of the Fire Services Department, candidates who have completed the training and obtained certification are awarded as a "Heart-Saver"(救心先鋒). We hope to improve public education on resuscitation as well as promote a culture of the Good Samaritan among Hong Kong citizens. After all, the success of an AED programme is dependent on the availability of both the AED and people who are willing to use it.

Last but not the least; the HKCC would like to thank the following organizations in supporting the HKCC AED programme: Auxiliary Medical Service, Hong Kong St. John Ambulance, Hong Kong College of Emergency Medicine, Hong Kong Disaster Medicine Association, and the Red Cross.



The medical profession joined hands to promote AED in the community



Demonstration by a lay person of how to use the AED

### 如何操作AED?



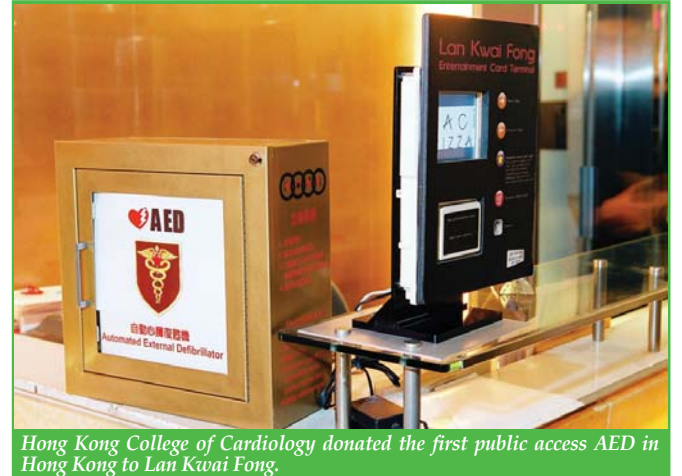
1. 開啓AED



2. 貼上電極片



3. 聽從 AED 指示



Hong Kong College of Cardiology donated the first public access AED in Hong Kong to Lan Kwai Fong.



The Lan Kwai Fong management team learning basic life support and operation of the AED



AED in the management office of California Tower, Lan Kwai Fong



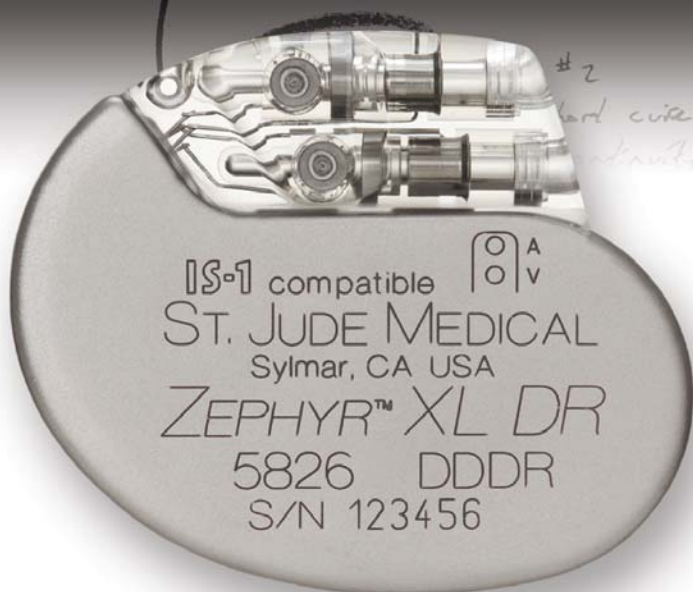
With the effort of the Hong Kong College of Cardiology, more AEDs are now installed in major shopping malls in Hong Kong.

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# The History of Ancient Chinese Jade Culture

## Dr. Patrick TH Ko

MD(Alberta), FRCPC, FHKCP, FHKAM(Medicine)  
Specialist in Cardiology



Dr. Patrick TH Ko

Jade, regarded as the legacy of the stone age and the essence of the mountains and rivers, has occupied an important role in Chinese culture ever since the Neolithic period from B.C. 4000 onward. To a certain extent, jades reflected many Chinese beliefs and values in ancient China. In the last few decades, scientific studies done on archaeological finds in various regions of China have revealed that many prehistoric cultures existed before Hsia, Shang and Zhou (夏、商、周), and such excavated finds included jades artefacts, since the earliest bronze vessels were not made until Hsia and Shang Dynasty. In this article, I shall focus mainly on how jade culture was developed, and how the making and appreciation of jade became intertwined with the philosophy of ancient scholars and the development and governance of early kingdoms that were shaping up in ancient China. To do that, I have to walk the reader back into Chinese history itself.

The history of Chinese jades can be arbitrarily divided into three broad chronological periods:

### 1. The Period of Myth and Magic, B.C. 4000 - B.C. 2000

- Hong Shan Culture	紅山文化	(BC 4000 to 2500)
- Liang Zhu Culture	良渚文化	(BC 3500-2100)
- Long Shan Culture	龍山文化	(BC 3000-2000)

### 2. The Period of Development and Order

- Three Dynasties Hsia, Shang, Western Zhou	三代：夏、商、周	B.C. 2000 to B.C. 771
- Eastern Chou Spring & Autumn	東周 - 春秋	B.C. 711 to B.C. 475
- Warring States	戰國時代	B.C. 475 to B.C. 221
- Qin	秦朝	B.C. 221 to B.C. 206
- Western Han	西漢	B.C. 202 to A.D. 8
- Eastern Han	東漢	A.D. 25 to A.D. 220

An interim period, often called the dark ages of jade culture, occurred from the Six Dynasties (六朝) A.D. 220 to A.D. 589 to the Sui Dynasty (隋朝) A.D. 581 to A.D. 618.

### 3. The Period of Art

- Tang	唐	A.D. 618 to A.D. 907
- Song	宋	A.D. 960 to A.D. 1279
- Yuan	元	A.D. 1279 to A.D. 1368
- Ming	明	A.D. 1368 to A.D. 1644
- Qing	清	A.D. 1644 to A.D. 1911

## The Period of Myth and Magic

From B.C. 4000 to B.C. 2000, several cultures began to develop in pre-historic China, centering in mainly three regions, where jades of intriguing design were made. During this period, jade was a reflection of the cultural beliefs prevailing of the time when people expressed and recorded their mythological and religious beliefs in jade and other artefacts.

