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Update on Obstetrics & Gynaecology

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Breast Milk as Gold Standard

Breast milk has long been recognized as nature's ideal nutrition for healthy term infants. Breast milk is the best form of infant nutrition because it provides the nutrients necessary to support the growth and development of infant.[1-3]

Biofactors are defined as both endogenous and exogenous factors that affect, modulate, or in some way interact with a biological system.[4] Breast milk is a complex matrix of over 200 biofactors that interact with one another, including proteins, carbohydrates, lipids, vitamins, minerals and nucleotides. They perform a number of biological functions, including immunologic, gastrointestinal and neurodevelopmental functions.[4]

Wyeth Biofactors System

The approach of Wyeth Biofactors System takes into account the importance of an integrated system of nutrients and other ingredients for promoting health and supporting optimal growth and development of infant.

Wyeth Innovation

Wyeth has steadfastly modeled its infant formula after the gold standard, Breast milk. Through decades of scientific studies, Wyeth, along with researchers and clinicians around the world, has identified many of the key biofactors that help ensure the health and development of infants. Detailed analysis has yielded a better understanding of breast milk, and nutrients can be added to infant formula to help bridge the nutritional gap between breast milk and formula when babies are not breastfed.

Heritage of Innovation

a. 1921 - Commercialization of 1st modern infant formula
b. 1933 - Carotene is added in amounts equal to those in breast milk
c. 1942 - Iron is added in amount sufficient to satisfy the infant's requirement
d. 1961 - First commercially infant formula with whey-to-casein ratio of 60:40, similar to that of mature breast milk
e. 1989 - First to add nucleotides to infant formula on a global basis
f. 1998 - First formula fortified with AA and DHA from pure vegetable sources
g. 2002 - First and only infant formula rich in alpha-lactalbumin
h. 2006 - First range of formula fortified with Lutein across Wyeth Gold range
i. 2008 - Launch of Biofactors System in Hong Kong

For medical professional's reference only

Reference: 1. Koletzko B, Aggett PJ, Bindels JP, et. al. Growth, development and differentiation: a functional food science approach. Br. J. Nutr. 1998;80 (Suppl. 1):S5-S45. 2. Breastfeeding, The National Women's Health information Center, www.4woman.gov/breastfeeding. Accessed on Jan 12, 2009. 3. American Academy of Pediatrics, Workshop on Breastfeeding. Breastfeeding and the use of human milk. Pediatrics. 1997; 100:1035-1039. 4. de Sierra TM. Biofactors: An integrated approach to infant nutrition. Proceedings of the Wyeth Nutrition satellite symposium. The 24th International Congress of Pediatrics, Cancun, Mexico, August 15-20, 2004.

Breast milk is best for babies. Infant formula is intended to replace breast milk when mothers do not breast-feed. Good maternal nutrition is important for preparation and maintenance of breast-feeding. Introducing partial bottle-feeding could negatively affect breast-feeding and reversing a decision not to breast-feed is difficult. Professional advice should be followed on infant feeding. Infant formula should be prepared and used as directed. Unnecessary or improper use of infant formula may present a health hazard. Social and financial implications should be considered when selecting a method of infant feeding.

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Contents

The Cover Shot

A Flower on IR Positive

Before the era of digital photography, in which every change of colour and tone comes with a click of the finger at the mouse, the last generation of photography enthusiasts had to experiment with different films, lenses, filters, lighting and even the focal planes to capture the 'best' rendition of realities in front of them. If they did their own processing, it would be another round of experimentation with chemicals, stop clock... . At the end, they were forced to be totally passive, held in suspense for as long as a few weeks before the results of the exercise could be known and seen - overjoyed very occasionally but mostly disappointed and yet too late to make those very minute changes which in their mind would have made the hell of a difference! These perhaps were part and parcel of the fun and gratification of photography of those bygone years.

This Calla Lily 馬蹄蘭 (Zantedeschia) was taken on Ektachrome Professional Infrared/EIR positive by Kodak with 105 mm Micro Nikkor to a Nikon F2 body. The original colour of the flower was replaced by a psychedelic shade of yellow. Documentation was not the goal but merely an experiment with colour. Different colour filters were tried at the same time but this was an absolute serendipity.

Dr. Dawson FONG

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Editorial

Dr. Dominic Fuk-him LI

Specialist in Obstetrics and Gynaecology

Editor

Dr. Dominic Fuk-him LI

This December issue is the last issue of the Medical Diary in 2009 and we have dedicated this to a clinical update on obstetrics and gynaecology. This year has been a very stimulating year for us obstetricians and gynaecologists. We saw a record high delivery rate since the SARS era, probably with improving economy in Hong Kong and the effect of "Reversed CEPA" contribution from our mainland mothers. How this baby boom affects our future education and social planning will be in the hands of our politicians, but our obstetric colleagues in the public and private sectors have been doing a great job to cope with this increasing demand. The high standard of our obstetric services should be commended.

"Prevention is better than cure" has been our motto for improving health since primary school. The development on HPV vaccines to prevent cervical cancer is encouraging. Solid scientific data prompted many governments to start national programmes on vaccination for young girls with this vaccine. However, many parents and doctors as well often asked the same question: Is this vaccine safe for my girls? Should we give the vaccine to adult women over the age of 25 and those already been sexually active? Dr Tam Kar-fai wrote an article on the latest development of the HPV vaccine so that we will have a better understanding of the topic. Primary prevention with vaccination against high risk HPV and secondary prevention with Pap smear will be the ultimate goal to eliminate cervical caners in our future generation.

It has been 7 years since the publication of the Women's Health Initiative (WHI) studies on hormone replacement therapy (HRT) after menopause. The negative impact of this study is still perpetuating in the lay media and in our medical arena. Reanalysis of the WHI results as well as recent studies showed that HRT is not only safe but beneficial to women under the age of 60. The duration of treatment also contributes to the safe use of HRT in symptomatic women. Professor Haines gave us an update on the proper use of HRT and serves as a useful practical guide for both OG specialists and non-OG doctors. I hope our readers will enjoy his article.

Umbilical Cord Blood Transplant (UCBT) is another hot topic in our field. Starting off in treating Fancoi anemia in 1988, UCBT takes off in many other therapeutic areas in medicine. Dr Anthony Chan and Dr Kent Tsang gave us an insight into the revolutionary use of UCBT in other diseases like cerebral palsy and diabetes mellitus. Debates on commercial cord blood banking will go on but that will not deter scientific advancement of this exciting field.

Sexual dysfunction in males attracted a lot of attention since the discovery of the "blue pill". This problem is not at all uncommon in the female counterpart. In this issue, Dr Sue Lo of Hong Kong Family Planning Association (HKFPA) writes on the diagnosis, assessment and management of female sexual dysfunction. I believe this article will be useful for every reader because half of our patients are female.

Merry Christmas and Season's Greetings and hope you all enjoy the Medical Diary December issue.

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Update of HPV Vaccines on Cervical Cancer

Dr. KF TAM

Division of Gynaecological Oncology, Department of Obstetrics and Gynaecology, The University of Hong Kong

Dr. KF TAM

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 December 2009.

Cervical Cancer

Cervical cancer is the second most common cancer in women worldwide and this is the commonest cancer in women in some of the developing countries where 83% of all cases occur.[1] Globally, it was estimated that there were about 493,000 cervical cancer cases in the year 2000 causing 274,000 deaths. Mortality from cervical cancers ranged from about 30% in developed countries to about 70% in developing countries.[2-4] The higher mortality rate in developing countries was probably contributed by late diagnosis and difficulties in accessing quality care. Women who survived cervical cancers would suffer a lot from psychosexual problems as a result of the disease and the treatment. The expenditure for this disease is a challenge to most of the health care systems. In Hong Kong, we had 459 new cases of cervical cancer in 2006 and the age-standardised rate was 9.4, which is relatively high when compared to some other developed countries (http://www3.ha.org.hk/cancereg/e_cx.pdf).

Cervical Cytology Screening

Since its introduction in the mid 20th century, cytology-based cervical cancer screening has been the most effective method in preventing cervical cancers. Cervical cancer screening is a mode of secondary prevention, which reduces the incidence and mortality of cervical cancers by detection and treatment of pre-cancerous cervical lesions. The success of a screening programme depends on the coverage. Some countries are performing better than the others due to differences in policies, input of resources and the call/recall systems.[5] Patients having abnormal cervical cytology would be subjected to colposcopy examination. High-grade cervical intraepithelial neoplasia, if found, could be treated by ablative or excisional procedures. Despite the effectiveness in preventing cervical cancers, the psychosocial impact to women arising from colposcopy or complications from local excisional procedures could be very distressing and should not be overlooked.[6-8]

Human Papillomavirus

It is now widely accepted that human Papillomavirus (HPV) is the cause for cervical cancers based on the fact that HPV DNA was detected in 99.7% of the cervical cancer samples.[9] Human Papillomaviruses are small DNA viruses that infect epithelial tissues. HPV consists of 8,000 base-pair long circular DNA molecules wrapped into a protein shell, which is composed of two molecules including the L1 and L2. More than 100 types of HPV have now been molecularly characterised and about 40 types are able to infect the genital tract. A subset of mucotrophic high-risk HPV types (16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, 68, 73 and 82) belonging to the alpha genus is associated with more than 99% of the cervical cancers.[9] Among the high-risk HPV types, HPV-16 and -18 accounted for about 70% of all the cervical cancers.[10] Together with another six high-risk HPV types including 31, 33, 35, 45, 52 and 58, they are the eighth most common HPV types accounting for about 90% of the cases. However, the relative importance of HPV types 31, 33, 35, 45, 52 and 58 appeared somewhat different among different continents.[11] Based on the knowledge on HPV and its causative effect on cervical cancers, HPV vaccines were developed to prevent this disease.

HPV Vaccines

Role of HPV Vaccines in Cancer Prevention

The role of the HPV vaccine is to prevent anogenital cancers especially cervical cancers by inducing immunity against high-risk HPV types.

Types of Vaccines

Only prophylactic HPV vaccines are available in the market. Currently, the use of therapeutic vaccines is only within the context of clinical studies.

How Does the Prophylactic Vaccine Work?

