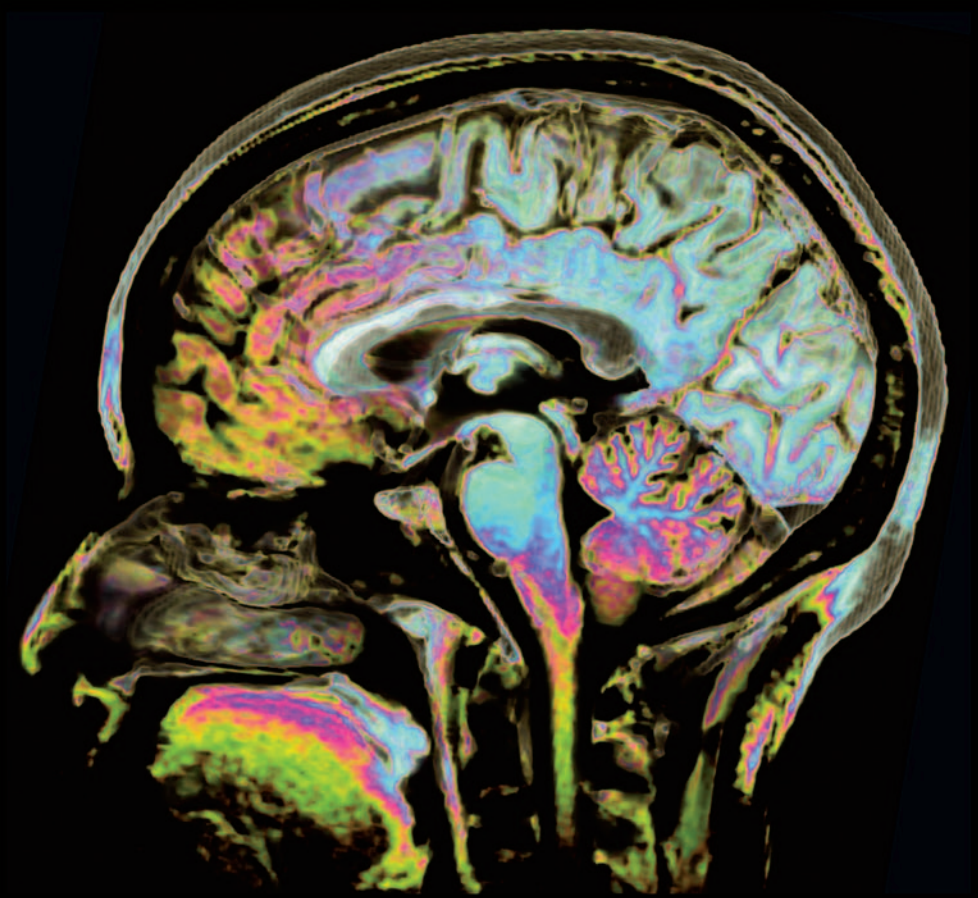
www.fmshk.org

THE HONG KONG MEDICAL DIARY

香 港 醫 訊

VOL.17 NO.8 AUGUST 2012

Psychiatry



OFFICIAL PUBLICATION FOR THE FEDERATION OF MEDICAL SOCIETIES OF HONG KONG ISSN 1812 - 1691

Valdoxan® 25 mg

Agomelatine

The first melatonergic antidepressant

RESETTING the biological clock for unique relief at EACH STEP of depression

NEW IN DEPRESSION

Week 1 Week 6 Week 12 Week 24

3 responders out of 4 [1]

3 remitters out of 4 [2]

8 relapse-free out of 10 [3]

Improvement in feeling good, daytime functioning and quality of sleep [1]

1 tablet at bedtime

1. Lemoine P, Guilleminault C, Alvarez E. Improvement of subjective sleep in major depression with a novel antidepressant, agomelatine: randomized, double-blind comparison with venlafaxine. *J Clin Psychiatry.* 2007;68:1723-1732.
2. Kennedy S.H, Rizvi S, Fulton K, et al. A double-blind comparison of sexual functioning, antidepressant efficacy and tolerability between agomelatine and venlafaxine-XR. *Clin Psychopharmacology.* 2008;28(3):329-333.
3. Goodwin G.M, Emsley R, Rembry S, et al. Agomelatine prevents relapse in patients with major depressive disorder without evidence of a discontinuation syndrome: a 24-week randomized, double-blind, placebo-controlled trial. *J Clin Psychiatry.* 2009;70:1128-1137.

Presentation and Composition: Each film-coated tablet contains 25 mg of agomelatine. **Indication:** Treatment of major depressive episodes in adults. **Properties:** Antidepressant. Melatonergic agonist (MT_1 and MT_2 receptors) and $5HT_{2C}$ antagonist. No influence on extracellular levels of serotonin. Proven antidepressant efficacy including in severe depression. Sustained antidepressant efficacy preventing relapse. Improvement of onset and quality of sleep, without daytime clumsiness from the first week of treatment. No discontinuation symptoms, or effects on sexual function, body weight, heart rate, or blood pressure. **Contraindications:** Hypersensitivity to the active substance or any excipient, hepatic impairment, concomitant use with potent CYP1A2 inhibitors (e.g. fluvoxamine, ciprofloxacin). **Dosage:** The recommended dose is 25 mg once daily taken orally at bedtime. After 2 weeks, the dose may be increased to two 25 mg tablets. **Interactions:** Combination of Valdoxan and alcohol is not advisable. Side effects: Common: headache, dizziness, somnolence, insomnia, migraine, nausea, diarrhea, constipation, upper abdominal pain, hyperhidrosis, back pain, fatigue, anxiety, increases serum transaminases. **Precautions:** Not recommended in patients under 18 years old, pregnant woman and during breast-feeding. Not for use in elderly patients with dementia. Use with caution in patients with a history of mania or hypomania and discontinue therapy if manic symptoms appear. Possible effects on the ability to drive a car or operate machinery. Perform liver function tests when initiating treatment, periodically after around 6, 12 and 24 weeks, and thereafter when clinically indicated. Perform liver function tests in patients with symptoms suggesting hepatic dysfunction. Do not use in patients with galactose intolerance or glucose-galactose malabsorption. As prescribing information may vary from country to country, please refer to the complete data sheet supplied in your country. **LES LABORATOIRES SERVIER France.** Correspondent: **SERVIER INTERNATIONAL:** 35 rue de Verdun, 92284 Suresnes Cedex, France. **www.servier.com www.valdoxan.com**

For further information, please contact:
Servier Hong Kong Ltd., Room 4201 - 03, 42/F, 248 Queen's Road East, Wan Chai, Hong Kong.
Tel: 2577 1922

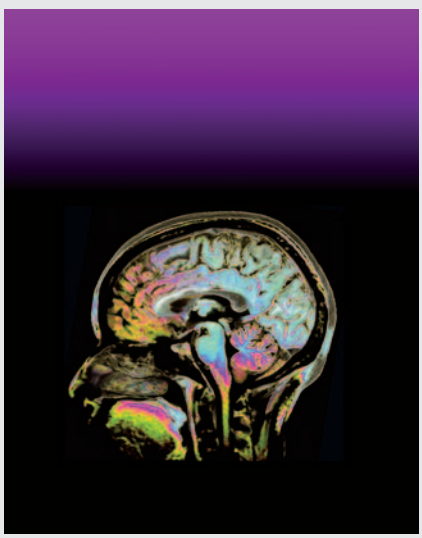
www.servier.com

SERVIER

Contents

Disclaimer

The Cover Shot



Colors in the Brain

Although different parts of the brain show similar appearance on grey-scale conventional MRI representation, the artistic color representation generated from 3D MRI data developed by Dr. Fung did review striking difference in various parts of the human brain.

Could this be useful in scientific analysis?

Dr. Kai-hung FUNG
MBBS, FRCR, FHKCR, FHKAM
Consultant Radiologist
Pamela Youde Nethersole Eastern Hospital

Published by
The Federation of Medical Societies of Hong Kong

Design and Production
A-PRO MULTIMEDIA LTD www.apro.com.hk

Editorial

Dr. Eric FC CHEUNG

M.B.,B.S.(HK); FRCPsych(UK); FHKCPsych; FHKAM(Psychiatry)
Specialist in Psychiatry, Consultant, Castle Peak Hospital.

Editor

Dr. Eric FC CHEUNG

Although it is well recognised that common mental disorders such as anxiety and depression are associated with significant physical, economic and social disabilities, Hong Kong has no accurate local epidemiological data to guide mental health care planning at both the specialist and primary care levels. To address this gap in knowledge and with support from the HKSAR Government, the Hong Kong Mental Morbidity Survey, currently in its second year of data collection, is the first territory-wide population-based epidemiological study that aims to determine the prevalence of mental disorders in working age adults in Hong Kong. In this issue of the Medical Diary, the research team, which consists of psychiatrists from all major departments of psychiatry in Hong Kong, reports their preliminary insights from their interim analysis of the first 2,217 participants.

While accurate data on prevalence will help to guide service development on a macroscopic level, at the individual level, the provision of the most up-to-date and evidence-based treatment remains the most essential element of clinical practice for individual practitioners. This is why we have also included several articles on updates in the management of several common mental disorders in this issue of the Medical Diary. Dr. William Chui's article presents a concise update on the assessment and management of generalised anxiety disorder, one of the most commonly encountered mental disorders in primary care; while Dr. Bonnie Siu's informative piece on postpartum depression provides readers with a comprehensive overview of the significance and potential effects of this disorder on not only the mother but perhaps more importantly, the developing child.

Sleeplessness or insomnia is commonly associated with many mental disorders. However, the clinical phenomenon of excessive sleepiness is seldom explored in detail. Dr. Samson Fong's systematic dissection of the problem and discussion on the differential diagnoses and management of excessive sleepiness in this issue aptly addresses this gap in knowledge. Last but not least, in this issue's update on drug therapy, Dr. WC Chan, an expert in old age psychiatry, has contributed a comprehensive review on the use of cholinesterase inhibitors in cognitive disorders.

On a lighter note, and in the spirit of a recovery-oriented approach in mental health care, we have also included an article by Dr. Ivan Mak, who chronicled the interesting process of incorporating photography in helping remitted mental patients on their road to recovery.

This issue represents the collective work of selected members of the Hong Kong College of Psychiatrists. I hope readers would find this issue on mental health both educational and thought-stimulating.

Atypical power in major depressive disorder and generalised anxiety disorder

- Symptom relief* as early as Week 1 in MDD and Day 4 in GAD[1-3]
- Broad-spectrum improvement including insomnia[1-5]
- Prevention of recurrence with good tolerability[4-6]

*measured by MADRS total score for MDD and HAM-A total score for GAD

AstraZeneca

Further information is available on request.

AstraZeneca Hong Kong Limited
18/F, Shui On Centre, 6-8 Harbour Road, Wanchai, Hong Kong
Tel:2420 7388 Fax:2422 6788

長效思緒康™
Once Daily
Seroquel XR™
quetiapine

Abbreviated Prescribing Information:

Presentation: Quetiapine fumarate extended-release tablet. **Indications: Bipolar Disorder:** Maintenance treatment of bipolar I disorder, as monotherapy or in combination with lithium or sodium valproate, for the prevention of relapse/recurrence of manic, depressive or mixed episodes. Treatment of depressive episodes associated with bipolar disorder; Treatment of acute mania associated with bipolar I disorder as monotherapy or in combination with lithium or sodium valproate **Schizophrenia:** Treatment of schizophrenia, prevention of relapse and maintenance of clinical improvement during continuation therapy. **Major Depressive Disorder:** Treatment of recurrent major depressive disorder (MDD) in patients who are intolerant of, or who have an inadequate response to alternative therapies. **Generalised Anxiety Disorder:** treatment of generalized anxiety disorder (GAD). **Dosage: Schizophrenia:** Once-daily in the evening. Initial dose: 300 mg (Day 1), 600 mg (Day 2) and up to 800 mg after Day 2. Range 400-800 mg/day depending on clinical response & tolerability of patient. Same dosage is used for maintenance therapy. **Bipolar Disorder:** Acute Mania: Starting daily dose is: 300 mg (Day 1) & 600 mg (Day 2) & up to 800 mg (after Day 2), alone or in combination with a mood stabilizer. Range 400-800 mg/day. **Bipolar Depression:** Starting dose is 50mg (Day 1) & 100 mg (Day 2) & 200 mg (Day 3) & 300 mg (Day 4). Titration can be up to 400 mg on Day 5 and up to 600 mg by Day 8. **Maintenance treatment:** Use same dose as active treatment for prevention of manic, depressive or mixed episodes in bipolar disorder. Range: 300-800 mg/day. **Recurrent major depressive disorder:** Once-daily in the evening. Initial dose: 50 mg (Day 1 & 2), increased to 150 mg on Day 3 & 4. Usual effective dosage: 150 mg. Range of 50 – 300 mg/day. Same dosage is used for maintenance. **Generalised Anxiety Disorder:** Initial dose: 50 mg (Day 1 & 2), increased to 150 mg on Day 3 & 4. Range of 50 – 150 mg/day. **Switching from Seroquel IR:** Switch at equivalent total daily dose. Individual adjustments may be necessary. *Elderly or hepatic impairment patients:* Slower dose titration is recommended. Initial dose: 50 mg/day up to target dose depending on clinical response and tolerability of patient. In elderly MDD, initial dose: 50 mg (Day 1-3), increased to 100 mg (Day 4), 150 mg (Day 8) and then up to 300 mg. In elderly GAD, initial dose: 50 mg (Day 1-3), increased to 100 mg (Day 4), up to 150 mg on day 8. *Renal impaired patients:* No dosage adjustment needed. **Contraindications:** Hypersensitive to the active substance or excipients of this product. **Precautions:** Not recommended for below 18y old; clinical worsening and suicide risk associated with psychiatric disorders; somnolence; severe neutropenia; known cardiovascular & cerebrovascular disease; Conditions predisposing to hypotension; orthostatic hypotension; extrapyramidal symptoms; history of seizures; tardive dyskinesia; neuroleptic malignant syndrome; not approved in elderly patients with dementia-related psychosis; established diabetes mellitus; dysphagia; jaundice development; venous thromboembolism; galactose intolerance; pregnancy & lactation. **Interactions:** CYP3A4 inhibitors; centrally acting drugs; grapefruit juice thioridazine; lorazepam; levodopa and dopamine agonists; carbamazepine, phenytoin, ketoconazole; ADHD medications & cardiovascular medicines that cause electrolyte imbalance or to increase QTc interval. **Undesirable effects:** Tachycardia; vision blurred; mild asthenia; peripheral edema; irritability; increased appetite; dysarthria; elevations in serum transaminases (ALT, AST), syncope; rhinitis; abnormal dreams & nightmares and elevations in serum prolactin. **Full local prescribing information is available upon request. API.HK.SXR.0810**

References: 1. Cutler AJ et al. J Clin Psychiatry 2009; 70(4): 526-539. 2. Bauer M et al. J Affect Disord 2010; 127: 19-30. 3. Bandelow B et al. Int J Neuropsychopharmacol 2010; 13: 305-320. 4. Liebowitz M et al. Depression and Anxiety 2010; 27: 964-976. 5. Katzman MA et al. Int Clin Psychopharmacol 2011; 26: 11-24. 6. Seroquel XR Package Insert Version: August 2010.

MDD: Major Depressive Disorder; GAD: Generalised Anxiety Disorder; MADRS: Montgomery Åsberg Depression Rating Scale; HAM-A: Hamilton Rating Scale – Anxiety

HK.1511.0811.001 09/2011

Update on Pharmacological Management of Generalised Anxiety Disorder

Dr. William CHUI

MBBS (HK), MRCPsych(UK), FHKCPsych, FHKAM(Psychiatry)
Associate Consultant, Castle Peak Hospital

Dr. William CHUI

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 1 CME credit under the programme upon returning the completed answer sheet to the Federation Secretariat on or before 31 August 2012.

Introduction

Generalised anxiety disorder (GAD) is one of the several disorders within the anxiety spectrum disorders. Anxiety spectrum disorders are characterised by excessive anxiety which is distressing and adversely affect functioning. Such abnormal anxiety takes two major patterns - generalised versus episodic. In GAD, there is a generalised and free-floating anxiety which does not happen in episodes and is not associated with a specific situation, but lasts for days and months, running in a milder severity and is related to a wide range of normal daily events. The patient has excessive worry on trivia, difficulty in controlling such worry, and is apprehensive for most days over a period of at least six months.[1] The patient also has symptoms like restlessness, palpitations, dry mouth, sweating, easy fatigability, difficulty in concentrating, muscle tension and sleep disturbance.