In the Northeast i.e. the western part of Liaoning to the eastern part of Inner Mongolia, a great civilisation now called Hong Shan Culture 紅山文化 emerged.

Jade artefacts of the **Hong Shan Culture** were mostly crafted in roundish forms, though a few slab-like jade pieces have been identified more recently.

These jade artefacts reflected nature and many were in the form of embryonic dragons now called "玉豬龍", Fig. 1 or jade eagles "玉鷹" Fig. 2. The pig dragon is symbolic of fertility and wealth while the eagle is symbolic of the mythical bird, the only animal that could fly from Earth to Heaven, and hence acted as a messenger between Heaven and Men.

In the South East Yangtze river basin, another civilisation emerged slightly later i.e. B.C. 3500 to B.C. 2100, in present-day Hangzhou (杭州), Tai Hu (太湖) region, the **Liang Zhu (良渚文化)**. An abundant amount of exquisitely carved jade artefacts were excavated from several burial sites in the 1970's to 80's of the last century. Many of these jades were in the form of Cong (玉琮) Fig.3, Bi-disk (玉璧) Fig. 4, or Axe (玉鉞) Fig. 5 and were certainly used for ceremonial or ritual purposes. Others such as pendants or other ornaments Fig. 6 were for decorative function. The delicately carved man and animal motifs on these jade objects are truly astounding, and craftsmen of today using the most technologically advanced machinery would find it difficult to emulate.

Civilisation of the central plain (中原) could probably be exemplified by **Long Shan (龍山文化)** B.C. 2500 to B.C. 2000. Many elegantly carved and designed jades such as the qui tablet (玉圭) Fig. 7 used for ceremonial purposes have been discovered in the past few decades. They were precursors to the Shang and Zhou jades.

## The Period of Development and Order

Shang, Zhou and Spring and Autumn saw a rapid development in jades, and it is evident that members of



the noble class valued jades highly. Confucius was quoted as saying: " A gentleman always carried a jade pendant 君子無故，玉不去身。", as a symbol of class and to remind him the virtues of a gentleman, since those virtues were found in jade. One type of jade pendants was thought to be representative of the golden rule (金科玉律).

According to Shu Wen (說文) compiled by Hsu Shen of the Eastern Han (東漢許慎), the five virtues of jade were: benevolence, integrity, intelligence, bravery, trustworthiness (仁、義、禮、智、信) which were exactly those expected of a gentleman.

It was the Duke of Zhou (周公) who chronicled the Zhou Rites (周禮) and put things in proper order.

The six ritual jades (六玉六瑞) were dedicated for ritual ceremonies:-

Bi-disk	玉璧	用以祭 For	天	Heaven
Cong	玉琮		地	Earth
Gui	玉圭		東	East
Zhang	玉璋		南	South
Tiger	玉虎		西	West
Huang	玉璜		北	North

During this period, the kings and nobles liked to show off their authority using ritual jade weapons: **gui** tablets, jade **axe** and jade **zhang** to represent their high position. The mythological divine power that people in the new Neolithic period revered and awed now began to shift to those with military power. The mythical bird came in handy as the bird, Figure 8, was revered as the predecessor of the Shang. According to the Book of Poems, Ode to Shang, the Bird (詩經、商頌、玄鳥), the sacred bird was sent down from Heaven, and gave birth to the first Shang King (天命玄鳥,降而生商). The King thereby justified his authority by proclaiming that he had divine right to rule over his people.

Politics assumed even more importance during this **Period of Order**, epitomising in the Warring States and the Han Dynasty, when the Phoenix and Dragon became the emblem of the king and the royal family, Figure 9. The propensity of the Dragon and Phoenix motifs, amidst the abundance of cloud (雲紋) and cereal (穀粒紋) designs on jade artefacts probably reflected the spiritual culture (Taoism) of the time, and reinforced the popular belief of the Yin and Yang (陰陽) and the FIVE ELEMENTS (五行) of this particular period), and this signified that people of the Han Dynasty tried to strike a balance between earthly and cosmic order, via achieving harmony with nature.

Backed by the teaching of Confucius, Han Wu Di 漢武帝 was able to assume absolute power, expecting his people to be loyal to their Emperor. Indeed, the Han Dynasty enjoyed over four centuries of stability and rapid growth. Jades of this period became a symbol of authority for the nobles, and wealth for the rich upper class.

Jade artefacts of the later period, from Tang - Five Dynasties, through Song - Yuan to Ming - Qing reflected the ways of life of the particular period, and were mostly used for ornamental purposes. They will be dealt with under separate cover.