Virus like particles (VLPs) containing the L1 capsid protein was created through recombinant DNA technology. This antigen, when presented to the immune system, would induce the production of neutralising antibodies. The early evidence of protection from HPV infection by antibodies came from animal studies.[12,13] The protective effect is believed to be conferred to the IgG, which is present in the epithelium neutralising the virus particles and prevents infection. The VLPs do not contain genetic materials. They are non-infectious and would not cause genital infection. The antibodies induced by the VLPs are type specific

and will therefore prevent infection of the relevant viruses only. However, some evidence from recently published data did suggest that there was cross protection against other HPVs of the same phylogenetic subtype, which share the same conformational epitopes.

Current Available HPV Vaccines

Two prophylactic vaccines have been developed by the drug companies. Gardasil®(Merck and Co., Inc.) is a quadrivalent HPV-6, -11, -16, -18 vaccine. It consists of purified L1 VLPs of HPV types 6/11/16/18 at 20/40/40/20 μg per dose formulated on 225μg of aluminium adjuvant hydroxyphosphate sulfate. The product is to be delivered by intramuscular injection as a 0.5ml dose at 0, 2 and 6 months.[14] Cervarix® (GlaxoSmithKline Biologicals) is a bivalent HPV-16, -18 vaccine. This vaccine consists of purified L1 VLPs of HPV types 16/18 at 20/20 g per dose formulated on ASO_4, an adjuvant containing 500μg of aluminium hydroxide and 50 g of 3-deacylated-monophosphoryl lipid A. This product is to be delivered intramuscularly as a 0.5ml dose at 0, 1 and 6 months.[15] Age indications for Gardasil® and Cervarix® are 9 - 26 and 10 - 25 respectively.

Areas of Protection: Both vaccines offer protection against cervical cancers through the prevention of HPV-16 and -18 infections. Gardasil® also offers protection against anogenital warts through the prevention of HPV-6 and -11 infections.

Safety: Details of the safety data were obtained prospectively during the clinical trials.[15,16] The most commonly reported adverse events were pain, redness or swelling over the injection sites. Fever was also common (one in 10 subjects) but most of these were low grade. No significant increase in serious adverse events was found in the vaccine group when compared to the placebo group. Data on pregnancy including the foetal outcome are now being collected in ongoing studies. So far, no vaccine-related adverse foetal outcome has been evident.

Immunogenicity: Both HPV vaccines are highly immunogenic causing seroconversion in more than 98% of subjects.[15,16] The peak antibody titres were found to have achieved one month after the completion of all the three doses of vaccination and then started to decline. After a follow-up period of 4.5 - 5 years, the antibody titres were still found to be higher than the antibody titres caused by a natural infection for both vaccines. Moreover, protection against HPV infection or HPV related diseases were observed in a wide range of antibody titres.

Efficacy: Clinical trials for both vaccines have used the precancerous lesions including cervical intraepithelial neoplasia (CIN) grade 2-3 and cervical adenocarcinoma in situ (AIS) as the primary end point for analyses.[15,16] The vaccines were more than 90% effective in preventing cervical precancerous lesions caused by the corresponding HPV types. From a recent publication on Cervarix®, it showed that there were potential cross protection against HPV -31, - 33, - 45 and - 58 , which are phylogenetically closely related to HPV - 16 and -18. 15 However, the extent of this potential cross protection and their contribution to cervical cancer/precancerous lesion prevention have to be elucidated.

Duration of Protection: Currently, the duration of protection provided by the HPV vaccines is not known. However, long term follow up studies have shown that efficacy is maintained for at least five years.[17,18] Up to this moment, the necessity for booster injections is still unclear.

Target Population for the HPV Vaccines: To achieve better protection, vaccines have to be delivered before exposure to the viruses. Since HPV is mainly transmitted sexually,[19] the vaccines should be given before sexual exposure. As better immune response was found in pre-pubertal subjects with higher antibody titres, injection before puberty may achieve better results.[19,20]

Gender: Genital warts do concern both men and women but not cervical cancers. Penile cancer occurs in men but with a much lower incidence when compared with cervical caner.[21] From the mathematical models, vaccination for men could further reduce the incidence of cervical cancers.[22] However, the cost-effectiveness is a major concern to most policy makers. For those localities having a high prevalence of genital warts, including men in the vaccination programme using the quadrivalent vaccine, which helps preventing 90% of the genital warts, would make it easier to justify.

Pregnancy: So far, there is no evidence showing vaccine-related adverse pregnancy outcomes. Nevertheless, those who are pregnant or contemplating pregnancy are advised against vaccination.

HPV Positive Subjects: The vaccine, which is now available, is a prophylactic vaccine. A cytotoxic and T-cell response is required to clear up the infected cells and this immune response is probably not triggered by the dose and way the VLPs are administered. Individuals who have been infected with the corresponding HPV types would lose the protection to the specific type of HPV from the vaccine. A negative serology test or HPV DNA test is not a reliable test on any prior HPV infection. Therefore, routine HPV serology test or HPV DNA test is not recommended before the use of vaccines.

History of Abnormal Cervical Cytology or Cervical Intraepithelial Neoplasia (CIN): If one has been infected by HPV types of the corresponding vaccines, leading to abnormal cervical cytology or CIN, the protective effect of the vaccines would not be as high as quoted. Unfortunately, using the currently available commercial kit, one cannot tell the causative HPV type leading to the abnormalities. Therefore, a history of CIN or abnormal cytology is not a contraindication for vaccination but one should bear in mind that the efficacy of the vaccines could be diminished.

Cervical Cancer Screening after Vaccination

HPV vaccine does not provide 100% protection from cervical cancer. It is very important to note that whoever has received the vaccine should continue with cervical cytology screening. However, the chance of having abnormal cervical cytology or CIN may be lower

when compared to the population without HPV vaccination. In the future, the mode of screening may be changed if the vaccine is incorporated in the immunisation programme. In the meantime, we do not have enough evidence to substantiate a change in our screening policy.

Conclusion

HPV causes cervical cancer, which is a major burden to the health care system especially in the developing countries. Cervical cytology is so far the best method in preventing cervical cancers but it is unable to prevent precancerous lesions. Psychosexual impact on women with abnormal cervical cytology and the expenditure on the follow-up of abnormal cytology results should not be overlooked. In countries with poor resources and those without an organised cervical cancer screening programme, HPV vaccines may help to alleviate the impact of cervical cancers. Although a lot of data has been available on the use of vaccines, there are still a lot of uncertainties to be clarified. The effect of HPV vaccines on a community would not be seen in the near future because it works only on those women who have not been infected. It will take another few decades before results become obvious. Therapeutic vaccines, if successfully developed, may be another significant progress in cervical cancer prevention.

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

Date	Course No	Course Name	Target Participants	CME/CNE
5 Mar 10 - 19 Mar 10 & 9 Apr 10 (Every Fri)	C157	催眠治療臨床應用課程(基礎訓練)	Medical and Health Professionals	9 CNE Points / CME Accreditation in application

MCHK CME Programme Self-assessment Questions

Please read the article entitled "Update of HPV Vaccines on Cervical Cancer Prevention" by Dr. KF TAM 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 December 2009. 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. Cervical cancer is rare in developing countries.
2. Cervical cytology screening is a mode of primary prevention.
3. HPV infection is essential of the development of cervical cancers.
4. HPV 16 and 18 account for about 70% of all cervical cancers.
5. Both prophylactic and therapeutic HPV vaccines are available in the market.
6. Both Gardasil and Cervarix are bivalent HPV vaccines.
7. HPV vaccines are potentially infectious.
8. HPV vaccines can prevent cervical intraepithelial neoplasia (CIN).
9. Pregnant women who are keen for HPV vaccination should receive the vaccine as soon as possible.
10. Cervical cytology screening is no longer necessary for women who have received HPV vaccines.

ANSWER SHEET FOR DECEMBER 2009

Please return the completed answer sheet to the Federation Secretariat on or before 31 December 2009 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

Update of HPV Vaccines on Cervical Cancer Prevention

Dr. KF TAM

Division of Gynaecological Oncology, Department of Obstetrics and Gynaecology, The University of Hong Kong

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

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Answers to November 2009 Issue

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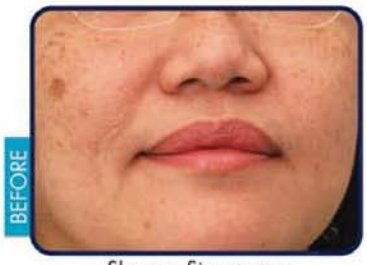
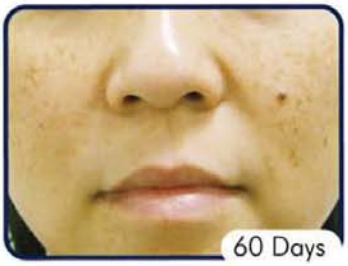


- Sharon, Singapore -



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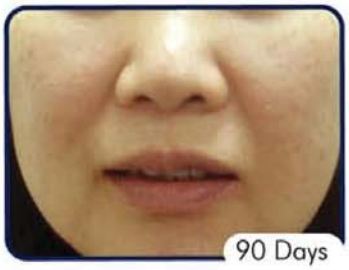

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600-60-60-MT-HK

Menopause and the Use of Hormone Replacement Therapy (In the Aftermath of the WHI Study)

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Introduction

In July 2002, alarming news appeared in the world's press and in other media suggesting that users of hormone replacement therapy (HRT) may be at increased risk of breast cancer and possibly cardiovascular disease. Until that time, there had been confidence that HRT was not only effective in treating acute menopausal symptoms, but that it also protected against osteoporosis and cardiovascular disease. Headline news appeared after the release of the initial results of Women's Health Initiative Trial[1], a study conducted in the United States involving 16,608 postmenopausal women. Both patients and doctors panicked at the sight of these headlines. Almost immediately, countless women stopped using HRT, and many medical practitioners who used the press as their source of information stopped prescribing HRT due to concerns about risks. This article will seek to clarify current information about the risks and benefits of HRT.

