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香港醫訊
THE HONG KONG MEDICAL DIARY

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卓健醫療體檢中心有限公司藥劑部董事

2008年6月17日

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診所藥品庫存及記錄

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2008年6月24日

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診所配藥管理

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Contents

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Editorial

Dr. Richard K Lo

MD(UCLA), MCPS(Manitoba), FCSHK,
American Board of Urology, FHKAM(Surgery)

Consultant Surgeon, Pedder Clinic
Editor

Dr. Richard K Lo

In this issue of the Medical Diary, we try to highlight some current medical problems our profession faces in everyday practice. Rather than an in-depth symposium, the papers attempt to broach a potpourri of subjects in urology, in a broad fashion for general reading on these subjects.

With the advent of the prostatic specific antigen (PSA) test, and general awareness of prostate cancer early detection, most of the prostate cancers found nowadays are of the low-grade, low-stage variety, in younger, sexually active males. These small cancers are amenable to radical treatment, like radical prostatectomy, with a high survival rate, with 10-year figures at 75% or above. After cure of the cancer, rehabilitation of these patients will have to be addressed. The two problems prostatectomy patients face are incontinence and erectile dysfunction (ED). Despite a good understanding of the molecular basis (nitric oxide pathways) of erections, the pelvic neurovascular bundle anatomy and surgical techniques to avoid injuring them, the rate of erectile dysfunction postoperatively is still disappointingly high. In the first article, Lo and Lue (page 14) reviewed the current approaches to sexual rehabilitation in prostate cancer: avoid injury to the neurovascular bundle located posteriorly in the prostate, and use of the phosphodiesterase 5 (PDE-5) inhibitor, sildenafil. In prospective, randomised and placebo-controlled studies, the early, daily use of sildenafil is shown to be superior to the placebo cohort. There is also a lot of research into rehabilitation using stem cell research and with neuromodulation.

The introduction of extracorporeal shock wave lithotripsy (ESWL) in the early 1980's was thought initially to be a panacea in the treatment of all urinary stones. Patients, and even some of our colleagues, think that with submersion of the patients into the water tub and the push of a button (like waving a magic wand), the stone will disappear and everyone goes home happy. It sounded too good to be true and it was. Private hospitals here in Hong Kong, with economic considerations in the background, allow the indiscriminate use of the lithotripter for the treatment of all types of stones, even by those untrained and uncredentialled to properly treat stone diseases. ESWL is but one of many modalities in our urologic armamentarium for stone treatment. Twenty-five years on and three more generations of lithotriptors later, we still have to resort to percutaneous ultrasonic nephrolithotripsy and especially ureteroscopic laser lithotripsy. The latter has been shown to be superior in stone clearance in distal ureteric stones. Lee (page 11) reviewed the benefits of the rigid and flexible ureteroscope in the treatment of upper tract and ureteric stones.

Drug abuse or illicit drug dependency crosses all ethnic, national and socioeconomic boundaries. Some of our young people go north of the boundary for clubbing and entertainment, where prices are cheaper and recreational drugs easily accessible. Some of the drugs also find its way to the 'in' places of the local clubbing scene, frequented by locals and expatriates alike. Ketamine cystitis is a new entity recognised only recently; not only are new cases on the

rise at Hospital Authority hospitals in rural regions, but also in private hospitals serving more upscale areas. Chu (page 5) shares with us her expertise with ketamine cystitis, and the devastating effects the drug has on the entire urinary tract, from a thimble bladder to papillary necrosis and loss of kidney function.

Urinary tract infections are simple, yet potentially complex medical problems. While the majority will do well and are cured after a short course of antibiotics, the proper use of antibiotics often confounds the frontline physician: what, which medication, when, how long and, with or without cultures and when to refer to the urologist. Lo (page 7) outlined a simplified approach of treating uncomplicated urinary tract infections in the primary care setting. CME questions will round out the article.

On the subject of CME, it is anticipated that future issues of the MD and the Federation will also provide avenues for CPD (Continuous Professional Development), in accordance with the requirement of the Academy of Medicine and its constituent Colleges.

Medical & Dental Directory of Hong Kong, 8th Edition

On behalf of the Editorial Board, it is our great pleasure to announce that the Medical & Dental Directory of Hong Kong (8th Edition) has been published. In this edition, we have prepared an electronic version of the Directory in form of a CD ROM. The CD has incorporated various search functions so that one can easily locate the information of the doctor, the dentist, the hospital, medical and dental websites and etc with great ease. The Editorial Board has made every effort to ensure accuracy. Notwithstanding that, we apologize for the errors made in the Directory. We will publish any corrigendum/updates in the next few issues of Medical Diary for your update.

Corrigendum/Updates to Medical & Dental Directory of Hong Kong (8th Edition)

Page No.	Particulars
442	Qualification attained by HO Hung Kwan, Michael should read as "MB BS (**Syd**) 1994"
455	"KONG Hot Tai" should read as "KONG **Hoi** Tai"
478	"LAU The Shan" should read as "LAU **Teh** Shan" and the Chinese name should read as **劉德譖**
519	Qualifications attained by MING Shiu Kow should read as "MB ChB(Bristol) 1973, DRCOG 1974, **DABIM 1978**, DABFP 1978, **DABIM (Rhu) 1980, FHKCP** 1998"; and His Practice should read as "Private; **Associate Professor of Medicine, The Chinese University of Hong Kong, Medicine, 1996-1998**"
658	Qualification year attained by LI Wai Hon should read as "MB BS (HK) **1991**"
766	"LEUNG Chi Tat, Anthony" should read as "LEUNG Chi Tat, **Antony**"
789	Qualification attained by IP Wing Kin should read as "MB BS (HK) 1982, MRCP (UK) 1990, FHKCP 1992, FHKAM (Medicine) 1995, FRCP (Lond) 1997, FRCP (Edin) 1997, **FRCP (Glasg) 2001**"
962	Email address of CHIU Hung Leung, Albert should read as "dralbertchi**u**@yahoo.com.hk"
1041	Chinese name of YIP Kar Leung, Daniel should read as, **葉嘉梁**

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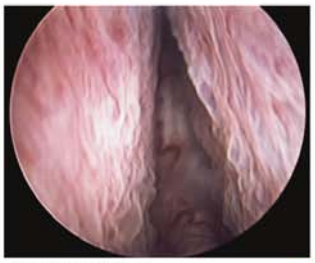

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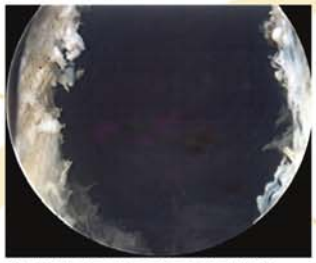

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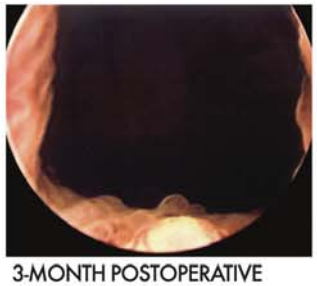

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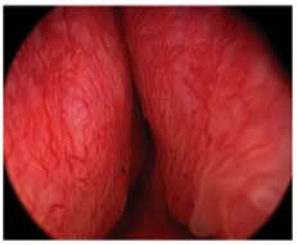

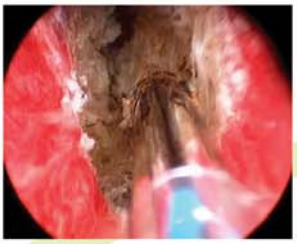

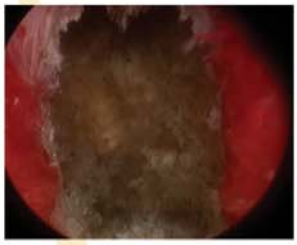

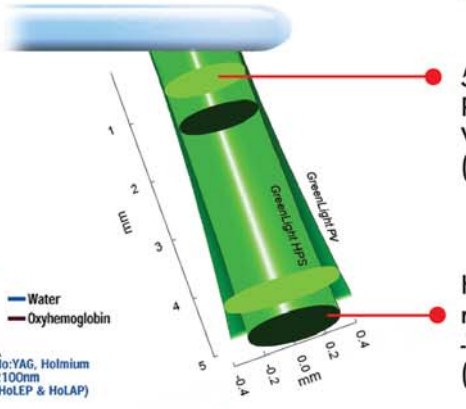

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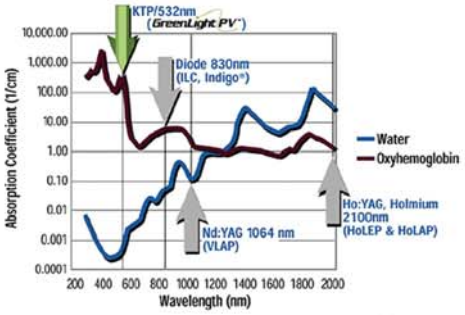

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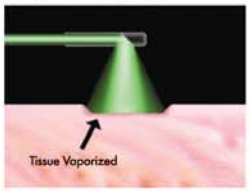

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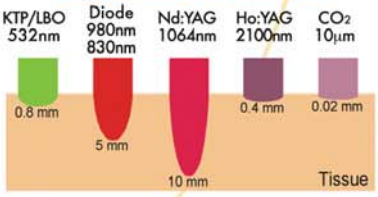

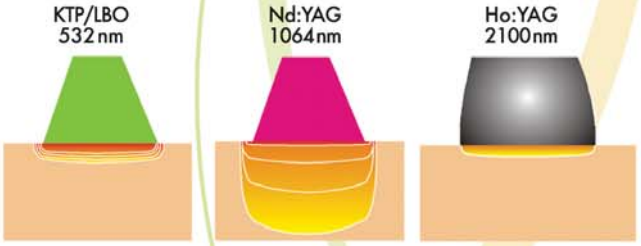

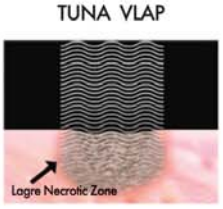

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'Street Ketamine' Associated Bladder Dysfunction: A Report of 10 Cases

Dr. Peggy SK Chu

MBBS(HK), FRCS(Edin), FCS(HK), FHKAM(Surg), Dip Urol(London)