Figure 1 Jade Pig-dragon 玉豬龍  
紅山文化 B.C. 3500 to B.C. 2000 Hong Shan Culture



Figure 2 Jade Eagle 玉鷹  
紅山文化 B.C. 3500 to B.C. 2000 Hong Shan Culture



Figure 3 Jade Cong 玉琮  
良渚文化 B.C. 3000 to B.C. 2100 Liang Zhu

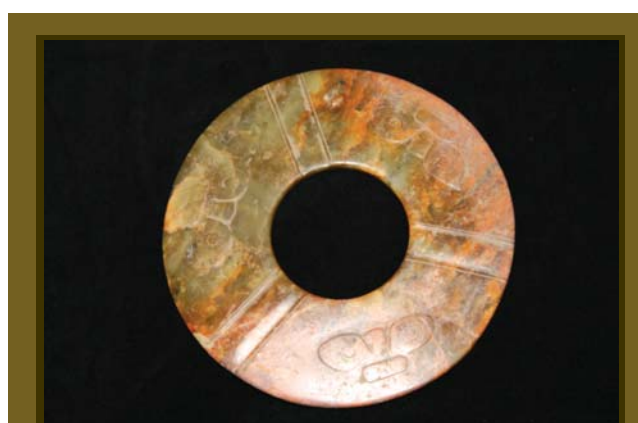


Figure 4 Jade BiDisk 玉璧  
良渚文化 B.C. 3000 to B.C. 2100 Liang Zhu



Figure 5 Jade Axe 玉鉞(斧)  
良渚文化 B.C. 3000 to B.C. 2100 Liang Zhu



Figure 7 Jade Gui 玉圭  
龍山文化 Long Shan  
B.C. 2500 to B.C. 2000



Figure 8 Jade Bird  
玉鳥(雙人首在下)  
龍山文化 Long Shan  
B.C. 2500 to B.C. 2000

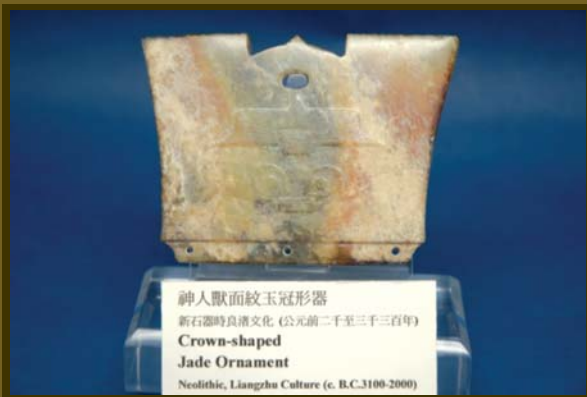


Figure 6 Jade Ornament 玉冠(形器)  
良渚文化 B.C. 3000 to B.C. 2100 Liang Zhu



Figure 9 Jade Decorative Plaque  
(with 11 dragons and 2 phoenixes) 玉牌飾  
戰國 B.C. 475 to B.C. 221 Warring States

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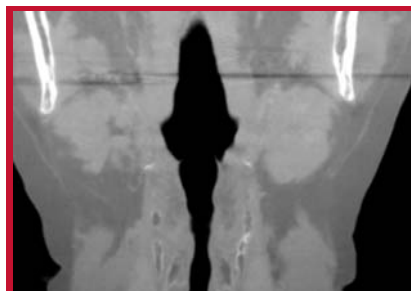
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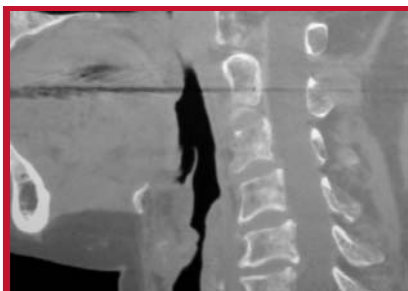
# Clinical Quiz

Dr. Stephen CW Cheung

Department of Radiology, Queen Mary Hospital



Relapsing Polychondritis.1



Relapsing Polychondritis.2



Relapsing Polychondritis.3



Relapsing Polychondritis.4

## Questions:

- F/56
- First presented with sore throat, chest pain and prolonged episodes of fever. Then sudden onset of redness and pain of the pinna.
- CT scan of the neck and thorax was done with multi-planar reformat done.
- Please comment on the findings and possible diagnoses

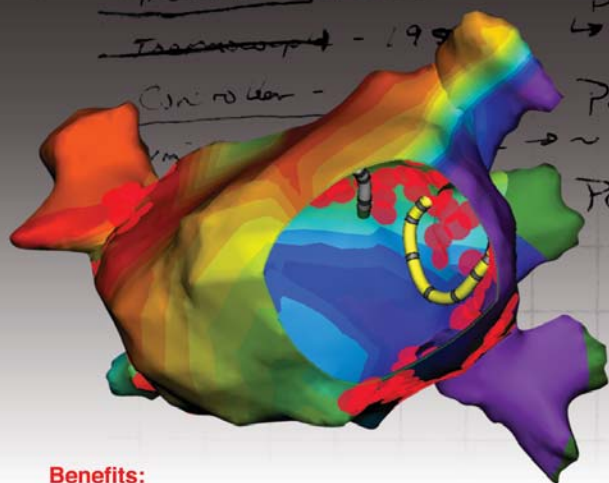
(See P. 29 for answers)

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## New Office Bearers and Executive Committee Members for 2007-2009

We are pleased to announce the new Office Bearers and Executive Committee members for 2007-2009 of the Federation of Medical Societies of Hong Kong elected at the 22nd Annual General Meeting held on 15th November 2007.

President:	Dr. FONG To Sang, Dawson
1st Vice President:	Dr. LO See Kit, Raymond
2nd Vice President:	Dr. LO Sze Ching, Susanna
Hon. Secretary:	Dr. CHAN Sai Kwing
Hon. Treasurer:	Mr. LAM Lop Chi, Nelson
Executive Committee Members	*Dr CHAN Chi Fung, Godfrey *Dr. CHAN Chi Kuen *Dr. CHAN Hau Ngai, Kingsley *Dr. CHIM Chor Sang, James *Dr. HO Chung Ping *Dr. LEE Kin Man, Philip #Ms. MAN Bo Lin, Manbo *Dr. MAN Chi Wai #Ms. MAN Wai Kin, Flossie *Dr. MOK Chun On *Dr. MUI, Winnie *Dr. NG Yin Kwok *Dr. YU Chau Leung, Edwin *Dr YU Kong San
* Representing Ordinary Members	
# Representing Associate Members	



Seated from left to right: Dr. Cheung Tse Ming, Ms. Tina WT Yap, Mr. Nelson LC Lam, Dr. Raymond SK Lo, Dr. Dawson TS Fong (President), Dr. Chan Chi Kuen, Dr. Chan Sai Kwing, Dr Winnie Mui, Dr. Peggy YH Tan

Back row from left to right: Ms. Paulina PK Tang, Ms. Sue SY Cheng, Dr. Kingsley HN Chan, Dr. Yu Chau Leung, Dr. Ho Chung Ping, Dr. Mok Chun On, Dr. Gavin KW Lee, Dr. Ng Yin Kwok, Mr. Peter YY To, Dr. Man Chi Wai, Dr. Maureen ML Wong, Dr Liu Wing Hong, Ms. Cora SH Tsang