HRT and Breast Cancer

The concern about breast cancer risk in users of HRT remains real, but for the WHI trial, the figures were released as percentage of risk rather than absolute risk. This exaggerated the risk perception. As it turned out, in absolute numbers, the difference in risk between users and placebo was small (Tables 1,2). For example, in women aged 50-59 years using HRT containing oestrogen as well as progesterone (the most common age bracket for HRT users in this region), there would be an estimated 3 additional cases of breast cancer per 1,000 women exposed to treatment over 5 years. More interestingly, in a WHI paper published later on the use of oestrogen by itself[2], in women aged 50-59 years there would be an estimated 4 fewer cases of breast cancer per 1,000 women exposed to treatment over 5 years. This reduction rather than increase in the number of cases of breast cancer with oestrogen treatment could not be fully explained. Not surprisingly, this apparent good news received little or no press coverage.

By far the most important indication for the use of HRT is the treatment of vasomotor symptoms (something that was not addressed in the WHI study). For this indication, HRT usually needs to be taken for only 1-2 years before the symptoms tend to subside. With this duration of treatment, the risk of breast cancer is no longer an issue. Oestrogen/progestogen therapy prescribed for up to 5 years does not add significantly to lifetime risk of breast cancer[3]. Beyond that time, the increase in risk is small, and is comparable to other risks such as being obese or drinking more than 2 standard drinks of alcohol per day. Oestrogen-only therapy for up to 7 years does not significantly increase breast cancer risk. The recommendations of the Asia Pacific Menopause Federation (APMF) and also the International Menopause Society (IMS) state this clearly[4]. Young postmenopausal women starting on combined HRT for the first time should be advised that breast cancer risks do not appear to increase in the first 7 years of use. Hysterectomised women on unopposed oestrogen are not at increased risk of breast cancer and some may even have a small reduction in risk.

Table 1. Risk of invasive breast cancer in users of unopposed oestrogen

	Oestrogen only: no. of events	Placebo: no. of events	Hazard ratio (95% confidence interval)	Absolute risk /1000 women if used for 5 years
Age group (years)				
All (50–79)	94	124	0.77 (0.57–1.06)	−4 (−7 to 0)
50–59	25	35	0.72 (0.43–1.21)	−4 (−7 to +3)
60–69	42	60	0.72 (0.49–1.07)	−5 (−9 to +1)
70–79	27	29	0.94 (0.56–1.60)	−1 (−9 to +12)

Adapted from Collins et al, 2005(9)

Table 2. Risk of invasive breast cancer in users of oestrogen combined with progestogen

	Oestrogen/ Progestogen: no. of events	Placebo number of events	Hazard ratio (95% confidence interval)	Absolute risk /1000 women if used for 5 years
Age group (years)				
All (50–79)	199	150	1.24 (1.01–1.54)	+4 (0 to +9)
50–59	52	40	1.20 (0.80–1.82)	+3 (−3 to +11)
60–69	94	72	1.22 (0.90–1.66)	+4 (−2 to +12)
70–79	53	38	1.34 (0.88–2.04)	+7 (−2 to +21)

Adapted from Collins et al, 2005 (9)

HRT and Cardiovascular Disease

In the initial report of the WHI trial, study results showed a non-significant increase in coronary heart disease deaths and non-fatal myocardial infarction in the treatment group. However, in this so-called healthy population of women, the mean age was 63 years, their

mean BMI was 28.5, almost 40% had a history of smoking, 36% a history of treatment for hypertension and 13% had been treated for hypercholesterolaemia. It was already understood well before the WHI study that HRT was not to be used for secondary prevention of cardiovascular disease. Women with established cardiovascular risk are unsuitable for treatment with HRT as they already have diseased arteries, and the use of HRT may cause plaque instability.

However, as common sense would suggest, current evidence supports the cardioprotective effects of HRT when treatment is initiated in younger postmenopausal women (Table 3). Reanalysis of the WHI data itself has shown that there is a likely beneficial effect on the cardiovascular system for women who begin treatment with HRT at or near the time of the menopause[5,6].

According to APMF and IMS guidelines, young healthy postmenopausal women can be started on HRT when clinically warranted without fear of increased cardiovascular disease risk. However, oral HRT should not be prescribed to women with a previous episode of venous thromboembolism. Women seeking HRT who have potential or confirmed risk factors for venous thromboembolism and stroke need individualised counselling; in these situations, transdermal HRT might be preferable to oral formulations.

Table 3. HRT and coronary heart disease risk according to reanalysis of WHI data

Years since menopause	HR for CHD	Risk /10,000 person years
< 10 years	0.76 (0.50-1.26)	-6
10-19 years	1.10 (0.84-1.45)	4
≥ 20 years	1.28 (1.03-1.58)	17
Age		
50-59 years	0.93 (0.65-1.33)	-2
60-69 years	0.98 (0.79-1.21)	-1
70-79 years	1.26 (1.00-1.59	19

Adapted from Roussow et al JAMA 2007;13:1465-77 (6)

HRT and Osteoporosis

HRT is effective in preventing the bone loss associated with the menopause and decreases the incidence of all osteoporosis related fractures, including vertebral and hip fractures, even in patients at low risk for fractures[7]. HRT is indicated for the prevention of bone loss in women with premature menopause and secondary amenorrhoea. It is also indicated in postmenopausal women in the age group 50-60 years presenting with a risk for fracture. Potential adverse effects of HRT can be limited by using lower than standard doses or by avoiding oral administration, without compromising the beneficial effect of HRT on bone.

Once again, APMF and IMS guidelines support the use of HRT as the most cost effective and relatively safe choice for prevention of fractures in women under 60 years of age. In addition, although some degree of fracture protection may remain after stopping HRT, the patient at risk for fracture should then receive other suitable therapy.

The continuation of HRT after the age of 60 for the sole purpose of the prevention of fractures should take into account the possible side effects in the individual of the specific dose and method of administration of HRT, compared to other proven therapies. The initiation of HRT for the sole purpose of the prevention of fractures is not recommended after the age of 60 years.

Aftermath of WHI

In the years since 2002, a number of things have become obvious. Firstly, the number of users of HRT dropped dramatically soon after the WHI announcement, and although there has been a slow increase in users of HRT, in most countries this has never returned to pre 2002 levels[8].

The WHI study was a prospective placebo controlled study of the effect of hormone replacement therapy with the primary outcome being the effect on cardiovascular events. The effect on breast cancer was not a primary outcome indicator, and there was no examination of the effect of HRT on hot flushes. The WHI trial was supposed to be a trial using primarily healthy postmenopausal women. Before 2002 (and since 2002 for that matter), as clinicians we have mainly been prescribing HRT to treat vasomotor symptoms in women at or soon after the menopause (i.e. usually around 50 years of age). Most of the women we see are healthy and are non smokers.

So why are both women as well as the doctors who care for them afraid of using HRT? The answer is obvious. Both groups still remember the headlines from 2002, and no headlines supporting the safety and benefits of HRT have been published since (because good news doesn't make headlines).

How Should I Advise My Patients?

The importance of individual risk benefit assessment cannot be over emphasised. For women with troublesome vasomotor symptoms, oestrogen is far superior to all other treatments in terms of efficacy. In Hong Kong, postmenopausal Chinese women more commonly have relatively mild symptoms which may need no treatment or else lower dose HRT which often needs to be taken for two years or less. For these women, the benefit clearly outweighs the risk.

If women present for consultation at the time of menopause, this is an ideal opportunity to also assess the need for other interventions which may include advice on diet and lifestyle and screening for other medical conditions which become more common in this age group. Recommendations for examination and investigation by the Asia Pacific Menopause Federation are as follows:

First Visit: General examination, including weight & height, blood pressure measurement, breast and pelvic examination.

Investigations: Advised: Pap smear, complete blood count, fasting blood sugar, fasting lipid profile.

Other investigations to be ordered on a case to case basis include: Liver function tests, thyroid function tests, mammography, bone mineral density, ultrasonography.

Summary

For the majority of healthy symptomatic women who have recently reached menopause, the benefits of low dose hormone replacement therapy outweigh the risks. Refusal to prescribe HRT for these women is against available medical evidence.

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Radiology Quiz

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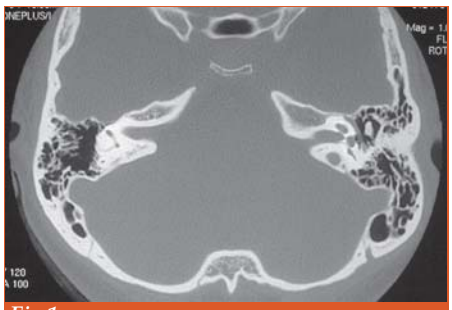

Fig 1

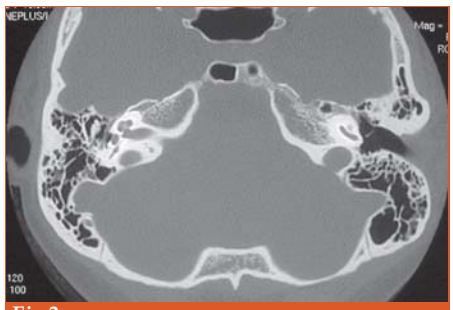

Fig 2

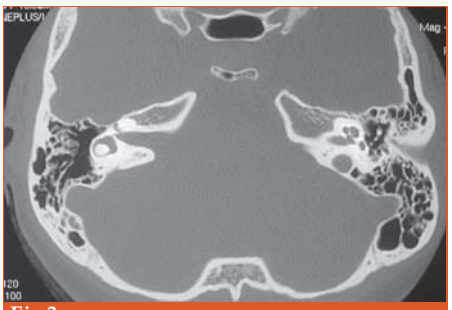

Fig 3

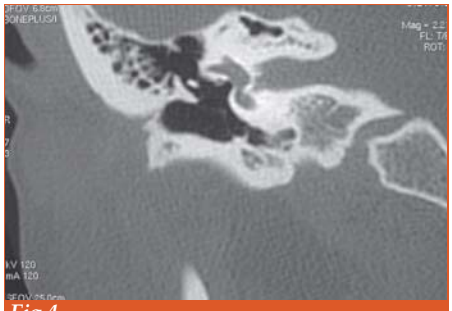

Fig 4

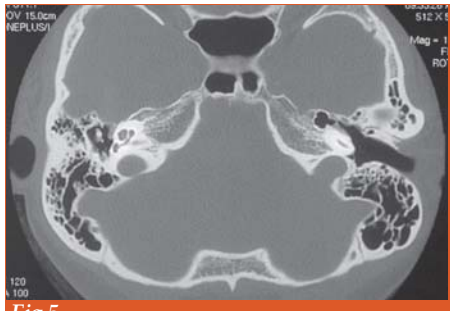

Fig 5

Questions:

F/ 23
C/O Rt sided hearing loss

1. What are the radiological findings in her CT temporal bones?

2. What is your diagnosis or DDX?

(See P. 32 for answers)

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Dr. Chun-fung CHAN Dr. Kam-sze TSANG

Introduction

Since the first report of successful pioneering umbilical cord blood transplant (UCBT) conducted in 1988 on a 5-year-old boy with Fanconi anaemia by Dr Eliane Gluckman and her colleagues of the Hospital Saint-Louis in France in collaboration with the team led by Dr Hal Broxmeyer of Indiana University in USA[1], approximately 10,000 UCBTs have been performed worldwide so far, and umbilical cord blood (UCB) has been utilised as an alternative rich source of haematopoietic stem cells for transplant. Clinical experiences and scientific breakthroughs gained and achieved in the past two decades provided ample evidence and encouraging results proving that UCBT is a safe and effective treatment modality for a number of incurable diseases.