Dr. Peggy SK Chu

Street ketamine, which is based on the ketamine drug used medically as an anaesthetic agent, is increasingly used as a "recreational drug" by some young people in Hong Kong. There was no previous record of the harmful effects of the use of this drug on the bladder. However from 2000 to 2007, seven male and three female patients, aged 20 to 30 years, who had all used street ketamine in this way for 1 to 4 years, presented themselves either to the Tuen Mun Hospital or to the Princess Margaret Hospital in Hong Kong with symptoms of dysuria, frequency, urgency, urge incontinence and painful haematuria. Investigations revealed that their functional bladder capacities ranged only from 30 to 100 ml, and three of them also had vesicoureteric reflux. Cystitis glandularis was detected on bladder biopsy. In addition, eight of them had bilateral hydronephrosis on renal ultrasonography, while four patients had deranged serum creatinine ranging from 177 - 400 umol/L. All 10 patients had abnormal liver function with raised alkaline phosphatase and alanine aminotransferase without sonographic evidence of liver abnormality. One patient had augmentation enterocystoplasty performed to relieve the effect of intolerable urinary frequency resulting from diminished bladder capacity. However, he was then admitted 3 months later in acute renal failure (creatinine 1200 umol/L) requiring bilateral nephrostomy drainage, and was shown to have bilateral upper ureteric stricture. In view of raised inflammatory markers in this patient (raised erythrocyte sedimentation rate), six weeks' course of oral steroid was prescribed for him. Subsequent antegrade nephrostogram revealed that his right sided ureteric stricture had resolved. Nevertheless, his left sided ureteric stricture remained the same and simultaneous antegrade and retrograde pyelogram demonstrated that it was a short segment ureteric stricture. Thus anastomotic ureteroplasty was performed. However his serum creatinine remained deranged at 250 umol/L. We observed that this new clinical entity of ketamine abuse and intractable urinary symptoms severely impair the quality of life in these abusers. Most importantly, the finding of hydronephrosis in most, and renal impairment in half, of our patients is suggestive of a progressive disease process that might end up with chronic renal failure. Possible pathophysiology includes the direct toxic effect of ketamine and its metabolites on the lower urinary tract. We wish to alert frontline doctors to this new form of uropathy. Early urology referral for comprehensive investigation and management would help combat this new form of urinary tract disease.

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References:
1) Narayan P et al. J Urol 2003; 170: 498-502. 2) Lowe FC. Reviews in Urol 2005; 7(Suppl.4): S13-S21. 3) Haab F, Cardozo L, Chapple C, Ridder AM for the Solifenacin Study Group. Eur Urol 2005; 47: 376-384. 4) Ikeda K et al. Naunyn-Schmiedeberg's Arch Pharmacol 2002; 366: 97-103. 5) Ridder DD. Eur Urol 2006; 50(2): 211-212. Epub 2006 Apr 19.

BPH is an abbreviation of Benign Prostatic Hyperplasia and OAB is an abbreviation of Overactive Bladder.

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Practical Hints in the Management of Urinary Tract Infections[$$]

Dr. Richard K Lo

MD(UCLA), MCPS(Manitoba), FCSHK, American Board of Urology, FHKAM(Surgery)
Consultant Surgeon, Pedder Clinic

Dr. Richard K Lo

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 May 2008.

In the outpatient, primary care setting, the most common type of urinary tract infection encountered by the family physician is an uncomplicated bacterial cystitis.

Patients are usually young, sexually-active females, who present with frequency, urgency, dysuria, sensation of incomplete emptying, malodorous urine, and in more severe cases, gross hematuria. The astute physician should enquire about fever, flank pain, vaginal discharge, and Last Menstrual Period (LMP), which might be suggestive of a diagnosis other than simple bacterial cystitis. Differential diagnoses should include acute pyelonephritis, vaginitis, sexually transmitted diseases, bladder stones or even bladder cancer.

Urine dipstick performed in the office is a worthwhile diagnostic test. While it will not yield the culture and sensitivity results, the presence of nitrites and leukocytes on the dipstick test indicates a more than 80% chance of a bacterial infection. For a first-time, simple cystitis, urine culture and sensitivity studies are probably not cost-efficient. As most patients are symptomatic on presentation, it is not necessary to wait for microscopic urinalysis or culture results before initiating treatment.

80% of outpatient, community-acquired simple bacterial cystitis are caused by E. coli. Psudomonas, enterococcus, and proteus round out the list of uropathogens. These E. coli are sensitive to most first-line, oral antibiotics. Because of the emergence of resistant strains of pathogens, the physician should be cognizant of the resistance profile of bacteria in the community where he/she practises. The clinical-bacteriology laboratory engaged should provide this resistance profile semi-annually to their physician-clients for reference.

The choice of antimicrobial therapy should take into consideration the efficacy, duration of treatment, side-effects and the cost. Sulfamethoxazole-trimethoprim (SMX-TMP), given as two tablets twice daily for a 3-day course is effective in 95% of uncomplicated bacterial cystitis, and should be given as first-line therapy. For patients with allergy to sulfa medications, trimethoprim 200 mg BID for 3 days is equally effective. Nitrofurantoin is associated with a low resistance profile and is a good alternative. In this locale which has a significant rate of G6PD deficiency, however, special attention should be exercised. Treatment with nitrofurantoin should be extended to 7 days, at 50 to 100 mg QID. Patient compliance is sometimes a problem with this regimen, as they might neglect to take the medication when they start to feel well after a few days. A second generation oral cephalosporin like cephalexin can also be substituted. These four medications share a unique characteristic in that they are completely absorbed in the stomach and small intestine, then excreted in the urine in high concentrations. While ampicillin and amoxicillin is effective in bacterial eradication, they can cause future bacterial resistance by eradicating sensitive species in the colon.

If symptoms do not subside after 4 to 5 days of medication, persistence of the cystitis due to ineffective antibiotics will have to be suspected. Urine microscopy, culture and sensitivity should then be performed to direct therapy. A second-line antibiotic, such as a quinolone, can be substituted, again only empirically, pending the outcome of the sensitivity study.

Clinical scenarios other than simple cystitis are considered 'surgical infections' and are usually associated with structural abnormalities, and should be referred to the urologist for specialist care. These include febrile pyelonephritis (vesico-ureteral reflux), recurrent urinary tract infections in females (diverticulum/ colo-vesical fistula), in pregnant women (progression to pyelonephritis, prematurity and low birth weights), in the elderly male (benign prostatic hyperplasia or bladder stones), in infants and children (duplicated collecting system, reflux, posterior urethral valves, phimosis, obstruction or other structural changes) and infections associated with a calculus (staghorn stone from proteus infection or infection behind an obstructive stone).

A special case of acute bacterial prostatitis in men should be mentioned here. They present with the typical irritable symptoms of cystitis, together with perineal pain, high fever, shaking chills, and obstructive symptoms with a poor stream, even acute retention of urine. These men should be admitted for intensive intravenous antibiotics to prevent progression into a relapsing, chronic bacterial prostatitis, where the bacteria reside in the sanctuary area in the prostate, which will periodically cause recurrence of the bacterial cystitis.

Patients with febrile pyelonephritis should be investigated initially with a contrast-enhanced triphasic Computerised Tomographic Intravenous Urogram (CT-IVU), looking for the typical wedge-like defect with hypoperfusion of the contrast. The study should be scrutinised for the presence of stones, urine extravasation or abscess formation. Most patients should be hospitalised for combination intravenous antibiotics, empirically with an aminoglycoside plus a third-generation cephalosporin, pending the outcome of urine and blood cultures. An occasional patient, however, can be treated on an outpatient basis, as the newer types of parenteral antibiotics can be given once-daily, supplemented by an oral quinolone.

For those patients with frequent urinary tract infections, various non-antibiotic therapies have been tried over the years. These include switching from nylon/synthetics to cotton underwear, wiping from front to back, drinking large quantities of water, voiding immediately after intercourse or the use of herbal preparations. These remedies lack the backing of proper scientific studies, and success reports appear only anecdotal. The use of cranberry juice is interesting: there appears to be improvement of infection free period in those taking cranberry juice or extracts. For those with limitations on fluid intake, cranberry concentrate is available in capsule form also.

References

$$ portions previously published in a newsletter of the Doctors' Union. Reprinted with permission.

MCHK CME Programme Self-assessment Questions

Please read the article entitled "Practical Hints in the Management of Urinary Tract Infections" by Dr. Richard K Lo, 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 May 2008. Answers to questions will be provided in the next issue of The Hong Kong Medical Diary.

Questions 1-5: Please choose the best answer.

1.As newer antibiotics are associated with less resistance and probably stronger than older drugs like SMX-TMP, they should be used first in the treatment of uncomplicated urinary tract infections.
True / False

2.Which of the following is not a likely uropathogen:
a) E coli
b) Staphylococcus epidermidis
c) Pseudomonas aeruginosa
d) Enterococcus
e) Proteus mirabilis

3.A urine culture should always be performed in simple urinary tract infections, as it will direct the choice of antibiotics.
True / False

4.The following are good choice as a first-line treatment for simple urinary tract infections, except:
a) Sulfamethoxazole-trimethoprim (SMX-TMP)
b) Trimethoprim
c) Ampicillin
d) Cephalexin
e) Nitrofurantoin

5.'Surgical urinary tract infections' include:
a) Honeymoon cystitis
b) Urinary tract infections related to catheters
c) Candida vaginitis
d) Staghorn calculus with proteus infection
e) Tuberculosis in urine

ANSWER SHEET FOR MAY 2008

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

Practical Hints in the Management of Urinary Tract Infections

Dr. Richard K Lo

MD(UCLA), MCPS(Manitoba), FCSHK, American Board of Urology, FHKAM(Surgery)
Consultant Surgeon, Pedder Clinic