## The new Directors of the HKFMS Foundation Limited are:

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1st Vice President:	Dr. LO See Kit, Raymond
2nd Vice President:	Dr. LO Sze Ching, Susanna
Hon. Secretary:	Dr. CHAN Sai Kwing
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### News from Member Societies:

#### Hong Kong Psychogeriatric Association Ltd

Updated office-bearers for the year 2007-2008 are as follows: President: Dr. Siu-Wah LI, Secretary: Dr. Chi-leung LAM, Treasurer: Mr. Man-Chiu David LAI

#### The Hong Kong Society of Nephrology Limited

Updated office-bearers for the year 2007-2008 are as follows: Chairman: Dr. Kui-man Andrew WONG, Secretary: Dr. Sing-leung LUI, Treasurer: Dr. Chi-bon LEUNG

## Hong Kong Society of Nephrology

The Hong Kong Society of Nephrology was founded in 1979 as a non-profit professional organization. The objectives of the Society are: (1) to promote the interest in and a better understanding of nephrology in Hong Kong; (2) to provide a venue for discussion of problems related to nephrology; (3) to endeavour to improve the standard of nephrology care and (4) to provide a means of liaison with workers in nephrology in other parts of the world.

We now have more than 650 full and associate members. Our members consist of doctors, nurses and other allied health professionals who are interested in the care of patients with kidney diseases.

### The major programs and activities of our Society include:

- (1) Annual Scientific Meeting, bi-weekly Inter-hospital Renal Meetings and regular Scientific Symposia.
- (2) Research and travel grants to our members.
- (3) Hong Kong Journal of Nephrology.
- (4) Annual Renal Patients' Gateball Competition.
- (5) Organization of International meetings such as the 11th Congress of the International Society for Peritoneal Dialysis in 2006 and the forthcoming 2nd Congress of the International Society for Haemodialysis in 2009.

### The Office Bearers of our Society are:

Chairman: Dr. Andrew K.M. WONG  
Hon. Secretary: Dr. LUI Sing Leung  
Hon. Treasurer: Dr. LEUNG Chi Bon  
Council Members: Dr. CHOI Koon Shing,  
Dr. Samuel K.S. FUNG,  
Dr. HO Yiu Wing,  
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Dr. Sydney C.W. TANG,  
Dr. Wong Kin Shing



## The Pharmaceutical Society of Hong Kong

The Pharmaceutical Society of Hong Kong was established in 1949 with the appointment of the HK government as a legal body of the pharmacy profession. Throughout these years, the PSHK has been actively involved in the professional development of pharmacy arena with the collaboration of the HKSAR Government. PSHK is empowered by law to nominate 3 representatives to the Pharmacy & Poisons Board.

Apart from being dedicated to the development of pharmacy profession, PSHK also takes up improving the health of general public as our ultimate goal. We have been working with old-aged homes for more than 5 years to improve the drug management standards for old-aged home residents. Unit-dose packing was introduced for easier drug administration and storage at floor level. It is especially useful for patients with complicated drug regimen. It would not only simplify the drug administration procedures, but could also enhance medication safety. In addition to that, we also launched an elderly outreach program with the CUHK to provide drug education and counselling to elderly in community centres.

The community service has been well-accepted by old-aged home staff and the elderly. This will be one of the development directions of the PSHK. We will continue to explore collaborative opportunities with all other health care disciplines to work cohesively and to provide more diverse community services to our society at large.





## The Hong Kong College of Family Physicians - Annual Scientific Meeting

### "Family Physicians and Our Community"

On behalf of the Annual Scientific Meeting Organising Committee, I am delighted to inform you that our College's Annual Scientific Meeting (ASM) 2008 will be held from 24 May 2008 to 25 May 2008. The venue of the meeting will be at the Hong Kong Academy of Medicine Jockey Club Building.

Since our establishment in 1977, our college has greatly influenced the growth and practice of many doctors working in the community. In order to further strengthen our field, ongoing improvements in teaching, training and research are essential. Without doubt the upcoming ASM 2008 will provide opportunities for family medicine and other specialty doctors, plus health care professional colleagues to share and learn new ideas, thus further promoting health in our community.

We now cordially invite you to submit abstracts for paper presentations and posters at ASM 2008. Instructions for abstract submission are available at our College's website ([www.hkcfp.org.hk](http://www.hkcfp.org.hk)). I look forward to meeting you at ASM 2008 and the fellowship conferment ceremony.

Dr. Winnie W. Y. Chan  
Chairlady  
ASM Organising Committee

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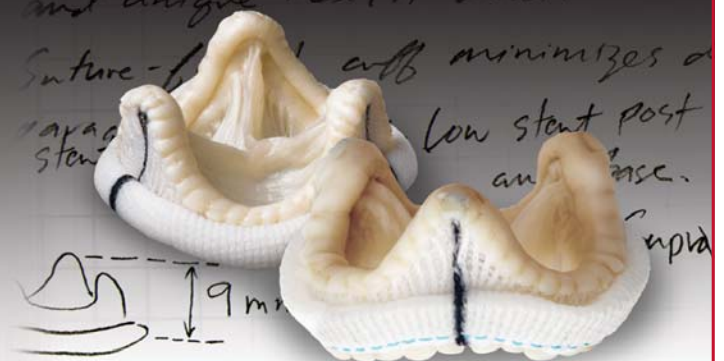