UCB is an invaluable source of stem cells for treatment of haematologic malignancies, immune deficiencies, and metabolic disorders[2]. Unlike the bone marrow donor registry, UCB collections with the typing of human leukocyte antigens (HLA) are physically stored and banked to allow a quick access compared to a relatively long period of three to four months for the search of HLA-matched unrelated bone marrow donors[3,4] (National Marrow Donor Program, 2004). In fact, some patients can hardly wait for completion of the bone marrow donor search, as their diseases may progress to a clinical condition ineligible to transplant and die. Besides, episodes of loss and attrition of bone marrow donors are inevitable.

UCB offers the advantages of having a higher proportion of primitive haematopoietic stem cells and naive immune cells in UCB than adult bone marrow, rendering the long-term engraftment and lower risk of severe graft-versus-host disease (GVHD) post transplant, and a reduced risk of transmission of infectious diseases as compared to matched unrelated bone marrow transplant. However, the limited number of stem cells in an UCB confines the general use and restricts UCBT in patients of small body weight, unless double or multiple units are employed otherwise.

Recent advances in stem cell technology provide an exciting and potentially new approach to finding a cure for many other currently incurable disorders such as neurological disorders, coronary artery diseases and defected metabolism. Multiple stem cells with the ability to self-renew and differentiate into different types of cells have been found and isolated in UCB. They may be applied to cell therapy for diseases related to cell loss and degeneration. The promising readouts derived from pre-clinical stem cell studies prompt the exploration of translational medicine to currently incurable diseases. The current clinical practice, research progress and pre-clinical studies of UCB stem cells are discussed.

Current Clinical Application of UCB

The episodes of successful UCBT in children rose quickly since the first report of UCBT in 1989 in which the patient has been deemed disease-free[1]. Thereafter UCBT has been particularly successful in children, and was regarded as a curative treatment modality for many malignancies and hereditary diseases such as leukaemia and thalassaemia. The availability of HLA-identical graft is critical for successful transplant. However, successful engraftments of up to two-antigen mismatched UCB allografts were evident suggesting that transplant of HLA-disparate UCB could be tolerated without a significant increase of graft rejection and a greater extent of GVHD. A recent study reported that unrelated UCBT for acute leukaemia in children had clinical outcomes comparable to that encountered in unrelated bone marrow transplant. This may be attributed to the preponderance of immature immune cells present in UCB that are less likely to elicit GVHD.

Compared to bone marrow transplant, a longer time interval of neutrophil engraftment was noted in UCBT with a median number of 22 - 24 days. The total nucleated cell count is a critical determinant that correlates significantly with engraftment after UCBT. UCBT was thought to be effective for children rather than adults, pertaining to the limited volume of and number of nucleated cells in UCB being harvested in a single UCB collection which is usually good enough for transplant of a patient with small body weight. In 2004 onwards, a substantial number of reports describing double unit UCBT emerged. Transplantation of double unit of partially HLA-matched UCB was shown to be feasible and efficacious in more than 200 episodes suggesting that UCBT may be eligible to more than 90% of adults in need. To date, the employment of double unit of UCB becomes a standard procedure for transplant in adults if a single UCB with a predetermined cell number is not achieved.

Research Progress

Other promising strategies have been undertaken to improve the outcome of UCBT in adults. UCB stem cells were ex vivo expanded in cultures supplemented with various growth factors to meet the requisite cell numbers for transplant[6,7]. Ex vivo expansion resulted in tens to hundreds of folds of increase of CD34+ cells and total nucleated cells in UCB. However, clinical trials of *ex vivo* expanded UCB have not yet been reported.

Injection of haematopoietic stem cells into the bone marrow has been suggested to potentially facilitate homing and hasten engraftment after transplant. The limited number of cells in UCB makes the injection into the bone marrow attractive. A clinical trial has been conducted to compare the intra-bone marrow injection to intravenous infusion in adults in bone marrow transplant. There was no conclusive evidence to support a better clinical outcome for patients undergoing intra-bone marrow injection.

Stem cells in UCB which under appropriate micro-environmental cues are able to be reprogrammed and contribute to a much wider spectrum of differentiated progeny than previously thought. A plethora of reports demonstrated that UCB-derived haematopoietic stem cells are able to give rise to the cells of the other germ layers[8,9,10,11]. The putative stem cell plasticity suggests the almost unlimited potential of transplanted haematopoietic stem cells to trans-differentiate into cell types that do not belong to the haematopoietic system. The potential ability of stem cells to cross beyond lineage barriers has drawn much attention. Studies have been conducted to investigate the application of UCB in regenerative medicine on other morbidities related to cell loss or degeneration.

Human UCB were infused intravenously into Alzheimer's disease mouse model. Amyloid plaques in the brains demonstrated a decrease suggesting the applicability of UCB to Alzheimer's disease in humans. A clinical trial of UCB stem cells in a patient with spinal cord injury demonstrated an improved sensory perception and mobility[12].

Future Promises for Incurable Diseases

Autologous UCB Transplant for Cerebral Palsy

Cerebral Palsy is a non-progressive and non-contagious motor impairment disorder that causes a wide spectrum of life-long physical disability encompassing mental retardation, epilepsy, visual and hearing impairment, speech and language disorders, and oral-motor dysfunction. Its prevalence in Hong Kong is 1.3 per 1,000 children, which is significantly lower than 2 to 2.5 per 1,000 births in other countries[13,14]. The current therapies are mainly palliative rather than restorative.

Intra-peritoneal administration of human UCB into a cerebral palsy rat model resulted in reduced spastic paresis with a significant improvement in walking[15]. The therapeutic effects may be attributed to multiple stem cells in UCB including haematopoietic stem cells, embryonic-like stem cells, endothelial stem cells, epithelial stem cells and mesenchymal stem cells. Cell tracking demonstrated that UCB stem cells migrated to the injured areas of the traumatic rat brain. The homing of UCB stem cells into the brain lesion may be related to specific chemo-attractants being released and up-regulated on injury and the impaired blood-brain-barrier in the damaged brain allowing the penetration of donor cells to the central nervous system. The pre-clinical outcomes of UCB observed in the animal study of cerebral palsy are reproducible in a clinical trial.

A clinical trial of autologous UCB infusion was carried out in a cohort of cerebral palsy children. A cell dose of > 1 x 10^7 UCB nucleated cells per kg body weight was injected intravenously. Post-infusion improvements in speech and motor function were evident in 60% of patients in the study cohort within 2 months or sooner. Among patients (n > 100) having undergone autologous UCB infusion, none experienced any adverse effect[5] (personal communication with Tom Moore, CEO of Cord Blood Registry).

The First Hong Kong Cerebral Palsy Patient Received Autologous UCB Transplant

A 7-year old girl with severe cerebral palsy has received autologous UCB transplant at Duke University Medical Center, US. Her UCB was stored at our facility in 2002 and it was requested to be retrieved for cerebral palsy treatment. Confirmatory HLA-typing, colony-forming unit (CFU) assay, viability and cell count were performed before autologous infusion. The quality of her cord blood unit was reviewed and confirmed to be suitable for the treatment. Subsequently the UCB stem cells were infused through the vein on the foot over 2 minute followed by 2 hours saline infusion (Figure 1). The patient was discharged the same day and returned Hong Kong two days later without any adverse effect. The improvement will be thought to be seen after few months.

Figure 1. A 7 year-old cerebral palsy patient received transplant with her own UCB that had been stored over 7 years. UCB was infused intravenously from the foot at Duke University Medical Center. The procedure took around 2 minute followed by saline infusion.

Autologous UCB Transplant for Type 1 Diabetes

Type°1 diabetes, which is an autoimmune disease that is characterised by T-cell-mediated destruction of insulin-producing pancreatic beta cells in all walks of life, is life-long and lethal unless properly treated with exogenous insulin administration. The prevalence in USA is 1 in 300 and continues to rise at approximately 3% per year[16]. Allogeneic non-myeloablative haematopoietic stem cell transplantation (HSCT) has been proposed to reconstitute immune tolerance of diabetic patients[17]. A pilot study using autologous UCB as a source of immunomodulatory cells to restore

proper immune regulation was initiated in a cohort of type°1 diabetes patients. Less than 100 mL of thawed UCB with cell viability more than 50% were infused intravenously and patients were allowed to return home after observation for at least six hours.

Preliminary data showed the administration of a less amount of exogenous insulin and a better maintenance of sugar levels in the test arm compared to the controlled arm (American Diabetes Association's 67th Scientific Sessions in Chicago in mid-2007). Such significant benefits might be mediated by an increase of circulating regulatory T cells which were thought to reverse the autoimmune disease in general and help preserve insulin production. Perhaps the most intriguing finding is that no significant adverse reaction was encountered in the test cohort having the novel stem cell therapy.