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

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Answers to April 2008 issue

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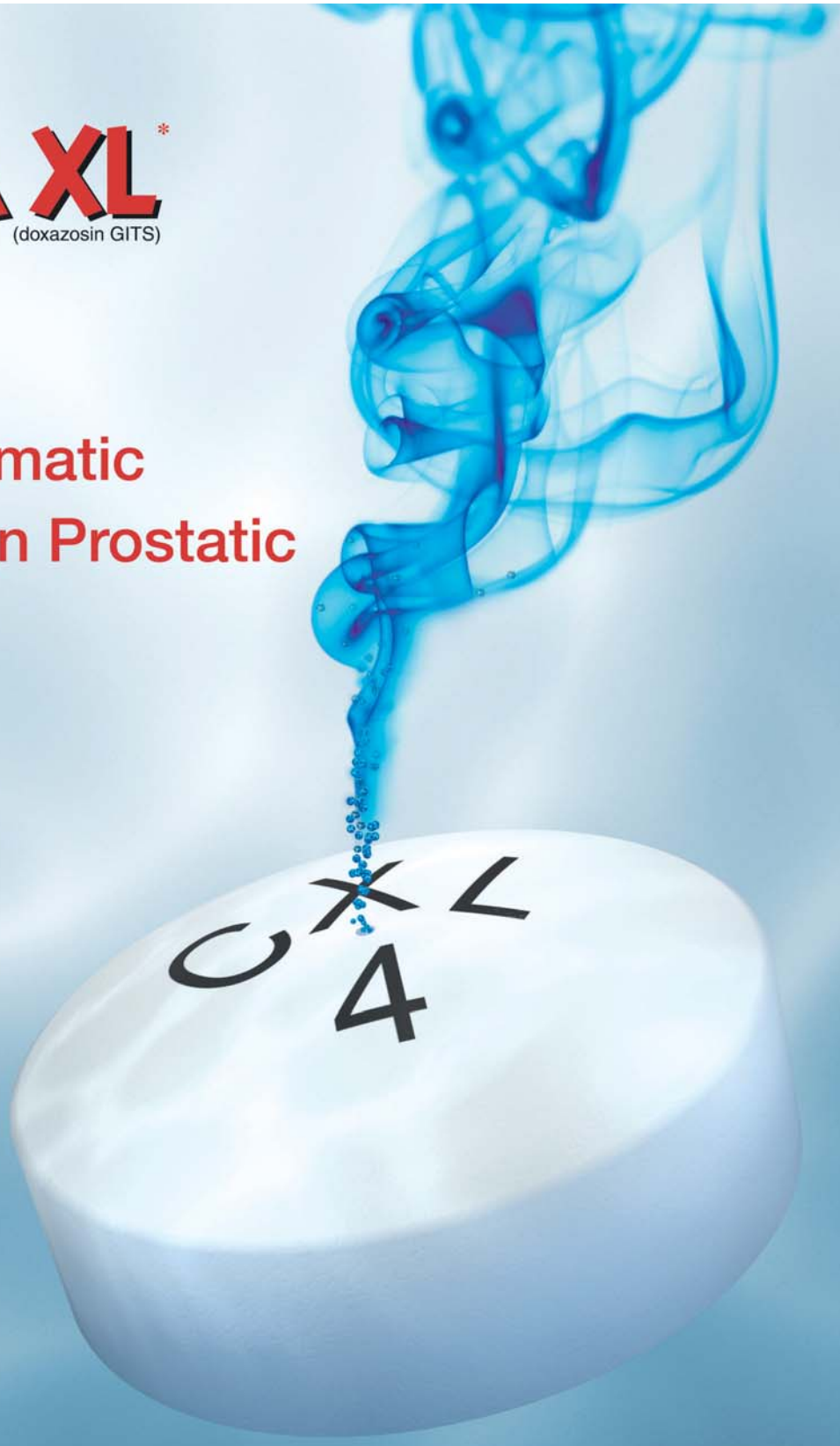

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Reference: 1. Roehrborn CG, Prajsner A, Kirby R, et al. A double-blind placebo-controlled study evaluating the onset of doxazosin gastrointestinal therapeutic system in the treatment of benign prostatic hyperplasia. Fur Urol 2005;48:445-452. **2.** Kirby RS, et al. A combined analysis of double-blind trials of the efficacy and tolerability of doxazosin in the gastrointestinal therapeutic system (GITS), doxazosin standard, and placebo in patients with benign prostatic hyperplasia. In preparation. **Detailed prescribing information is available upon request.**

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Update on the Management of Ureteric Stones

Dr. Francis Lee

BScMed(Syd), MBBS(Syd), FRCSEd, FRACS, FACS, FCSHK, FHKAM(Surgery)
Specialist in Urology

Dr. Francis Lee

Urinary stone disease is a very common disease in human beings with a prevalence rate of up to 10%. Most urinary stones become symptomatic when they fall into the ureter causing pain or obstruction. Since the early 1980s, extracorporeal shock wave lithotripsy (ESWL) has been the mainstay of treatment for urinary stones including ureteric stones, due to its high success rate and relatively non-invasive nature. However, with advances in knowledge and technology, there have been recent changes in therapeutic options for ureteric stones.

Conservative Treatment

It is well known that there is a high incidence of spontaneous passage of ureteric stones depending on stone size and location. Up to 98% of small stones may pass spontaneously.[1] A recent meta-analysis shows an overall spontaneous stone passage rate of 68% for ureteric stones ≤ 5 mm, 47% for stones >5 mm and <10 mm and rarely for stones > 10 mm.[2] Most stones that will pass will do so in 4 to 6 weeks.[3,4] Various medications have been used to enhance stone passage. A recent meta-analysis shows a significant 29% increase in stone passage rate, a shorter time to stone passage and less analgesic requirement with the use α blockers.[5] The addition of a corticosteroid may further shorten the time for stone passage.[6]

According to the latest AUA guideline, the prerequisites for conservative treatment of ureteric stones are a stone size < 10 mm, well controlled pain, no clinical evidence of sepsis and adequate renal functional reserve. Regular imaging should be performed to monitor stone progression and to assess upper tract obstruction. Stone removal is indicated in stones > 10 mm and in stones when there is persistent obstruction, failed stone progression, uncontrolled pain or sepsis.[2]

Definitive Treatment

The efficacy of ESWL on the treatment of ureteric stones is related to stone size and stone location. Stone clearance rates range from 74% for stones < 10 mm to 43% for those > 10 mm.[7] Clearance rates for stone located at proximal, mid and distal ureter are 82%, 73% and 74%, respectively. An average of 0.62, 0.52 and 0.37 additional procedure per patient are required for proximal, mid and distal ureteric stone, respectively.[2] Serious complications are rare. It has been found that failure of ESWL in the treatment of ureteric stones is significantly related to pelvic location, stone size >10 mm, ureteric obstruction and obesity (BMI >30). The strongest independent predictors of failure were pelvic stones and stones >10mm.[8]

Comparing with in-situ ESWL, no improvement with stone clearance rate has been shown with the use of push-back or ureteric stent.[9] In one study the use of stent decreases stone clearance rate significantly.[10] The use of CT scan to measure stone density and hardness can predict treatment success. ESWL should not be used in stones with density > 750 HU as it predicts lower stone clearance rate and requirement for more treatment sessions.[11] A change of practice from the use of fast rate (120/minute) to slow rate (60/minute) has shown to increase the success rate of ESWL significantly with a smaller number of shock waves and less complications.[12] The use of α blocker after ESWL can improve stone clearance rate and decrease the use of analgesic drugs.[13,14]

ESWL is not suitable in the presence of distal obstruction, coagulopathy, obese patients and in female patients who are pregnant. Furthermore, there are concerns regarding the effects of ESWL on fertility of both sexes in the treatment of distal ureteric stones. Possibility of damage to unfertilised eggs and ovaries has been raised. Although, no definite clinical effect on female fertility has been found,[15] the latest AUA guideline suggests that informed consent should be obtained from women aged 40 or younger.[2] While for men, there is significant deterioration in semen quality, in particular, a higher number of abnormal spermatozoa can be found for up to 12 weeks after ESWL.[15,16]

With advances in intracorporeal lithotripsy and miniature of ureteroscopes, it has been shown than ureteroscopy consistently gives a high chance of stone clearance in a single procedure. Stone clearance rate is over 86% for mid and proximal ureteric stones and 94% for distal ureteric stones. These rates, in contrast to ESWL, have little variations with respect to stone sizes.[2] Ureteroscopy using holmium:YAG laser can achieve a very high stone clearance rate of over 97% in distal, mid and proximal ureter with only 6% of patients requiring an additional procedure.[17] Overall complication rate nowadays stands at less than 7% with a ureteric perforation and stricture rate of 2% and < 1%, respectively.[18]

Although, ESWL and ureteroscopic lithotripsy are both acceptable treatment options in the latest AUA guideline

on the management of ureteric stones.[2], more evidence is showing favour towards the use of ureteroscopy with holmium laser lithotripsy, especially in the treatment of distal ureteric stones and stones > 10 mm in size when the disparity between ESWL and ureteroscopy on stone clearance rate is great and difference in complication rate is minimal. Ureteroscopy is particularly indicated in cases when ESWL is technically difficult or contraindicated such as radiolucent stones, stone density > 750 HU, obese patients, anticoagulation or pregnancy. Ureteroscopy is also indicated in failed ESWL as stone clearance rate after initial unsuccessful attempt drops off rapidly from 68% to 46% at first re-treatment to 31% for second re-treatment with ESWL.[19] Ureteroscopy should also be favoured in young adults with distal ureteric stones because of the unknown effect of ESWL on fertility.

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Erectile Dysfunction after Radical Pelvic Surgery

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Erectile dysfunction (ED) remains a common cause of significant post-operative morbidity for men undergoing radical therapies for prostate cancers or other pelvic malignancies, as the cavernous nerves (CNs) are inadvertently transected, lacerated, or stretched (neuropraxia) at the time of surgery.

Refinements in anatomic surgical technique, as evidenced by an improved understanding of penile autonomic innervation, first advocated by Walsh and Lue in the 1980's, and the implementation of innovative technological advances, such as laparoscopic and robot-assisted surgery, have led to significant improvements in post-operative erectile function. Most men, however, still demonstrate compromised erectile function (delayed, compromised or lack of post-surgical potency) as varying degrees of CN damage occur even with successful bilateral nerve-sparing procedures. Contemporary data indicate that the probability of ED following radical prostatectomy for clinically localised cancer of the prostate is 20-90% at 24 months, even in institutions with high surgical volumes.

With CN injury, definite pathological changes are observed in the penis: including apoptosis of smooth muscle and endothelium, reduction of nitric oxide synthase (NOS) nerve density, up-regulation of fibroproliferative cytokines, and smooth muscle fibrosis or loss of cavernosal cycling between flaccid and erect state, with the potential for further structural damage to the cavernosal smooth muscle. With transection or neuropraxia, there can be degeneration distal to the level of injury, compromising the transport of neurotrophins (neurotrophic factors).

It is imperative, therefore, that penile erectile function rehabilitation starts as soon as the early post-operative period after radical prostatectomy. There are three different approaches to rehabilitation: Neuromodulation, Electrical Stimulation and use of PDE-5 inhibitors.

Nerve Growth Factor, a neurotrophin, has received considerable interest because of its ability to regenerate peripheral nerves in experimental animals. The immunosuppressant drug FK506 (tacrolimus), as an immunophilin ligand, has neuroprotective and neuroregenerative properties, which was first demonstrated at the in vivo level in animals. Use of stem cell/tissue engineering or gene therapy is still confined to the laboratory and will not be in clinical trials anytime soon.

Electrical stimulation, with or without the use of a sural nerve graft, is used in cases where there is CN loss during prostatectomy. Riding on the success of using direct electrical stimulation of the cavernous nerves in animal studies and also during radical prostatectomy, direct electrical stimulation of the corpous cavernosum nerves is somewhat successful in restoring response to vasoactive medications in ED patients. The feasibility of implanting electrical stimulating devices near the CN at the time of surgery is being studied.

The use of other types of medications, like tacrolimus, as an immunophilin ligand, or large amounts of corticosteroids, have been tried with limited success only. The theory behind using steroids was to minimise the level of inflammation at the surgical site. Even at high doses, there was no discernible differences between the steroid group or the placebo group. In a phase II, multicentre, randomised, double blind, placebo-controlled trial using a non-immunosuppressant immunophilin ligand in preoperatively potent men undergoing nerve-sparing radical prostatectomy has been initiated to determine whether the treatment improves erectile function recovery. The study combines preoperative and postoperative dosing and allows for phosphodiesterase 5 (PDE-5) inhibitor use on an intermittent basis.

