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References and study design:

1. Köhler G, et al. Int J Gynaecol Obstet 2010;108:21-25. An open-label, randomized, dose-ranging study to determine the efficacy and safety of 1, 2, 4mg of dienogest daily over 24 weeks in women (n=68) with confirmed endometriosis. Primary efficacy variable was change in severity of endometriosis according to the rAFS classification and patient-reported symptoms of dysmenorrhea, dyspareunia, diffuse pelvic pain, and premenstrual pain. Primary safety variable was tolerability, assessed by solicited questioning.
2. Strowitzki T, et al. Eur J Obstet Gynecol Reprod Biol 2010;151:193-198. A 12-week, randomized, double-blind, placebo-controlled study in women aged 18-45 (n=198) with confirmed endometriosis and EAPP score at least 30mm on a VAS to investigate the efficacy and safety of dienogest 2mg daily compared with placebo. Primary efficacy measure was absolute change in EAPP score from baseline to study end. Safety variables included adverse event profile and lab parameters.
3. Strowitzki T, et al. Hum Reprod 2010;25:633-641. A 24-week, randomized, open-label and non-inferiority study in women aged 18-45 (n=252) with confirmed endometrosis compared the efficacy and safety of dienogest 2mg orally once a day against leuprolide acetate 3.75mg depot i.m. every 4 weeks. The primary efficacy variable was absolute change in pelvic pain from baseline to treatment end, assessed by VAS. Safety variables included adverse event profile, lab parameters, BMD, bone markers and bleeding patterns.
4. Petraglia F, et al. Arch Gynecol Obstet 2012;285:167-173. An open-label extension study for up to 53 weeks to investigate the efficacy and safety of long-term use of dienogest 2mg daily in women aged 18-45 with confirmed endometriosis (n=168), who have previously completed a double-blind randomized 12-week placebo-controlled study. The primary efficacy variables were endometriosis-associated pelvic pain (EAPP), assessed by VAS score every 4 weeks, and uterine bleeding pattern documented by the patients. Safety variables included adverse event profile and lab parameters.

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The Cover Shot

在夕照餘暉下，整齊的駝隊、嫵媚的維族少女，更為浩瀚的沙海，添上一點神秘的色彩。

此圖攝於新疆南部，時維二零一三年十月。

Dr Thomas HK WONG
M.B.B.S.
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Pitfalls in the Prenatal Screening for Thalassaemia

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Editor

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Thalassaemia is the commonest genetic disorder in Hong Kong with the incidence of α thalassaemia and β thalassaemia being 4.5% and 2.8% respectively. In α or β thalassaemia couples, there will be a one in four chance that their offsprings will be affected by major thalassaemia because it is an autosomal recessive disorder. The main aim of prenatal screening for thalassaemia is to detect homozygous α^0 thalassaemia and βthalassaemia major. The Hong Kong College of Obstetricians and Gynaecologists guidelines recommend a mean corpuscular volume (MCV) cutoff of 80 fL. When a pregnant woman or her partner has a MCV above the cutoff value, her pregnancy is usually considered not at risk of severe thalassaemia.

However, β–E thalassaemia, or haemoglobin (Hb) H disease will not be detected because MCV of Hb E carriers or α^+-thalassaemia carriers may be greater than 80fL. The phenotype of β–E thalassaemia is variable, and can be associated with severe anaemia. In Hb H disease, three α-globin genes are affected. The prevalence of Hb H disease is around 6 in 10,000 live births. Invasive prenatal testing is usually not indicated as an affected individual is usually not transfusion dependent, and can enjoy a normal life-span. Besides, MCV may also be greater than 80fL when there is a concomitant inheritance of α^0 thalassaemia and heterozygous β-thalassaemia, or triplicated α-globin genes. Furthermore, sickle cell-βthalassaemia will not be picked up.

When interpreting MCV results, it is important to note the normal range as some local haematology laboratories adopt a cutoff of 82 fL. Besides, the normal range or standard deviation is affected by the quality control of a laboratory. In at risk ethnic groups of Hb E (including Cambodian, Thai, Laotian, Vietnamese), or sickle cell disease (including African, Spain and Portugal), the Hb pattern can be performed irrespective of MCV results. DNA studies can be used to exclude α^0 or α^+-thalassaemia in a woman/ partner with low MCV but normal Hb pattern, or to exclude concomitant inheritance of α0 thalassaemia in a β-thalassaemia carrier.