Conclusion

In the past two decades stem cell technology and clinical experience of UCBT have pursued tremendous breakthroughs and the applications of UCB in the clinical arena are far more than thought of previously. According to recent data released by the National Marrow Donor Program, the episodes of paediatric UCBT in 2008 outnumbered bone marrow transplant in children, and the trend continues. It is apparent that UCBT is not merely confined to the availability of HLA-matched allografts. Patients, who were previously ineligible for HLA-matched unrelated bone marrow transplant, would be benefited with partially HLA-matched UCB transplants or double unit UCBT. The plasticity of UCB stem cells also allows the potential differentiation of UCB stem cells into cells of interest for treatment of morbidities related to cell loss and degeneration, such as neurologic disorders of cerebral palsy, stroke and spinal cord injury; metabolic disease of type°1 diabetes and functional defects related to myocardial infarct, coronary artery disease and etc., which were regarded as incurable at the moment. All of these have led to the increased awareness of the prerequisites in UCB collection and cryopreservation. In fact, the number of UCB collections stored in either public or private banks increase progressively implying that more patients will be benefited in the future.

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Managing Female Sexual Dysfunction in the 21st Century

Dr. Sue LO

MBBS, FRCOG
Senior Doctor, The Family Planning Association of Hong Kong

Dr. Sue LO

The invention of the "blue pill" revolutionised the management of male erectile dysfunction in the past ten years and raised optimism about a quick fix for other sexual problems. Despite significant anatomic and embryologic parallels between men and women, the multifaceted nature of female sexual response clearly makes it distinct from the male response. Therefore, clinicians cannot approach female sexual dysfunction using the protocol for male patients. Much effort has been put into the study of female sexuality but a major breakthrough is still awaiting.

Diagnosis and Aetiology

Most of the description on female sexual response is based on the male model: desire, arousal, orgasm and resolution. However, female sexual responses are different from that of male. Women can achieve orgasm without achieving desire and arousal. Penetrative sex and reproductive outcome can be achieved without arousal and orgasm. On the other hand, women can have multiple successive orgasms.

The DSM-IV : Diagnostic and Statistical Manual of Mental Disorders (4th edition) of the American Psychiatric Association [1] described female sexual dysfunction based on Kaplan's triphasic model of sexual response [2], plus a fourth category of sexual pain disorders. The revised classification (DSM-IV-R) [3] was expanded to include psychogenic and organic causes of sexual dysfunction as well as personal distress as a diagnostic criterion. Since female sexual response is a complex and interrelated process, most patients have more than one dysfunction.

Female sexual dysfunction is subjective as personal experience cannot be verified or quantified. Sexual desire is a complex drive that is rather mysterious in terms of its strength, source, trajectory and expression. There are interpersonal, intrapsychic and biological variations in the experience of sexual desire. Up till now, an individual's willingness and ability to find and respond to sexual stimuli is still immeasurable. Sexual arousal includes subjective feelings of excitement and pleasure as well as physical responses like increased vaginal lubrication and tenting, increased muscle tension, blood pressure, heart rate and respiratory rate during sexual stimulation. However, even in sexually healthy women, the correlation between subjective and objective sensation was highly variable among individuals [4]. In fact, psychophysiological research often showed dysynchrony between objective measures of vasocongestion and self-perception of genital engorgement or subjective excitement [3-5]. During history taking, clinicians need to differentiate whether the woman really does not respond physiologically or she is not aware of it or ignores / dislikes that feeling thus simply shuts down or she fails to derive pleasure from the sexual stimuli. Arousal disorders are rarely diagnosed in isolation from hypoactive sexual desire disorder and anorgasmia. Anorgasmia is generally defined as the inability to achieve orgasm under sexual stimulation. It was reported that women experience orgasm only 40-80% of the time, regardless of the method of stimulation [6]. The experience of orgasm is unique to each woman and largely depends on individual awareness of one's own sexuality hence some researchers proposed that anorgasmia was not a dysfunction [7, 8]. Finally, although sexual pain is subjective, careful medical assessment is needed to exclude organic causes. Psychosocial factors can aggravate the pain sensation thus need to be tactfully addressed too.

Although the DSM-IV-R classification is simple, the underlying causes for the four types of sexual dysfunctions are multifaceted. The Working Group for a New View of Women's Sexual Problems has compiled a comprehensive guide to causes of female sexual dysfunction, which is summarised in Table 1 [9]. Across the lifespan, physical and emotional well being as well as sociocultural expectation continues to shape women's sexuality. At specific time point, life event like marriage, childbearing, divorce, ageing, cancer, surgery, medications and hormonal changes will also make an impact. Anxiety, depression and a history of sexual, physical or emotional abuse are also important causes. It is not easy to elucidate these causes as patients may be reluctant to disclose as a result of embarrassment, guilt, internal conflict or low self esteem.

Clinical Assessment

Clinical assessment includes history taking on the present sexual status, past sexual experience, psychological framework, personal perception and interpretation of the problem, interpersonal relationship and social functioning. Medical disorders such as cardiovascular diseases (e.g. atherosclerosis), endocrine diseases (e.g. diabetes mellitus, prolactinoma), gynaecological diseases (e.g. pelvic surgery, endometriosis, chronic pelvic pain), neurological diseases (e.g. multiple sclerosis), psychiatric diseases (e.g. depression, anxiety), medications (e.g. neuroleptics,

sedatives, selective serotonin reuptake inhibitors, β-blockers) including substance abuse (e.g. alcohol, hallucinogens, marijuana, cocaine, amphetamines) have to be excluded. A detailed gynaecological examination is essential to identify any organic cause for the sexual complaints as well as to educate the patient and her partner about her body.

Most of the sexual distress occurs as a result of wrong information and unrealistic expectation. Therefore, sex education including explanation of sexual anatomy, normal sexual response in men and women, sexual position and technique can correct the problem. Other patients will improve after their myth about sexual intercourse is dispelled, moral inhibition is liberated and awareness of sexual response is restored.

Some couples require sex coaching that provides them with a step-by-step guide to sexual intimacy and introduces them to use aids such as sex toys, games and audio-visual materials.

Referral to a sex therapist should be offered to couples who fail to improve after education and counselling or when the problem is likely to be thorny (Table 2).

Table 1: Causes of female sexual dysfunction

Sociocultural, political or economic factors
- Ignorance and anxiety due to inadequate sex education, poor access to health services and misconception
- Sexual avoidance or distress due to perceived inability to meet cultural norms, shame about one's body, sexual attractiveness or sexual identity
- Inhibitions due to conflict between the sexual norms of one's subculture and those of the dominant culture
- Lack of interest, fatigue or lack of time due to family and work obligations
Partner and relationship factors
- Inhibition, avoidance or distress arising from betrayal, dislike or fear of partner, partner's abuse, power imbalance, poor communication
- Discrepancies in desire for sexual activity or preferences
- Difficulty in communicating preferences or initiating, pacing or shaping activities
- Loss of sexual interest as a result of conflicts or traumatic experiences (e.g. infertility or the death of a child)
- Inhibitions in arousal or spontaneity due to partner's health or sexual problems
Psychological factors
- Sexual aversion, mistrust or inhibition of sexual pleasure due to past abuse, problems with attachment, depression or anxiety
- Sexual inhibition due to fear of sexual acts or their consequences (e.g. pain during intercourse, pregnancy, sexually transmitted disease, loss of partner, loss of reputation)
Medical factors
- Medical diseases affecting neurological, neurovascular, cardiovascular, endocrine or other systems of the body
- Pregnancy, sexually transmitted diseases or other sex-related conditions
- Side effects of drugs, medications or medical treatments
- Iatrogenic conditions

Table 2: Red flags indicating the need for detailed psychosexual evaluation

- Symptoms are lifelong, not acquired.
- Symptoms are situational.
- History of sexual / psychological / emotional trauma and abuse.
- Co-existing psychiatric illness.
- Suspected depression with or without anxiety.
- Dysfunctional relationship, power struggle, conflicts in the couple.
- Poor communication skills.
- Personality trait or disorder.

Sex Therapy

Sex therapy aims at improving sexual functioning and the active participation by a supportive, available partner will positively affect the outcome. A sex therapist is a "sex detective" who conducts comprehensive assessment of the couple including the context in which the patient experiences her sexuality, her self esteem and body image, her relationship with her partner and how does the couple communicate on sexual issues. The analytical skill of the therapist is crucial in identifying the cause(s) of the problem(s) and to elucidate solutions to solve the problem(s). Cognitive-behavioural therapy is adopted to change maladaptive thinking that hinders sexual function and to correct dysfunctional behavioural patterns. A number of home exercises are assigned to them to practise in the privacy of their own rooms. Exercises are tailor-made to suit individual needs and adjusted at each visit according to their progress.

The most established series of homework exercises was designed by Masters and Johnson - Sensate Focus [10]. This series of exercises can be tailored to help couples explore their sexual preferences and feelings, relief performance anxiety, facilitate communication at a number of levels or enjoy sexual intimacy. Controlled genital self-stimulation (directed masturbation) with or without mechanical aids (e.g. vibrators, clitoral stimulators) help women with orgasmic disorder. Kegel's exercise, which strengthens the pubococcygeus muscle and enhances pelvic sensation, improves sexual arousal and orgasm. For the treatment of vaginismus, Kegel's exercise is performed after the finger or dilator is inserted into the vagina and the pubococcygeus muscle is trained to relax.

Drugs

Vaginal oestrogen is useful in treating dyspareunia caused by dryness and atrophy in postmenopausal women. In Hong Kong, the formulations available are cream and tablet. These are usually prescribed biweekly or every 3 months depending on the product used and the symptom control of the patient [11, 12]. To minimise the risk of hyperplasia, the lowest dose of oestrogen should be given at longest intervals.