GAD is common. The lifetime prevalence in the general population is around 5–6%.[2] About 90% of patients with GAD have at least one co-morbid lifetime psychiatric disorder[3], and co-morbidity with major depression is present in 60%.[4] In diagnosing GAD, it is important to exclude anxiety due to a physical illness, such as hyperthyroidism, or anxiety as a complication of substance misuse disorders, particularly alcohol misuse.[5] GAD is associated with substantial social dysfunction[6] and poor quality of life.[7] The functional impairment associated with GAD is similar in severity to that seen with major depressions.[8] Treating GAD may prevent the development of major depression.[9]

Treatment approaches in GAD

A stepped-care approach is recommended for the treatment of GAD. Treatment should take into account the patients' needs and preferences, and patients should have the opportunity to make informed decisions about their treatment.[10]

A patient with mild GAD should first be offered low-intensity psychological interventions which include education on the diagnosis and means of self-help. If the patient fails to improve with these interventions, or the GAD is associated with marked functional impairment, the patient should be offered an individual high-intensity psychological intervention (cognitive behavioural therapy or applied relaxation) or pharmacological treatment. There is no evidence that either mode of treatment (individual high-intensity psychological intervention or pharmacological treatment) is better.[10] It is also uncertain whether it is more helpful to combine pharmacological and psychological approaches in GAD, compared to using a single approach alone.[11]

First-line pharmacological treatment of GAD

The first-line pharmacological treatment of GAD, as recommended by the National Institute for Health and Clinical Excellence (NICE) in the United Kingdom, is a selective serotonin reuptake inhibitor (SSRI), such as citalopram, escitalopram, fluoxetine, paroxetine, and sertraline. Serotonin–noradrenaline reuptake inhibitors (SNRI), such as duloxetine and venlafaxine and the newer anxiolytic drug pregabalin, are alternative choices.[10]

Selective serotonin reuptake inhibitors (SSRI) and serotonin–noradrenaline reuptake inhibitors (SNRI)

Abnormalities of serotonergic and noradrenergic neurotransmission have been found in patients with GAD. Serotonin is involved in the mediation of anxiety, through serotonergic innervation of the limbic system, hypothalamus and thalamus.[12] Patients with GAD could have a specific cognitive bias that leads to increased attention to threat-related information and to misinterpretation of ambiguous stimuli as threatening; this bias has been shown to diminish after SSRI treatment.[13]

A SSRI or SNRI should be initially prescribed at half the normal starting dose for the treatment of depression and titrated upwards into the normal antidepressant dosage range as tolerated.[14] The patient should be reminded that initial worsening of anxiety may be seen when the SSRI or SNRI is started. It might take up to four weeks to show effectiveness but clinically significant improvement may be noted after as early as two weeks.[15] There is still uncertainty about how long an initial SSRI or SNRI for GAD should continue,

before it is reasonable to conclude that the chance of responding is too low to justify continuing with the current medication. It has been suggested that if an onset of efficacy (reduction of score in the Hamilton Anxiety Rating Scale of more than 20%) is not seen after four to six weeks of treatment, the likelihood of eventual response is low.[16] There is insufficient evidence to define an optimal duration of treatment, as few randomised controlled trials (RCTs) of the treatment of patients with GAD examined outcomes beyond early response to acute treatment. A treatment duration of at least one year has nevertheless been recommended.[9] Therefore, when prescribing medications for GAD, doctors should counsel patients that they will not respond immediately and that long-term treatment is often needed to maintain the initial response.[17]

Different SSRIs and SNRIs have similar efficacy for GAD. Some differences in efficacy were shown in a few trials, but often the differences could be explained by different dosages, and these differences tend to diminish in meta-analyses.[18] The NICE recommended sertraline as the first choice SSRI, because it is the most cost-effective. If sertraline is ineffective, an alternative SSRI or a SNRI should be offered, taking into account the tendency to produce a withdrawal syndrome (especially with paroxetine and venlafaxine), the side-effect profile and the potential for drug interactions, the risk of suicide and likelihood of toxicity in overdose (especially with venlafaxine), and the person's prior experience of treatment with individual drugs. If the person cannot tolerate SSRIs or SNRIs, pregabalin should be considered.[10]

Pregabalin

Pregabalin is a new anxiolytic that has been recently licensed for the treatment of GAD in Europe.[19] Pregabalin binds potently to the alpha-2-delta protein, an auxiliary subunit associated with voltage-gated calcium channels. Potent binding at this site reduces calcium influx at nerve terminals and eventually leads to anxiolytic activity.[20]

Several RCTs had demonstrated its efficacy and tolerability and comparable speed of onset of action to a benzodiazepine.[3] The effect on cognitive function is minimal and notably less than that observed with benzodiazepines. Discontinuation symptoms following abrupt treatment cessation are similar to the rates with SSRIs and lower than with benzodiazepines with no sign of tolerance or dependence.[19] Nevertheless, pregabalin should not be stopped abruptly as it may precipitate seizure.[14]

Other pharmacological treatments of GAD

Benzodiazepine

The gamma-aminobutyric acid (GABA)/benzodiazepine receptor system is implicated in the pathophysiology of GAD.[21] Benzodiazepine has been established, in meta-analysis of randomised controlled trials, as an effective and rapid treatment for many patients with GAD. However, benzodiazepine is far from ideal in the treatment of GAD, having limited efficacy against co-morbid depressive symptoms. Benzodiazepine also has side-effects of sedation, memory disruption and psychomotor impairment. Benzodiazepine is associated with risk of dependence after long-term use[22], and might lead to requests for long-term prescription. There can be distressing withdrawal symptoms on stopping a benzodiazepine.[21] Initial treatment by an SSRI or SNRI could be combined with a benzodiazepine and the benzodiazepine dose should be tapered off after two to three weeks when the antidepressant becomes effective.[18] Benzodiazepine should only be used as a short-term treatment for not more than four weeks.[10]

Beta-blockers

Beta-blockers, such as propranolol, have been widely used for anxiety, although the specific efficacy in GAD is unproven.[23] Beta-blockers act primarily by blocking peripheral adrenergic beta-receptors; symptoms that are mediated through beta-stimulation, such as tremor and palpitations, are helped most. Improvements could be noted within one to two hours and with relatively low doses (e.g. propranolol 40 mg/day).[24] Some evidence suggests that propranolol combined with a benzodiazepine could be more effective than a benzodiazepine alone in GAD[25]. This combination may also help with the subsequent withdrawal of the benzodiazepine.[26]

Second generation antipsychotics

A small placebo-controlled study with olanzapine (mean dose 8.7mg/day) showed an enhanced response to a SSRI (fluoxetine).[27] Two small placebo-controlled trials suggested benefits of adjunctive risperidone (at flexible doses of 0.5 to 1.5 mg/day) on anxiolytics,[28] and augmentative quetiapine (mean dose of 50 mg/day) on SSRI.[29] Nevertheless, the latest NICE clinical guideline does not suggest offering an antipsychotic for treatment of GAD in primary care.[10]

Conclusion

GAD is a common mental disorder which causes significant suffering and functional impairment. Psychiatric co-morbidity is common. Early treatment of GAD may prevent the development of a major depression. SSRIs, SNRIs and pregabalin are established first-line pharmacological treatments for GAD. Benzodiazepine is only suitable for short-term use at the initial stage of treatment. Giving the patients adequate information about the diagnosis and medications is an integral part of effective pharmacological treatment of GAD.

References

1. Diagnostic and statistical manual of mental disorders : DSM-IV. 4th ed. ed. Washington, D.C.: American Psychiatric Association; 1994.
2. Wittchen HU. Generalized anxiety disorder: prevalence, burden, and cost to society. Depress Anxiety. 2002; 16(4): 162-71.
3. Pollack MH. Refractory generalized anxiety disorder. J Clin Psychiatry. 2009; 70 Suppl 2: 32-8.
4. Wittchen HU, Jacobi F. Size and burden of mental disorders in Europe--a critical review and appraisal of 27 studies. Eur Neuropsychopharmacol. 2005; 15(4): 357-76.
5. Helzer JE, Pryzbeck TR. The co-occurrence of alcoholism with other psychiatric disorders in the general population and its impact on treatment. J Stud Alcohol. 1988; 49(3): 219-24.
6. Stein DJ. Comorbidity in generalized anxiety disorder: impact and implications. J Clin Psychiatry. 2001; 62 Suppl 11: 29-34; discussion 5-6.
7. Massion AO, Warshaw MG, Keller MB. Quality of life and psychiatric morbidity in panic disorder and generalized anxiety disorder. Am J Psychiatry. 1993; 150(4): 600-7.
8. Kessler RC, DuPont RL, Berglund P, Wittchen HU. Impairment in pure and comorbid generalized anxiety disorder and major depression at 12 months in two national surveys. Am J Psychiatry. 1999; 156(12): 1915-23.

9. Davidson JR, Zhang W, Connor KM, Ji J, Jobson K, Lecrubier Y, et al. A psychopharmacological treatment algorithm for generalised anxiety disorder (GAD). J Psychopharmacol. 2010; 24(1): 3-26.
10. National Institute for Health and Clinical Excellence. Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. Clinical Guidance 113.; 2011.
11. Lader MH, Bond AJ. Interaction of pharmacological and psychological treatments of anxiety. Br J Psychiatry Suppl. 1998; (34): 42-8.
12. Connor KM, Davidson JR. Generalized anxiety disorder: neurobiological and pharmacotherapeutic perspectives. Biol Psychiatry. 1998; 44(12): 1286-94.
13. Mogg K, Baldwin DS, Brodrick P, Bradley BP. Effect of short-term SSRI treatment on cognitive bias in generalised anxiety disorder. Psychopharmacology (Berl). 2004; 176(3-4): 466-70.
14. Taylor D, Paton C, Kapur S. The Maudsley prescribing guidelines in psychiatry. 11th ed. ed. Oxford: Wiley-Blackwell; 2012.
15. Goodman WK, Bose A, Wang Q. Treatment of generalized anxiety disorder with escitalopram: pooled results from double-blind, placebo-controlled trials. J Affect Disord. 2005; 87(2-3): 161-7.
16. Bandelow B, Zohar J, Hollander E, Kasper S, Moller HJ, Allgulander C, et al. World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for the pharmacological treatment of anxiety, obsessive-compulsive and post-traumatic stress disorders - first revision. World J Biol Psychiatry. 2008; 9(4): 248-312.
17. Baldwin DS, Waldman S, Allgulander C. Evidence-based pharmacological treatment of generalized anxiety disorder. Int J Neuropsychopharmacol. 2011; 14(5): 697-710.
18. Tyrer P, Baldwin D. Generalised anxiety disorder. Lancet. 2006; 368(9553): 2156-66.
19. Montgomery SA. Pregabalin for the treatment of generalised anxiety disorder. Expert Opin Pharmacother. 2006; 7(15): 2139-54.
20. Fink K, Dooley DJ, Meder WP, Suman-Chauhan N, Duffy S, Clusmann H, et al. Inhibition of neuronal Ca(2+) influx by gabapentin and pregabalin in the human neocortex. Neuropharmacology. 2002; 42(2): 229-36.
21. Baldwin DS, Polkinghorn C. Evidence-based pharmacotherapy of Generalized Anxiety Disorder. Int J Neuropsychopharmacol. 2005; 8(2): 293-302.
22. Tyrer P, Owen R, Dawling S. Gradual withdrawal of diazepam after long-term therapy. Lancet. 1983; 1(8339): 1402-6.
23. Meibach RC, Dunner D, Wilson LG, Ishiki D, Dager SR. Comparative efficacy of propranolol, chlordiazepoxide, and placebo in the treatment of anxiety: a double-blind trial. J Clin Psychiatry. 1987; 48(9): 355-8.
24. Tyrer P. Current status of beta-blocking drugs in the treatment of anxiety disorders. Drugs. 1988; 36(6): 773-83.
25. Hallstrom C, Treasaden I, Edwards JG, Lader M. Diazepam, propranolol and their combination in the management of chronic anxiety. Br J Psychiatry. 1981; 139: 417-21.
26. Tyrer P, Rutherford D, Huggett T. Benzodiazepine withdrawal symptoms and propranolol. Lancet. 1981; 1(8219): 520-2.
27. Pollack MH, Simon NM, Zalta AK, Worthington JJ, Hoge EA, Mick E, et al. Olanzapine augmentation of fluoxetine for refractory generalized anxiety disorder: a placebo controlled study. Biol Psychiatry. 2006; 59(3): 211-5.
28. Brawman-Mintzer O, Knapp RG, Nietert PJ. Adjunctive risperidone in generalized anxiety disorder: a double-blind, placebo-controlled study. J Clin Psychiatry. 2005; 66(10): 1321-5.
29. Altamura AC, Serati M, Buoli M, Dell'Osso B. Augmentative quetiapine in partial/nonresponders with generalized anxiety disorder: a randomized, placebo-controlled study. Int Clin Psychopharmacol. 2011; 26(4): 201-5.

MCHK CME Programme Self-assessment Questions

Please read the article entitled "Update on Pharmacological Management of Generalised Anxiety Disorder" by Dr. William CHUI and complete the following self-assessment questions. Participants in the MCHK CME Programme will be awarded 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 August 2012. 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. Generalised anxiety disorder (GAD) is characterised by episodic anxiety which is associated with a specific situation.
2. Psychiatric co-morbidity is rare in GAD.
3. When the GAD is associated with marked functional impairment, the patient should be offered an individual high-intensity psychological intervention or pharmacological treatment.
4. It is uncertain whether it is more helpful to combine pharmacological and psychological approaches in GAD, compared to using single approach alone.
5. In treatment of GAD, a selective serotonin reuptake inhibitors (SSRI) or serotonin–norepinephrine reuptake inhibitors (SNRI) should be initially prescribed at half the normal starting dose for the treatment of depression.
6. If the person cannot tolerate SSRIs or SNRIs, pregabalin should be considered.
7. Pregabalin binds potently to the alpha-2-delta protein, an auxiliary subunit associated with voltage-gated calcium channels.
8. Benzodiazepine should be prescribed for at least one year to maintain remission of GAD.
9. Benzodiazepine has well proven efficacy in treating co-morbid depressive symptoms.
10. Treating GAD by an antipsychotic in primary care has been recommended by the latest NICE clinical guideline.

ANSWER SHEET FOR AUGUST 2012

Please return the completed answer sheet to the Federation Secretariat on or before 31 August 2012 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

Update on Pharmacological Management of Generalised Anxiety Disorder

Dr. William CHUI

MBBS (HK), MRCPsych(UK), FHKCPsych, FHKAM(Psychiatry)

Associate Consultant, Castle Peak Hospital

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

Name (block letters):_____ HKMA No.: _____ CDSHK No.: _____

HKID No.: __ __ - __ __ __ __ X X (X) HKDU No.: _____ HKAM No.: _____

Contact Tel No.:_____

Answers to July 2012 Issue

Prenatal screening and diagnosis of foetal Down syndrome (Trisomy 21)

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

Welcome to calm

LYRICA®
PREGABALIN

Relieving worry
in generalized anxiety disorder

LYRICA, provides powerful anxiolysis you can trust

- Significant reduction in GAD psychic and somatic symptoms from **Day 4** of treatment[1]
- Sustained clinical improvement over duration of treatment[1,2]
- Improved sleep outcomes in patients with insomnia[3]

References: 1. Kasper S, et al. Efficacy of pregabalin and venlafaxine-XR in generalized anxiety disorder: results of a double-blind, placebo-controlled 8-week trial. Int Clin Psychopharmacol 2009;24:87-96. **2.** Rickels K, et al. Pregabalin for treatment of generalized anxiety disorder: a 4-week, multicentre, double-blind, placebo-controlled trial of pregabalin and alprazolam. Arch Gen Psychiatry 2005;62:1022-1030. **3.** Mychaskiw MA, et al. Insomnia and quality of life in generalized anxiety disorder: impact on clinical presentation and response to pregabalin and venlafaxine-XR. Presented at the 17th EPA European Congress of Psychiatry; January 24–28, 2009; Lisbon, Portugal.

Pfizer Corporation Hong Kong Limited
16/F., Stanhope House, 738 King's Road, North Point, Hong Kong
Tel: (852) 2811 9711 Fax: (852) 2579 0599
Website: www.pfizer.com.hk

Visit MEDICAL FAIR ASIA 2012, Asia's No. 1 Medical Event!

MEDICAL FAIR ASIA

9th International Exhibition on
Hospital, Diagnostic,
Pharmaceutical,
Medical & Rehabilitation
Equipment & Supplies

12 - 14 sept 2012

Suntec Singapore • Level 6

because health matters

Pre-register your visit at www.medicalfair-asia.com

Scan this code for
Exhibitor & Product Highlights

Opening hours: 10.00am - 6.00pm
Open to all involved in medical and health care.
Admission is free by registration only.

Concurrent events:

MEDICAL MANUFACTURING ASIA

OS+H Asia
The 8th Occupational Safety+Health Exhibition for Asia

Sponsored by:

MINISTRY OF HEALTH SINGAPORE

Endorsed by:

aif Approved International Fair

Held in:

YourSingapore

Supported by:

Singapore Medical Association

AMDI Association of Medical Device Industry (Singapore)

Asian Hospital Federation

APHM

admi Association of Diagnostics Manufacturers of India

Messe Düsseldorf / Organizer of :

Messe Düsseldorf

MEDICA

RIHACARE

Representative in Hong Kong:

World-Fair Consultants Ltd.
Room 1202, 12th Floor
Emperor Group Centre
288 Hennessy Road
Wanchai, Hong Kong, SAR
Tel : (852) 2838 3183
Fax : (852) 2838 1107
info@worldfair.com.hk

Organized by:

Messe Düsseldorf Asia

Use of Cholinesterase Inhibitors in Early Dementia and Mild Cognitive Impairment

Dr. Wai-chi CHAN

FHKAM (Psychiatry), FHKCPsych
Senior Medical Officer, Department of Psychiatry, Shatin Hospital

Dr. Wai-chi CHAN

A pressing healthcare issue

The population in Hong Kong has been ageing rapidly. According to the latest population census, the older population has increased from 10.5 percent in 2001 to 13.3 percent in 2011 (Hong Kong Census and Statistics Department, 2011). It is expected that by 2039, 28 percent of the local population will be 65 or above (Hong Kong Census and Statistics Department, 2010). Since the prevalence of dementia doubles every five years after the age of 60 (Jorm et al., 1987), an expanding older population inevitably leads to a boom in the number of people with dementia. As reported in a recent study, around one in 10 local older persons are suffering from dementia (Lam et al., 2008). It has made dementia one of the pressing healthcare issues in Hong Kong.