The most success in the treatment of erectile dysfunction after radical prostatectomy is with PDE-5 inhibitors. In a study published in the British Journal of Urology (February 2008), 43 men were divided into a sildenafil 25 mg nightly group and a placebo group. The medication was started the night after catheter removal, usually 5 to 8 days after the radical prostatectomy. It is interesting to note that, even on the first night after catheter removal, 95% of the men had one to five nocturnal erections, as measured by the nocturnal tumescence penile scans. At 52 weeks, a significant difference was demonstrated in the time to recovery, the International Index of Erectile Function, IIEF-5, scores and overall potency (86% vs 66%).

In another study published in the J Sexual Medicine, the group from New York University used higher doses of sildenafil at 50 and 100 mg. The study period was for 36 weeks of nightly medications after radical prostatectomy. Post-operative IIEF scores all decreased, as expected. There was a dose-related gradual increase in rigidity with time in the two

treatment groups compared with the placebo group, which showed little improvement. Eight weeks after termination of the medications, natural or native erections reported by the three groups were: 24% for the 50 mg group, 33% of those receiving 100mg of sildenafil, and only 5% in the placebo group. Sildenafil demonstrated a definite efficacy in improving nocturnal and native, pharmaceutically unassisted erectile function.

The group from Johns Hopkins University Brady Urological Institute, reviewed their experience and research in an article published in February 2008 issue of the International Journal of Impotence Research. They reviewed the basic physiology of penile erections. Novel means of delivering stem and endothelial cells and stem cell biology were discussed as potential cell-based therapy is showing promise in the treatment of erectile dysfunction.

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Curative Treatment for Prostate Cancer

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Introduction

Latest Hong Kong Cancer Registry figures rank prostate cancer as the 6th most common cancer in 2005[1]. It was the 4th most common cancer (after lung, colorectum, and liver) and the 7th major cause of cancer deaths among males of Hong Kong in 2005. There has been dramatic rise in recent years, not only in the number of new cases registered (970 in year 2005), but also in the number of deaths (at least 231 in year 2005) dying from prostate cancer.

In the Seventies, the approach to prostate cancer had generally been expectant, and it had once been the belief that there was no reason to do anything after having made sure that the patient can pass water. As evidenced from the above statistics, the statement that 'patients die with, rather than die of, prostate cancer' is now questionable, if not obsolete.

Natural History

The incidence of prostate cancer has been increasing due to a multitude of factors: improved methods of diagnosis particularly with the wide availability of serum prostate specific antigen (PSA) assay, an ageing population with longer life expectancy, and the general increase in awareness among doctors and lay public. Prostate cancers do progress and metastasise, albeit at a slower rate than other cancers. The natural course of the disease is long, often more than 10 years. These factors together have resulted in an exponential increase in prostate cancer patients presenting with clinical problems, developing symptoms or metastases during their life span.

Observational studies, particularly that of Chodak et al[2], showed that for patients with reasonable life expectancies from other predictors, watchful waiting is associated with a much higher rate of disease progression and mortality from prostate cancer. Surgical therapy gave a 10-year survival of 78%, compared with 34% for men under surveillance as their disease progressed. While managed by watchful waiting, half of the patients with moderately differentiated tumours will have metastases if they survive 10 years, compared with two-thirds of those with poorly differentiated tumours and even 13% of those with well differentiated tumours. The importance and aggressiveness of prostate cancer cannot be denied. An expectant policy can only be deemed indicated for the infirm, unfit and elderly patients.

When tumours are detected by pathological examination of surgical specimens following transurethral resection for a clinical diagnosis of benign prostatic hyperplasia, some patients may have relatively good outcome at 5 years, but those with extensive or less than well differentiated tumours do not. With longer term follow-up, a Johns Hopkins[3] and a Mayo Clinic[4] series have both shown that even those with tumours involving 5% or less of tissue can have disease progression, metastases and die from the cancer.

Choice of Therapy

As it is evident that patients with clinically localised prostate cancer have substantial risk of progressing within their expected life span and dying from the disease, those diagnosed with early-stage prostate cancer should be offered treatment with a goal to eradicate the disease.

The choice of the optimal curative therapy is more controversial. Radical surgery and radical radiotherapy remain the mainstay options. It is difficult to compare their relative merits because there is a lack of randomised studies. Variations in patient selection criteria, clinical and biological follow-up data, and in particular definitions of tumour clearance and recurrence, render outcome results not strictly comparable.

Radical Radiotherapy

Radical radiotherapy had been considered a relatively safe option due to lesser immediate side-effects. There has yet to be consensus in the assessment of response after radiotherapy: nadir values ranging from 0.5 to 2.0 ng/ml, or simply a stable level of PSA with absence of 2 or 3 consecutive rises above the nadir level, have been suggested. PSA tends to fall slowly after radiation reaching a nadir at a median of 17 months. The definition of PSA recurrence by the American Society for Therapeutic Radiology and Oncology (ASTRO) as three consecutive rises in serum PSA above nadir level is now generally accepted.

Recent developments in radiotherapy include conformal techniques and brachytherapy. Both aim at reducing radiation complications. A retrospective cohort study by D'Amico et al comparing biochemical outcome after various treatment modalities for clinically localised prostate cancer showed that intermediate- and high-risk patients treated with radical prostatectomy or external beam radiation did better than those treated by interstitial radiation[5].

Adjuvant hormonal therapy has been used to improve the results of radiotherapy. An EORTC randomised prospective trial conducted by Bolla et al demonstrated that adjuvant treatment with a LHRH-agonist analogue, when started simultaneously with external beam radiation, improves local control and survival in patients with locally advanced prostate cancer[6].

Radical Prostatectomy

Radical prostatectomy, first described by Young in 1905, has been the dominant therapy for organ-confined prostate cancer. Standard surgical approaches have been either perineal or retropubic. Renewed interest in surgical treatment in the early 1980s has been due to a reduction in operative morbidity, particularly since Walsh has introduced the nerve-sparing retropubic technique which preserves potency as well. Latest addition to the surgical armamentarium is the laparoscopic technique, particularly robot-assisted. To date, the majority of radical prostatectomies worldwide continue to be performed by the retropubic approach, be it open, laparoscopic or robot-assisted, as most practising urologists are well trained and familiar with the anatomy of this approach.

What is important other than the surgical technique is the outcome after surgery. Large institutional series have reported a positive margin rate of 16-46%, but this is affected by specimen artifacts and interpretations. Serum PSA should decline to below detectable levels (less than 0.1 ng/ml) within 21-30 days after radical prostatectomy for organ-confined prostate cancer. This PSA nadir or biochemical clearance is generally regarded a better reflection of the absence of residual disease. More recent large series have reported that, at 10 years, PSA recurrence-free rate is 60-70%, metastasis-free rate is 80-85% and cancer-specific survival is 90% or greater. The post-operative complications of radical prostatectomy as summarised in EAU Guidelines (2001) are listed in Table 1.

The idea of giving neoadjuvant hormonal therapy prior to radical surgery to shrink the tumour or improve the outcome might appear attractive. However, two separate studies, by its proponent the Canadian Uro-oncology Group[7] and by Soloway et al[8] respectively, have categorically concluded that neoadjuvant hormonal therapy produces no difference in biochemical recurrence rate after radical prostatectomy.

Pound et al at Johns Hopkins studied the natural history of progression following radical prostatectomy, and reported a 91% overall cancer-specific survival at 15 years after surgery[9]. 15% developed biochemical recurrence (increase in PSA level), 34% of whom developed metastatic disease. The median actuarial time to metastasis was 8 years from the time of PSA increase, and the median actuarial time to death was 5 years from having metastases. Radical prostatectomy can be deemed a treatment with curative intent. It should be offered as a treatment option to the otherwise fit, well-motivated men with early-stage prostate cancer, and at least 10 years life expectancy.

Other Therapy

Cryotherapy has been reintroduced for prostate cancer after improvements in the delivery system and development of the percutaneous TRUS-guided, transperineal percutaneous technique. It may have a role in certain cohorts of prostate cancer patients, but longer term results are awaited.

Endocrine therapy is not a curative treatment option for early-stage prostate cancer. Its 'palliative' role in the symptomatic patients unfit for curative treatment has to be balanced against its mostly unavoidable side-effects, which have a negative impact on patients' quality of life. Androgen-deprivation therapy for prostate cancer increases the risk of fracture in men surviving five years after diagnosis[10]. A further worry is its limited duration of effect. A local study evaluating orchidectomy and LHRH agonist, though in the treatment of metastatic prostate cancer, confirmed that around 50% of patients could become hormone refractory and had tumour progression by 18 months after starting either treatment[11], similar to findings in the Western population.

Conclusion

Early aggressive treatment provides the only chance to eradicate prostate cancer. Efforts should therefore be made to detect prostate cancer at a curable stage, and to offer patients with reasonable life expectancy effective curative therapy in order to prevent metastasis or recurrence of the cancer. Patients should not be denied curative therapy on the grounds of age alone.

Table 1: Complications of radical prostatectomy

Complication	Incidence (%)
Peri-operative death	0.0-2.1
Major bleeding	1.0-11.5
Rectal injury	0.0-5.4
Deep venous thrombosis	0.0-8.3
Pulmonary embolism	0.8-7.7
Lymphocele	1.0-3.0
Urine leak, fistula	0.3-15.4
Slight stress incontinence	4.0-50.0
Severe stress incontinence	0.0-15.4
Impotence	29.0-100.0
Bladder neck obstruction	0.5-14.6
Ureteral obstruction	0.0-0.7
Urethral stricture	2.0-9.0