Endogenous testosterone levels have not been clearly linked to sexual function in postmenopausal women but exogenous testosterone has been shown to improve sexual function in women with surgical menopause [13, 14]. In a prospective trial, oral oestrogen, vaginal oestrogen and the combination of oestrogen and testosterone (tibolone) had been shown to be effective in improving various aspects of sexual function in healthy postmenopausal women [15]. In premenopausal women, testosterone therapy was also found to be effective in improving sexual desire, arousal and satisfaction [16]. However, testosterone supplementation is not approved in the United States for treating female sexual dysfunction because it lacks safety data. Possible testosterone side-effects include virilisation and reduction in high density lipoprotein cholesterol level. Testosterone can be converted into oestrogen by the aromatase enzyme in the body and thus is

contraindicated in women with breast cancer. Data on endometrial safety are limited.

With the success of phosphodiesterase type 5 inhibitors in treating male erectile dysfunction, various studies in women had been carried out. Some studies found it effective in women on antidepressants [17] and some women with multiple sclerosis [18]. Other studies did not show any treatment effectiveness in both oestrogen-replete and oestrogen-deficit women without underlying medical problems [19, 20]. Based on the limited data available, it appears that sildenafil offers little or no benefit to most women with sexual dysfunction [21].

Conclusion

Female sexuality is a complex blend of physical, psychological, emotional and sociocultural stimuli. Researchers and clinicians are still working their way through the intricacy of female sexual complaints, trying to understand both the psychological and physiological aspects of the female sexual experience and how they influence one another. There is no magic pill to treat female dysfunction yet and the assessment by an experienced professional in itself is a powerful therapeutic intervention. Couples' adherence to home exercises and their motivation to make a change is the key to success.

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A Worthwhile Baby

Dr. David Sau-yan WONG

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Dr. David Sau-yan WONG

Inspired by the sincerity of colleagues in this column, I want to share also a precious and much valued recent 'hobby' of mine.

I have always wanted to be a lawyer. I also wanted to be a doctor. When you cannot have the best of both worlds, parental wish and examination results decide, as is often the case.

So it was and twenty-seven years now from medical school, my urge to learn the law has not really diminished. In fact, in the past 7 years, I have been attempting to put myself to the test to see if the mind had not gone too rusty.

I started in 2002 as an external student of the University of London for the LLB degree. Looking back, it was a bit crazy, because the results were marked together with those of the internal students and we were ranked together. Many of course would and did attend courses of preparation organised by the local universities. I was not able to secure such regular hours of classes being a surgeon in the public service. Only knowing afterwards that the passing rate of the first year examination was 10 percent, I was indeed lucky to have wandered my way through, alone and ignorant of the tricks and shortcuts.

When it came to the second year, things got even tougher. A lot more time was needed for studying and the subject matter was a lot more difficult to understand. More references were required to be read to enable comprehension. I remarked that it was three times more difficult to do the second year and so again it was a lucky pass.

The third and last year of studying was no joke. It ended up nine times more difficult to go through on my evaluation. The developed studying skills were not even compensating for the increased amount of study needed and the time called for. The then London university degree of course was well-known for requiring no coursework. The whole assessment was based solely on a year-end closed book examination of essay questions, 45 minutes each for four per paper, alive or dead.

And so an LLB certificate but I found myself not much wiser! 'Perhaps a little more studies may help', I thought, and so I submerged back into the hard studies for the LLM, naturally with the same university.

This time it was not just studying books, learning facts, and some elementary analyses. It was self research the assessment of which were examinations as before because the syllabus consisted of many topics which one cannot find in the texts. With a prepared for death ideology, the venture was fortunately again successful.

The PCLL was the bottle-neck final common pathway through which law students get to become lawyers, and it was, in one word, 'intensive'. Part-timers underwent the same course as full-timers except that the course was in two years, each covering one of the two terms of the full-timers. Lessons were after work in the evenings, when your energy levels were already in the red region.

What kind of life was it? Chronic anxiety with over-surges, and perhaps risks of depletion, of adrenalin, combined with extreme tiredness. Mental fatigue demanded extreme caution in the selective input of information into the mind. Constantly on the hurry, days always passed just too fast. Friends unfortunately have to await second attention; social life was abstained. Meals were a luxury, often better skipped to avoid the drowsiness afterwards. Physical exercises no way, not to say sports or leisure. News was too remote to be read apart from those law-related. TV and motion pictures were never thought of. Every minute and every second were to meet planned targets or it would not be possible to make ends met. Staying up late became ridiculously much valued if the body could stand it, to allow a few more pages to be covered. Holidays and weekends were treasures as they provided for great leaps forwards. The constantly exhausted mind yet had had to remain sparkling clear always. It was a continuous challenge of managing time and a lot of information. Family fortunately was a blessing because my dear wife was forgiving.

Was that life as a dog worth it at all? These are my feelings. It was education. It enhanced my presentation skills. It helped how better to convey ideas. It trained me to be persuasive and specific. It offered alternative perspectives at problem solving. It polished my power of analysis of complex problems. It helped me to pick out critical issues. It enlarged my life circle, allowing for interaction with very many people from different disciplines and backgrounds. It gave insight into what and how people outside our profession think. More than merely learning legal rules, it involved an appreciation of history and culture, societal needs and values, and dictated inquiry into the value and meaning of the law and how the institution of law is regarded or being utilised in different ways in different countries. It improved critical skills, taught me how to appraise and

how to analyse. It widened my vocabulary and command of useful expressions. It developed further my ability to strike a better balance and to achieve a more appropriate proportionality. It educated me formally on professional ethics and etiquette. It broadened my scope of thinking. It imparted me with knowledge and confidence. It made me more goal-oriented and more skillful in setting priorities. It had simply enhanced my personal effectiveness.

It was not self torture; it was realisation of a long-time wish and its accomplishment. It was an enrichment of the mind with nutritious soup. It was self-fulfilment with delight and joy. It was indulgence. It was precious experience. It was a challenge that paid back. It was meaningful because it was difficult to achieve. It has made my medical practice safer. It is highly recommended as a pastime to those who are receptive. It is now my baby.

課程編號:C157

催眠治療臨床應用課程
(基礎訓練)

合辦機構：

香港醫學組織聯會

適健中心 The Centre on Health & Wellness
(香港復康會屬下單位)

催眠是一種心理治療介入方法之一，對於紓減壓力、處理失眠和一些情緒的困擾如：抑鬱等癥狀甚為有效。此外，催眠在改善身心健康亦有顯著的效果。現代醫療及心理輔導已將之歸納於心理治療，在歐美及台灣十分流行。本課程更專為從事護理專業的人士，目的是將催眠治療的基本技巧：如自我催眠應用於臨床工作中。

目的：

1. 協助參加者掌握正確的催眠治療知識及自我催眠的運用
2. 學習運用自我催眠技巧於相關的臨床工作
    - 改善睡眠質素
    - 舒導情緒(一)
        - 平衡與轉化情緒
        - 紓減壓力

內容：

- 一般人對催眠的誤解
- 催眠的定義、歷史及用途
- 催眠對身心的效用
- 催眠與潛意識
- 認識潛意識的力量
- 催眠能力的測試
- 自我催眠的基本概念及運用技巧
- 導入催眠意境的基本技巧
- 漸進式放鬆技巧
- 催眠治療提示的運用(直接提示)
- 改善睡眠質素的技巧
- 平衡與轉化情緒的方法
- 紓減壓力的技巧

導師：

尹婉萍小姐

(認可催眠培訓導師、註冊社工)

尹小姐擁有香港中文大學社工學士，香港大學社會科學碩士學位。她從事社區復康工作十五年，為慢性健康問題人士及其家屬提供個案輔導及小組治療服務，尤精於情緒舒導、壓力處理、家庭關係等，現時她更為香港大學社會工作及社會行政學系的臨床實習導師，教授修讀行為與身心健康碩士的學生於催眠治療與心理輔導的臨床應用。

日期　　：2010年3月5日至3月19日及4月9日 (逢星期五)
時間　　：晚上7:00至9:30
地點　　：香港灣仔軒尼詩道15號溫莎公爵社會服務大廈4字樓演講廳
教授語言：廣東話
名額　　：40人
費用　　：$1,000

如對此課程有任何查詢，可致電香港醫學組織聯會秘書處2527 8898
或電郵至info@fmshk.org

有興趣之人士可登入本網站www.fmshk.org下載報名表格，
填妥後連同有關費用以郵寄或親身交回本秘書處

延續醫學教育（CME）/持續專業發展 (CPD)之學分正在申請中
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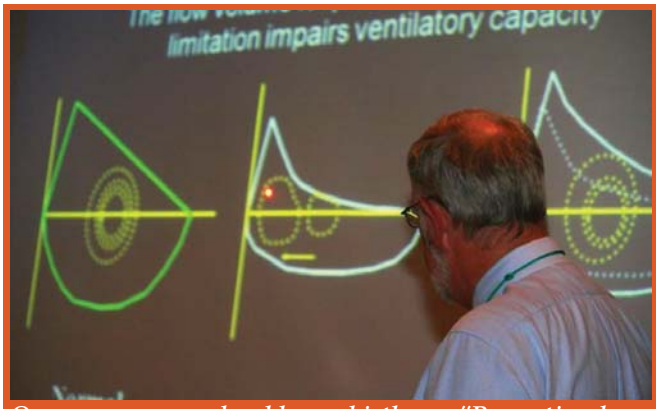
ANZSRS Respiratory Physiology Course

Judging from the overbooking of the ANZSRS Respiratory Physiology Course, an overwhelming need to keep abreast of advancements of lung function testing is an understatement for health care professionals in the city.

In anticipation of such necessity in the digital era, the **Hong Kong Thoracic Society and American College of Chest Physicians (HK & Macau Chapter)** co-organised a one-and-a half-day refresher course and workshop on 30 & 31 Oct 09 at the Ruttonjee Hospital, with support from Asian Pacific Society of Respirology (APSR) and Australian & New Zealand Society of Respiratory Science (ANZSRS).

Overseas speakers, with vast experience working in Australia and New Zealand, excited the audience with their lively presentation and useful tips in hands-on workshops; local speakers unveiled the insider story of recently published local studies on derivation of reference values of spirometry, diffusion study and its application.