Cholinesterase inhibitors for mild dementia

Efforts have been made to identify effective treatment for mild dementia. So far, cholinesterase inhibitors (ChEIs) have the best evidence supporting their efficacy in this group of patients. By incorporating the latest studies, National Institute for Health and Clinical Excellence (NICE) guidance recommends ChEIs (donepezil, rivastigmine & galantamine) as options for managing mild and moderate Alzheimer's disease (NICE, 2011).

Donepezil is a selective, reversible acetylcholinesterase inhibitor. The oral dose ranges from 5 mg to 10 mg in mild dementia[1], and can be given in a convenient once-daily regimen. Orodispersible tablets are also available to cater for the special needs of patients. Donepezil is taken at bedtime with or without food. Rivastigmine is a pseudo-irreversible inhibitor of acetylcholinesterase. It also inhibits butyrylcholinesterase, another enzyme involved in the degradation of acetylcholine in normal as well as Alzheimer's brain. It comes in the form of oral capsules, which are given twice daily, and the once-daily transdermal patches. Oral rivastigmine should be taken with food. The treatment dose ranges from 3 mg to 12 mg for capsules, and from 4.6 mg to 9.5 mg for patches. Galantamine is a selective, reversible inhibitor of anticholinesterase. It also modulates nicotinic receptors. Previously requiring twice-daily regimen, galantamine's prolonged release formulation allows it to be taken once a day. Galantamine should be taken with food. The treatment dose ranges from 8 mg to 24 mg.

Clinical benefits

Though differing in pharmacological actions, all three ChEIs seem to have broadly similar clinical effects (Taylor et al., 2012). Clinical trials suggest that patients receiving ChEIs are maintained near treatment baseline levels for at least one year of therapy, and then decline, but then appear to maintain higher levels of function than expected if untreated (Farlow et al., 2007). ChEIs may also alleviate behavioural and psychological symptoms associated with dementia though the evidence base of such efficacy is limited so far (Rodda et al., 2009). In a recent review, Popp et al. (2011) summarised that a higher MMSE score at baseline, a good initial response, a short time between diagnosis and treatment, and a higher mean dose of ChEI might predict better long-term response to the medication.

Safety and tolerability

As expected, cholinergic side effects such as nausea, vomiting, diarrhoea, dizziness and insomnia are common. But they are often transient and dose related. Such side effects are more frequent during dose titration, and tolerability can be improved with a slower dose titration schedule. Switching from oral preparations like rivastigmine capsule to transdermal patch has also been shown to reduce gastrointestinal side effects. In addition, ChEIs may be associated with bradycardia. Caution should therefore be exercised when using ChEIs in patients with cardiovascular disease or taking medications that slow down heart rates. Furthermore, the majority of older persons have concomitant health conditions requiring drug treatments. Rivastigmine, which has almost no potential for interaction, is probably the drug of choice when drug-drug interaction is a concern.

Switching ChEIs

It is suggested that failure to respond to one ChEI does not necessarily mean that a patient will not benefit from another (Farlow, et al., 2007). Similarly, poor tolerability of one ChEI does not preclude tolerance to another (Farlow, et al., 2007). It is thus reasonable to consider switching from one agent to another in cases of poor clinical responses or tolerability. By reviewing eight clinical studies, Massoud et al. (2011) suggested the following practical approach to switching ChEIs:

1. Donepezil also comes in 23 mg tablets (not yet available in Hong Kong), which is approved by US Food and Drug Administration as a treatment for moderate-to-severe Alzheimer's disease.

(1) In the case of intolerance, switching to a second agent should be done only after the complete resolution of side effects following discontinuation of the initial agent;
(2) In the case of lack of efficacy, switching can be done overnight, with a quicker titration scheme thereafter; and
(3) Switching ChEIs is not recommended in individuals who show loss of benefit several years after initiation of treatment.

Cholinesterase inhibitors for MCI

Considering its efficacy in improving cognitive symptoms in dementia, it is logical to postulate that ChEIs may be useful in persons with MCI. Disappointingly, results of MCI treatment trials were in general unfavourable (Raschetti et al., 2007; Jelic et al., 2006). In view of the questionable efficacy and potential adverse effects, routine treatment of MCI with ChEIs is not supported by current evidence.

References

Farlow MR, Cummings JL. Effective pharmacologic management of Alzheimer's disease. Am J Med 2007;120:388-397.

Hong Kong Census and Statistics Department. 2011 Population Census summary results. http://www.census2011.gov.hk/pdf/summary-results.pdf

Hong Kong Census and Statistics Department. Projected mid-year population by age group and sex for 2010-2039. http://www.censtatd.gov.hk/products_and_services/ products/individual_statistical_tables/index.jsp

Jelic V, Kivipelto M, Winblad B. Clinical trials in mild cognitive impairment: lessons for the future. J Neurol Neurosurg Psychiatry 2006;77:429-438.

Jorm AF, Korten AE, Henderson AS. The prevalence of dementia: a quantitative integration of the literature. Acta Psychiatr Scand 1987;76:465-479.

Lam LCW, Tam CWC, Lui VWC, et al. Prevalence of very mild and mild dementia in community dwelling Chinese older persons in Hong Kong. Int Psychogeriatr 2008;20:135-148.

Massoud F, Desmarais JE, Gauthier S. Switching cholinesterase inhibitors in older adults with dementia. Int Psychogeriatr 2011;23:372-378.

National Institute for Health and Clinical Excellence. Dementia: supporting people with dementia and their carers in health and social care. Clinical guidelines 42. Updated March 2011. www.nice.org.uk/CG42

Popp J, Arlt S. Pharmacological treatment of dementia and mild cognitive impairment due to Alzheimer's disease. Curr Opin Psychiatry 2011;24:556-561.

Raschetti R, Albanese E, Vanacore N, et al. Cholinesterase inhibitors in mild cognitive impairment: a systematic review of randomised trials. PLoS Med 2007;4:e338.

Rodda J, Morgan S, Walker Z. Are cholinesterase inhibitors effective in the management of behavioral and psychological symptoms of dementia in Alzheimer's disease? A systematic review of randomized, placebo-controlled trials of donepezil, rivastigmine and galantamine. Int Psychogeriatr 2009;21:813-824.

Taylor D, Paton C, Kapur S (Eds.). (2012). The Maudsley prescribing guidelines in psychiatry, 11th Ed. Chichester: Wiley-Blackwell.

Dermatological Quiz

Dermatological Quiz

Dr. Ka-ho LAU

MBBS(HK), FRCP(Edin, Glasg), FHKCP, FHKAM(Med)
Yaumatei Dermatology Clinic, Social Hygiene Service

Dr. Ka-ho LAU

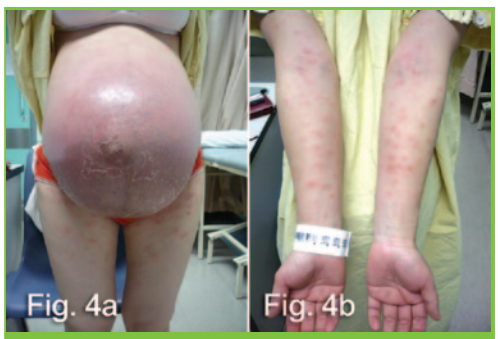


Fig 4: Lesions at the (a) abdomen and (b) forearms

This 30-year-old pregnant woman complained of these very itchy skin lesions starting at the sides of her abdomen (Fig. 4a) and spreading to her proximal upper limbs (Fig. 4b) and proximal thighs in the recent few days. There were no associated systemic symptoms. She was having her first pregnancy with twins at 36th week of gestation. She enjoyed good past health and did not have any previous skin disease or taking any medication.

Question:

1. What is your diagnosis or possible differential diagnoses?
2. How will you manage her skin disease?
3. Is there any associated risk for the mother or the twin foetuses? Will the skin rash recur in subsequent pregnancies?

(See P.37 for answers)

Aricept®
Giving Alzheimer's patients time

Extend the Power of Recall

Continuous Aricept® treatment significantly improves cognition & preserves function[1]

Further information is available upon request.

hhc Eisai
Human Health Care Company

Reference:
1. Howard R. McShane R. Lindesay J, et al. Donepezil and memantine for moderate-to-severe Alzheimer's disease. N Engl J Med 2012;366:893-903.

EISAI (HONG KONG) COMPANY LTD.
Rm. 2007, Fortress Tower, 250 King's Road., North Point, Hong Kong Tel: 852.2516 6128 Fax: 852.2561 5042 E-mail: ehk6128@eisaihk.com

How common is common mental disorders in Hong Kong? Preliminary insights from the Hong Kong Mental Morbidity Survey

Ms. Corine SM WONG

MSocSc

Project Coordinator, Hong Kong Mental Morbidity Survey (HKMMS), Department of Psychiatry, The Chinese University of Hong Kong

Ms. Corine SM WONG

HKMMS Team: Linda CW Lam[1], SF Hung[2], Eric FC Cheung[3], Roger MK Ng[4], Eric YH Chen[5], PC Sham[5], M Lam[3], WC Chan[6], Helen FK Chiu[1], WC Chang[5], TP Chiang[3], Edwin HM Lee[5], Joseph TF Lau[7], Grace TY Leung[8], Joey SY Leung[2], WH Cheung[2], Victoria WK Tang[3], Bonnie WM Siu[3], Ricky CK Tung[3], Kavin KW Chow[3], Amy SW Yeung[3], Karen SY Hung[3], Paulina PL Chow[3], Jackie CK Fu[3], Fiona YK Tam[3], CS Kan[3], Gary KW Lau[8], Allen TC Lee[8], Winki WK Tai[8], Candy HY Wong[8], Chario CC Chan[6], LK Chan[2], Patricia WY Choi[2], Condy HS Kwan[2], HS Yu[2], Ada WT Fung[1], Harriet WY Tang[1], Samantha WS Li[1], Edric KC Wong[1], Ruth SY Wong[1], Calvin PH Lam[1], Janet SY Yick[1], Catherine HM Li[1], Katie YK Chan[1], Kaspar KW Lee[1], TY Wong[1], Jody YF Ng[1], WY Law[1], Jonathan CL Liu[1].

Introduction

Mental disorders are highly prevalent health conditions. According to the World Health Organization's World Mental Health Survey Initiative (WHOWMHSI), the estimated lifetime prevalence of having one or more mental disorders ranged from 18.1 - 36.1% across different countries.[1] Common mental disorders (CMDs) like depression, anxiety disorders, psychosis and substance-use disorders are associated with a high level of physical, social and economic morbidity.[2] The significance of mental health is increasingly being recognised throughout the world.[3]

Comprehensive understanding of community prevalence of mental disorders is important for health care planning.[4] In recent years, the demand for mental health care in both specialist service and primary care has increased significantly. Effective mental health planning should be based on epidemiological data of psychiatric morbidity. Despite rapidly changing socio-demographic characteristics and economic environment, the impact of these changes on mental health status in Hong Kong have not been adequately evaluated.[5]

The Hong Kong Mental Morbidity Survey (HKMMS)

The HKMMS is the first territory-wide door-to-door epidemiological study on the prevalence of mental health problems in Hong Kong. The main objective of the study is to estimate the prevalence of significant mental disorders in community dwelling adults. It also collects information on health related factors for mental well-being.

The survey adopted a two-phase design corresponding to the Adult Psychiatric Morbidity Survey (APMS) in the United Kingdom.[6-8] The HKMMS commenced in 2010 and would last for three years. The first phase aims to collect mental health information in 5,700 Chinese adults aged 16 - 75 for estimation of the prevalence of common mental disorders (CMDs) and their significant clinical correlates. The Revised Clinical Interview Schedule (CIS-R)[9] is used as a structured assessment for diagnosing CMDs. This phase also includes screening instruments for psychotic disorders[10], suicidal ideation[11-12], substance and alcohol misuse[13], life events[14], everyday functioning[15] and service utilisation. The second phase comprises clinician interviews for psychotic disorders using the Structured Clinical Interview for DSM-IV (CB-SCID-I/P)[16-17], as well as psychosocial risk factors for suicidal idea and behaviours.[18-20]

How common is common mental disorders in Hong Kong?

From the interim analysis of the first 2,217 participants of the HKMMS, 931 males (42.0%) and 1,286 females (58.0%) were recruited. The mean age of the participants was 46.4 years (SD=15.4). Three hundred and thirty (14.9%) participants reported significant levels of neurotic symptoms with a CIS-R score of 12 or above. For ICD-10 diagnoses generated by the CIS-R, the prevalence of depressive episode and generalised anxiety disorder were 4.5% and 4.8% respectively. One hundred and forty-nine (6.7%) participants suffered from mixed anxiety and depressive disorder. Psychiatric co-morbidities were found in 55 (2.5%) participants. Seventy-one (3.2%) participants had suicidal ideation in the past one week and 161 (7.3%) had had lifetime suicide attempts. One hundred and thirty-nine (6.3%) participants scored 8 or above in the Alcohol Use Disorders Identification Test (AUDIT), indicating harmful use of alcohol.

Two hundred and sixty-one participants (11.8%) reported insomnia for more than four nights in the past one week. More than half of them had sleep problems for more than two years. Participants with sleep problems had a higher chance of having depressive episode ($p<0.001$) and generalised anxiety disorder ($p<0.001$), as well as using hypnotics ($p<0.001$). While one could not determine the causality between sleep disturbance and mental disorders, it is important to note that both conditions co-exist, thus increases morbidity and distress.

CMDs are also significantly related to chronic physical health. Participants with significant neurotic symptoms

reported more chronic physical health issues. Their physical illness burden as rated by the Cumulative Illness Rating Scale (CIRS) was significantly higher (mean=4.23, SD=3.12) than those without significant neurotic symptoms (mean=2.40, SD=1.93) (p<0.001). Cardiac (p<0.001), respiratory (p<0.01), gastrointestinal (p<0.001), musculoskeletal (p<0.001) and genitourinary (p<0.001) conditions were the most commonly reported health concerns.

Participants with significant neurotic symptoms had poorer daily functioning (p<0.001), more adverse social situations with lower family income and space (p< 0.001). Female participants had a higher risk to develop mental health problems (OR=0.53, 95% CI=0.39-0.74). Marital status and working status were observed to be major risk factors for significant neurotic symptoms. Participants who were widowed and divorced had a higher risk to develop neurotic symptoms (OR=0.62, 95% CI=0.48-0.87). Participants who were not working also had a higher chance of developing mental morbidity (OR=0.60, 95% CI=0.44-0.83).

Among the 330 participants with CMDs, only about a quarter (N=79, 23.9%) had received services from doctors, psychologists, social workers or other helping professionals for mental health problems in the past year. The prevalence of medication use and psychological intervention were 48.7% and 18.9% respectively.

Conclusion

While the HKMMS is still underway, the preliminary findings suggest that CMDs are as common in Hong Kong as in other major cities in the world. Mental health problems adversely affect physical health and social functioning. More importantly, only a minority of people suffering from these conditions have accessed appropriate service for help, indicating an urgent need for better mental health care planning for early treatment in the community.

HKMMS Team:
[1]Department of Psychiatry, The Chinese University of Hong Kong, HKSAR. [2]Department of Psychiatry, Kwai Chung Hospital, HKSAR. [3]Department of Psychiatry, Castle Peak Hospital, HKSAR. [4]Department of Psychiatry, Kowloon Hospital, HKSAR. [5]Department of Psychiatry, The University of Hong Kong, HKSAR. [6]Department of Psychiatry, Shatin Hospital, HKSAR. [7]School of Public Health, The Chinese University of Hong Kong, HKSAR. [8]Department of Psychiatry, Tai Po Hospital, HKSAR. [9]Department of Psychiatry, Queen Mary Hospital, HKSAR.