Recently, we encountered two unusual cases of homozygous α^0 thalassaemia or Hb Bart's disease due to maternal uniparental disomy or non-paternity in which a woman's MCV is low while her partner's MCV is normal[1]. Uniparental disomy is rare, but non-paternity is not uncommon though the exact prevalence is unknown. Prenatal detection of this unusual Hb Bart's hydrops relies on the awareness of the operators to pick up the abnormal findings of severe anaemia including cardiomegaly, placentomegaly or hydrops during a routine mid-trimester anomaly scan. Through maternal uniparental disomy or non-paternity, unusual cases of βthalassaemia major can also be inherited but will probably go unnoticed until the occurrence of severe anaemia six months after birth.

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Inverting the Pyramid of Antenatal Care?

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This article has been selected by the Editorial Board of the Hong Kong Medical Diary for participants in the CME programme of the Medical Council of Hong Kong (MCHK) to complete the following self-assessment questions in order to be awarded 1 CME credit under the programme upon returning the completed answer sheet to the Federation Secretariat on or before 30 September 2014.

Background

Like many other developed countries and cities, standard antenatal care to pregnant women has been provided in Hong Kong for more than 50 years. Under the British colonial influence, the HK standard antenatal care was based on the UK model (1929 Memorandum on Antenatal Clinics) – pregnant women first be seen at 16 weeks, then at 24 & 28 weeks, fortnightly afterwards until 36 weeks, and then weekly until delivery.[1] This antenatal care model looks like a pyramid (Figure 1), [2] with increasing concentration of antenatal visits towards the third trimester of pregnancy. This pattern of antenatal care has indeed been followed in many parts of the world. There are two basic assumptions behind this traditional pyramid of antenatal care.[2] Firstly, most obstetric complications occur in late pregnancy. Secondly, these complications are not predictable in the first and second trimesters. But note that in those days, obstetric complications could only be predicted from the obstetric history and maternal characteristics.

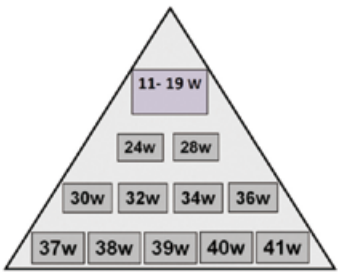

Figure 1. Traditional pyramid of antenatal care[2] (12 visits for all pregnant women)

Inverting the pyramid of antenatal care

With the continuous research and development of biophysical (mainly ultrasound) and biochemical tests, Prof. Kypros Nicolaides from London challenged the applicability of this traditional pyramid of antenatal care in modern obstetrics.[2] He proposed an inverted pyramid of antenatal care instead (Figure 2),[2] with the main emphasis (and thus manpower and resources) put in the first rather than the third trimester of pregnancy. The rationale behind this inverted pyramid is based on the hypothesis that at 11-13 weeks, an integrated assessment combining maternal history and characteristics with results of biophysical and biochemical tests, could calculate a pregnant woman's specific risk for obstetric complications such as foetal abnormalities (chromosomal and structural), pre-eclampsia (PET), preterm delivery, gestational diabetes (GDM) and intrauterine foetal growth restriction (IUGR). If that is the case, pregnant women can be classified into high-risk & low-risk after the initial 11-13 weeks integrated assessment. High-risk women (smaller proportion) would be channelled to specialist antenatal clinics for close surveillance throughout the antenatal course tailored to the specific obstetric complications. On the other hand, low-risk women (larger proportion) could well be seen in only three subsequent antenatal visits:

- 20-22 weeks – perform routine foetal anatomy ultrasound examination, and reassess risk for PET and preterm delivery;
- 37-38 weeks – assess maternal and foetal well-being, to decide time and mode of delivery;
- 40-41 weeks – if not delivered, plan for induction of labour.

In other words, antenatal clinic visits are no longer routines (measuring body weight, blood pressure (BP), urine protein & glucose, symphysis-fundal height), but tailored to predefined objectives. Ideally, the overall cost-effectiveness of the antenatal care programme would be improved by adopting this new inverted pyramid.

So, are we ready to change over to this inverted pyramid of antenatal care? The million dollar questions are how accurate is the risk assessment at 11-13 weeks for the various obstetric complications and whether there are effective interventions available. Let's look at some common obstetric complications to testify this hypothesis.