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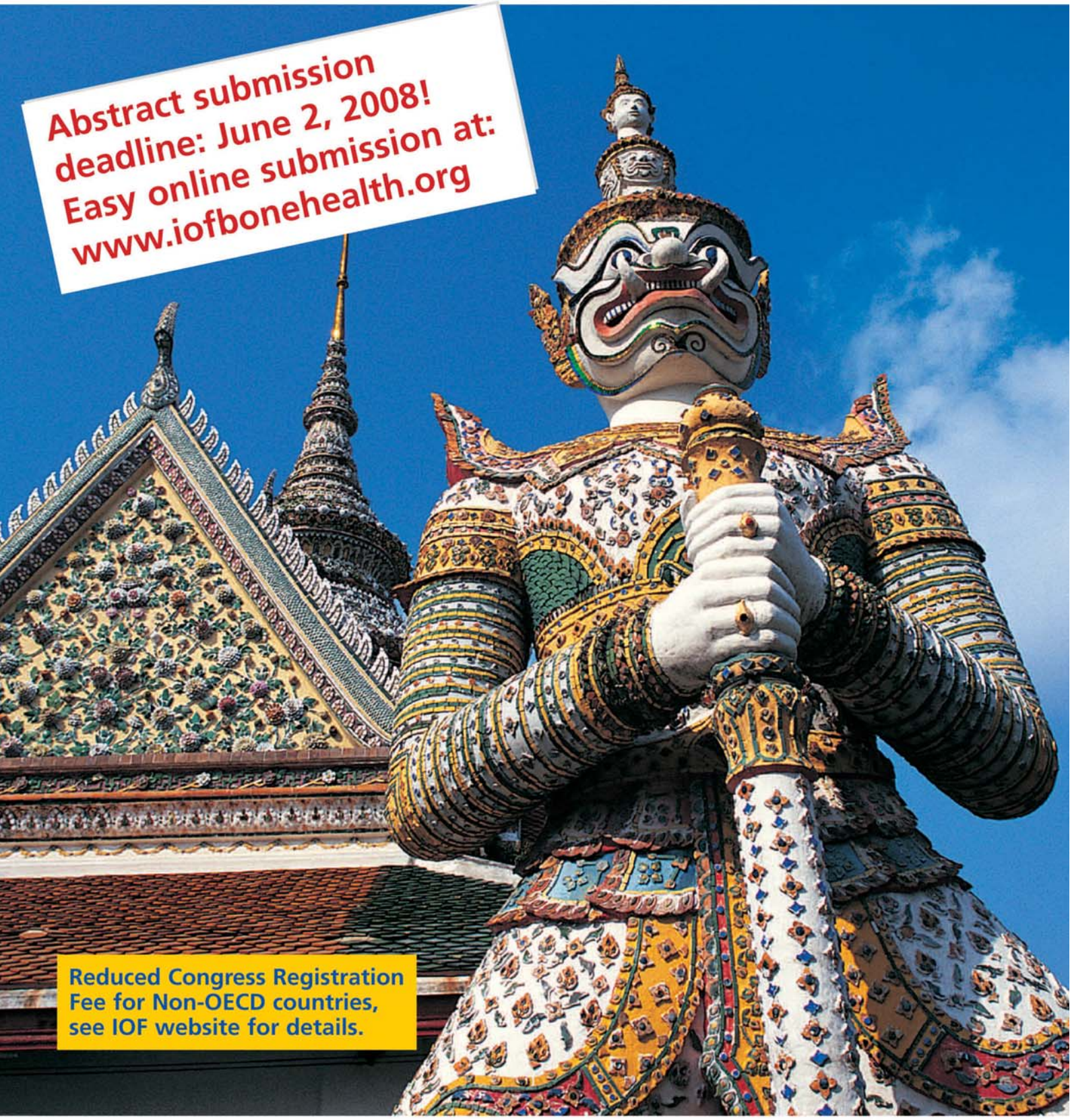

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Restrictions on Practice Promotion A personal recount of the recent historic judicial review

Dr. David Fang

Dr. David Fang

Recent events have shown that in matters of professional ethics, the judiciary will always have the final say. Not that the top judges in Hong Kong do not recognize the good intention of stringent controls on professional practice promotion, nor that they are not obviously aware of the domino effect on all professions, but it simply boils down to this, the more liberal we become, the closer we are to achieving inviolable guarantees on human rights.

Where unconstrained professional freedom threatens the health or wellbeing of the public, the decisive test of proportionality will have to be applied. Is the restriction in the professional code proportional to the intended objective of protecting those who are vulnerable? And that proportionality test shall be applied, measured, and its outcome determined by those members of the legal profession who sit in their silken wigs on the benches of the High Court.

In Oct 2005, amidst a liberal revision of the Professional Code and Conduct (the existing Code) by the Medical Council, a group of senior specialists, including Dr Kwong Kwok-Hay, wrote to the Council warning that the then restrictions on practice promotion infringed the Basic Law and the Hong Kong Bill of Rights Ordinance (HKBORO). They had sought legal advice from Mr. David Pannick, Q.C. who was instructed by Johnson Stokes and Masters (JSM). Against such formidable counsel, the Medical Council accepted its own legal advice, which was that if the proportionality test was satisfied the existing restrictions would not contravene the Basic Law and the HKBORO. Since the Ethics Committee was already revising the Code and finding ways to relax the restrictions, there was no need to take urgent action and the Council therefore replied to the group of doctors accordingly.

Apparently the group of doctors either interpreted the reply as a snub, or were not prepared to wait, or truly had an urgent agenda which could not afford to wait. On 7 April 2006 Dr K H Kwong, the then deputy medical superintendent of the HK Sanatorium and Hospital, in his personal capacity, took out a judicial review on the Code on four counts, on grounds of violation of the Basic Law and HKBORO.

- Mr. Justice Reyes of the Court of First Instance, High Court on 11 August 2006 ruled that "the Code breaches Articles 27 and 39 of the Basic Law and Article 16 of the HKBORO insofar as:-

(1) section 5 of the updated Code of Professional Code (the updated Code) promulgated by the Medical Council in March 2006 prevents a doctor from providing to the press basic information about his practice which he can otherwise provide through forms of media allowed by section 5;

(2) section 5 and Appendix E of the updated Code limit a doctor to mentioning only a maximum of 5 items of information about available medical services, procedures or operations in Service Information Notices;

(3) paragraph 5 of the existing Code prohibits a doctor from informing the public about medical and health developments if in so doing the doctor's practice is incidentally promoted; and

(4) Paragraph 14.1.1 of the existing Code imposes strict liability on a doctor for breaches by an associated medical organization of the Code's provisions on practice promotion.

The Council appreciated Mr. Justice Reyes' declaration that there was much that was commendable in section 5 of the Updated Code and paragraph 14 of the existing Code, but was concerned that in the context of his written judgment on the first two declarations, a free-for-all situation would result. With regard to the 3rd declaration there never was any intention to prohibit public education where personal attributes were incidentally promoted, so long as the exercise was not so organized as to deliberately attract patients to the professional services of a doctor (such as providing the consultation address or other contact details of the doctor). As to the 4th declaration the Council's own interpretation, and that of its legal advice, had always been that there was no strict liability on doctors, so long as they had exercised due diligence.

The Council took advice from Mr. Michael Beloff, Q.C. and decided to appeal on the ground that there were proper justifications for the restrictions. Mr. Justice Reyes had repeatedly asked for justifications for the restrictions, which he found to be absent in the Medical Council's defense during the judicial review in the Court of First Instance. To adduce the justifications as fresh evidence in the appeal, the Council had to apply for leave from the Court of Appeal. The application was initially rejected by Mr. Justice Robert Tang, Vice-President of the Court of Appeal on 6 June 2007.

However, on appeal with Mr. Michael Beloff as leading counsel, Justices Ma, Stock and Stone unanimously and immediately granted the application on 5, September, 2007.

Meanwhile the Council in its April 2007 Newsletter made it abundantly clear that there was no argument with the Court in respect of incidental promotion in paragraph 5.1 of the existing Code and strict liability for breaches by an associated organization in paragraph 14.1.1 of the existing Code. However, in accordance with legal advice, the Council's planned revision and particularly further relaxation of the restrictions on practice promotion was put on hold pending the outcome of the appeal.

Despite the most genuine efforts of the Council and Mr. Beloff, the three judges of the Court of Appeal (Ma CJHC, Tang VP and Stock JA) on 24 January 2008 ruled unanimously against the appeal and upheld the judgment of Reyes J.

At the beginning, when JSM applied for admission of Mr David Pannick to the Hong Kong Bar, Mr. Justice Ma, Chief Judge of the High Court had predicted that the case would eventually reach the Court of Final Appeal. Alas, his own judgment in the Court of Appeal contained such finality of wording as to sound the death knell for any further appeal.

It should be emphasized that both the Court of First Instance and the Court of Appeal placed considerable weight on the Medical Council's consultation exercise back in October 2005, when the majority of respondents rejected a proposal to allow service information to be published in four printed media. The Courts pointed out that the majority may not interfere with the constitutional right of free expression of the minority.

Of crucial importance is the fact that the judgments did not result in a free-for-all situation. Much leeway was allowed by all the judges for justifiable controls on the medium of publication of service information, their format, and contents.

At the recent policy meeting of the Medical Council on 2 April 2008, the Council accepted the recommendation of the Ethics Committee that the Code be amended as follows:-

5. Professional communication and information dissemination

5.2.3.8 Newspapers, magazines, journals and periodicals

A doctor may publish his service information in bona fide newspapers, magazines, journals and periodicals for the purpose of enabling the public to make an informed choice of doctors.

A publication published for the predominant purpose of promotion of the products or services of a doctor or other persons is not regarded as an acceptable newspaper, magazine, journal or periodical for this purpose.

A doctor who publishes his service information in these publications must ensure that:-

(a) the published information includes only the information which is permitted in Service Information Notices and Doctors Directories;

(b) the same rules as to terminology of procedure and operations for Service Information Notices and Doctors Directories are complied with, and no questionable terminology is adopted;

(c) a written undertaking is secured from the publisher that his service information will not be published in a manner which may reasonably be regarded as suggesting his endorsement of other medical or health related products/services, such as publication in close proximity to advertisements for those products/services;
(d) the published information does not exceed the size limit of 300 cm2, and not more than one notice is published in the same issue of a publication; and

(e) a proper record of the published information and the arrangements for its publication is kept for two years.

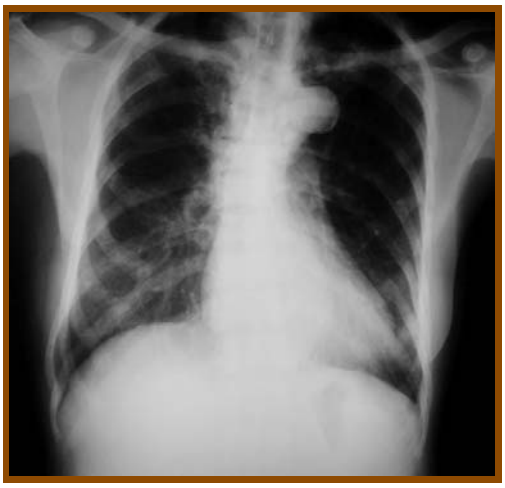
With regard to Service Information Notices, Doctor's Directories, and practice websites, the restriction on number of services/procedures (previously not exceeding 15 items in total) is lifted. The new guidelines simply state that the Permitted Contents include medical services, procedures and operations provided by the doctor and range of fees.

Finally, paragraphs 5.1 and 14.1.1 of the existing Code are still being amended to further clarify the Council's stand on incidental promotion during public education, and a doctor's liability in relation to affiliated organizations.

Clinical Quiz

Dr. Wendy WM Lam
Consultant, Department of Radiology, Queen Mary Hospital

Dr. Wendy WM Lam



Clinical History:

Male / 61 yr.
c/o Cough

Clinical History:

This is his CXR
What are the findings ?
What is your diagnosis ?