References

1. Kessler RC, Angermeyer M, Anthony JC, et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry. 2007;6:168-176.
2. Phillips MR, Zhang JX, Shi QC, et al., Prevalence, treatment, and associated disability of mental disorders in four provinces in China during 2001-2005: an epidemiological survey. Lancet., 2009;373:2041-2053.
3. The WHO World Mental Health Survey Consortium. Prevalence, Severity, and Unmet Need for Treatment of Mental Disorders in the World Health Organization World Mental Health Surveys. JAMA, 2004;291:2581-2590.
4. Prince M, Patel V, Saxena S, et al, No health without mental health. Lancet. 2007;370(9590):859-877.
5. Chen CN, Wong J, Lee N, Chan-Ho MW, Lau JT, Fung M. The Shatin community mental health survey in Hong Kong. II. Major findings. Arch Gen Psychiatry. 1993;50:125-133.
6. Adult psychiatric morbidity in England, 2007. Results of a household survey. Edited by McManus S, Meltzer H, Brugha T, Bebbington P, Jenkins R. The NHS Information Centre for health and social care. http://www.ic.nhs.uk/pubs/
7. Jenkins R, Bebbington P, Brugha T, et al. The National Psychiatric Morbidity Surveys of Great Britain – Strategy and Methods. Psychological Medicine, 1997;27:765-774.
8. Singleton N, Bumpstead R, O'Brien M, Lee A and Meltzer H. Psychiatric Morbidity among adults living in private household, 2000, London:TSO, 2001.
9. Lewis G, Pelosi AJ, Araya R, Dunn G. Measuring psychiatric disorder in the community: a standardized assessment for use by lay interviewers. Psychol Med. 1992;22:465-486.
10. Yung, A.R., McGorry, P.D. The prodromal phase of first-episode psychosis: past and current conceptualizations. Schizophr Bull 1996;22:353-370.
11. Beck AT, Steer RA, Raneri WF. Scale for Suicidal Ideation – psychometric properties of a self-report version. J Clin Psychol, 44, 499-505.
12. Beck, A.T. & Steer, R.A. Manual for the Beck Hopelessness Scale. San Antonio, TX: Psychological Corporation, 1988.
13. Saunders JB, Aasland OG, Babor TF, Dela Fuente JR, Grant M. (1993) Development of the Alcohol Use Disorders Identification Test (AUDIT):WHO collaborative project on early detection of persons with harmful alcohol consumption, part II. Addiction, 88, 791-804.
14. Gray MJ, et al. Psychometric Properties of the life events checklist, Assessment, 2004;11:330-341.
15. Frances A. Pincus HA, The essential companion to the Diagnostic and Statistical manual of Mental Disorders, 4th ed, Text Revision. DSM-IV TR. APA. Edited by First M., Social and Occupational Functioning Assessment Scale (SOFAS), 83.
16. So E, Kam I, Leung CM, et al. The Chinese-bilingual SCID-I/P Project: Stage 1 - reliability for mood disorders and schizophrenia. Hong Kong J Psychiatry 2003; 13: 7-18.
17. So E, Kam I, Leung CM, et al. The Chinese-bilingual SCID-I/P Project: Stage 2 - reliability for anxiety disorders, adjustment disorders, and 'no diagnosis'. Hong Kong J Psychiatry 2003; 13: 19-25.
18. Gilbert P, Allan S. The role of defeat and entrapment (arrested flight) in depression: an exploration of the evolutionary view. Psychol Med 1998, 28, 585-598.
19. Brown, G.W. & Harris, T.O. The Bedford College Life Events and Difficulties Schedule: Directory of contextual threat of events. London: Bedford College, University of London, 1978.
20. Schotte, D.E., Cools, J. & Payvar, S. (1990). Problem-solving deficits in suicidal patients – trait vulnerability or state phenomenon. J Consult Clin Psychol, 58, 562-564

Excessive Daytime Sleepiness (EDS) – Differential Diagnoses and Management

Dr. Samson YY FONG

FHKAM (Psychiatry), FHKCPsych

Private Psychiatrist

Dr. Samson YY FONG

Defining EDS

Daytime sleepiness is defined as the inability to stay awake and alert during the major waking period in the daytime, resulting in unintended lapses into drowsiness or sleep (International Classification of Sleep Disorders, 2nd edition, ICSD-2)[1]. In making differential diagnoses for excessive daytime sleepiness (EDS), it would be necessary to differentiate between EDS and fatigue. Fatigue is a state of discomfort and decreased efficiency, with a perception of lack of energy and power. Fatigue is not equivalent to daytime sleepiness but it is often difficult for a clinician to differentiate them from each other simply based on the patient's complaint; and in some situations, they may coexist.

Assessment of EDS

Sleep log and sleep diary provide information about daytime and nocturnal sleep patterns. Subjective evaluation of EDS includes the Stanford Sleepiness Scale[2] (a seven point scale for qualifying the degree of subjective sleepiness) and Epworth Sleepiness Scale (ESS, an eight-item questionnaire for measuring the propensity of dozing off / falling asleep in different circumstances, with its scores ranging from 0 to 24)[3].

Objective polysomnographic measurement of EDS includes Multiple Sleep Latency Test (MSLT) which is a measurement of the physiological tendency of sleepiness[4,5]. It is performed in a sound-proof and dark bedroom, with the subject being monitored by polysomnogram. MSLT consists of five scheduled naps with a two-hour interval between each nap. The latency of each nap, the mean sleep latency and any REM sleep during each nap (sleep onset REM period [SOREMP]; in contrast to the nocturnal sleep in normal subjects, the first REM period usually occurs 60-90 minutes after the sleep onset) are recorded. Each nap test is stopped if the subject cannot fall asleep after 20 minutes. Subjects are considered to have EDS if their mean sleep latency is less than 10 minutes. Maintenance of Wakefulness Test (MWT) is a measurement of the subject's ability to remain awake during the test period. Similar to MSLT, a five-nap test is performed.[6,7] For normal subjects, the mean latency to fall asleep is 18.1 ± 3.6 (with lower limit of 10.9min) in a 20-minute MWT, and is 35.2 ± 7.9 (with lower limit of 19.4min) in a 40-minute MWT.[8]

EDS not due to a primary sleep disorder

Insufficient sleep (sleep deprivation) should first be excluded in patients complaining of EDS. Although there exists individual differences in sleep need, sleep deprivation is not uncommon across different age groups in the local populations including infants and toddlers (night-time sleep of 9.02 ± 1.46 hours and total sleep time of 12.16 ± 2.10 hrs) 9, in adolescents (school night total sleep time = 7 hrs 17 mins, and a delay in weekend bed time and rise time leading to average weekend oversleep of 131 mins),[10] and in adults (self-reported sleeping time vs expected sleeping time in non-insomniac males [7.03 ± 1.15 hrs vs 7.76 ± 1.48 hrs] and females [7.25 ± 1.16 hrs vs 8.02 ± 1.34 hrs]).[11]

Psychiatric disorders also need to be looked for in subjects with EDS. Patients with depression may present with hypersomnia and fatigue. Insomniac patients may present with lapses of drowsiness and sleepiness in the daytime. Dementia patients may also present with EDS. Medical disorders may also present with EDS, which may be a symptom of the illness per se (e.g. Parkinsonism, CNS tumour or infection, hypothyroidism, genetic disorders like myotonic dystrophy), a side effect from the treatment medications, or a secondary consequence from the insomnia caused by the underlying medical problems (e.g. pain).

EDS due to sleep disorders

Non-central causes

1. Obstructive Sleep Apnoea (OSA)

Ip et al[12,13] reported that the prevalence of sleep-disordered breathing (OSA defined as Apnoea Hypopnoea Index ≥ 5 and with EDS) is 4.1% in 4.1% of males and 2.1% of females of age from 30-60 in Hong Kong. Therefore, OSA is another common cause for EDS. Apart from measurement by ESS and/or MSLT[14], other symptoms of OSA include loud snoring, dry mouth after sleep, subjective feeling of choking or observed cessation in breathing by the sleep partner, drooling of saliva, morning headache, increased nocturia, nocturnal enuresis, and sexual dysfunction. The gold standard for diagnosis of OSA is nocturnal polysomnography. Treatment for OSA includes nasal continuous positive airway pressure (CPAP), dental appliance and/or surgery. The choices amongst these treatment modalities depend on the severity of the OSA, the treatment response and the tolerability of patients towards each modality of treatment.

It is noteworthy that some patients may continue to have residual EDS even after adequate treatment

with n-CPAP over a significant period.[15,16] In this circumstance, depression, underlying narcolepsy, periodic leg movements and other underlying central causes of hypersomnia would need to be excluded.[15] Modafinil has been suggested to be effective in improving the functional outcomes in patients with this residual EDS even after CPAP treatment.[17]

2. Periodic Limb Movement Disorder (PLMD)

Patients with PLMD present with unilateral or bilateral flexion of their big toe, ankle and sometimes even with partial flexion of their knee or hip. In nocturnal polysomnogram, a minimum of four consecutive leg movement events are needed to define a PLMD series, with each leg movement event lasting for 0.5-10 seconds and the period between leg movement events ranging from 5-90 seconds.[18] While PLMD could be asymptomatic, it is believed that it causes brief arousals from sleep and the resulting sleep interruption may lead to EDS. For patients with PLMD, it would be necessary to look out for any co-existing Restless Leg Syndrome (RLS). Patients with RLS present with 1) feeling of restlessness, twitching and/or other discomfort in the lower limbs and even in upper limbs in severe cases; 2) such feeling tends to increase in intensity in the evening and when lying down; and 3) relief of symptoms by active or passive movements. Other conditions that are associated with PLMD include uraemia, iron deficiency anaemia, peripheral vascular disease, peripheral neuropathy, antidepressant medications, pregnancy, Parkinson's disease.[1,19] Dopaminergic agonists and benzodiazepines have been reported to be useful in PLMD. [1,20]

3. Circadian Rhythm Disorders

Jet-lag disorder is one of circadian rhythm disorders that can cause EDS. It is usually temporary, provided that the patients can follow good sleep hygiene and the day-night rhythm at the destination of their journey. For patients with either circadian rhythm disorders of advanced or delayed phase type, they tend to have a stable habitual advance or delay in their sleep for more than two hours 1, but once they fall sleep, their sleep duration is often normal as measured by sleep log or actigraphy. Treatments include regular sleep-wake schedules, chronotherapy (for both the advanced or delayed type), bright light therapy (given in the evening for the advanced type and in the morning for the delayed type), and oral melatonin (to be taken in the evening for the delayed type).

Central causes

1. Narcolepsy with or without cataplexy

The classical tetrad of narcolepsy includes excessive daytime sleepiness presenting as irresistible sleep attacks, cataplexy (sudden symmetrical muscle weakness without loss of consciousness, precipitated by emotions [usually laughter but rarely by other sensory stimuli][21]), sleep paralysis and sleep related hallucinations. It is found that patients with narcolepsy also have disrupted nocturnal sleep and increased risks to present with REM sleep behavioural disorder.

The prevalence of narcolepsy varies in different ethnic groups with the Japanese showing a prevalence of 0.18% whereas the lowest figure of 0.002% was found in Jews.[22] In Hong Kong, the prevalence of narcolepsy was found to be 0.038%.[23]

Current diagnostic criteria for narcolepsy in the ISCD-2 include the presence of excessive daytime sleepiness for at least three months, with either the presence or absence of cataplexy, and the hypersomnia is not better explained by other medical or sleep disorders. Measurement of EDS by MSLT in patients with narcolepsy shows a mean sleep latency of less than eight minutes and there are also two or more SOREMPs during the test. A low CSF hypocretin-1 level of less than 110pg/ml or less than one third of the mean normal control is also found in the group of narcoleptic patients with cataplexy. This low CSF hypocretin-1 level, however, is highly specific but only observed in 10-20% of patients of narcolepsy without cataplexy.

2. Idiopathic hypersomnia (IH)

There exists two subtypes of IH according to the ISCD-2: "with a long sleep time" (prolonged nocturnal sleep duration for more than 10 hours) and "without long sleep time" (nocturnal sleep duration of 6-10 hours). Diagnostic criteria also include a persistent daily EDS for more than three months and with the exclusion of other medical or sleep disorders causing the EDS. The mean sleep latency in IH is also found to be less than eight minutes (with a mean of 6.2 ± 3 minutes) but there are less than two SOREMP during the MSLT.

3. Treatment for narcolepsy and IH

Treatment options have been discussed in detail by Wise et al.[24] To summarise, a stimulant is used for the treatment for the EDS in narcolepsy and IH, with 1) methylphenidate, which has been reported to be effective in the treatment of narcolepsy and may be effective in myotonic dystrophy; 2) modafinil, which is effective for the treatment of EDS in narcolepsy, and may be effective in treatment of EDS in IH, myotonic dystrophy and in Parkinsonism. Scheduled periods of naps are helpful to the EDS but not sufficient as a primary treatment for narcolepsy or IH. Antidepressants with serotonin activity (including clomipramine, SSRI and SNRI) have been reported to be effective in the treatment of cataplexy and may be effective in sleep paralysis and sleep related hallucinations. In the United States, sodium oxybate is also used for the treatment for EDS, cataplexy and also the disrupted nocturnal sleep.

4. Kleine-Levin Syndrome (KLS)

KLS presents as recurrent episodes of hypersomnia lasting from several days to weeks. It usually starts in the second decade with a male preponderance of 4:1. There can be up to 10 episodes in a year and patients may sleep up to 16-18 hours per day and only get up to eat or void without any incontinence during the long sleep hours. Other behavioural symptoms in KLS may include binge eating, hypersexuality, and irritability. Between the attacks, patients can function normally. Lithium may be useful in treating KLS.

Conclusion

A good history is of primary importance in the assessment of EDS as most symptoms required for making different differential diagnoses can be elucidated from it. Together with the assessment with subjective and objective measurements and nocturnal polysomnography, suitable and effective treatment options are available for individual patients.

References

1. The International Classification of Sleep Disorders, Diagnostic and Coding Manual, 2nd edition. 2005. American Academy of Sleep Medicine.
2. Hoddes E, Dement WC, Zarcone V. The development and use of the Stanford Sleepiness Scale (SSS). Psychophysiology 1972; 9:150.
3. Johns MW. A new method for measuring daytime sleepiness: the Epworth Sleepiness Scale. Sleep 1991; 14:540-545.
4. Carskadon MA, Dement WC. The multiple sleep latency test: what does it measure? Sleep 1982; 5:S67-S72.
5. Carskadon MA, Dement WC, Milter MM, et al. Guidelines for the multiple sleep latency test (MSLT): a standard measure of sleepiness. Sleep 1986; 9:519-524
6. Milter MM. Gujavarty KS. Browman CP. Maintenance of wakefulness test: A polysomnographic technique for evaluating treatment efficacy in patients with excessive somnolence. Electroencephalography and Clinical Neurophysiology 1982; 53:658-661.
7. A review by the MSLT and MWT Task Force of the Standards of Practice Committee of the American Academy of Sleep Medicine. The clinical use of the MSLT and MWT. Sleep 2005; 28:123-144.
8. Doghramji K, Milter MM, Sangal RB, et al. A normative study of the maintenance of wakefulness test (MWT). Electroencephalography and Clinical Neurophysiology 1997; 103:554-562.
9. Mindell JA, Sadeh A, Wiegand B, et al. Cross-cultural differences in infant and toddler sleep. Sleep Medicine 2010; 11:274-280.
10. Chung KF, Cheung MM. Sleep-wake patterns and sleep disturbance among Hong Kong Chinese Adolescents. Sleep 2008; 31: 185-194.
11. 11. Li RHY, Wing YK, HO SC, et al. Gender differences in insomnia - a study in the Hong Kong Chinese Population. Journal of Psychosomatic Research 2002; 53: 601-609.
12. Ip MSM, Lam B, Lauder IJ, et al. A community study of sleep-disordered breathing in middle-aged Chinese men in Hong Kong. Chest 2001; 119: 62-69.

13. Ip MSM, Lam B, Tang LCH, et al. A community study of sleep-disordered breathing in middle-aged Chinese women in Hong Kong. Chest 2004; 125:127-134.
14. 14. Fong SYY, Ho CKW, Wing YK. Comparing MSLT and ESS in the measurement of excessive daytime sleepiness in obstructive sleep apnoea syndrome. Journal of Psychosomatic Research 2005; 58: 55-60.
15. Santamaria J, Iranzo A, Montserrat JM, et al. Persistent sleepiness in CPAP treated obstructive sleep apnea patients: Evaluation and treatment. Sleep Medicine Reviews 2007; 11: 195-207.
16. Fong SYY, Ho CKW, Li AM, et al. Excessive daytime sleepiness in obstructive sleep apnea patients after home CPAP treatment: a long-term outcome study. Journal of Sleep and Biological Rhythms 2009; 7(3):193-200.
17. Weaver TE, Chasens ER, Arora S. Modafinil improves functional outcomes in patients with residual excessive sleepiness associated with CPAP treatment. Journal of Clinical Sleep Medicine 2009; 5(6):499-505.
18. The AASM Manual for the Scoring of Sleep and Associated Events. Rules, Terminology and Technical Specification. American Academy of Sleep Medicine. 2007
19. Vaughn BV, D'Cruz OF. Cardinal manifestations of sleep disorders. In Kryger MH, Roth T, Dement WC. Principles and Practice of Sleep Medicine. Fifth edition. 2011. Elsevier Saunders.
20. Montplasier J, Allen RP, Walters A, et al. Restless legs syndrome and periodic limb movements during sleep. In Kryger MH, Roth T, Dement WC. Principles and Practice of Sleep Medicine. Fifth edition. 2011. Elsevier Saunders.
21. Lam SP, Fong SYY, Wing YK. Status cataplecticus leading to the obstetrics complication of prolonged labour. Journal of Clinical Sleep Medicine. 2007: 3(1):56-57
22. Mignot E. Genetic and familial aspects of narcolepsy. Neurology 1998; 50 (suppl 1):S16-S22.
23. Wing YK, Li R, Lam WC, et al. The prevalence of narcolepsy among Chinese in Hong Kong. Annals of Neurology 2002; 51:578-584.
24. Wise MS, Arand DL, Auger RR, et al. Treatment of narcolepsy and other hypersomnias of central origin. An American Academy of Sleep Medicine Review. .Sleep 2007; 30:1712-1727.

Lexapro® 20 mg

Release the power

Step up the dose

US FDA
Approval for the treatment of MDD in Adolescents

Globally No. 1 Prescribed Antidepressant*

全球銷量第一的抗抑鬱症藥物

Indications:

- **Major Depressive Disorder (MDD)**
- **Generalized Anxiety Disorder (GAD)**
- Social Anxiety Disorder (SAD)
- Panic Disorder (PD)
- Obsessive-Compulsive Disorder (OCD)

[1] IMS Health December 2011
[2] HKAPI data December 2011

Lundbeck Hong Kong
Suite 4303, Central Plaza,
18 Harbour Road, Wanchai, Hong Kong
Tel: 2827 1988 Fax: 2827 2228
www.lundbeck.com

Product information is available upon request

Lundbeck

Lexapro®
escitalopram

The Screening and Early Intervention of Postnatal Depression in the Community

Dr. Bonnie WM SIU

MBChB (CUHK), MRC Psych (UK), FHKC Psych, FHKAM (Psychiatry)

Associate Consultant, Department of General Adult Psychiatry, Castle Peak Hospital

Introduction

Postnatal depression is one of the commonest forms of psychiatric morbidity of child-bearing affecting 10 to 15 % of recently delivered women.[1,2] It imposes a series of adverse psychosocial complications to the mother, the children, and the family. The early identification and management of postnatal depression is important for the well-being of the mother and her family members. The Comprehensive Child Development Service (CCDS) launched in Hong Kong in 2005 aims to provide comprehensive and timely support to children aged 0 to 5 years and their families. Because of the potential adverse effects of maternal postnatal depression on the health of the families, the screening and early treatment of postnatal depression is one of the major service components of the CCDS.