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Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<p>★ HKMA Structured CME Programme at Queen Elizabeth Hospital Year 07/08 (X) - Ophthalmology <b>6</b></p>		<p>★ FMSHK Officers' Meeting</p> <p>★ HKMA Newsletter Editorial Meeting <b>8</b></p>	<p>★ Hong Kong Neurosurgical Society Monthly Academic Meeting - Review of Management of Spasticity in Neurosurgical Patients <b>9</b></p>	<p>★ 催眠治療臨床應用課程</p> <p>★ HKMA Council Meeting <b>3</b></p> <p>★ HKMA Structured CME Programme with Hong Kong Sanatorium &amp; Hospital Year 2008 (I)</p> <p>★ Kidney Disease Management Course 2008 (I)</p> <p>★ 催眠治療臨床應用課程 <b>10</b></p>	<p>★ Mental Health Seminar and Press Conference</p> <p>★ Hong Kong Surgical Forum, Winter 2008 <b>11</b></p>	<p>★ Beat Drugs Seminar <b>5</b></p>
<p>★ Course on Epidemiology and Control of Infectious Diseases <b>13</b></p>	<p>★ Course on Epidemiology and Control of Infectious Diseases <b>14</b></p>	<p>★ FMSHK Executive Committee Meeting <b>15</b></p>	<p>★ Course on Epidemiology and Control of Infectious Diseases <b>16</b></p>	<p>★ 催眠治療臨床應用課程 <b>17</b></p>	<p>★ Course on Epidemiology and Control of Infectious Diseases <b>18</b></p>	<p>★ Course on Epidemiology and Control of Infectious Diseases <b>19</b></p>
<p>★ Course on Epidemiology and Control of Infectious Diseases <b>20</b></p>	<p>★ Course on Epidemiology and Control of Infectious Diseases <b>21</b></p>	<p>★ Course on Epidemiology and Control of Infectious Diseases <b>22</b></p>	<p>★ Kidney Disease Management Course 2008 (II)</p> <p>(1) "Somewhere, Nowhere, Everywhere," (2) A Patient with Recurrent Chest Infections</p> <p>★ 催眠治療臨床應用課程 <b>24</b></p>	<p>★ Certificate Course in Ward Management Module II: "Managing resources in health service" (Code No. TC-WM-0107II)</p> <p>★ Advanced Trauma Life Support (ATLS) Provider Course <b>25</b></p>	<p>★ 3rd HKMA Sports Night</p> <p>★ Advanced Trauma Life Support (ATLS) Provider Course <b>26</b></p>	
<p>★ HKMA Structured CME Programme at Kwong Wah Hospital Year 07/08 (X) - Radiology &amp; Pathology</p> <p>★ Advanced Trauma Life Support (ATLS) Provider Course <b>27</b></p>	<p>★ Kidney Disease Management Course 2008 (III)</p> <p>★ 催眠治療臨床應用課程 <b>31</b></p>	<p>★ Kidney Disease Management Course 2008 (III) <b>30</b></p>				