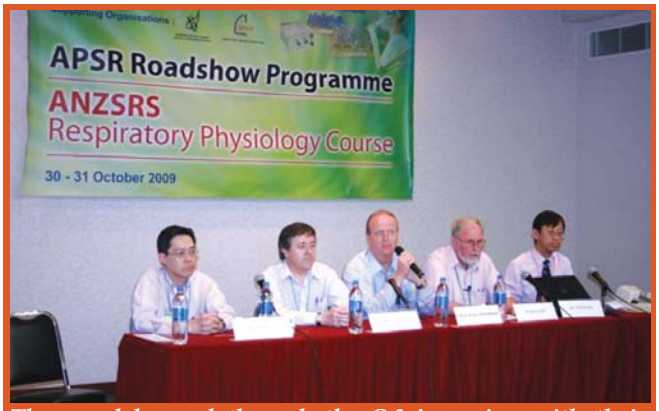
The 134 participants gave very positive responses, and are looking forward to more educational activities to be delivered by the local chest societies in the coming "**Year of the Lung 2010**".



One overseas speaker blew whistle on "Promoting lung function for the needed".


Breath- holding moments were too many to be counted in the workshop!


The hands-on section really blew in useful and memorable tips!



The panel breezed through the Q&A session with their immense knowledge.

News from Member Societies

Hong Kong College of Cardiology
Updated office-bearers for the year 2009-2010 are as follows: President: Dr. Chung-seung CHIANG; Honorary Secretary: Dr. Kam-tim CHAN; Honorary Treasurer: Dr. Shu-kin LI

Hong Kong Dental Association (Ltd.)
Updated office-bearers for the year 2009-2011 are as follows: President: Dr. Sigmund Sai-man LEUNG; Honorary Secretary: Dr. Raymond Kin-man LEE; Honorary Treasurer: Dr. Vincent Fun-shing LEUNG

The Hong Kong Ophthalmological Society
Updated office-bearers for the year 2009-2010 are as follows: President: Dr. Nancy Shi-yin YUEN; Honorary Secretary: Dr. Dexter Yu-lung LEUNG; Honorary Treasurer: Prof. Dorothy Shu-ping FAN

The Hong Kong Society of Dermatology & Venereology
Updated office-bearers for the year 2009-2010 are as follows: President: Dr. King-man HO; Honorary Secretary: Dr. Kwok-hung YEUNG; Honorary Treasurer: Dr. Chi-keung YEUNG

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

Central & Western District Health Festival 2009/10

HKFMS Foundation Limited has been actively involved in the Central & Western Health Festivals in the past years and we continue our support. This year, the festival was held at the Smithfield Sports Centre, Kennedy Town on 7th and 8th November and the Foundation organised four booths.

From left to right: Dr. Raymond LO, 1st Vice President of The HKFMS Foundation Limited; Dr. Dawson FONG, President of The HKFMS Foundation Limited; Mr. Nelson WONG, Chairman of Working Group on Health & Rehabilitation Service, Central & Western District Council; Mrs. Winnie HO, District Officer, Central & Western

Under the leadership of Dr. Raymond Lo, chairman of the organising committee, we arranged various health checks to promote the well-beings of participants - eye checks performed by PolyVision; dental oral checks performed by dentists; elderly fall risk screening, cognitive assessment and general physical function tests performed by the Hong Kong Occupational Therapy Association; and BMI and fat proportion measurement performed by the Foundation.

Grateful thanks were due to our collaborating parties - PolyVision and Hong Kong Occupational Therapy Association, and Dr. Sai Kwing CHAN who liaised for us several volunteer dentists to help out on site for the dental checks.

Participants lining up for eye checks

What is your body mass index? Your fat proportion?

Assessment tests for the elderly

Participants learnt how to do exercises with the theraband

Oral checks done by a team of dentists

Special thanks should also go to Mr. Ernest Yu and Dr. Henry Ho for delivering health talks that were highly welcomed by the general public in health promotion.

Health talk on elderly care delivered by Mr. Ernest Yu

Health talk on oral care delivered by Dr. Henry Ho

Last but not least, we would like to express our heartiest thanks to our sponsors, Abenefits Limited, Colgate, SureCare Medical and Health Network, and the International Medical Co. Ltd. for their support, both financially and in gifts donation.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		* HKMA-Tai Po Community Network - Post-prandial Hyperglycemia and Cardiac Outcomes * FMSHK Officers' Meeting **1**	**2**	* Singing Course * HKMA Council Meeting **3**	* Joint Surgical Symposium - Striving toward Zero Morbidity in Thyroid Surgery * HKMA CME - Updates in Joint and Back Pain **4**	* 2nd HKMA Table-Tennis Training Course **5**
* HKMA Certificate Course on Family Medicine 2009 * HKMA Tennis Tournament **6**	**7**	* HKMA Kowloon West Community Network - Chest Inflection * HKMA Tai Po Community Network - Pre-surgical Treatment of Painful Joints **8**	* Hong Kong Neurosurgery Society Monthly Academic Meeting - Unruptured Cerebral Aneurysms : To Treat or Not To Treat ? * HKMA Central, Western and Southern Community Network - Certificate Course on Dermatology (I) & (II) * HKMA Yau Tsim Mong Community Network - Annual General Meeting **9**	* Singing Course * HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2009 - Radiology - What's New? **10**	* HKMA - Shatin Doctors Network - Modern Concepts in Managing Isolated Systolic Hypertension **11**	* Advanced Medical Life Support (AMLS) Provider Course **12**
* HKMA Tennis Tournament * Advanced Medical Life Support (AMLS) Provider Course * 4th Seasonal Photo Sharing Session * HKMA Structured CME Programme with PMH Year 2009 (11) - 1) DM Photo Screening in KWC * Joint Professional Table-Tennis Tournament (tbc) **13**	**14**	**15**	* HKMA Central, Western and Southern Community Network - Certificate Course on Dermatology (I) & (II) * HKMA - Shatin Doctors Network - Nasal Problems and Nasal Sprays **16**	* FMSHK Executive Committee Meeting **17**	**18**	* HKMA KE Network - HBV Inflection Update **19**
20	**21**	* HKMA Tai Po Community Network - CME Course on Maintaining Bone Health and Preventing Falls and Fractures in the Elderly (IV) **22**	**23**	**24**	**25**	**26**
27	**28**	**29**	**30**	* The Federation Annual Dinner 2009 * HKMA 89th Anniversary Ball **31**		

Date / Time	Function	Enquiry / Remarks
1 TUE 1:00 pm	**HKMA-Tai Po Community Network - Post-prandial Hyperglycemia and Cardiac Outcomes** Organiser: HKMA-Tai Po Community Network, Speaker: Dr. TONG Chun Yip Peter, Venue: Tai Po	Miss Viviane LAM Tel: 2527 8452 1.5 CME Points
8:00 pm - 10:00pm	**FMSHK Officers' Meeting** Organiser: The Federation of Medical Societies of Hong Kong, Venue: Gallop, 2/F., Hong Kong Jockey Club Club House, Shan Kwong Road, Happy Valley, Hong Kong	Ms. Paulina TANG Tel: 2527 8898 Fax: 2865 0345
3 THU 7:00 pm *(10)*	**Singing Course** Organiser: The Hong Kong Medical Association, Venue: 油麻地海燕音樂學院	Ms. Dora HO Tel: 2527 8285
8:00 pm	**HKMA Council Meeting** Organiser: The Hong Kong Medical Association, Chairman: Dr. H.H. TSE, Venue: HKMA Head Office, 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong	Ms. Christine WONG Tel: 2527 8285
4 FRI 8:00 am - 9:00 am	**Joint Surgical Symposium - Striving toward Zero Morbidity in Thyroid Surgery** Organiser: Department of Surgery, The University of Hong Kong & Hong Kong Sanatorium & Hospital, Chairman: Dr. SIU Wing Tai, Speakers: Dr. Brian LANG & Dr. CHOW Man Po, Venue: Hong Kong Sanatorium & Hospital	Department of Surgery, Hong Kong Sanatorium & Hospital Tel: 2835 8698 Fax: 2892 7511 1 CME Point (Active)
1:00 pm	**HKMA CME - Updates in Joint and Back Pain** Organiser: The Hong Kong Medical Association, Speaker: Dr. HUNG Hak Hon, Venue: The HKMA Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	Miss Viviane LAM Tel: 2527 8452 1 CME Point
5 SAT 4:00 pm	**2nd HKMA Table-Tennis Training Course** Organiser: The Hong Kong Medical Association, Kowloon Park Sports Centre	Ms. Dora HO Tel: 2527 8285
6 SUN 2:00 pm	**HKMA Certificate Course on Family Medicine 2009** Organiser: The Hong Kong Medical Association, Speakers: Dr. WU Wing Keung Ricky & Dr. CHAN Yee Shing Alvin, Venue: Queen Elizabeth Hospital, Kowloon	Miss Viviane LAM Tel: 2527 8452 3 CME Points
8:00 pm *(13)*	**HKMA Tennis Tournament** Organiser: The Hong Kong Medical Association, Venue: Kowloon Tong Club	Ms. Dora HO Tel: 2527 8285
8 TUE 1:30 pm	**HKMA Kowloon West Community Network - Chest Inflection** Organiser: HKMA Kowloon West Community Network, Speaker: Dr. LAM Bing, Venue: Panda Hotel, Tsuen Wan	Miss Alice TANG Tel: 2527 8285
1:45 pm	**HKMA Tai Po Community Network - Pre-surgical Treatment of Painful Joints** Organiser: HKMA Tai Po Community Network, Speaker: Dr. LEE Wai Keung Edison, Venue: Tai Po	Miss Alice TANG Tel: 2527 8285 1.5 CME Points
9 WED 7:30 am	**Hong Kong Neurosurgery Society Monthly Academic Meeting - Unruptured Cerebral Aneurysms : To Treat or Not To Treat ?** Organiser: Hong Kong Neurosurgical Society, Chairman: Dr. CHENG Kin Ming, Speaker: Dr. WOO Yat Ming Peter, Venue: Seminar Room, G/F., Block A, Queen Elizabeth Hospital, Kowloon	Dr. Y.C. PO Tel: 2990 3788 Fax: 2990 3789 2 CME Points
1:30 pm *(16)*	**HKMA Central, Western and Southern Community Network - Certificate Course on Dermatology (I) & (II)** Organiser: HKMA Central, Western and Southern Community Network, Chairman: Dr. P.Y. YIK & Dr. CHAN Kit Ling Amy, Speakers: Dr. CHONG Lai Yin & Dr. CHAN Hau Ngai Kingsley, Venue: The HKMA Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	Miss Alice TANG Tel: 2527 8285
1:30 pm	**HKMA Yau Tsim Mong Community Network - Annual General Meeting** Organiser: HKMA Yau Tsim Mong Community Network, Chairman: Dr. C.P. HO, Speakers: Dr. CHAK Wai Leung & Dr. HO Chung Ping, Venue: Eaton Hotel Hong Kong, Kowloon	Miss Alice TANG Tel: 2527 8285
10 THU 2:00 pm	**HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2009 - Radiology - What's New?** Organiser: The Hong Kong Medical Association, Speaker: Dr. CHAN Ka Fat John, Venue: The HKMA Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	Miss Viviane LAM Tel: 2527 8452 1 CME Point
11 FRI 1:00 pm	**HKMA - Shatin Doctors Network - Modern Concepts in Managing Isolated Systolic Hypertension** Organiser: HKMA - Shatin Doctors Network, Speaker: Dr. CHAN Wai Kwong Andy, Venue: Shatin	Ms. Mandy LAU Tel: 2506 8694 1 CME Point
12 SAT *(13)*	**Advanced Medical Life Support (AMLS) Provider Course** Organiser: Department of Surgery, Queen Mary Hospital & Hong Kong Chapter of the American College of Surgeons, Venue: The Jockey Club Skills Development Centre, C3, Main Block, Queen Mary Hospital, Pokfulam, Hong Kong	Course Administrator, Tel: 2855 4885 / 2855 4886, Fax: 2819 3416, Email: hnsrg@hkucc.hku.hk Web site: http://www.hku.hk/surgery
13 SUN 2:00 pm	**4th Seasonal Photo Sharing Session** Organiser: The Hong Kong Medical Association, Venue: HKMA Head Office, 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Dora HO Tel: 2527 8285
2:00 pm	**HKMA Structured CME Programme with PMH Year 2009 (11) - 1) DM Photo Screening in KWC** Organiser: The Hong Kong Medical Association, Speaker: Dr. TSE Ka Tai Taylor, Venue: Princess Margaret Hospital, Kowloon	Miss Viviane LAM Tel: 2527 8452 2 CME Points
2:00 pm	**Joint Professional Table-Tennis Tournament (tbc)** Organiser: The Hong Kong Medical Association	Ms. Dora HO Tel: 2527 8285
16 WED 1:00 pm	**HKMA - Shatin Doctors Network - Nasal Problems and Nasal Sprays** Organiser: HKMA-Shatin Doctors Network, Speaker: Dr. CHAN Wing Kwan Anthony, Venue: Shatin	Ms. Queenie HO Tel: 2839 4320 1 CME Point