Presentation and prevalence of postnatal depression

Postnatal depression (PND) refers to a non-psychotic depressive illness occurring during the first postnatal year, usually presents in the first few weeks or months after delivery.[3] The clinical pictures are comparable to those of depression unrelated to childbirth, with the most common presenting symptoms being dysphoria, depressive thoughts, insomnia, fatigue and feelings of inadequacy.[4] On the other hand, some researchers highlighted the strong association of PND with anxiety, which is usually centred on the baby's health, feeding, sleeping and other bodily functions.[5] Poor concentration, feelings of exhaustion, increased irritability, and emotional lability are also common. A recent study on 114 Chinese women with PND in Hong Kong revealed that the most common presenting symptom was low mood, followed by increased irritability and anxiety.[6]

Overseas epidemiological studies revealed that 10 to 15 % of recently delivered women were affected by postnatal depression.[1,2,7] Postnatal depression was originally thought to be absent in the Chinese population because of the traditional practice of "peiyue support (doing the month)" during which additional social support is provided by the family for women in the first month after delivery.[8] It was not until recently when postnatal depression has been considered to be an important and prevalent psychiatric disorder for Chinese women.[9,10] In 1998, Lee et al. found that the prevalence rate of PND in Chinese women six weeks after delivery was 5.5% which was relatively low as compared with the prevalence rates found in studies on non-Chinese women.[11,12] Lee et al. (1998) elaborated that the low prevalence rate could be related to the protective effect of "peiyue" support preventing the occurrence of PND in early puerperium and that the prevalence rate might be higher if a longer follow up period was adopted. In 2001, Lee et al., in a psychiatric epidemiological study among 959 postpartum Chinese women revealed a prevalence rate of PND of 10.3% and 11.2% at one month and three months respectively.[9] Siu et al. (2012) studied a community sample of 805 Chinese postpartum women and found a two-month prevalence rate of 15.7%.[13] The findings in these studies on Chinese women suggested that PND is not uncommon in the Chinese population and that the prevalence rates of PND are comparable with those in Western societies.

Aetiology

Evidence supporting the attribution of PND to hormonal changes and genetic predisposition are inconsistent and contradictory.[14,15] Instead, researchers believe that PND often develops from an interplay of multiple biopsychosocial factors (Table 1).[12, 16-20]

Table 1: Putative risk factors for postnatal depression.

Risk factors
Personal vulnerability / personality traits
• neuroticism
• high prenatal anxiety
• dysfunctional cognitions
Previous history of psychiatric disorder
Family psychiatric history
Psychological disturbance during pregnancy
• mainly depression or anxiety
Social factors
• unplanned pregnancy
• occupational instability
• unemployment of woman and partner
• low income
• poor social support from partner and mother
• younger age
Family factors
• single parenthood
• marital discord
• divorce
• poor parental relationship
Life events
• occurred in the year immediately before the birth
• undesirable
• had a negative impact
Hormonal factors
• oestrogens
• progesterone
Baby factors
• low birth weight
• infant ill health
• birth abnormalities
• female sex
• absence of breast-feeding
Primiparous
Women in third pregnancy

For the Chinese population, Lee et al. (2000) found the following risk factors for PND:

- depression during pregnancy
- elevated depression score at delivery
- prolonged postnatal blues
- temporary housing accommodation
- financial difficulties
- two or more induced abortions
- past psychiatric disorders (including depression)
- elevated neuroticism score
- spouse disappointment with the female gender of the newborn
- history of abortion

In the same study, Lee et al. (2000) also found that the presence of "peiyue" support was a protective factor for PND.[21] In 2004, Lee et al. revealed that "conflict with mother-in-law", "marital dissatisfaction", "past depression" and "antenatal depression" predicted PND independently.[10] Siu et al. (2012) found that "marital dissatisfaction (Relative Risk = 8.27)", "dissatisfied relationship with mother-in-law (Relative Risk = 3.93)", "antenatal depressive symptomatology (Relative Risk = 3.90)", and "anxiety-prone personality (Relative Risk = 2.14)" predicted PND in Chinese women independently.[15] In Siu et al.'s study (2012), spouse dissatisfaction with the gender of the baby was not a significant risk factor for PND.[13] On the other hand, they found that quite a large number of Chinese women and their spouse preferred to have a girl rather than a boy. The Chinese women opined that a daughter might be more obedient and attached to the family and that a daughter might be more caring towards her parents when they get old. This phenomenon may reflect a change in values in the Chinese society in recent years that instead of the gender, the character and relationship of the child with the family are considered by parents as the most preferred attribute of the child. It would be important to evaluate in future studies whether this change in cultural preference of offspring gender may also exist in other Chinese communities, especially in Mainland China with the implementation of its one-child policy.

Adverse effects and treatment of PND

Postnatal depression can bring about psychological distress to the new mother as well as her family at a time of anticipated hope and happiness. It can cause tension within a marriage, impose substantial impact on the social functioning of the mother, and affect the mother's ability to take care of her child.[22] It causes difficulty for the mother to develop a loving relationship with her baby and brings about disturbances of the bonding between the mother and the baby.[23] In its severe form, postnatal depression can end up with suicide and infanticide.[19,24]

One third of women suffering from postnatal depression are still ill beyond the first postnatal year if treatment is not provided appropriately and prolonged postnatal depression is associated with adverse effects on the mother-infant relationship and disruptive effects on families and older children.[25-27] The potential detrimental effects of postnatal depression on the mother-infant relationship and the subsequent poorer cognitive and emotional development of the child have been discussed by different researchers.[26,28] Poobalan et al. (2007) conducted a systematic review on the effects of treating postnatal depression on mother-infant relationship and child development. They concluded that the cognitive development in children, along with a better mother-infant relationship, might be improved with timely and sustained interventions for postnatal depression.[29]

Postnatal depression is a reversible and treatable illness. Different types of treatment such as psychotropic medications and patient-centred counselling therapies are available. For psychological treatment, there is evidence to support the effectiveness of self-help strategies including self-help programmes based on cognitive behavioural therapy (CBT); non-directive counselling; brief CBT; and interpersonal psychotherapy.[30] Antidepressants should be considered for women with PND of moderate or severe severity and those with mild PND not responding to psychological treatments. The risks and benefits of medications should be discussed with the patients especially for those who are breastfeeding. The tricyclic antidepressants (TCAs) imipramine and nortriptyline and the serotonin reuptake inhibitor (SSRI) sertraline are present in breast milk at relatively low levels, whereas the SSRIs fluoxetine and citalopram are present in breast milk at relatively high levels. In general, SSRIs are better tolerated and less toxic in overdose than TCAs.[30]

Screening for PND in the community

Because of its high prevalence, potential adverse consequences, and treatment availability, the early identification and management of PND is of imminent importance for the health of postnatal women and their families in the community. Researchers investigating postnatal depression in the Chinese populations opined that Chinese women tend to keep their feelings and might choose to keep silent instead of taking the initiative to admit that they have problems so their depressive symptoms are under-reported.[11, 27] Therefore, the active screening and identification of PND by healthcare professionals are particularly essential for the Chinese populations.

Lee & Chung (1999) raised the need for a territory-wide screening programme in Hong Kong in primary health care setting for postnatal depression as the fear of being labelled by their family and friends as "mad and bad" and not fit to take care of a child, together with the lack of knowledge of postnatal depression, often prevents Chinese women from seeking help and treatments.[31] As the screening programme would likely identify a significant proportion of postnatally depressed women who would otherwise be left untreated, they further elaborated that the programme had to be well-resourced and be backed up by a multidisciplinary team.

The Comprehensive Child Development Service (CCDS) launched in Hong Kong in 2005 aims to provide comprehensive and timely support to children and their

families.[6,32] Because of the potential adverse effects of postnatal depression on the early development of the children, one of the major service components of CCDS is the early identification and management of maternal postnatal depression. CCDS has been implemented in phases at different districts in Hong Kong. Under the CCDS, postnatal women will be routinely screened for depression at the Maternal and Child Health Centres (MCHCs) (i.e., at the primary health care settings) at six to eight weeks postnatally with the Chinese version of the Edinburgh Postnatal Depression Scale (EPDS).[33] Those screened positive with the EPDS will be counselled by MCHC nurses or MCHC doctors and be assessed and managed at MCHCs by psychiatric nurses who will triage and refer patients in need directly to the perinatal out-patient psychiatrist clinic at MCHCs or at HA hospitals.

For the period from 1st April 2008 to 31st March 2009, 200 new cases of PND were seen by the psychiatric team of Castle Peak Hospital under CCDS. The patients had significantly decreased EPDS score 6 months after treatment (8.2, SD = 4.3) as compared with that at intake (17.3, SD = 5.9) (p = 0.000). The Clinical Global Impression (CGI) scale score of the patients had decreased significantly six months after treatment (1.8, SD = 0.8) as compared with that at intake (4.1, SD = 0.8) (p = 0.000) indicating significant clinical improvement after treatment by the CCDS team.[32] Moreover, the patients were asked to rate the satisfaction on CCDS with a 7-point scale ranging from very dissatisfied to very satisfied with the service. Eighty-four percent of the patients were either satisfied or very satisfied with the service provided. They opined that the arrangement of seeing psychiatric workers at MCHCs made them feel less stigmatizsed and was more convenient for them as they were familiar with the environment at MCHCs. [32]

On the other hand, the psychiatric team of Castle Peak Hospital had studied the pathway to care for postnatal depression on 114 Chinese women from July 2008 to December 2008 attending the psychiatrist clinics under CCDS.[6] The screening programme for postnatal depression under CCDS was found to have served the purpose of treating postnatal depression early before the symptoms of depression became severe and before the functioning of the postnatally depressed women deteriorated.[6]

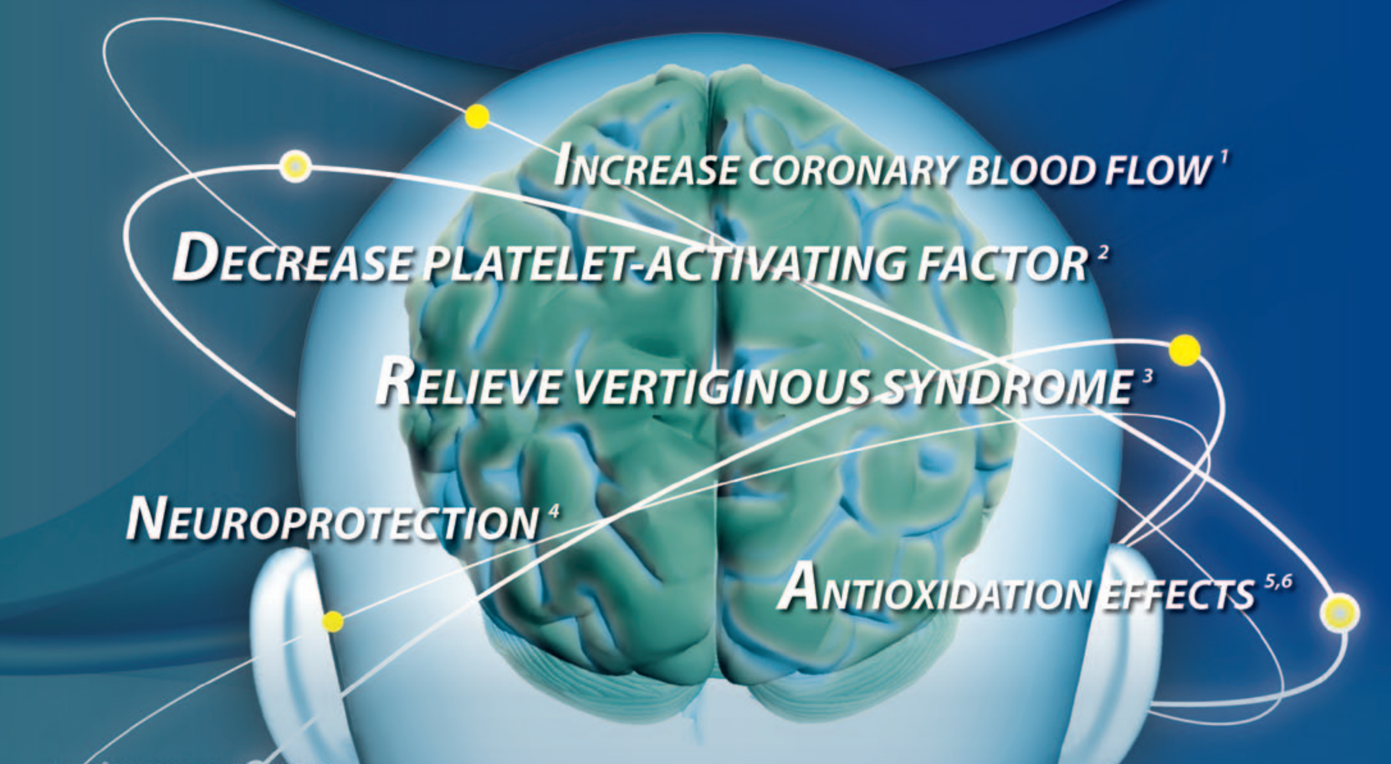
Conclusion

PND is a common psychiatric disorder affecting 10 to 15% of recently delivered women. Because of its potential adverse consequences on the postnatal women and their families, its reversibility and treatability, the early identification and management of PND is of imminent importance for the health of the community. The screening of PND at primary health care setting under CCDS can serve the purpose of intervening PND early in this locality.

References

1. Brugha TS, Sharp HM, Cooper SA, et al. The Leicester 500 project. Social support and the development of postnatal depressive symptoms, a prospective cohort survey. Psychol Med. 1998; 28: 63-79.
2. Chandran M, Tharyan P, Muliyil J, et al. Post-partum depression in a cohort of women from a rural area of Tamil Nadu, India: incidence and risk factors. Br J Psychiatry. 2002; 181: 499-504.
3. Cox J. Depression in the puerperium: a conceptual controversy. In Depression: an Integrative Approach (Herbst K & Paykel E. eds). London: Heinemann Medical Books; 1989: 124–139.
4. Creedy D, Shochet I. Caring for women suffering depression in the postnatal period. Australian and New Zealand Journal of Mental Health Nursing. 1996; 5:13–19.
5. Pitt B. Atypical depression following childbirth. Br J Psychiatry. 1968; 114: 1325-1335.
6. Siu BWM, Chow HMT, Kwok SSP, Li OL, Koo ML, Poon PW. The pathway to care for postnatal depression after implementation of the Comprehensive Child Development Service in a regional hospital in Hong Kong. Asia-Pacific Psychiatry. 2011; 3: 54-60.
7. Appleby L, Kumar R, Warner R. Perinatal Psychiatry. Int Rev Psychiatry. 1996; 8: 5-7.
8. Pillsbury BLK. "Doing the month": confinement and convalescence of Chinese women after childbirth. Soc Sci Med. 1978; 12:11–22.
9. Lee DTS, Yip SK, Chiu HF, et al. A psychiatric epidemiological study of postpartum Chinese women. Am J Psychiatry. 2001; 158: 220-226.
10. Lee DTS, Yip ASK, Leung TYS, Chung TKH. Ethnoepidemiology of postnatal depression: Prospective multivariate study of sociocultural risk factors in a Chinese population in Hong Kong. Br J Psychiatry. 2004; 184: 34-40.
11. Lee DTS, Yip ASK, Chiu HFK, Leung TYS, Chan KP, Chau IOL, et al. Detecting postnatal depression in Chinese women: Validation of the Chinese version of the Edinburgh postnatal depression scale. Br J Psychiatry. 1998; 172: 433-437.
12. O'Hara MW, Neunaber DJ, Zekowski EM. Prospective study of postpartum depression: prevalence, course and predictive factors. J Abnorm Psychol. 1984; 93: 158-171.
13. Siu BWM, Leung SSL, Ip P, Hung SF, O'Hara MW. Antenatal risk factors for postnatal depression: a prospective study of Chinese women at Maternal and Child Health Centres. BMC Psychiatry. 2012; 12: 22.
14. Bloch M, Schmidt PJ, Danaceau M, et al. Effects of gonadal steroids in women with a history of postpartum depression. Am J Psychiatry. 2000; 157: 924-930.
15. Halbreich U. Postpartum disorders: multiple interacting underlying mechanisms and risk factors. J Affect Disord. 2005; 88: 1-7.
16. Cox JL, Conner Y, Kendel RE. Prospective study of the psychiatric disorders of childbirth. Br J Psychiatry. 1982; 140: 111-117.
17. O'Hara MW. Social support, life events and depression during pregnancy and the puerperium. Arch Gen Psychiatry. 1986; 43: 567-573.
18. Paykel ES, Emms E, Fletcher J, Rassaby ES. Life events and social support in puerperal depression. Br J Psychiatry. 1980; 136: 339-346.
19. Kumar R., Robson K.M. A prospective study of emotional disorders in
20. Warner R, Appleby L,Whitton A, et al. Demographic and obstetric risk factors for postnatal psychiatric morbidity. Br J of Psychiatry. 1996; 168: 607– 611.
21. Lee DTS, Yip ASK, Leung TYS, Chung TKH. Identifying women at risk of postnatal depression: prospective longitudinal study. HKMJ. 2000; 6: 349-354.
22. Murray L, Cooper P, Hipwell A, et al. Mental health of parents caring for infants. Arch Womens Ment Health. 2003; 6 (Suppl. 2): 71-77.
23. Brockington IF. Postpartum psychiatric disorders. Lancet. 2004; 363: 303-310.
24. Friedman SH, Resnick PJ. "Neonaticide: Phenomenology and Considerations for Prevention. International Journal of Law and Psychiatry. 2009; 32: 43-47.
25. Oates M. Psychiatric disorder and childbirth. Curr Obstet Gynaecol. 1995; 5: 564-569.
26. Sharp D, Hay DF, Pawlby S, et al. The impact of postnatal depression on boy's intellectual development. J Child Psychol Psychiatry. 1995; 36: 1315-1336.
27. Siu BWM, Ip P, Chow HMT, Kwok SSP, Li OL, Koo ML, Cheung EFC, Yeung TMH, Hung SF. Impairment of mother-infant relationship: Validation of the Chinese version of Postpartum Bonding Questionnaire. J Nerv Ment Dis. 2010; 198: 174-179.
28. Murray L, Cooper PJ, Wilson A, Romaniuk H. Controlled trial of the short- and long-term effect of psychological treatment of postpartum depression: Impact on the mother-child relationship and child outcome. Br J Psychiatry. 2003; 182: 420-427.
29. Poobalan AS, Aucott LS, Ross L, Smith WCS, Helms PJ, Williams JHG. Effects of treating postnatal depression on mother-infant interaction and child development. Br J Psychiatry. 2007; 191: 378-386.
30. Antenatal and postnatal mental health: clinical management and service guidance, NICE Clinical Guideline (April 2007).
31. Lee DTS, Chung TKH. What should be done about postnatal depression in Hong Kong? Hong Kong Med J. 1999; 5(1): 39-42.
32. Siu BWM, Chow HMT, Kwok SSP, Koo ML, Poon PW. The Comprehensive Child Development Service for early identification and management of postnatal depression: service data of a regional hospital in Hong Kong. Hong Kong Journal of Mental Health. 2010; 36: 14-20.
33. Lee DTS, Yip SK, Chiu HF, et al. Detecting postnatal depression in Chinese women. Validation of the Chinese version of the Edinburgh postnatal depression scale. Br J Psychiatry. 1998; 172: 433-437.