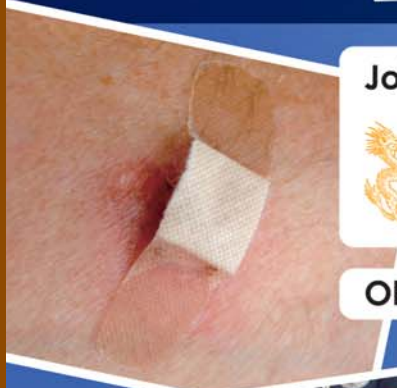
(See P. 26 for answers)

CERTIFICATE COURSE FOR GENERAL PUBLIC

Certificate Course on Wilderness Medicine

野外醫學證書課程

Course no. C131



Jointly organized by

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

Hong Kong Society for Emergency Medicine & Surgery
香港急症醫學會

Objective

Hong Kong people are now keen to participate in wilderness activities. This course aims at providing the basic medical knowledge on wilderness medicine and specific practical information related to the situation in Hong Kong.

DATE	TOPIC	SPEAKER
5 June 2008	Introduction to Wilderness Medicine 野外醫學介紹 Heat Stroke, Heat Exhaustion and Hypothermia 高温及低温症	Dr. Sara Ho 何婉霞醫生 急症醫學專科醫生
12 June 2008	Vertical Limits, High Altitude and Diving Medicine 高度及深度極限；高山症及潛水引發的病症	Dr. Ho Man Kam 何文錦醫生 急症醫學專科醫生
19 June 2008	Snake Bite, Snake Recognition, Diagnosis of Envenomation, First Aid and Management in Wilderness 毒蛇咬傷處理，包括：認定蛇的品種、受毒蛇咬傷的診斷及在野外處理毒蛇咬傷的原理	Dr. Ng Wah Shan 伍華山醫生 急症醫學專科醫生
26 June 2008	Management of Accidents in Wilderness, Wound Care, Fracture, Dehydration and Lightning 野外創傷處理，包括：傷口護理、骨折、脫水及雷擊	Dr. Siu Yuet Chung 蕭粵中醫生 急症醫學專科醫生
3 July 2008	Poisonous Sting and Bite, from Land to Sea and Infection in Wilderness 帶毒的刺傷及咬傷的診斷和處理及野外傳染病	Dr. Chan Yiu Cheung 陳耀祥醫生 香港中毒資詢中心 副顧問醫生
10 July 2008	Search and Rescue Service in Hong Kong 香港搜索及救援工作 Flight Physiology and its Implication in Patient Care 認識飛行生理及其對照顧病人的影響	Dr. Ma Hing Man 馬慶文醫生 高級航空醫生

Date	5 June 2008 to 10 July 2008 (Every Thursday)	Language	Cantonese (Supplemented with English)
Time	7:00 p.m. – 8:30 p.m.	Certificate	Awarded to participants with a minimum attendance of 70%
Venue	Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Enquiry	The Secretariat of the Federation of Medical Societies of Hong Kong
Course Fee	HK$750 (6 Sessions)		

Tel.: 2527 8898 Fax: 2865 0345 Email: info@fmshk.com.hk

CME/ CPD/ CPE Accreditation applied for

For downloading the application form, please refer to our website: http://www.fmshk.com.hk/courses/index.htm

News from Member Societies:

Hong Kong Society of Flow Cytometry
Updated office-bearers for the year 2008-2009 are as follows: President: Prof. Chun-kwok WONG; Honorary Secretary: Dr. Phyllis Fung-yi CHEUNG; Honorary Treasurer: Ms Yonna LEUNG

The Hong Kong Neurological Society
Updated office-bearers for the year 2008-2009 are as follows: President: Dr. Tak-hong TSOI; Honorary Secretary: Dr. Wing-chi FONG; Honorary Treasurer: Dr. Jonas Hon-ming YEUNG

The Hong Kong Society of Diagnostic Radiologists
Updated office-bearers for the year 2008-2009 are as follows: President: Ming-keung YUEN; Honorary Secretary: Dr. Samuel Shun LAU; Treasurer: Dr. Samuel Shun LAU

Welcome New Members

Hong Kong Museum of Medical Sciences Society
Office-bearers: Chairman: Dr. Laurence LT HOU; Vice Chairmen: Prof. Shew-ping CHOW; Dr. Edwin CL YU; Honorary Secretary: Dr. Robert J COLLINS; Acting Honorary Treasurer: Dr. Peter PF CHAN

The FMSHK would like to welcome Hong Kong Museum of Medical Sciences Society as associate members of the Federation.

Hong Kong Society for Nursing Education

Hong Kong Society for Nursing Education (the Society) was founded in 1985. The Society's mission is to achieve excellence in nursing service through the enhancement of quality nursing education. Our objectives include: 1) to promote the welfare and protect the interests of the nursing profession; 2) to make application or representation to the Government or other appropriate authorities on any question or matter affecting the nursing education or the members of the Society; 3) to facilitate and encourage the sharing of personal experiences and research findings; and 4) to hold and deliver lectures, conferences, exhibitions and public meetings, and to publish bulletins or other publications for the advancement of nursing education.

The major programs and activities of the Society include:

1. Organisation of various continuing nursing education courses for nurses and health professionals
2. Organisation of local and national conferences such as the 3rd Macau-Hong Kong Nursing Conference "Community Partnership - Nursing contribution" in 2007, and the 22nd Anniversary Symposium "Trends and development of contemporary health services: Opportunities and challenges for nursing" in 2008
3. Publications such as of 'The Transition of Nursing Education in Hong Kong' in 2002, 'Evidence-based Education and Related Issues' in 2004' and '護理專業，燃亮生命' in 2008

The Office Bearers of our Society in 2008-2010 are:

Chairperson:	Prof Frances Wong
Vice-chairperson:	Prof Sally Chan
1st Secretary:	Dr Winnie So
2nd Secretary:	Dr Sharron Leung
1st Treasurer:	Mr Edmond Tong
2nd Treasurer:	Mr Mark Lai
Education subcommittee:	Dr Vico Chiang (coordinator)
	Ms Mary Au
	Ms Angie Lam
Publication subcommittee:	Dr Mak Yim Wah (coordinator)
	Dr Marie Tarrant
Membership promotion subcommittee:	Ms Polly Li (coordinator)
	Ms Annie Lam
Welfare & recreation subcommittee:	Dr William Li (coordinator)
	Dr Gemma Wong

You're most welcomed to visit the Society's web http://www.hksne.org.hk for more information.

Hong Kong Dental Association

The Hong Kong Dental Association was founded in 1950. Including associate and affiliate members, we currently have more than 1559 members with constant growth in membership size. As the sole dental representative body, our missions are (1) to represent the dental profession in the formulation of dental policy; (2) to represent the profession in the international and mainland dental organisations as a regional dental association; (3) to maintain the standard of ethics of the profession; (4) to maintain the dental service to the public at high standard; (5) to promote continuous dental professional development; (6) to raise the general public awareness of dental health care and (7) to promote fraternity among members.

Major programmes and activities of our Association include:

(1) To hold monthly Meeting, workshop, 1-day course, FDI/HKDA Joint Scientific Meeting
(2) To organise international events such as 31th Asia Pacific Dental Congress (APDC) 2009
(3) To conduct dental related surveys
(4) To reflect opinion on dental policy as a professional representative body
(5) To participate in APDC, FDI Annual World Dental Congress and South China Dental Expo
(6) To organise quality CME programmes
(7) To organise oral health promotional projects and events

The list of the incumbent Council of the Association:

President:	Dr Sigmund S.M. LEUNG	
Vice-President:	Dr. Vincent F.S. LEUNG	
Honorary Treasurer:	Dr. WONG Chi Wai	
Honorary Secretary:	Dr. Michael W.K. TSANG	
Council Members:	Dr. Nelson K.H. AU YEUNG	Dr. Lawrence C.K. LAM
	Dr. Raymond K.M. LEE	Dr. George C.K. LAU
	Dr. LIU Wing Hong	Dr. Johnny WONG

The Hong Kong College of Family Physicians - Annual Scientific Meeting

"Family Physicians and Our Community"

On behalf of the Annual Scientific Meeting Organizing 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 and the programme are available at our College's website (www.hkcfp.org.hk). Full papers submitted before the deadline will automatically be competing for the ***'Best research', the 'Best trainee submission' and the 'Best innovation'*** awards. I look forward to meeting you at ASM 2008 and the fellowship conferment ceremony.

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

THE HONG KONG COLLEGE OF MENTAL HEALTH NURSING
香港精神健康護理學院

The Hong Kong College of Mental Health Nursing (the College) was established in 1998 by a group of mental health nurses in Hong Kong. It is a non-profit making organization registered under Companies Ordinance of Hong Kong. The College contributes to promoting health of the Hong Kong society by examining the health care policy, developing its positions, and making suggestions to the government. Also, the College helps promoting the professional competence and status of mental health nurses in Hong Kong by launching the fellowship system, participating in establishing the regulatory body for advanced practice of mental health nursing, and safeguarding the professional interest of mental health nurses.

Since its establishment, the College has been organizing courses, workshops and seminars to meet the continuing education needs of its members and nurses in Hong Kong. The College also encourages its members to participate in professional development activities by offering sponsorship for attending conferences, etc.

Through networking with other professional bodies and academic institutes in Hong Kong, the Mainland China, and overseas, the College represents local mental health nurses to communicate and collaborate with other health care professionals and academics for attainment of its objectives.

All affairs of the College are managed by its Council which is made up with elected members. The new office-bearers of the Council for the term 2007-2010 are:

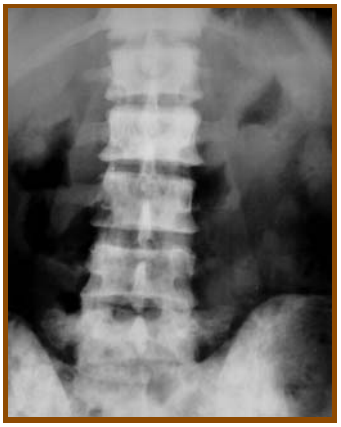
President: Dr. Sally Wai-chi CHAN
Vice-President: Mr. Michael Kwok-fung MAK
Secretaries: Mr. Kwok-wah SHUN,
Ms. Josephine Dick-fung YU
Treasurers: Ms. Maggie Yuen-fung TO,
Ms. Michelle Mei-sum NG

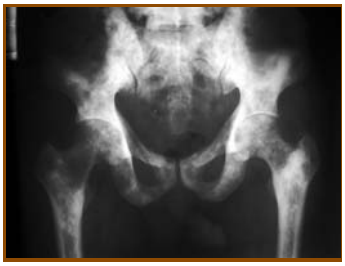
Photo caption: Members of the College's Council (2007-2010)

For further information and enquiries, please contact us at:

P.O. Box 92585, Tsim Sha Tsui Post Office, Kowloon, Hong Kong.
Homepage: www.hkcmhn.org.hk
e-mail: secretary@hkcmhn.org.hk
We look forward to working with you for promoting the health of the Hong Kong community.