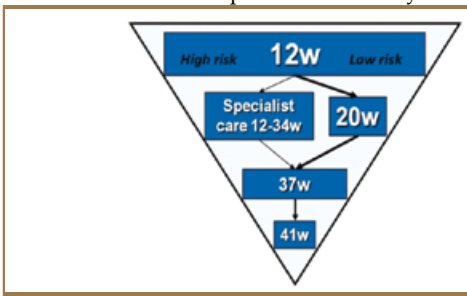

Figure 2. Inverted Pyramid of antenatal care[2] (4 visits only for low risk pregnant women)

Foetal chromosomal and structural abnormalities

This is perhaps the best model demonstrating early screening and diagnosis can effectively sort out the obstetric complications. Screening at 11-13 weeks by a combination of maternal age, foetal nuchal translucency thickness (NT) measurement by ultrasound, and maternal serum free beta-hCG & PAPP-A, can identify 90% of foetuses with trisomy 21 (Down syndrome) and other major aneuploidies (such as trisomy 18 and trisomy 13) for a false-positive rate of 5%.[3,4] The performance is highly reproducible as demonstrated by the Hospital Authority universal Down syndrome screening programme starting from 2010.[5] Additional ultrasound and maternal serum markers with different contingent policies have been studied to further improve the detection rate and reduce the false-positive rate.[6] But the most important recent development must be the non-invasive prenatal testing (NIPT) for foetal chromosomal abnormalities using maternal plasma foetal DNA.[7] The detection rate for Down syndrome using NIPT is more than 99% with a false-positive rate of only 0.1%. NIPT can be performed from maternal blood samples from 10 weeks onwards. NIPT is currently available for secondary screening for pregnancies with positive conventional Down screening as well as for primary screening for Down syndrome. Together with development of new molecular tests such as PCR (polymerase chain reaction)[8] and array CGH (comparative genomic hybridisation),[9] the entire algorithm in prenatal diagnosis is revolutionised (Figure 3). Ultrasound examinations (11-13 weeks for NT + foetal structural abnormalities; 18-22 weeks for foetal structural abnormalities) play a pivotal role in this new algorithm, which is making prenatal diagnosis more effective and comprehensive, and facilitating the parental decision to continue the pregnancy within the first and second trimesters.

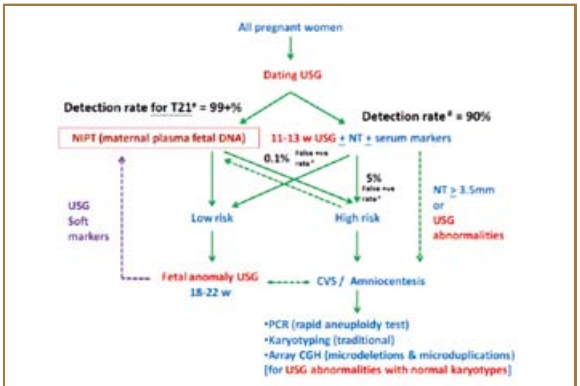

Figure 3. New algorithm in prenatal diagnosis(2014)

Pre-eclampsia (PET)

Pre-eclampsia is a major cause of maternal and perinatal morbidity & mortality, affecting 2% of pregnancies. PET is the classic obstetric complication which could be picked up "in-time" by the increasing frequency of routine antenatal visits in the third trimester under the traditional pyramid of antenatal care (Figure 1). Management "in-time" refers to the use of antihypertensives to control BP + early delivery of the baby. However, PET has occurred and it would not be "in-time" for potential prophylactic interventions, such as the use of low-dose aspirin. Algorithms which combine maternal characteristics (e.g. age, BMI, ethnic groups, nulliparity, family history of PET, personal history of chronic hypertension &/or PET), biophysical tests (mean arterial pressure and uterine artery pulsatility index by Doppler ultrasound), and biochemical tests (e.g. PAPP-A, placental growth factor, activin-A, endoglin, inhibin-A), at 11-13 weeks could potentially detect 90, 80 & 60% of pregnancies that would subsequently develop early (<34 weeks), intermediate (34-37 weeks) and late (>37 weeks) PET, with a 5% false-positive rate.[10] The implication of early identification of this high risk group for PET is not only that the women could be channelled to specialist antenatal clinics for close surveillance, but also there would be the opportunity to start the prophylactic use of low-dose aspirin in early pregnancy which could potentially halve the incidence of PET.[11] A large scale randomised controlled trial in UK/Europe is going on to testify this hypothesis (http://fetalmedicine.org/aspre-1).

Preterm delivery

Preterm delivery continues to be a leading cause of perinatal morbidity & mortality and childhood handicap despite continuous improvements in neonatal care. The incidence over the recent decades in Hong Kong remains at 6% for deliveries < 37 weeks and 2% < 34 weeks. For deliveries < 34 weeks, two-thirds are due to spontaneous onset of labour or preterm prelabour rupture of membranes and in the other third it is iatrogenic, mainly due to PET.[12]

When preterm labour occurs, tocolytic medications can only allow time (48 hours) for in-utero transfer and corticosteroids to accelerate foetal pulmonary maturity. It would only be useful if preterm labour could be predicted early enough in the first, at most second trimester, for the potential application of vaginal progesterone,[13] cerclage[14] or cervical pessary,[15] in preventing preterm delivery.