NEUROPROTECTION POWERED BY VASCULAR CIRCULATION



Tanakan® Abbreviated Prescribing Information

Description: Each tablet contains standardized Ginkgo biloba extract (EGb 761) with 24% Ginkgo heterosides and 6% of Ginkgolides-bilobalide. **Therapeutic indications:** Minor neurologic disorders related to the age. Symptomatic treatment of arteritis of the lower limbs (leg arteries disease involving painful cramps during walking). Ocular disorders and other disorders (hearing or vertigo) of circulatory origin. Raynaud's disease. **Dosage and administration:** One dose is equal to one tablet containing 40mg of pure extract. Usual dosage: 3 tablets per day (in divided doses) at mealtimes. Tablets should be taken with a half-glass of water during meals. **Precautions:** Hypersensitivity to one of the ingredients of the tablet. Pregnancy. Breastfeeding. **Adverse effects:** Digestive disorders. Skin disorders. Headaches. **Contraindications:** This medicinal product contains lactose, it is contra-indicated in subjects presenting with congenital galactosemia, glucose or galactose malabsorption syndrome or with lactase deficiency. **Storage conditions and shelf life:** Store below 25°C. Do not exceed he expiry date plainly indicated on the packaging. Keep out reach of children. **Form and presentations:** tablets. Box of 30 tablets in blisters.

References:

1. Wu Y, Li S, Cui W, et al. Ginkgo biloba extract improves coronary blood flow in healthy elderly adults: role of endotheliumdependent vasodilation. Phytomedicine 2008;15:164-169. 2. Akisü M, Kültürsay N, Coker I, et al. Platelet-activating factor is an important mediator in hypoxic ischemic brain injury in the newborn rat. Biol Neonate 1998;74:439-444. 3. Haguenauer JP, Cantenot F, Koskas H and Pierart H. (1988) Treatment of disturbed equlibrium with Ginkgo biloba extract. In: Fünfgeld EW. Rökan (Ginkgo Biloba). Recent Results in Pharmacology and Clinic. (pp. 260-268). Springer-Verlag Berlin Heidelberg New York. 4. Lee EJ, Chen HY, Wu TS, et al. Acute administration of ginkgo biloba extract (Egb 761) affords neuroprotection against permanent and transient focal cerebral ischemia in Sprague-dawley rats. J Neurosci Res 2002;68:636-645. 5. Le Bars PL, Kieser M, Itil KZ. A 26-week analysis of a double-blind, placebo-controlled trial of the ginkgo biloba extract EGb 761® in dementia. Dement Geriatr Cogn Disord 2000;11:230-237. 6. Pietri S, Séguin JR, d'Arbigny P, et al. Ginkgo biloba extract (EGb761) pre-treatment limits free radical-induced oxidative stress in patients undergoing coronary bypass surgery. Cardiovasc Drugs Ther 1997;11:121-131.

Vital Base/HK/09057/0429/AA

Place of origin: France

Full prescribing information is available upon request.

LFASIAAD2011080

Manufactured by:

IPSEN
Innovation for patient care

Distributed by:

LF ASIA

LF Asia (Hong Kong) Limited - Healthcare Division
Address: 15/F, Li Fung Centre, 2 On Ping Street, Siu Lek Yuen, Shatin, Hong Kong
Tel: 2635 5950 Fax: 2637 5818

tanakan®
Standardized Ginkgo Biloba Extract (EGb 761) 40mg

IMH Conference Abstract

Age Differences in People with Generalised Anxiety Disorder

Kit-wai LEE
the Hong Kong Mental Morbidity Survey Team

Department of Psychiatry, The Chinese University of Hong Kong

Introduction
Generalised anxiety disorder (GAD) is one of the most common mental disorders. Patients with GAD often have high psychiatric co-morbidities such as depression and sleeping problems, which might hinder their social and occupational functions. People in different age groups have different roles and needs in their social network and work settings. It would be helpful to investigate if there is any age difference in people with GAD.

Method
The Hong Kong Mental Morbidity Survey is an on-going territory wide epidemiological study started in 2010, targeting at Chinese residents aged between 16 and 75 years in Hong Kong. The preliminary report analysed responses from the first 896 subjects. Diagnoses of common mental disorders were made based on the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) with the Revised Clinical Interview Schedule (CIS-R). The present article focused on studying subjects with a diagnosis of GAD, where symptom scores were compared across three age groups, 16-34, 35-64 and 75-year-old or above.

Results
Out of 896 subjects, 62 (6.9%) were diagnosed as having GAD, 13 (21%) of whom aged between 16 and 34, 43 (69.4%) aged between 35 and 64, and 6 (9.7%) aged 75 or above. Two differences between these subjects of different age groups were found. Firstly, 33 subjects in the 35-64 age group (53.2% of those with GAD diagnoses) reported having anxious/nervous/tense feelings for four days or more within the past seven days, in contrast to 6 (9.7% each) each for the other age groups (p=0.027). Secondly, 28 subjects in the 35-64 age group (45.2% of those with GAD diagnoses) reported feeling anxious/nervous/tense for more than three hours in total in any of the past seven days, while only 10 (16.1%) in the 16-34 age group and 1 (1.6%) in the >65 age group reported the same (p=0.035).

Conclusion
These findings suggest that mid-aged people with GAD may experience more intense core anxiety symptoms. The differential symptomatology across different age groups offers information to the design of intervention and caring schemes.

Antenatal Risk Factors for Postnatal Depression: Prospective Study of Chinese Women at Maternal and Child Health Centres

SIU B.W.M.[1], LEUNG S.S.L.[2], IP P.[3], HUNG S.F.[4], O'HARA M.W.[5]

1. Associate Consultant, Castle Peak Hospital; 2. Assistant Director of Health (Family and Elderly Health Services), Department of Health; 3. Associate Professor, Department of Paediatrics and Adolescent Medicine, the University of Hong Kong; 4. Hospital Chief Executive, Kwai Chung Hospital, 5. Professor, Department of Psychology, the University of Iowa, USA

Introduction
Overseas and local epidemiological studies revealed that 10 to 15% of recently delivered women were affected by postnatal depression. Postnatal depression has substantial impact on the quality of life and social functioning of the mother as well as the emotional and cognitive development of the newborn child. Because of the adverse consequences on the mother, the child and the family as a whole, the early identification and management of postnatal depression is of eminent importance for the health care system in a society. There is increasing recognition of the importance of identifying predictive factors during the antenatal period for postnatal depression and the main objective of this study was to identify these risk factors.

Method
A convenient sample of Chinese women aged 18 or above attending nine of the Maternal and Child Health Centres (MCHCs) for routine antenatal assessment was recruited. The participants were interviewed twice. The first interview was conducted during their routine antenatal assessment in the third trimester at MCHCs. Socio-demographic data, clinical data, and putative antenatal risk factors for postnatal depression were collected in a semi-structured manner by a questionnaire. The second interview was performed at

around two months postpartum and the participants were asked to complete the Chinese Edinburgh Postnatal Depression Scale and the Chinese Beck Depression Inventory; the Chinese version of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) was conducted to confirm the diagnosis of postnatal depression. The two-month postnatal depression status was used as the dependent variable for univariate and multivariate analyses of putative risk factors.

Results
A total of 805 participants completed the study. The prevalence of postnatal depression was 15.7%, which was comparable with overseas and local epidemiological studies. The results of this study revealed that marital dissatisfaction, dissatisfied relationship with mother-in-law, antenatal depressive symptomatology, and anxiety-prone personality independently predicted postnatal depression.

Conclusion
The findings supported the importance of assessing antenatal depressive symptomatology and to monitor women with these symptoms closely during the antenatal and postnatal periods. Health care professionals need to pay particular attention to women with anxiety-prone personality and those with relationship problems with their husbands and mother-in-law during the antenatal and postnatal periods in order to detect postnatal depression early. Moreover, interventions and supportive measures aiming at reducing the impact of these risk factors on these women may help to reduce the chance of the subsequent development of postnatal depression.

Dementia Caregivers Training Programme for Improving Care-giving Self-Efficacy

Natalie LAI, Cycbie MOK

Occupational Therapy Department, Castle Peak Hospital

Introduction
Dementia is a progressive disease which affects the person's cognition, emotion and behaviour. It also imposes great burden on caregivers. Caregivers play a significant role in maintaining people with dementia in the community. There is evidence that caregivers have increased physical and psychological morbidity and even mortality. A number of caregivers training programmes had demonstrated effectiveness in reducing caregivers' burden and the incidence of depression as well as delaying institutionalisation for those suffering from dementia. Caregiving self-efficacy is enhanced through knowledge and skills acquisition. This study aimed to explore the difference of caregiving self-efficacy between primary caregivers who had received dementia caregivers training and those who had not.

Method
Static group comparison of quasi-experimental design was adopted. Eighteen caregivers were recruited into a regional Dementia Caregivers Support Group by purposive sampling. With multi-disciplinary involvement of occupational therapists, community psychiatric nurses and social workers, a variety of topics including disease process, communication technique, management of daily living tasks and challenging behaviour, psychological support and introduction of social services were covered in 6 weekly sessions. Caregiving self-efficacy was measured and compared between those who had received dementia caregivers training (n = 10) and those who had not (n = 8).

Results
Caregiving self-efficacy, mainly for handling obstructive behaviour ($t = 3.6$, $p = 0.002$) and controlling upsetting thoughts ($t = 3.3$, $p = 0.004$), was significantly better in caregivers who had received dementia caregivers training programme. In contrast, caregiving self-efficacy for obtaining respite ($t = 1.4$, $p = 0.18$) did not show any significant difference between the two groups.

Conclusion
Apart from equipping the caregivers with the skills and knowledge on disease management, the training programme may contribute towards improving caregiving self-efficacy, mainly on reinforcing positive thoughts and beliefs of caregivers.

Depression among Hong Kong Primary and Secondary School Teachers

CHEUNG, K., YEUNG, K.K., LEUNG, S.F., LEE, R., and French, P.

School of Nursing, The Hong Kong Polytechnic University

Introduction
Results of studies worldwide have shown that school teachers are stressful and Hong Kong school teachers are no exception. In the Legislative Council meetings in 2000 and 2006, members have raised to the Hong Kong Government about their concerns on teachers' stress. With the current change of the education system in Hong Kong, primary and secondary school teachers might face more work stress than before. Studies have also shown that stress would affect teachers' performance and their health but few studies have been conducted in Hong Kong. The purpose of this study is to investigate school teachers' work stress and their mental health.

Method
This is a retrospective cross-sectional survey study. A self-administered questionnaire named "Teachers' work stress and mental health" was distributed to all primary and secondary schools teachers participating in this study in Kwai Tsing District. Fifteen schools (seven primary and eight secondary schools) with a total of 455 teachers participated in the study.

Results

Among the 455 participants, there were 288 (63.3%) secondary school teachers and 167 (37.3%) primary school teachers. The mean age was 38.7 years old (SD=9.41). Two thirds of the participants were female (n=294). On the visual analogue scale of 0-10 (0 = no stress and 10 = very stressful), participants had a high mean score of 7.29 (SD=1.62) for their work stress. In addition they had a fair job satisfaction with a mean score of 5.80 (SD=1.94) on the visual analogue scale of 0-10 (0 = very dissatisfied and 10 = very satisfied). About 13% (n=58) of the participants were identified to have depressive symptoms. Results of the independent t-test analysis showed that there was a significant difference ($P<0.05$) between depressed and non-depressed participants on their work stress, and work stress elements such as time management, work-related stressors, professional distress, professional investment, discipline and motivation, and emotional, fatigue, cardiovascular and behavioural manifestations. Furthermore, logistic regression found that work stress, emotional, cardiovascular and behavioural manifestations were predictors of depressive symptoms among school teachers.

Conclusion

Results of the study showed that 13% of school teachers suffered from depressive symptoms. Predictors identified are modifiable and preventable. Employers should pay attention to school teachers' physical, psychological and behavioural indicators for work stress. Mental health promoting activities and appropriate intervention on work stress management should be provided to the school teachers to reduce their risks in developing depression or other psychological problems.

The Effects of Exercise on Depression among Women: A Systemic Review

Windy TSUI

Physiotherapy Department, United Christian Hospital, HKSAR

Introduction

Previous studies suggested exercise is a potential alternative intervention to traditional treatment for depression. In view of the gender difference in epidemiology of depression and exercise pattern, this review focused on the effects of exercise therapy among women with depression.

Method

The author searched Medline, EMBASE, PubMed, PsychINFO, CINAHL, the Cochrane Central Register of Controlled Trials and Physiotherapy Evidence Database. Chinese database including CJN, CMCC and Taiwan Electronic Periodical Service were also searched. Only randomised controlled trails (RCTs) examining effects of exercise among adult women with clinical depression were included. Data were extracted using a structured form and the qualities of the trials were assessed by the PEDro scale.

Results

Ten RCTs were identified. Meta-analysis found a pooled SMD (-0.94; 95% CI: -1.54,-0.33) of large effect size for both aerobic and resistance training. When low-quality (PEDro <= 5) RCTs were excluded, the SMD declined to -0.69, which still indicated a moderate effect size.

Conclusion

The result is encouraging and suggests the probable benefits of integrating exercise therapy into traditional treatment for depression in women. In addition, exercise therapy brings about more positive images, less stigma, and physical benefits.

Feburic®
(febuxostat)

A novel non-purine, selective xanthine oxidase inhibitor[2]

Significantly superior to allopurinol 300 mg in lowering serum uric acid level[3]

83% reduction in tophus area by week 52[3]

References:

1. Schlesinger N. Curr Rheumatol Rep 2010; 12(2):130-134. 2. Takano Y et al. Life Sci 2005; 76:1835-1847.
3. Becker MA et al. N Engl J Med 2005; 353(23):2450-2461.

FEBURIC® 80mg Abridged Prescribing Information
Indication: Treatment of chronic hyperuricaemia in conditions where urate deposition has already occurred (including a history, or presence of, tophus and/or gouty arthritis). **Dosage and administration:** The recommended oral dose of FEBURIC is 80 mg once daily without regard to food. Gout flare prophylaxis of at least 6 months is recommended **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** Patients with cardio-vascular disorders, acute gouty attacks, xanthine deposition, thyroid disorder, galactose intolerance, Lapp lactase deficiency, glucose-galactose malabsorption and who are concomitantly treated with mercaptopurine/azathioprine and theophylline. Liver function test is recommended prior to the initiation of therapy with febuxostat and periodically thereafter based on clinical judgement. **Undesirable effects:** The most commonly reported ADRs are liver function abnormalities (3.5%), diarrhoea (2.7%), headache (1.8%), nausea (1.7%), rash (1.5%).
Full prescribing information is available upon request

Astellas Pharma Hong Kong Co., Ltd.
Unit 1103-07, 11/F, Tower 1, Grand Century Place,
193 Prince Edward Road West, Mongkok, Kowloon, Hong Kong
Tel: (852) 2377 9801 Fax: (852) 2856 1440

astellas
Leading Light for Life

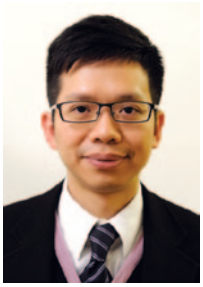
FBR-MAD-060712-0001

Interaction between Psychiatrists and Psychiatric Service Users Through Photography

Dr. Ivan WC MAK

FHKAM (Psychiatry), FHKCPsych

Associate Consultant, Department of Psychiatry, United Christian Hospital



Dr. Ivan WC MAK

In February 2012, the Hong Kong College of Psychiatrists organised a "Here and Now" photography project with the Tung Wah Group of Hospitals Radio-i-Care and Rotary Club of Peninsula. It consisted of a photography-sharing workshop and a cross-over outdoor shooting event with participation of both psychiatric doctors and service users.