Answer to Clinical Quiz





Findings:

CXR

Heart size is at upper limit of normal. No active lung lesion seen.
Generalized sclerotic changes of the rib cage. Gynaecomastia.

Pelvis and LS spine:

Multiple sclerotic lesions involving pelvis and LS spine seen. No definite bony erosion or bony collapse is noted. Pedicles are preserved. No periosteal reaction seen.

Diagnosis:

CA prostate with multiple bony metastases

Discussion:

The most common causes of generalized sclerotic bony lesions at this age is bony metastases, most commonly in CA prostate and CA breast.

The other differential diagnoses are:
1. Lymphoma
2. Mastocytosis
3. Multiple healed or healing benign/maligrlant lesions such as lytic metastases following radiotherapy or chemotherapy, Langerhans cell Histiocytosis and Brown tumours.
4. Multiple myeloma - sclerosis in up to 3%
5. Osteomata in Gardner's syndrome
6. Fibrous dysplasia
7. Tuberous sclerosis

Dr. Wendy WM Lam
Consultant, Department of Radiology, Queen Mary Hospital

Medical Diary of May

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	★ 16th Annual Scientific Congress of Hong Kong College of Cardiology ★ Certificate Course in Ward Management - Module III: "Managing risk at workplace" (Code No. TC-WM-0107III) ★ Certificate Course on Development of Advanced Practice (Code No. TC-DAP-0801) 2	★ 5th Exercise Prescription Course ★ 16th Annual Scientific Congress of Hong Kong College of Cardiology 3
★ 16th Annual Scientific Congress of Hong Kong College of Cardiology ★ HKMA Structured CME Programme at Queen Elizabeth Hospital Year 08/09 (II) - Paediatrics ★ Dragon Boat Practice Session 4	★ 16th Annual Scientific Congress of Hong Kong College of Cardiology ★ HKMA Choir Rehearsal ★ A Young Man with Severe Haematuria 5	★ FMSHK Officers' Meeting ★ 8 Lessons in Practical Psychiatry for General Practitioners: A Certificate Course ★ HKMA - Tai Po Community Network CME Lecture on Management of COPD and its risk factor - Smoking Cessation ★ Certificate Course on Stress Management (Code No. TC-SM-0801) ★ Certificate Course on Wound Management (Code No. TC-WC-0801) 6	★ CME Lecture in Dermatology Lecture 5: Recent Advances in Acne Treatment ★ HKMA Orchestra Rehearsal 7	★ HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2008 (V) ★ HKMA Council Meeting 8	★ Certificate Course in Ward Management - Module III: "Managing risk at workplace" (Code No. TC-WM-0107III) ★ Certificate Course on Development of Advanced Practice (Code No. TC-DAP-0801) 9	★ Refresher Course for Health Care Providers 2007/2008 (IX) - Palliative Care Services 10
★ Dragon Boat Practice Session 11	★ HKMA Choir Rehearsal 12	★ Certificate Course on Stress Management (Code No. TC-SM-0801) ★ Certificate Course on Wound Management (Code No. TC-WC-0801) ★ HKMA - Tai Po Community Network CME Lecture on Optimal Assessment & Treatment of Childhood Asthma 13	★ Risk Management Seminar ★ Hong Kong Neurosurgical Society Monthly Academic Meeting - Special Lecture: Dizziness - A Neuro-otological Approach 14	15	★ Certificate Course in Ward Management - Module III: "Managing risk at workplace" (Code No. TC-WM-0107III) ★ Certificate Course on Development of Advanced Practice (Code No. TC-DAP-0801) ★ HKMA - Tai Po Community Network CME Lecture on Management of COPD and Smoking Cessation ★ ISCD Bone Densitometry Course 16	★ ISCD Bone Densitometry Course ★ 9th Regional Osteoporosis Conference 17
★ 5th Exercise Prescription Course ★ Dragon Boat Practice Session ★ 8 Lessons in Practical Psychiatry for General Practitioners: A Certificate Course ★ 9th Regional Osteoporosis Conference ★ HKMA Squash Tournament 18	★ HKMA Choir Rehearsal 19	★ Certificate Course on Stress Management (Code No. TC-SM-0801) ★ Certificate Course on Wound Management (Code No. TC-WC-0801) 20	21	★ FMSHK Executive Committee & Council Meeting 22	★ Certificate Course in Ward Management - Module III: "Managing risk at workplace" (Code No. TC-WM-0107III) ★ Certificate Course on Development of Advanced Practice (Code No. TC-DAP-0801) 23	★ Annual Scientific Meeting "Family Physicians and Our Community" 24
★ 5th Exercise Prescription Course ★ Dragon Boat Practice Session ★ Annual Scientific Meeting "Family Physicians and Our Community" 25	★ HKMA Choir Rehearsal 26	★ Certificate Course on Stress Management (Code No. TC-SM-0801) ★ Certificate Course on Wound Management (Code No. TC-WC-0801) 27	28	29	★ Certificate Course in Ward Management - Module III: "Managing risk at workplace" (Code No. TC-WM-0107III) ★ Certificate Course on Development of Advanced Practice (Code No. TC-DAP-0801) 30	31

Medical Diary of May

Date / Time	Function	Enquiry / Remarks
2 FRI *(3,4,5)*	**16th Annual Scientific Congress of Hong Kong College of Cardiology** Organised by: Hong Kong College of Cardiology Chairman: Dr. CHIANG Chung Seung # Sheraton Hong Kong Hotel & Towers, 20 Nathan Road, Tsimshatsui, Kowloon	Ms. Dora HO Tel: 2527 8285 Fax: 2865 0943 Email: dorahkma@hkma.org Website: http://www.hkcchk.com/scientificcongress.php
6:30 pm - 9:30 pm *(9,16,23,30)*	**Certificate Course in Ward Management - Module III: "Managing risk at workplace" (Code No. TC-WM-0107III)** Organised by: College of Nursing, Hong Kong	Secretariat Tel: 2572 9255 Fax: 2838 6280 24 CNE Points
6:30 pm - 9:30 pm *(9,16,23,30)*	**Certificate Course on Development of Advanced Practice (Code No. TC-DAP-0801)** Organised by: College of Nursing, Hong Kong	Secretariat Tel: 2572 9255 Fax: 2838 6280 24 CNE Points
3 SAT 2:00 pm *(18,25)*	**5th Exercise Prescription Course** Organised by: The Hong Kong Medical Association Speaker: Dr. CHOW Chun Chung & Dr. LEUNG Chung Chuen # Argyle Street Dental Clinic	Miss Viviane LAM Tel: 2527 8452 (Registration Fee is required) 2 CME Points
4 SUN 2:00 pm	**HKMA Structured CME Programme at Queen Elizabeth Hospital Year 08/09 (II) - Paediatrics** Organised by: The Hong Kong Medical Association & Queen Elizabeth Hospital Speaker: Dr. CHANG Kai On, Dr. Dora WONG, Dr. Oliver S.C. TANG & Dr. Ada Y.F. YIP # Lecture Theatre, G/F., Block D, Queen Elizabeth Hospital, Kowloon	Miss Viviane LAM Tel: 2527 8452 (Registration Fee is required) 3 CME Points
3:00 pm *(11,18,25)*	**Dragon Boat Practice Session** Organised by: The Hong Kong Medical Association # Sai Kung	Ms. Dora HO Tel: 2527 8285
5 MON 7:30 pm - 8:30 pm	**A Young Man with Severe Haematuria** Organised by: Hong Kong Urological Association Chairman: Dr. LAW In Chak Speaker: Dr. TSU Hok Leung James # Seminar Room, G/F, Block A, Queen Elizabeth Hospital, Kowloon	Dr. CHU Sau Kwan Peggy / Ms Siddy MA Tel: 2958 6006 Fax: 2958 6076 1 CME Point
8:00 pm *(12,19,26)*	**HKMA Choir Rehearsal** Organised by: The Hong Kong Medical Association # Hong Kong Professional Teachers' Union Causeway Bay Service Centre	Ms. Candy YUEN Tel: 2527 8285
6 TUE 8:00 pm - 10:00pm	**FMSHK Officers' Meeting** 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	Secretariat Tel: 2527 8898 Fax: 2865 0345
1:00 pm *(18)*	**8 Lessons in Practical Psychiatry for General Practitioners: A Certificate Course** Organised by: The Hong Kong Medical Association Chairman: Prof. SIU Wa Tang Speaker: Dr. CHAN Kwok Tung & Dr. WONG Chi Keung # Harbour Plaza Resort City, 18 Tin Yan Road, Tin Shui Wai, NT)	Miss Jo WONG Tel: 2527 8285 1 CME Point
1:30 pm	**HKMA - Tai Po Community Network CME Lecture on Management of COPD and its risk factor - Smoking Cessation** Organised by: HKMA - Tai Po Community Network Speaker: Dr. Edwin POON # 新界大埔安慈路昌運中心商場一樓京都海鮮酒樓	Miss Viviane LAM Tel: 2527 8452 1 CME Point
6:30 pm - 9:30 pm *(13,20,27)*	**Certificate Course on Stress Management (Code No. TC-SM-0801)** Organised by: College of Nursing, Hong Kong	Secretariat Tel: 2572 9255 Fax: 2838 6280 24 CNE Points
6:30 pm - 9:30 pm *(13,20,27)*	**Certificate Course on Wound Management (Code No. TC-WC-0801)** Organised by: College of Nursing, Hong Kong	Secretariat Tel: 2572 9255 Fax: 2838 6280 24 CNE Points
7 WED 1:30 pm	**CME Lecture in Dermatology Lecture 5: Recent Advances in Acne Treatment** Organised by: The Hong Kong Medical Association Speaker: Dr. CHAN Hau Ngai Kingsley # HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, HK	Miss Viviane LAM Tel: 2527 8452 1 CME Point
8:00 pm	**HKMA Orchestra Rehearsal** Organised by: The Hong Kong Medical Association # Pui Ching Education Centre	Ms. Candy YUEN Tel: 2527 8285
8 THU 2:00 pm	**HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2008 (V)** Organised by: The Hong Kong Medical Association & Hong Kong Sanatorium & Hospital Speaker: Dr. SIU Tak Hing # HKMA Dr. LI Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road C, Hong Kong	Miss Viviane LAM Tel: 2527 8452 (Registration fee is required) 1 CME Point
8:00 pm	**HKMA Council Meeting** 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, Hong Kong	Ms. Christine WONG Tel: 2527 8285
10 SAT 2:30 pm	**Refresher Course for Health Care Providers 2007/2008 (IX) - Palliative Care Services** Organised by: The Hong Kong Medical Association & Our Lady of Maryknoll Hospital Speaker: Dr. KWOK Oi Ling # Training Room II, 1/F., OPD Block, Our Lady of Maryknoll Hospital, 118 Shatin Pass Road, Wong Tai Sin, Kowloon	Ms. Clara TSANG Tel: 2354 2440 2 CME Points
13 TUE 1:00 pm	**HKMA - Tai Po Community Network CME Lecture on Optimal Assessment & Treatment of Childhood Asthma** Organised by: HKMA - Tai Po Community Network Chairman: Dr. CHOW Chun Kwan Speaker: Dr. WONG Tak Wai #大埔昌運中心2/F ,京都酒樓	Miss Viviane LAM Tel: 2527 8452 1.5 CME Points
14 WED 7:30 am	**Hong Kong Neurosurgical Society Monthly Academic Meeting - Special Lecture: Dizziness - A Neuro-otological Approach** Organised by: Hong Kong Neurosurgical Society Speaker: Dr. AU Kin Kwok Dennis # Seminar Room, G/F, Block A, Queen Elizabeth Hospital, Kowloon	Dr. Y.C. PO Tel: 2990 3788 Fax: 2990 3789 2 CME Points