Date / Time	Function	Enquiry / Remarks
<b>3</b> 7:30 pm - 9:30 pm (10,17,24,31) <b>THU</b> 8:00 pm	<b>催眠治療臨床應用課程</b> Organised by: The Federation of Medical Societies of Hong Kong # Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai <b>HKMA Council Meeting</b> Organised by: The Hong Kong Medical Association Chairman: Dr. K CHOI # HKMA Head Office, 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai	Ms. Karen CHU Tel: 2821 3515 Fax: 2865 0345  Ms. Christine WONG Tel: 2527 8285
<b>5</b> <b>SAT</b> 1:45 pm	<b>Beat Drugs Seminar</b> Organised by: The Hong Kong Medical Association Chairman: Prof. A LEE & Dr. C.C. LEUNG Speaker: Various # Lecture Theatre, Hospital Authority Building, Kowloon	Miss Viviane LAM Tel: 2527 8452 (Registration Fee is required) 2.5 CME Points
<b>6</b> <b>SUN</b> 2:00 pm	<b>HKMA Structured CME Programme at Queen Elizabeth Hospital Year 07/08 (X) - Ophthalmology</b> Organised by: The Hong Kong Medical Association & Queen Elizabeth Hospital Speaker: Dr. L WONG, Dr. K.M. CHAN & Dr. C.O. CHENG # Lecture Theatre, G/F., Block M, Queen Elizabeth Hospital, Kowloon	Miss Viviane LAM Tel: 2527 8452 (Registration Fee is required) 3 CME Points
<b>8</b> <b>TUE</b> 8:00 pm - 10:00 pm 8:00 pm	<b>FMSHK Officers' Meeting</b> Organised by: The Federation of Medical Societies of Hong Kong # Gallop, 2/F., Hong Kong Jockey Club Club House, Shan Kwong Road, Happy Valley, Hong Kong <b>HKMA Newsletter Editorial Meeting</b> Organised by: The Hong Kong Medical Association Chairman: Dr. H.H. TSE # HKMA Head Office, 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai	Secretariat Tel: 2527 8898 Fax: 2865 0345  Ms. Tammy TAM Tel: 2527 8941
<b>9</b> <b>WED</b> 7:30 am	<b>Hong Kong Neurosurgical Society Monthly Academic Meeting - Review of Management of Spasticity in Neurosurgical Patients</b> Organised by: Hong Kong Neurosurgical Society Chairman: Dr. HUNG Kwan Ngai Speaker: Dr. Marco KWAN # Seminar Room, G/F, Block A, Queen Elizabeth Hospital,	Dr. Y.C. PO Tel: 2990 3788 Fax: 2990 3789 2 CME Points
<b>10</b> <b>THU</b> 2:00 pm 2:00 pm	<b>HKMA Structured CME Programme with Hong Kong Sanatorium &amp; Hospital Year 2008 (I)</b> Organised by: The Hong Kong Medical Association & Hong Kong Sanatorium & Hospital Speaker: Dr. P.M. YUEN # HKMA Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central, Hong Kong <b>Kidney Disease Management Course 2008 (I)</b> Organised by: The Hong Kong Medical Association # Lecture Theatre, G/F., Block M, Queen Elizabeth Hospital, Kowloon	Miss Viviane LAM Tel: 2527 8452 (Registration Fee is required) 1 CME Points  Miss Gloria CHEUNG Tel: 2527 8941 (Registration Fee is required)
<b>11</b> <b>FRI</b> 1:00 pm  (12)	<b>Mental Health Seminar and Press Conference</b> Organised by: The Hong Kong Medical Association # HKMA Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central, Hong Kong <b>Hong Kong Surgical Forum, Winter 2008</b> Organised by: Department of Surgery, Li Ka Shing Faculty of Medicine, University of Hong Kong Medical Centre; Queen Mary Hospital & Hong Kong Chapter of the American College of Surgeons # Underground Lecture Theatre, New Clinical Building, Queen Mary Hospital, Pokfulam, Hong Kong	Miss Viviane LAM Tel: 2527 8452 (Registration Fee is required)  Forum Secretary Tel: 2855 4885 Fax: 2819 3416 Email: hksf@hkucc.hku.hk Website: http://www.hku.hk/surgery
<b>12</b> <b>SAT</b> 9:00 am - 10:00 am 2:00 pm 2:30 pm	<b>G B Ong Lecture - A Quarter Century of Liver Transplantation Orator: Ronald Busuttil, Professor and Executive Chairman, Department of Surgery, University of California Los Angeles, Los Angeles, California, USA</b> Organised by: Skills Development Centre, Department of Surgery, Li Ka Shing Faculty of Medicine, The University of Hong Kong & the American College of Surgeons, Hong Kong Chapter # Underground Lecture Theatre, New Clinical Building, Queen Mary Hospital, Pokfulam, Hong Kong <b>Infectious Diseases Seminar</b> Organised by: The Hong Kong Medical Association # Princess Margaret Hospital <b>Refresher Course for Health Care Providers 2007/2008 (V) - Management of Peptic Ulcer Disease and GERD in Primary Care</b> Organised by: The Hong Kong Medical Association & Our Lady of Maryknoll Hospital Speaker: Dr. H.T. TO # Training Room II, 1/F., OPD Block, Our Lady of Maryknoll Hospital, 118 Shatin Pass Road, Wong Tai Sin, Kowloon	Forum Secretary Tel: 2855 4885 / 2855 4886 Fax: 2819 3416 E-mail: hksf@hkucc.hku.hk Website: http://www.hku.hk/surgery  Miss Viviane LAM Tel: 2527 8452 (Registration Fee is required)  Ms. Clara TSANG Tel: 2354 2440 2 CME Points
<b>15</b> <b>TUE</b> 8:00 pm - 10:00 pm	<b>FMSHK Executive Committee Meeting</b> Organised by: The Federation of Medical Societies of Hong Kong # Council Chambers, 4/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Secretariat Tel: 2527 8898 Fax: 2865 0345
<b>18</b> <b>FRI</b> 9:00 am - 5:30 pm (19,20,21,22)	<b>Course on Epidemiology and Control of Infectious Diseases</b> Organised by: Stanley Ho Centre for Emerging Infectious Diseases, School of Public Health, The Chinese University of Hong Kong # Prince of Wales Hospital, Shatin, N.T	Tel: 2252 8812 Fax: 2635 4977 Email: ceid@med.cuhk.edu.hk Website: http://ceid.med.cuhk.edu.hk
<b>24</b> <b>THU</b> 2:00 pm 2:00 pm	<b>Kidney Disease Management Course 2008 (II)</b> Organised by: The Hong Kong Medical Association # Lecture Theatre, G/F., Block M, Queen Elizabeth Hospital, Kowloon <b>(1) "Somewhere, Nowhere, Everywhere"</b> <b>(2) A Patient with Recurrent Chest Infections</b> Organised by: Hong Kong Thoracic Society / ACCP (HK & Macau Chapter) Chairpersons: Dr. CHU Chung Ming & Dr. CHAN Kam Keung Speakers: Dr. Veronica CHAN & Dr. Ida WONG # LG1, Lecture Room, Ruttonjee Hospital, Wanchai	Miss Gloria CHEUNG Tel: 2527 8941 (Registration Fee is required)  Dr. C.Y. TAM / Dr. Maurine M.L. WONG Tel: 2468 5407 Fax: 2468 6188 1 CME Point
<b>25</b> <b>FRI</b> 6:30 pm - 9:30 pm  (26, 27)	<b>Certificate Course in Ward Management Module II: "Managing Resources in Health Service" (Code No. TC-WM-0107II)</b> Organised by: College of Nursing, Hong Kong <b>Advanced Trauma Life Support (ATLS) Provider Course</b> Organised by: Skills Development Centre, Department of Surgery, Li Ka Shing Faculty of Medicine, The University of Hong Kong & the American College of Surgeons, Hong Kong Chapter # Skills Development Centre, Department of Surgery, Li Ka Shing Faculty of Medicine, University of Hong Kong Medical Center, Queen Mary Hospital, Pokfulam, Hong Kong	Secretariat Tel: 2572 9255 Fax: 2838 6280 24 CNE Points  Program Manager Tel: 2855 4885 / 2855 4886 Fax: 2819 3416 E-mail: qmhsdc@hkucc.hku.hk Web site: http://www.hku.hk/surgery
<b>26</b> <b>SAT</b> 7:00 pm	<b>3rd HKMA Sports Night</b> Organised by: The Hong Kong Medical Association # Wan Chai Ho Choi Banquet & Seafood Restaurant	Ms. Dora HO Tel: 2527 8285
<b>27</b> <b>SUN</b> 2:00 pm	<b>HKMA Structured CME Programme at Kwong Wah Hospital Year 07/08 (X) - Radiology &amp; Pathology</b> Organised by: The Hong Kong Medical Association & Kwong Wah Hospital Speaker: Dr. P.Y. FUNG & Dr. W.S. TSE # Seminar Room, G/F., Block D, Queen Elizabeth Hospital, Kowloon	Miss Viviane LAM Tel: 2527 8452 (Registration Fee is required) 3 CME Points
<b>31</b> <b>THU</b> 2:00 pm	<b>Kidney Disease Management Course 2008 (III)</b> Organised by: The Hong Kong Medical Association # Lecture Theatre, G/F., Block M, Queen Elizabeth Hospital, Kowloon	Miss Gloria CHEUNG Tel: 2527 8941 (Registration Fee is required)