Background

In a conventional psychiatric service setting, it usually involves service user consulting a psychiatrist on how to deal with various psychiatric problems and life stressors. With our services becoming more community-orientated, it would be interesting to go out from our consultation rooms to have mutual sharing of life experience with service users in a more interactive way. Photography is one of the desirable media for such purpose. Apart from learning technical skills, participants may enhance their communication skills and ability to view things in different perspectives, both of which may be useful for their recovery.

Photography sharing workshop

On 11 February 2012, a photography-sharing workshop was held. Below are some interesting excerpts of interaction:

During the workshop, I asked the service users, *'What do we need to have and pay attention to in order to take a good picture?'* They correctly highlighted the importance of light source, good composition and a good subject of interest.

While all of us would use our hands to hold our cameras, a service user suggested that *'Legs are also necessary'*. He added that *'we need a good tripod to shoot sometimes'*.

Their knowledge and understanding about photography were beyond my expectation. They understood the need to use our brains, our hearts (mind), as well as to widen our exposure to other areas and apply them all to photography.

One service user also commented, *'We have to use our ears.'* This, of course, immediately attracted my further exploration. She replied *'we have to listen to the wind and use our eyes to communicate with our environment'*. I thought she had grasped some of the most important principles for *"here and now"* photography.

During the workshop, I shared with them some photos taken inside a temple in China Mainland. A service user raised other interesting questions. *'Would it be scary to shoot inside a temple? Would this practice attract ghosts?'* I was not sure whether it might be related to any underlying psychiatric symptoms and I didn't have an immediate valid answer but I suggested him choosing the topics that he felt comfortable to shoot with.

At the end of the workshop, a service user raised an issue on how to overcome hand tremors while taking photos. I realised that they might encounter such problems due to the side effects of psychiatric medications. I suggested her to try to increase the shutter speed, use a higher ISO, and pay more attention to her posture. She left happily and said *'I will try!'*.

We also discussed about the experience of shooting in a rainy day. Initially, many in the audience opined that probably there could be no great photos without sunlight. I then shared with them some of my favourite pictures taken in a rainy day. At the end of the workshop, I repeated this question. *"Do you think you can take good pictures in a rainy day? Do you think you can take good pictures in Hong Kong without the need to travel abroad?"* I heard a resounding yes from a group of enthusiastic and confident audience.

"Will you be able to enjoy life even if you suffer from mental problems?" I forgot to ask this question during the workshop but I would expect positive answers from them as well.

Cross-over outdoors shooting event:

On 18 February 2012, some psychiatric colleagues and I were divided into three groups to go to different areas for shooting with different subjects of interest. I was responsible for leading a group in Central to take pictures on the theme *"Human and Love"*. It was hard to imagine what it would be like to shoot in a crowded inner city area with a group of psychiatric service users. It turned out to be an interesting and exciting experience. Instead of writing, I would like to share with you some pictures taken by our service users that touched many of us.

A service user who interacted with a foreigner impressed me. She said, *"I have talked to the foreigner with*

the only English sentence that I know in such situation: May I take a photo with you?" and she was very excited as it was the first time for her to speak to a foreigner.

西人在中環 Foreigner in Central – taken by a psychiatric service user

Another service user took a photo of two apparently non-forthcoming persons who were drinking beer and smoking cigarettes besides the road. Our service users were asked who they were. They openly admitted that they were mental patients and they received a favourable response. They added that it was not easy to admit having psychiatric illness in the public, but they had to overcome this obstacle.

煙與酒 Cigarettes and alcohol – taken by a psychiatric service user

The blurring was not special Photoshop effect but was caused by hand tremor, a common side-effect related to psychiatric medications.

迷濛看中環 Blurred Central – by a psychiatric service user

Sharing of the whole experience

It is possible that some readers may not think these are great pictures, but all the participants really treasured the process of interacting with others and the messages that were brought out through these events. The learning was not one-sided. For the service users, they learned some practical skills in photography and communicating with others. For the psychiatric doctors, the events helped us understand that our patients need to tackle various life obstacles, including medication side effects, stigmatisation and self-esteem issues etc. As their treating psychiatrists, we need to guide and encourage our patients and pay attention to every single and apparently trivial complaint from them.

結步同行 Walk besides you- taken by Dr Ivan Mak on 18 February 2012

Finally, I would like to share a group photo taken by me on that day. It involved the feet of the participating doctors and service users pointing at a symbol with a pair of shoes connected by shoelaces. I do hope we can join hands as well as "feet" to help our patients lead better lives and overcome obstacles caused by their mental illness.

Last but not least, I would like to express my heartfelt gratitude to other psychiatric doctor colleagues who contributed to these meaningful events. If readers find the content interesting and would like to join similar photography events in the future, please feel free to email me at ucmakwc1@ha.org.hk

Reliable Lateral Flow Rapid Test

ACON® brand is changing to ABON™

The Lateral Flow immunoassay business of ACON Laboratories Inc. (“**ACON**”) was acquired by **Alere** Inc. and this product line is rebranded to “**ABON**” from now on.

The manufacturing and research facility of ABON complies to the latest quality systems, employs state of the art manufacturing processes and cutting edge technology which is recognized by their accreditation with the major global regulatory authorities such as the US **FDA**, **CE** IVD, the **Japanese GMP** and the Brazilian ANVISA. The manufacturing facilities of ABON is US **FDA audited** and **ISO 13485:2003** certified.

ABON™

1 July 2012

INFECTIOUS DISEASES — **HIV, HBV** surface antibody / antigen, **Syphilis, TB, *H.pylori*** antibody / antigen, **Rotavirus, Adenovirus** etc.

WOMEN’S HEALTH — **HCG** urine/serum, **LH, Chlamydia** etc.

ONCOLOGY — **Fecal Occult Blood, PSA** etc.

DRUG OF ABUSE — Single and Multiple Drug Screen Device: **Cotinine, Ketamine, AMP, BZO, COC, MDMA, MET, MOP, THC** etc.

CARDIOVASCULAR — **Troponin I** etc.

Inverness Medical Innovations Hong Kong Limited (IMIHK), an affiliate of **Alere** Inc., has appointed **Science International Corporation** as the exclusive distributor of ABON in Hong Kong.

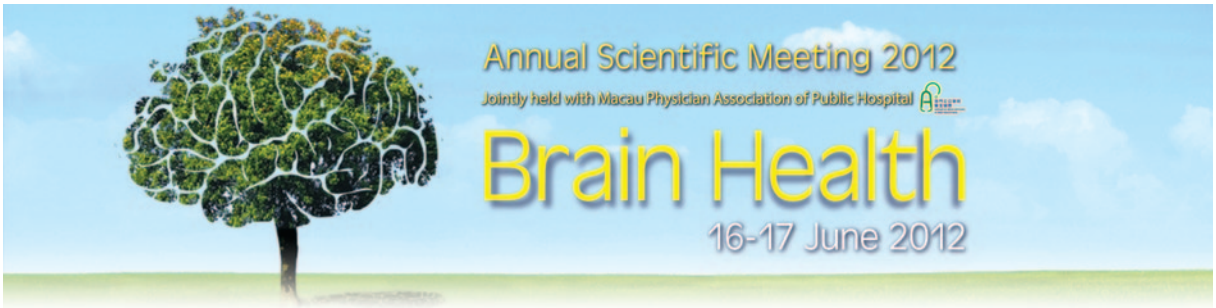
Alere™ inverness medical®

www.imihongkong.com

新 儀 公 司
Science International Corporation

Tel.: **2543-7442**, e-mail: **medical@scienceintel.com**

Annual Scientific Meeting 2012 – Brain Health



On 16 and 17 June 2012, the Federation of Medical Societies of Hong Kong (FMSHK) and the Macau Physician Association of Public Hospital (AMHFPM) co-organised the Annual Scientific Meeting (ASM) with the theme of "Brain Health". This year, the ASM was held in the Mandarin Oriental Macau Hotel with the aim to connect medical professionals in Hong Kong, Macau and the China Mainland through the sharing of the latest advances in medical knowledge and experiences.

The Scientific Meeting was kicked off with the ribbon cutting ceremony officiated by Dr. Raymond LO, President of FMSHK; Dr. LEE Pui-I, President of AMHFPM, 澳門衛生局代局長陳偉蒨醫生 , 澳門鏡湖醫院院長王庭槐教授 , Dr. Mario CHAK, Co-chairman, Education Committee of FMSHK and 澳門公里醫院醫生協會監事長楊健梅醫生 Opening speeches were presented by Dr. TAI Wa Hou, Executive Director of AMHFPM, and Dr. Mario CHAK.

Through the two half-day sessions on Saturday afternoon and Sunday morning, 16 chairmen and 27 speakers joined hands to deliver talks with rich contents and impressive insights. The talks covered a wide range of medical issues, including Epilepsy, Rehabilitation and Spasticity Management, Medical and Surgical treatment of Stroke, Neuro-degenerative Disease, Sleep Problems, Mental Health, Attention Deficit Hyperactivity Disorder and Autism, Pain Management and Parkinson's Disease. Parallel symposiums were also arranged on both days to offer different options for participants to choose their preferred talks. Towards the end of each symposium, the respective chairmen presented to each of our guest speakers a Bound Copy of the Hong Kong Medical Diary 2011 as a souvenir. Six booths were set up by drug manufacturers and they attracted crowds of participants, especially during coffee breaks.

The Gala Dinner started with the keynote speech by Dr. Dawson FONG on Controversies of Brain Death and it was highly stimulating. Under a pleasant and enjoyable atmosphere, with live band performance and lucky draw, Hong Kong and Macau delegates gathered together and shared the fun and laughter. The highlight of the event was the toasting ceremony headed by Presidents of organisers, Dr. Raymond LO and Dr. LEE Pui-I, as well as their teams.

The Meeting was a success with 800 participants from Macau. From Hong Kong, there were also doctors, nurses, therapists, and even dental and medical students, representing the various member societies under FMSHK. The collection on knowledge, the exchange of insights, as well as the platform for sharing - all proved the Meeting memorable and successful.

We would like to express our sincere gratitude to Dr. Raymond LO, President of FMSHK and Dr. LEE Pui-I, President of AMHFPM; the chairmen of both organising teams, Dr. Mario CHAK and Dr. TAI Wa Hou; all guest chairmen and speakers. Our gratitude also extends to various supporting sponsors. Last but not least, heartfelt appreciation must be expressed for the kind help and support from the Macau Physician Association of Public Hospital, the Macau Government and our Macau professional colleagues. We look forward to organising more academic activities for our members in the near future.

Acknowledgement is due to our chairmen and speakers from our Hong Kong side as follows:

Dr. Raymond LO; Prof. Godfrey CF CHAN; Dr. Yin-kwok NG; Dr. Dawson TS FONG; Dr. Wai-kwong CHAK;
Dr. Chi-wai MAN; Mr. Samuel KC CHAN; Dr. Kwong-yui YAM; Dr. Kam-fuk FOK; Dr. Howan LEUNG;
Dr. Carina CF LI; Dr. Leonard SW LI; Dr. Kenneth FONG; Prof. Dahong ZHUO; Dr. Joyce SP LAM;
Dr. Jamie CM LAM; Dr. Sik-chuen TING; Dr. Willy CH WONG; Dr. Wing-chi FONG; Dr. Bruce KT CHAN;
Dr. Ki WANG; Dr. Tony TS LAI; Prof. Timothy CY KWOK; Dr. Nelson YF CHEUNG

ASM 2012 - Photo Gallery


Brain Health
Expect delays
Temodal

CERTIFICATE COURSE FOR MEDICAL AND HEALTH PROFESSIONALS

Course No. C199 | CME/CNE Course

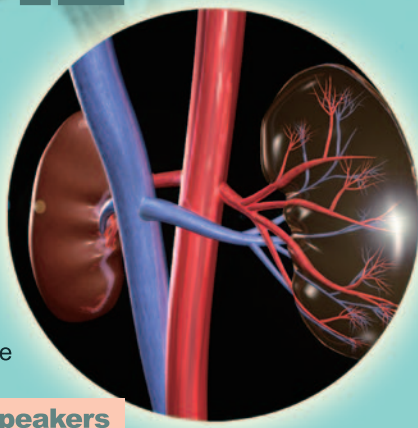
Certificate Course on

Renal Medicine 2012

Jointly organised by

The Federation of Medical Societies of Hong Kong

Hong Kong Society of Nephrology



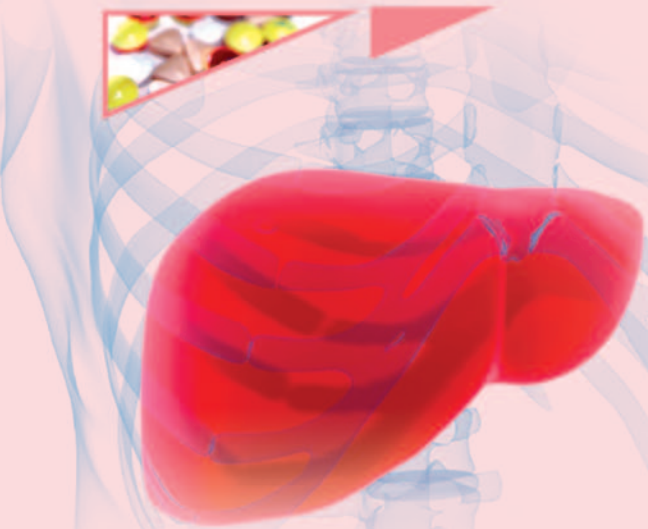
Objectives: To update the participants on new advances in renal medicine and clinical practice of common renal problems, and to help the participants to interpret results of common renal investigations

Date	Topics	Speakers
20 Sep	Screening tests for renal disease including approach to proteinuria & haematuria	Dr. Bonnie Ching-ha KWAN
	How to interpret common investigation tests for renal disease	Dr. Chi-kwan WONG
27 Sep	Update and management of primary glomerulonephritis	Dr. Kai-ming CHOW
	Renal protective strategy for chronic kidney disease	Dr. Sze-kit YUEN
4 Oct	Drug prescribing in renal failure	Dr. Kay-tai LEUNG
	Update and management of acute kidney injury	Dr. Terence Pok-siu YIP
11 Oct	Update on diabetic nephropathy	Dr. Kin-yee LO
	Palliative care in end stage renal disease	Dr. Hoi-wong CHAN
18 Oct	ABC of peritoneal dialysis therapy	Dr. Man-fai LAM
	ABC of hemodialysis therapy	Dr. Kwok-hong CHU
25 Oct	ABC of kidney donation	Dr. Sunny Sze-ho WONG
	ABC of renal transplantation	Dr. William LEE

Date : 20 September 2012 – 25 October 2012 (Every Thursday)
Time : 7:00 pm – 8:30 pm
Venue : Lecture Hall, 4/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong
Language Media : Cantonese (Supplemented with English)
Course Fee : HK$750 (6 sessions)
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 in application

A total of 9 CNE points for the whole course and the points will be awarded according to the number of hours attended.
Application form can be downloaded from website: http://www.fmshk.org



Certificate Course on
Hepatology

Jointly organised by

The Federation of Medical Societies of Hong Kong

Hong Kong Association For The Study Of Liver Diseases

Objective: To improve the knowledge of common liver problems

Dates	Topics	Speakers
4 Sep	Acute viral hepatitis – an overview	Dr. Thomas Sik-to LAI Part-time Consultant Department of Medicine & Geriatrics Princess Margaret Hospital / Private Practice
11 Sep	NASH	Dr. Cecilia Wai-hing WONG Medical Consultant / Private Practice
18 Sep	Approach to Space Occupying Lesion in liver	Dr. Yat-wah YEUNG Private Practice
25 Sep	Drug-induced liver injury	Dr. Tai-nin CHAU Consultant, Gastroenterologist and Hepatologist Union Hospital / Honorary Consultant, Department of Medicine and Geriatrics United Christian Hospital / Private Practice
9 Oct	Update in the management of HBV	Dr. Nancy Wai-yee LEUNG Clinical Professor (Hon) CUHK / Private Practice
16 Oct	Alcohol and alcoholic liver diseases	Dr. Jak-yiu LAI Private Practice / Part-time Consultant Department of Medicine & Geriatrics Princess Margaret Hospital

Date : 4 September 2012 – 16 October 2012 (Every Tuesday)
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
Language Media : Cantonese (Supplemented with English)
Course Fee : HK$750 (6 sessions)
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 in application
A total of 9 CNE points for the whole course and the points will be awarded according to the number of hours attended.
Application form can be downloaded from website: http://www.fmshk.org