Medical Diary of May

Date / Time	Function	Enquiry / Remarks
14 WED 1:00 pm	**Risk Management Seminar** Organised by: The Hong Kong Medical Association Chairman: Dr. CHOI Kin Gabriel Speaker: Dr. TEOH Ming Keng, Dr. Marika DAVIES, Mr. Woody W.Y.CHANG # Medical Records, Langham Place Hotel, Kowloon	Miss Viviane LAM Tel: 2527 8452 1.5 CME Points
16 FRI 1:00 pm	**HKMA - Tai Po Community Network CME Lecture on Management of COPD and Smoking Cessation** Organised by: HKMA - Tai Po Community Network Chairman: Dr. MAK Wing Kin Speaker: Dr. IP Lap Shun #新界沙田白鶴汀街八號帝都酒店2/F 帝都軒	Miss Viviane LAM Tel: 2527 8452 1 CME Point
(17)	**ISCD Bone Densitometry Course** Organised by: Osteoporosis Society of Hong Kong Chairman: Prof. Annie KUNG Speaker: Various # Hong Kong Convention & Exhibition Centre, Wanchai, Hong Kong	Ms. Lenora YUNG Tel: 2871 8787 Fax: 2871 8898
17 SAT (18)	**9th Regional Osteoporosis Conference** Organised by: Osteoporosis Society of Hong Kong & Hong Kong College of Radiologists Speaker: Various # Hong Kong Convention & Exhibition Centre, Wanchai, Hong Kong	Ms. Lenora YUNG Tel: 2871 8787 Fax: 2871 8898
18 SUN 2:00 pm	**HKMA Squash Tournament** Organised by: The Hong Kong Medical Association # Kowloon Cricket Club	Ms. Dora HO Tel: 2527 8285
22 THU 7:00 pm - 10:00 pm	**FMSHK Executive Committee & Council Meeting** 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
24 SAT (25)	**Annual Scientific Meeting "Family Physicians and Our Community"** Organised by: Hong Kong College of Family Physicians Chairman: Dr. Winnie W.Y. CHAN # HKAM Jockey Club Building , 99 Wong Chuk Hang Road, Hong Kong	Ms. Erica SO Tel: 2528 6618 Fax: 2866 0618

Calendar of Events

Meetings

11-12/7/2008	**Hong Kong Surgical Forum, Summer 2008** 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: http://www.hku.hk/surgery
26 - 28 /9/2008	**3rd Regional Conference in Dermatological Laser and Facial Cosmetic Surgery 2008** Organised by: The Hong Kong Association of Specialists of Dermatology and Venereology & Hong Kong Society of Plastic, Reconstructive and Aesthetic Surgeons # Hong Kong Convention and Exhibition Centre, Wanchai, Hong Kong Enquiry: Ms. Ruby LUI Tel: 3151 8813 Fax: 2590 0099 Website: www.dlfcs2008.com
22-25/11/2008	**2nd Asian Preventive Cardiology & Cardiac Rehabilitation Conference cum 7th Certificate Course in Cardiac Rehabilitation** Organised by: Hong Kong College of Cardiology Co-Chairman: Prof. LAU Chu Pak & Dr. LAU Suet Ting Speaker: Various # Hong Kong Convention & Exhibition Centre, 1 Expo Drive, Wanchai, Hong Kong Enquiry: Secretariat Tel: 2527 8285 Fax: 2865 0943 Email: dorahkma@hkma.org Website: http://www.apccrc.com
20-22/2/2009	**CardioRhythm 2009** Organised by: Hong Kong College of Cardiology & Chinese Society of Pacing and Electrophysiology Co-Chairman: Prof. LAU Chu Pak Enquiry: Secretariat Tel: 2899 2035 Fax: 2899 2045 Email: info@cardiorhythm.com Website: http://www.cardiorhythm.com

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

Date	Course No	Course Name	Co-organiser	Target Participants
5 Jun - 10 Jul 2008	C131	Certificate Course on Wilderness Medicine	Hong Kong Society for Emergency Medicine & Surgery	General Public
10 Jun - 8 Jul 2008	C129	Certificate Course on Drug Dispensing in Office Clinics	NIL	Medical and Health Care Professional
5 Aug - 16 Sep 2008	C132	Common Psychiatric Problems for GPs and Healthcare Professionals	The Hong Kong College of Psychiatrists	General Practitioners & Healthcare Professionals
4 Sep - 25 Sep 2008	C134	Clinical Management of Vertigo	NIL	General Practitioners & Paramedic

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Common Psychiatric Problems

for General Practitioners and Healthcare Professionals

Course No. C132

Jointly organized by:

The Federation of Medical Societies of Hong Kong

The Hong Kong College of Psychiatrists

Objective: Mental disorders have been more and more recognized to be important in the community. Some of the disorders have also become more and more prevalent eg depression and substance abuse. Stigmatization remains significant and discourages people seeking help. Front line practitioners should always be alert to the possibility of encountering mental problems. After the course the attendants should be aware of the latest developments of common psychiatric problems regarding their epidemiology, etiology, psychopathology, pharmacotherapy and psychotherapy. Practitioners should also know their limitations and know when they should seek second opinion or referral. Risk assessment concerning suicide, psychosis, relapse and deterioration, side effects of treatment, need of use of more dangerous drugs, need of more specialized and integrated services is also an important objective of the course. Mental patients should always receive timely, fair and appropriate treatment just like patients suffering from any other bodily disorders.

Date	Title	Speaker
5-Aug-08	Depression	Dr Chiu Siu Ning
19-Aug-08	The Psychoses	Dr Chiu Siu Ning
26-Aug-08	Mental Disorders in the Elderly	Dr Wong Yee Him John
2-Sep-08	Common Sleep Disorders	Dr Lai Tze Kin Samuel
9-Sep-08	Alcohol and Other Substance Abuse	Dr Wong Chi Keung
16-Sep-08	Anxiety Disorders	Dr Lee Wing King

Date : 5 August 2008 - 16 September 2008
Time : 7:00 p.m. - 8:30 p.m.
Venue : Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong
Course Fee : HK$750 (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

CME/CPD Accreditation applied for
To download the application form, please visit our website:
http://www.fmshk.org

CERTIFICATE COURSE FOR GENERAL PRACTITIONERS & PARAMEDIC

Clinical Management of Vertigo

暈眩的臨牀處理

Course No. C134

Organised by:

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

Objective: **The course aim at providing a practical approach to patients who present with vertigo, a basic understanding of vestibular function tests and management principles.**

Date & Time	Topic	Speaker
4 Sep 08	Introduction Causes of Vertigo History Taking and Physical Examination	Dr. Hui Yau ENT Surgeon
11 Sep 08	Vestibular Function Tests: Basic Principles, Diagnosis and Interpretation	Dr. Dennis Au Audiologist
18 Sep 08	Common Causes and Their Treatment (Part 1): Vestibular Neuronitis, BPPV and Meniere's Disease	Dr. Wong Ling Yuen Otorhinolaryngologist
25 Sep 08	Common Causes and Their Treatment (Part 2): Acoustic Neuroma, Stroke	Dr. Fan Yiu Wah Neurosurgeon
	Verstibular Rehabilitation	Mr. Chris Wong Physiotherapist I

Date : 4 September 2008 - 25 September 2008
Time : 7:00 pm - 8:30 pm
Venue : Lecture Hall, 4/F, Duke of Windsor Social Service Building,
15 Hennessy Road, Wanchai, Hong Kong
Course Fee : HK$500 (4 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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APPLICATION FORM – CERTIFICATE COURSE

*Please delete as appropriate

Name of Applicant: Prof/Dr./Mr./Ms./Mrs.* (Surname) _____ (First name)_____

(Chinese Name)_____

Correspondence Address: _____

_____

Tel.No.: _____ Fax No.: _____ Email Address: _____

Company Name:_____ Occupation: _____

Title: _____ Age: _____ Sex: Male / Female *

Course Title: (Please tick)

☐ Wilderness Medicine (C131)

☐ Drug Dispensing in Office Clinics (C129)

☐ Common Psychiatric Problems (C132)

☐ Clinical Management of Vertigo (C134)

Education (please tick):

☐ Secondary ☐ Undergraduate ☐ Postgraduate ☐ Others _____

Sources of learning about the course:

☐ Patient resources & social Centre
☐ Clinics of Department of Health
☐ Health related organizations
☐ University libraries
☐ Nursing societies
☐ Self help groups
☐ FMS Website
☐ The Hong Kong Medical Diary
☐ Schools
☐ Sports centres
☐ Youth centres
☐ Hospital wards
☐ CME/CPE/CNE colleges
☐ Others (please specify)_____

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.

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Advanced I 進階班	Suitable for players with basic tennis skills & wishing to improve their overall level of tennis, or for those who have completed the Intermediate Stage & recommended by the coach. 適合有基本技術而欲繼續進修之人士或已經完成中班及經教練推薦之人士
Advanced II 高級班	Suitable for players with basic tennis skills & wishing to improve their overall level of tennis, or for those who have completed the Advanced I Stage & recommended by the coach. 適合有基本技術而欲繼續進修之人士或已經完成進階班及經教練推薦之人士

上課地點 ： 維多利亞公園
日期 ： 2008 年 5 月至 12 月 (逢星期日)
上課時間 ： 2 小時，共 4 節 (早上 10:00 – 12:00 或 下午 1:00 – 3:00)
名額 ： 20 人 (每班人數: 2-6 人)
費用 ： $1440
參加資格 ： 香港醫學組織聯會會員暨家屬
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表格可於以下網址 www.fmshk.org 下載

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