## Meetings

11-12/7/2008	<b>Hong Kong Surgical Forum, Summer 2008</b> Organised by: Department of Surgery, Li Ka Shing Faculty of Medicine, University of Hong Kong Medical Centre; Queen Mary Hospital & Hong Kong Chapter of the American College of Surgeons # Underground Lecture Theatre, New Clinical Building, Queen Mary Hospital, Pokfulam, Hong Kong Enquiry: Forum Secretary Tel: 2855 4885 Fax: 2819 3416 Email: hksf@hkucc.hku.hk Website: <a href="http://www.hku.hk/surgery">http://www.hku.hk/surgery</a>
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## Courses

1,15,22,29/2/2008 7,14,28/3/2008 11/4/2008 6:30pm to 9:30pm	<b>Certificate Course in Ward Management - Module II: "Managing Resources in Health Service" (Code No. TC-WM-0107II)</b> Organised by: College of Nursing, Hong Kong Enquiry: Secretariat Tel: 2572 9255 Fax: 2838 6280
23/2/2008 2:00pm-3:00pm	<b>Course on Epidemiology and Control of Infectious Diseases</b> Organised by: Stanley Ho Centre for Emerging Infectious Diseases, School of Public Health, The Chinese University of Hong Kong # Prince of Wales Hospital, Shatin, N.T Tel: 2252 8812 Fax: 2635 4977 Email: ceid@med.cuhk.edu.hk Website: <a href="http://ceid.med.cuhk.edu.hk">http://ceid.med.cuhk.edu.hk</a>
14,15,16/3/2008	<b>Advanced Trauma Life Support (ATLS) Provider Course</b> Organised by: Skills Development Centre, Department of Surgery, Li Ka Shing Faculty of Medicine, The University of Hong Kong & the American College of Surgeons, Hong Kong Chapter # Skills Development Centre, Department of Surgery, Li Ka Shing Faculty of Medicine, University of Hong Kong Medical Center, Queen Mary Hospital, Pokfulam, Hong Kong Enquiry: Program Manager Tel: (852) 2855 4885 / 2855 4886 Fax: (852) 2819 3416 E-mail: qmhsdc@hkucc.hku.hk Web site: <a href="http://www.hku.hk/surgery">http://www.hku.hk/surgery</a>
28/3/2008 5:30pm-8:30pm, 1-3/4/2008 6:30pm-9:30pm, 6/5/2008 6:30pm-7:30pm	<b>Course on Nosocomial Infection and Control Measures in Hospital</b> Organised by: Stanley Ho Centre for Emerging Infectious Diseases, School of Public Health, The Chinese University of Hong Kong # Prince of Wales Hospital, Shatin, N.T Tel: 2252 8812 Fax: 2635 4977 Email: ceid@med.cuhk.edu.hk Website: <a href="http://ceid.med.cuhk.edu.hk">http://ceid.med.cuhk.edu.hk</a>
8,15,22,29/4/2008, 13,20,27/5/2008, 3/6/2008 6:30pm-9:30pm 10/6/2008 6:30pm-8:30pm	<b>Course on Common Viral Infections</b> Organised by: Stanley Ho Centre of Emerging Infectious Diseases, School of Public Health and Department of Microbiology, The Chinese University of Hong Kong # Prince of Wales Hospital, Shatin Tel: 2252 8812 Fax: 2635 4977 Email: ceid@med.cuhk.edu.hk Website: <a href="http://ceid.med.cuhk.edu.hk">http://ceid.med.cuhk.edu.hk</a>
4/2008-6/2008	<b>Course on Application of Geographic Information System (GIS) In Public Health</b> Organised by: Stanley Ho Centre for Emerging Infectious Diseases, School of Public Health, The Chinese University of Hong Kong # Prince of Wales Hospital and CUHK Campus, Shatin, N.T Tel: 2252 8812 Fax: 2635 4977 Email: ceid@med.cuhk.edu.hk Website: <a href="http://ceid.med.cuhk.edu.hk">http://ceid.med.cuhk.edu.hk</a>
2,9,16,23,30/5/2008 6,13,20,27/6/2008	<b>Certificate Course in Ward Management - Module III: "Managing Risk at Workplace" (Code No. TC-WM-0107III)</b> Organised by: College of Nursing, Hong Kong Enquiry: Secretariat Tel: 2572 9255 Fax: 2838 6280

## Answer to Clinical Quiz

### Diagnosis:

Relapsing Polychondritis

### Description:

- Narrowing of the sub-glottic trachea which is best seen on reformat images
- Diffuse thickening of the wall of the trachea and main bronchi
- Diffuse luminal narrowing of the trachea and the main bronchi
- No tracheal wall calcification

### Discussion:

Relapsing polychondritis (RP) is an immune mediated disease with destruction of the type II collagen in cartilage at multiple sites, eg. Ear, nose, articular cartilage etc.

There is association with other collagen vascular diseases like SLE.

Sudden swelling and pain of the ears with discoloration is a classical finding. Calcification and deformity are later results. The trachea can be dilated or narrowed and collapsibility is known. This can be a life threatening part of the disease. This patient was being planned for endo-tracheal stenting while she was having exertional dyspnoea. There was no hyperinflation of the lungs noted.

Her initial presentations also involved persistent fever, joint pain and on blood test an elevated white cell count. Her treatment includes prednisolone and methotrexate.

**Dr. Stephen CW Cheung**

*Department of Radiology, Queen Mary Hospital*



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





# MEETING FACILITIES

of The Federation of Medical Societies of Hong Kong

Venue or Meeting Facilities	Member Society (Hourly Rate HK\$)	Non-Member Society (Hourly Rate HK\$)
Meeting Room (Max 30 persons)	115.00	230.00
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	<b>Per Session</b>	<b>Per Session</b>
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The Federation of Medical Societies of Hong Kong

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## The Hong Kong Medical Diary

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ISSN 1812 - 1691

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To improve the healthcare of our patients through the development and education of our members and the advancement of our specialty fields.