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			* HKMA Yau Tsim Mong Community Network – Clinical Nephrology Update 2012 (Session 2) **1**	**2**	* Joint Surgical Symposium - From Microscope to Robot: Urologist Practice Tools **3**	**4**
* Joint Professional Basketball Tournament 2012 (Semi-final) **5**	**6**	* HKMA CME – The Hong Kong Medical Association Community Network Exercise Prescription Courses (Session 1) * FMSHK Officers' Meeting * HKMA Council Meeting **7**	* Hong Kong Neurosurgical Society Monthly Academic Meeting –HIV in neurosurgery * HKMA CW&S Community Network- Management of Insomnia and the Use of Hypnotic Medications **8**	* HKMA Kln East Community Network - Acne and Acne Scar Management * HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2012 – Disorder of growth and puberty * FMSHK Executive Committee Meeting **9**	**10**	**11**
* Joint Professional Ten-Pin Bowling Tournament 2012 **12**	**13**	* HKMA CME – The Hong Kong Medical Association Community Network Exercise Prescription Courses (Session 2) **14**	* HKMA Yau Tsim Mong Community Network – Clinical Nephrology Update 2012 (Session 3) **15**	* HKMA Hong Kong East Community Network - Individualizing Diabetes Management **16**	* HKPS 50th Anniversary Multidisciplinary Conference –The Evolution and Revolution of Child Health in Hong Kong: Past, Present and the Future **17**	* HKPS 50th Anniversary Multidisciplinary Conference –The Evolution and Revolution of Child Health in Hong Kong: Past, Present and the Future * HKMA CME – Health Personnel 2012 **18**
* HKPS 50th Anniversary Multidisciplinary Conference –The Evolution and Revolution of Child Health in Hong Kong: Past, Present and the Future * Joint Professional Basketball Tournament 2012 (Final) **19**	**20**	* HKMA CME – The Hong Kong Medical Association Community Network Exercise Prescription Courses (Session 3) **21**	* HKMA CW&S Community Network- Practical Challenge & Insights in Osteoporosis Management * HKMA Shatin Doctors Network - Update Management of DM **22**	* FMSHK Executive Committee and Council Meeting **23**	**24**	* HKMA YTM Community Network – Certificate Course on Bringing Better Health to Our Community (Session 4) **25**
26	**27**	* HKMA Kowloon West Community Network - New Insight in Osteoporosis and Role of RANK Ligand Inhibitor **28**	* HKMA Yau Tsim Mong Community Network – Clinical Nephrology Update 2012 (Session 4) **29**	* HKMA Hong Kong East Community Network - Rhythm vs Rate Control in AF Management **30**	**31**	

Calendar of Events

Date / Time	Function	Enquiry / Remarks
1 WED	**HKMA Yau Tsim Mong Community Network – Clinical Nephrology Update 2012 (Session 2)** Organiser: HKMA Yau Tsim Mong Community Network, Queen Elizabeth Hospital & Hong Kong Nephrology Group, Chairman: Dr. CHAU Ka Foom, Speakers: Dr. WONG Ho Sing, Joseph & Dr. HO Chung Ping, MH, JP, Venue: Block M, Lecture Theatre, Queen Elizabeth Hospital, 30 Gascoigne Road, Kowloon, Hong Kong	Miss Candice TONG Tel: 2527 8285 1 CME point
3 FRI	**Joint Surgical Symposium - From Microscope to Robot: Urologist Practice Tools** Organiser: Department of Surgery, The University of Hong Kong & Hong Kong Sanatorium & Hospital, Chairman: Dr. WONG Wai-sang, Speakers: Dr. YIU Ming-Kwong & Dr. HO Kwan-Lun, Venue: Hong Kong Sanatorium & Hospital	Department of Surgery, Hong Kong Sanatorium & Hospital Tel: 2835 8698 1 CME point
5 SUN 2:00 pm	**Joint Professional Basketball Tournament 2012 (Semi-final)** Organiser: The Hong Kong Medical Association	Ms. Dorothy KWOK Tel: 2527 8285
7 TUE 1:30 pm	**HKMA CME – The Hong Kong Medical Association Community Network Exercise Prescription Courses (Session 1)** Organiser: The Hong Kong Medical Association, Speaker: Prof. Ip Wing Yuk, Venue: Panda Hotel, 3 Tsuen Wah Street, Tsuen Wan, NT	Ms. Viviane LAM Tel: 2527 8452 2 CME points
8:00 pm	**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. Nancy CHAN Tel: 2527 8898
8:00 pm	**HKMA Council Meeting** Organiser: The Hong Kong Medical Association, Chairman: Dr. TSE Hung Hing, Venue: HKMA Head Office (5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong)	Ms. Christine WONG Tel: 2527 8285
8 WED 7:30 am	**Hong Kong Neurosurgical Society Monthly Academic Meeting –HIV in neurosurgery** Organiser: Hong Kong Neurosurgical Society, Chairman: Dr. LAW Hing Yuen, Speaker: Dr. YU Chi Hung, Venue: Seminar Room, Ground Floor, Block A, Queen Elizabeth Hospital	Dr. Gilberto LEUNG Tel: 2255 3368 1.5 CME points
1:00 pm	**HKMA CW&S Community Network- Management of Insomnia and the Use of Hypnotic Medications** Organiser: HKMA CW&S Community Network, Chairman: Dr. TSANG Chun Au, Speaker: Dr. KWOK Wai Ming, Henry, Venue: HKMA Central Premises, 2/F. Chinese Club Building, 21-22 Connaught Road Central, HK	Mr. Alan LAW Tel: 2527 8285 1 CME point
9 THU 1:00 pm	**HKMA Kln East Community Network - Acne and Acne Scar Management** Organiser: HKMA-KLN East Community Network, Chairman: Dr. AU Ka Kui, Gary, Speaker: Dr. CHIU Lai Shan, Mona, Venue: Lei Garden Restaurant, Shop No. L5-8 on Level 5, APM Millennium City 5, 418 Kwun Tong Road, Kwun Tong	Mr. Alan LAW Tel: 2527 8285 1 CME point
2:00 pm	**HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2012 – Disorder of growth and puberty** Organiser: The Hong Kong Medical Association, Speaker: Dr. LOW Chung Kai, Louis, Venue: The Hong Kong Medical Association Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central	Ms. Viviane LAM Tel: 2527 8452 1 CME point
8:00 pm	**FMSHK Executive Committee Meeting** Organiser: The Federation of Medical Societies of Hong Kong, Venue: Council Chamber, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Nancy CHAN Tel: 2527 8898
12 SUN 1:30 pm	**Joint Professional Ten-Pin Bowling Tournament 2012** Organiser: The Hong Kong Medical Association, Venue: Magic Fun Bowling World	Ms. Dorothy KWOK Tel: 2527 8285
14 TUE 1:30 pm	**HKMA CME – The Hong Kong Medical Association Community Network Exercise Prescription Courses (Session 2)** Organiser: The Hong Kong Medical Association, Speaker: Dr. Raymond HF CHAN, Venue: Panda Hotel, 3 Tsuen Wah Street, Tsuen Wan, NT	Ms. Viviane LAM Tel: 2527 8452 2 CME points
15 WED 1:00 pm	**HKMA Yau Tsim Mong Community Network – Clinical Nephrology Update 2012 (Session 3)** Organiser: HKMA Yau Tsim Mong Community Network, Queen Elizabeth Hospital & Hong Kong Nephrology Group, Chairman: Dr. CHAK Wai Leung, Speakers: Dr. CHIU Kai Ming, Leo& Dr. HO Chung Ping, MH, JP, Venue: Block M, Lecture Theatre, Queen Elizabeth Hospital, 30 Gascoigne Road, Kowloon, Hong Kong	Miss Candice TONG Tel: 2527 8285 1 CME point
16 THU 1:00 pm	**HKMA Hong Kong East Community Network - Individualizing Diabetes Management** Organiser: HKMA Hong Kong East Community Network, Chairman: Dr. AU YEUNG Shiu Hing, Speaker: Dr. Norman CHAN, Venue: HKMA Head Office (5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong)	Miss Candice TONG Tel: 2527 8285
17 FRI *(18,19)*	**HKPS 50th Anniversary Multidisciplinary Conference –The Evolution and Revolution of Child Health in Hong Kong: Past, Present and the Future** Organiser: The Hong Kong Paediatric Society, Venue: The Hong Kong Academy of Medicine, Aberdeen	Conference Secretariat Tel: 2871 8897
18 SAT 1:30 pm	**HKMA CME – Health Personnel 2012** Organiser: The Hong Kong Medical Association, Chairman: Dr. LEUNG Man Fuk, Speaker: Dr. Elaine CHEUNG Yun Ning, Venue: Lecture Theatre, G/F, Block F, UCH	Miss Candice TONG Tel: 2527 8285
19 SUN 2:00 pm	**Joint Professional Basketball Tournament 2012 (Final)** Organiser: The Hong Kong Medical Association	Ms. Dorothy KWOK Tel: 2527 8285
21 TUE 1:30 pm	**HKMA CME – The Hong Kong Medical Association Community Network Exercise Prescription Courses (Session 3)** Organiser: The Hong Kong Medical Association, Speaker: Mr. Eyckle WONG, Venue: Panda Hotel, 3 Tsuen Wah Street, Tsuen Wan, NT	Ms. Viviane LAM Tel: 2527 8452 2 CME points
22 WED 1:00 pm	**HKMA CW&S Community Network- Practical Challenge & Insights in Osteoporosis Management** Organiser: HKMA Central, Western & Southern Community Network, Chairman: Dr. HO Lai Ching, Sabrina, Speaker: Dr. KUNG Wai Chee, Annie, Venue: HKMA Central Premises, 2/F. Chinese Club Building, 21-22 Connaught Road Central, HK	Mr. Alan LAW Tel: 2527 8285 1 CME point
1:00 pm	**HKMA Shatin Doctors Network - Update Management of DM** Organiser: HKMA Shatin Doctors Network, Chairman: Dr. MAK Wing Kin, Speaker: Dr. LUK On Yan, Andrea, Venue: Jasmine Room, Level 2, Royal Park Hotel, 8 Pak Hok Ting Street, Shatin, Hong Kong	Miss Candice TONG Tel: 2527 8285

Date / Time	Function	Enquiry / Remarks
23 THU 7:00 pm	**FMSHK Executive Committee and Council Meeting** Organiser: The Federation of Medical Societies of Hong Kong, Venue: Council Chamber, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Nancy CHAN Tel: 2527 8898
25 SAT 1:00 pm	**HKMA YTM Community Network – Certificate Course on Bringing Better Health to Our Community (Session 4)** Organiser: HKMA Yau Tsim Mong Community Network and Department of Family Medicine & General Outpatient Clinic and Department of Medicine, Kowloon Central Cluster, Speakers: Dr. NG Ying Wai & Dr. AU YEUNG Yick Toa, Venue: Block M, Lecture Theatre, Queen Elizabeth Hospital,30 Gascoigne Road, Kowloon, Hong Kong	Miss Candice TONG Tel: 2527 8285
28 TUE 1:00 pm	**HKMA Kowloon West Community Network - New Insight in Osteoporosis and Role of RANK Ligand Inhibitor** Organiser: HKMA Kowloon West Community Network, Chairman: Dr. WONG Wai Hong, Bruce, Speaker: Dr. YAU See Yun, Joyce, Venue: Crystal Room I-III, 30/F., Panda Hotel, 3 Tsuen Wah Street, Tsuen Wan, N.T.	Miss Candice TONG Tel: 2527 8285
29 WED 1:00 pm	**HKMA Yau Tsim Mong Community Network – Clinical Nephrology Update 2012 (Session 4)** Organiser: HKMA Yau Tsim Mong Community Network, Queen Elizabeth Hospital & Hong Kong Nephrology Group, Chairman: Dr. NG Kwok Keung, Speakers: Dr. CHAK Wai Leung & Dr. CHAN Hoi Wong, Venue: Block M, Lecture Theatre, Queen Elizabeth Hospital, 30 Gascoigne Road, Kowloon, Hong Kong	Miss Candice TONG Tel: 2527 8285
30 THU 1:00 pm	**HKMA Hong Kong East Community Network - Rhythm vs Rate Control in AF Management** Organiser: HKMA Hong Kong East Community Network, Chairman: Dr. LAM See Yui, Joseph, Speaker: Dr. KO Lap Yan, Ryan, Venue: HKMA Head Office (5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong)	Miss Candice TONG Tel: 2527 8285

Upcoming Meeting

12-14/9/2012	**MEDICAL FAIR ASIA 2012 – 8th International Exhibition on Hospital, Diagnostic, Pharmaceutical, Medical & Rehabilitation Equipment & Supplies** Organiser: Messe Düsseldorf Asia Pte Ltd, Venue: Suntec, Singapore	Miss Lucinda CHIU Miss Natalie TSANG Tel: 2838 3183
23/9/2012	**2012 Paediatric Update No. 2 – Recent Advances in Paediatric Surger** Organiser: Hong Kong College of Paediatricians, Chairmen: Dr. WONG Sik-nin & Dr. Kelvin LIU, Speakers: Dr. Patrick CHUNG, Dr. Jennifer SIHOE, Dr. Michael LEUNG & Dr. Kelvin LIU, Venue: Hospital Authority Head Office M Floor, Lecture Theatre	Hong Kong College of Paediatricians Tel: 2871 8773 3 CME points (Category A)
27-28/10/2012	**20th Annual Scientific Meeting of Hong Kong College of Radiologists** Organiser: Hong Kong College of Radiologists, Venue: Hong Kong Academy of Medicine Jockey Club Building, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong	Hong Kong College of Radiologists Tel: 2871 8788

Answer to Dermatological Quiz

1. The extensive intensely itchy polymorphic erythematous urticated papules, patches and plagues with scaling affecting the patient's abdomen (Fig. 4a), proximal upper limbs (Fig. 4b) and thighs in this primiparous woman carrying twin pregnancies was most compatible with polymorphic eruption of pregnancy, PEP (also named as pruritic urticarial papules and plaques of pregnancy, PUPPP).

   It is the most common pregnancy specific dermatosis and estimated to affect as high as 1:160 deliveries. It is commonly seen in primiparous women with rapid and excessive weight gain as a possible predisposing factor. Onset is most often in the later part of the third trimester or in the immediate postpartum period. It usually presents with pruritic urticarial papules starting in the abdominal striae and spreads over a matter of days. Typical cases may show periumbilical sparing. The face, palms and soles are usually not affected. Microvesiculation may occur but blister formation is not seen. Target or annular and polycyclic lesions are seen uncommonly.

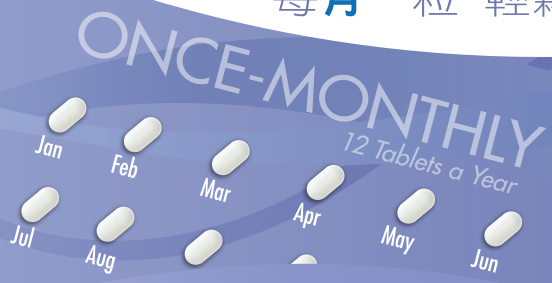
   Differential diagnoses include urticaria, viral exanthems and drug eruption. But the most important differential diagnosis is the pre-bullous phase of pemphigoid gestationis which is a pregnancy specific immunobullous disease with blistering eruption.

2. The histological finding for PEP is usually non-specific. For atypical cases, skin biopsy can be considered to rule out other important diseases such as pemphigoid gestationis. For typical cases of PEP, potent topical steroid and oral antihistamine are given for the control of the disease. But occasionally severe extensive disease may require systemic steroids. A conservative approach is indicated as most of the PEP tends to resolve in 1-2 weeks after delivery.

3. Unlike pemphigoid gestationis, PEP does not carry excessive maternal and foetal risk of morbidities and it rarely recurs in subsequent pregnancies.

Dr. Ka-ho LAU
MBBS(HK), FRCP(Edin, Glasg), FHKCP, FHKAM(Med)
Yaumatei Dermatology Clinic, Social Hygiene Service

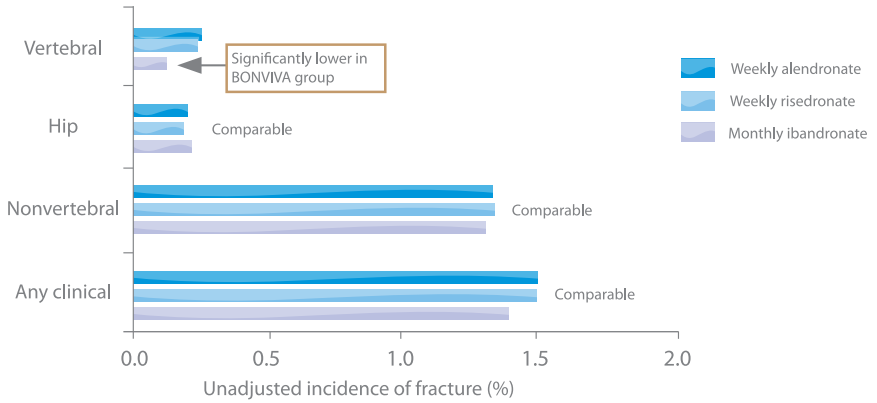
ONCE-MONTHLY Bonviva® 邦維亞
ibandronic acid
There's only one
每月一粒 輕鬆護骨



The VIBE* Study

Proven efficacy: Once-monthly Bonviva vs. weekly bisphosphonates (BP)

One year retrospective observational fracture study[1]



Bonviva-treated patients had statistically lower incidence of vertebral fractures.[1]

BONVIVA
66%
significant lower risk vs. Alendronate (p=0.004)

BONVIVA
61%
significant lower risk vs. Risedronate (p=0.014)

*The eValuation of IBandronate Efficacy (VIBE) study was a retrospective claims database study with a 12-month observational period that included women ≥45 years of age (n=64,182), newly prescribed monthly oral ibandronate (Bonviva) (n=7345) or weekly oral BPs (alendronate 35 mg or 70 mg, or risedronate 35 mg) (56,837) for a period between April 1, 2005 and December 31, 2005. Ref:1. Bone. 2009;44:758–765. Full prescribing information available upon request

Takeda Pharmaceuticals (Hong Kong) Limited
Unit 3706-8, 37/F, AIA Tower 183 Electric Rd North Point Hong Kong 香港北角電氣道183號友邦廣場37樓3706-8室
Tel: 2133 9800 Fax: 2856 2728

HK/ML/BON/10/07-2011