Date / Time	Function	Enquiry / Remarks
17 THU 7:00 pm - 8:00 pm	**FMSHK Executive Committee Meeting** Organiser: The Federation of Medical Societies of Hong Kong, Venue: Council Chambers, 4/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Paulina TANG Tel: 2527 8898 Fax: 2865 0345
19 SAT 1:30 pm	**HKMA KE Network - HBV Inflection Update** Organiser: HKMA KE Network & UCH, Chairman: Dr. TSANG Man Wo, Speaker: Dr. Vincent LEUNG, Venue: Lecture Theatre, G/F, Block P, United Christian Hospital, Kowloon	Miss Alice TANG Tel: 2527 8285 2 CME Points
21 MON 1:45 pm	**HKMA Tai Po Community Network - CME Course on Maintaining Bone Health and Preventing Falls and Fractures in the Elderly (IV)** Organiser: HKMA Tai Po Community Network, Venue: Chiuchow Garden Restaurant, Tai Po, New Territories	Miss Alice TANG Tel: 2527 8285
31 THU 7:00 pm	**The Federation Annual Dinner 2009** Organiser: The Federation of Medical Societies of Hong Kong, Venue: Run Run Shaw Hall, The Hong Kong Academy of Medicine Jockey Club Building, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong	Ms. Paulina TANG Tel: 2527 8898
7:00 pm	**HKMA 89th Anniversary Ball** Organiser: The Hong Kong Medical Association, Venue: Conrad Hong Kong, Pacific Place, 88 Queensway, Hong Kong	Ms. Candy YUEN Tel: 2527 8285

Meetings

9/1/2010	**Hong Kong Surgical Forum - Winter 2010** Organiser: Department of Surgery, the University of Hong Kong, Queen Mary Hospital & Hong Kong Chapter of American College of Surgeons, Venue: Undeground Lecture Theatre, New Clinical Building, Queen Mary Hospital, Pokfulam, Hong Kong, Enquiry: Forum Secretary, Tel: 2855 4855 / 2855 4886, Fax: 2819 3416, Email: hksf@hkucc.hku.hk, Website: http://www3.hku.hk/surgery/forum.php

Rental Fees of Meeting Room and Facilities at The Federation of Medical Societies of Hong Kong

(Effective from October 2009)

Venue or Meeting Facilities	Member Society (Hourly Rate HK$)			Non-Member Society (Hourly Rate HK$)		
	Peak Hour	Non-Peak Hour	All day Sats, Suns & Public Holidays	Peak Hour	Non-Peak Hour	All day Sats, Suns & Public Holidays
Multifunction Room I *(Max 15 persons)*	150.00	105.00	225.00	250.00	175.00	375.00
Council Chamber *(Max 20 persons)*	240.00	168.00	360.00	400.00	280.00	600.00
Lecture Hall *(Max 100 persons)*	300.00	210.00	450.00	500.00	350.00	750.00

Non-Peak Hour: 9.30 am - 5.30 pm
Peak Hour: 5.30pm - 10.30pm

LCD Projector	500.00 per session
Microphone System	50.00 per hour, minimum 2 hours

NOTES:

1. Rental Hours: Monday - Sunday 9:30 a.m. - 10.30 p.m.
2. Hirer will be liable to pay an **extra hour** of room charge if the booked session is not completed within **15 minutes at the end of the rental period.**
3. Cancellation of room reservation will only be accepted in writing and **NOT less than two weeks before the date of rental. Insufficient notice will require FULL payment of rental fees.** The fee conditions are subject to review at the discretion of the Federation.
4. There will be a surcharge of 20% of the total food and drink cost if such is served in the meeting facilities. An extra deposit of HK$1,000 is required when booking the facilities and will be returned if cleaning or repair is not required after the rental.
5. When typhoon signal no. 8 or black rainstorm warning signal is hoisted, all meeting facilities will be closed and the rental charges will be refunded. The facilities will reopen two hours after typhoon signal no. 8 or the black rainstorm warning signal is lowered.
6. For enquiry and booking, please contact the Secretariat on 2527 8898.

Answer to Radiology Quiz

Diagnosis:

Rt sided conductive hearing loss due to disruption of ear ossicles.

Radiological Findings:

1. Disruption of Rt incus and stapes is noted.
2. Rt malleus and incus connection can be seen (Fig2,4).
3. Long process of Rt malleus and stapes cannot be seen.
4. No ear ossicle is connected to the Rt oval window (Fig4,5).
5. Compared to the normal Lt ear:
   i. Malleus/incus complex can be seen (Fig1).
   ii. Incus and stapes can be seen (Fig3).
   iii. Stapes is connected to the Lt oval window (Fig3).

Discussion:

Disruption of ear ossicles is one of the common causes of conductive hearing loss.
High resolution CT of temporal bone is the imaging of choice for investigation.
The most common site of abnormality is usually located at the site of connection between the long process of incus and stapes.

Dr. Wendy LAM
Consultant Radiologist, Queen Mary Hospital

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* *Study Design: In a randomized, placebo-controlled phase 2 trial of 551 women 16 to 23 years of age, a subset of 241 participants was enrolled in an extension of the study to obtain an additional 2 years of follow-up data for safety, efficacy, and immunogenicity. Subjects in the extension phase had additional follow-up visits at Months 54 and 60. The efficacy of GARDASIL against Human Papillomavirus 6-, 11-, 16-, or 18- related disease was 100% [95% CI, 12.4-100.0]. There were no cases of Human Papillomavirus 6-, 11-, 16-, or 18- related precancerous cervical dysplasia or genital warts in the GARDASIL group (n=235) vs 6 cases in the placebo group (n=233).[1] The GMTs of anti-HPV 6,11,16,18 after vaccination peaked at month 7 then decreased and stabilized above baseline throughout 5 years.*

References:
1. Villa LL. High sustained efficacy of a prophylactic quadrivalent human papillomavirus types 6/11/16/18 L1 virus-like particle vaccine through 5 years of follow-up. Br J Cancer. 2006;95:1459-1466. 2. GARDASIL Hong Kong Product Circular

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References:

1. Data on file (BSP Hong Kong)
2. Klipping C, et al. Contraception 2008; 78:16-25
3. Bachmann G, et al. Contraception 2004; 70(3): 191-8
4. Yonkers KA, et al. Obstet Gynecol 2005; 106(3): 492-501
5. YAZ® Product Insert (BHC Hong Kong)

YAZ® Abbreviated Prescribing Information [1,5]: YAZ® consists of 24 active tablets containing 3mg drospirenone and 0.02mg ethinylestradiol together with 4 placebo tablets. Take once daily at about the same time. Indication: Hormonal oral contraception. Contraindication: Presence or history of venous or arterial thromboembolic events or of a cerebrovascular accident; presence or history of prodromi of a thrombosis; history of migraine with focal neurological symptoms; diabetes mellitus with vascular involvement; severe or multiple risk factor(s) for venous or arterial thrombosis; pancreatitis or history associated with severe hypertriglyceridemia; presence or history of severe hepatic disease as long as liver function values have not returned to normal; severe renal insufficiency or acute renal failure; presence or history of liver tumors; known or suspected sex-steroid influenced malignancies; undiagnosed vaginal bleeding; known or suspected pregnancy; hypersensitivity to the ingredients. Side Effects: Nausea, abdominal pain, weight increased, headache, depressed mood, mood altered, breast pain, breast tenderness. For less common side effects, please see package insert.

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