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2. List of full names (both English and if Chinese applicable) of authors, giving a maximum of two qualifications and current appointment of each.
3. The principal author should give his or her address for correspondence. A passport size photo of the principal author(s) (*maximum of two photos*) can be supplied for publication.
4. Spelling should conform to the Oxford Dictionary. Abbreviation should be written in full when first used.
5. Both generic names and proprietary names of drugs may be used.
6. Tables and illustrations should be on separate sheets and clearly labelled.
7. Photographs should be labelled on the reverse. The Editorial Board reserves the right to print photos in black and white only. Colour illustrations or photos should be submitted in a CD-ROM.
8. References should conform to the Vancouver style and should be numbered in correct order in the text. Journal titles should be abbreviated to index medicus style.  
(e.g. 1. *Ahuja A, Ying M. Sonography of neck Lymphnodes. Clin Radiol 2003;58:359-366,*  
2. *Van Hasselt CA, Leung S. F. Clinical Picture. In: Van Hasselt CA, (Gibb A. (eds) Nasopharyngeal Carcinoma. 2<sup>nd</sup> ed. Hong Kong The Chinese University Press; 1999:105-110).*
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Original research papers, recent advances, educational updates, review papers, discussion papers on medical topics relevant to medical practice are welcome. Articles should be between 800 and 2,400 words (one to three pages). References are encouraged but not required.

#### Drug Review

Articles on clinical approach to the safe use of a particular drug or groups of drugs are welcome. These articles should be from 800 to 1,600 words. (one to two pages).

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Interviews with presidents of member societies and prominent members of the medical and health profession; publication of keynote addresses and presentations.

#### Clinical Quiz

Case studies in question and answer format in dermatology, radiology, medicine and surgery will be considered for publication. These articles should be under 500 words (one page).

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Selected summaries and proceedings of local, regional and overseas medical meetings will be published.

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Interesting articles on hobbies, sports, travel, dining, movies, investments and careers are welcome. These articles should be kept under 1,600 words (two pages).

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Medical events of the month will be printed as a service to members (all should be submitted before the 10th of the previous month).

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THE FEDERATION OF MEDICAL SOCIETIES OF HONG KONG

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Duke of Windsor Social Service Building, 4/F, 15 Hennessy Road, Hong Kong  
Tel: (852) 2527 8898 Fax: (852) 2865 0345 Homepage: www.fmshk.org E-mail: info@fmshk.org

## Application Form for Certificate Course

Name of Applicant:(Prof/Dr./Mr./Ms./Mrs.)\* \_\_\_\_\_ (English) \_\_\_\_\_ (Chinese)

\*Please delete as appropriate (in block letters)

Correspondence Address: \_\_\_\_\_

Tel. No. : \_\_\_\_\_ Fax No.: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Email Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Course Title:  催眠治療臨床應用課程 (C127)  
(please tick)

Education : Secondary Undergraduate Postgraduate Others \_\_\_\_\_  
(please tick)

Fee enclosed (please tick):

Cheque No: \_\_\_\_\_ made payable to **The Federation of Medical Societies of Hong Kong**

Cash HK\$ \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Note:

1. The application form together with the appropriate fee should be sent to the Secretariat of the Federation of Medical Societies of Hong Kong, 4/F Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong.
2. Fees are not refundable, except in the event of a course being oversubscribed or cancelled.
3. The Federation of Medical Societies of Hong Kong reserves the right to cancel the course should too few participants enroll for the course.
4. No classes will be held when typhoon signal No. 8 or above or black rainstorm warning is still hoisted after 12:00 noon. Please contact the Secretariat at 2527 8898 to enquire matters regarding cancellation of class due to typhoon or black rainstorm.

### For office use:

Registration confirmed on : \_\_\_\_\_ Registration Number : \_\_\_\_\_

Cheque Issuing Bank : \_\_\_\_\_ Cheque Number: \_\_\_\_\_

# 催眠治療臨床應用課程

合辦機構：



香港醫學組織聯會



香港復康會適健中心

課程目標: 催眠治療是一種心理治療方法，對於處理情緒壓力、失眠、焦慮、恐懼和抑鬱等問題甚為有效。此外，催眠在提升個人自信心、動力、與及改善人際社交關係也有顯著的效果。因此，對於從事醫療及護理工作的專業人士，催眠治療可以成為一種有效的方法，協助你處理病人不同的問題。本課程的目標是令參加者掌握簡單催眠治療的技巧，並應用於其日常臨床工作上。

## 目的：

1. 掌握正確催眠治療知識及技巧
2. 學習運用自我催眠技巧於不同病人的臨床工作
  - 舒緩痛楚
  - 情緒舒導
  - 改善睡眠質素
  - 處理壓力及焦慮
3. 提昇參加者處理工作壓力時的能力及信心

## 導師：

### 尹婉萍小姐

註冊臨床催眠治療師、認可催眠治療培訓導師、註冊社工

尹小姐擁有香港中文大學社會工作學士學位，香港大學社會科學碩士學位〈家庭輔導〉。她從事個案輔導及小組治療服務十多年，尤精於應用催眠治療及輔導於改善失眠、情緒舒導、壓力處理、家庭關係、親子溝通及管教等。尹小姐亦為香港大學行為健康教研中心臨床實習導師，於「催眠治療」學科督導碩士課程的學生。

## 內容：

- 一般人對催眠的誤解
- 催眠的定義、歷史及用途
- 催眠對改善身心的效用
- 催眠與潛意識的關係
- 認識潛意識的力量
- 催眠能力的測試
- 導入催眠意境的基本技巧
- 自我催眠的基本步驟及技巧
- 如何運用催眠技巧於
  - 舒導情緒
  - 治療失眠
  - 舒緩痛楚
  - 減壓
  - 改善身心健康

## 對象：

從事醫療及護理工作的專業人士

日期：2008年1月3日至2008年1月31日  
(整個課程共 5 節，逢星期四，每星期 1 節，每節 2 小時)

時間：晚上七時半至九時半

地點：香港醫學組織聯會課室

教授語言：廣東話

名額：50人

收費：\$950