Risk-scoring systems using maternal characteristics (age, height, ethnic groups, smoking) and clinical history (previous second trimester miscarriage, preterm births, cervical surgery) could detect 38% of preterm deliveries < 37 weeks with a false-positive rate of 17%.[16] Cervical length measurement of 25mm or less by transvaginal ultrasound at 20-24 weeks could detect 76% of preterm deliveries < 34 weeks with a false-positive rate of 32%.[17] The detection rate of screening for preterm deliveries < 32 weeks, at a fixed false-positive rate of 10%, was 38% for maternal factors, 55% for cervical length and 69% for combined testing.[18] However, cervical length measurement at 20-24 weeks has two disadvantages.[2] Firstly, cervical incompetence leading to miscarriages before this gestation will be missed. Secondly, the effectiveness of progesterone, cervical cerclage or cervical pessary might be inversely related to the gestation at which treatment is started. There is some evidence that cervical length measurements at 11-13 weeks can be incorporated into algorithms in predicting early preterm deliveries.[19]

A positive foetal fibronectin test at 24-36 weeks in cervical and/or vaginal fluids is associated with preterm delivery in the next 7 days in patients with threatened preterm labour, at a positive predictive value of 13-30% and a negative predictive value of 99%.[20] On the other hand, there are no useful biochemical markers at 11-13 weeks (such as PAPP-A, free beta-hCG, placental growth factor, PP13, ADAM12, inhibin-A, activin-A) of early preterm deliveries.[21]

Gestational diabetes (GDM)

GDM is common in Hong Kong with a prevalence of 14.2% based on the WHO 1998 diagnostic criteria.[22] It has been associated with multiple perinatal complications including macrosomia, shoulder dystocia, brachial plexus injury and neonatal hypoglycaemia.[23] There is a continuous relationship between maternal glycaemia and macrosomia-related perinatal risks without a biological threshold.[24] Various screening algorithms have been suggested by different professional bodies. They differ in terms of the approach (risk factor based vs. universal), the gestation to perform the screening, the screening methods (random glucose or direct oral glucose tolerance test (OGTT) – 75 or 100 gram) and the cut-offs used. Risk factors include advanced maternal age, high BMI, ethnic groups (South East Asians), previous large babies, family history of DM, excessive weight gain and cigarette smoking.[25] The latest screening algorithm recommended by the International Association of Diabetes and Pregnancy Study Groups (IADPSG), based on the Hyperglycaemia and Adverse Pregnancy Outcome (HAPO) study,[24] encompasses the use of fasting, 1-hour and 2-hour 75 gram OGTT with any one value above the threshold (5.1, 10.0, 8.5 mmol/l respectively) indicating a diagnosis of GDM.[26] Random or fasting glucose is performed in the first prenatal visit to diagnose overt diabetes. OGTT is then performed at 24-28 weeks for the remaining. More research is required to demonstrate whether this screening algorithm could result in improved perinatal outcomes.

In the last decade, there have also been promising results from the use of biomarkers (maternal serum adiponectin and sex hormone-binding globulin) at 11-13 weeks, combined with maternal characteristics, which could predict 65% of pregnancies that would develop GDM, with a false-positive rate of 20%.[27] Earlier diagnosis of GDM could theoretically maximise the duration of therapeutic intervention for reducing the corresponding perinatal complications. However, more prospective, large-scale studies are required to verify the results before clinical use.

Intrauterine foetal growth restriction (IUGR)

Small for gestational age (SGA) foetuses with birth weights < 5th centile for gestational age at delivery have increased risks of perinatal death and handicap. SGA includes constitutionally small foetuses (the normal small) and IUGR foetuses due to placental insufficiency or genetic diseases. The perinatal risks of IUGR foetuses could be substantially reduced if they are identified prenatally.[28] Screening for SGA (in the absence of PET) at 11-13 weeks by a combination of maternal characteristics (age, weight, height, ethnic groups, smoking, history of chronic hypertension), obstetric history (previous SGA baby), biophysical markers (NT, uterine artery pulsatility index, mean maternal arterial pressure, placental volume) and biochemical markers (PAPP-A, free beta-hCG, placental growth factor, PP13, ADAM12), could potentially identify 75% of pregnancies delivering SGA babies < 37 weeks and 45% of those delivering at term.[29] Early identification of this high risk group for SGA / IUGR could improve pregnancy outcomes by regular monitoring of foetal growth and well-being to determine the time of delivery. Low-dose aspirin started in early pregnancy can potentially halve the incidence of IUGR.[11]

Current situation of antenatal care in Hong Kong

The antenatal care system in Hong Kong has already been moving away from the traditional pyramid. Much emphasis has been put in the 11-13 weeks Down syndrome screening programme (NT with maternal serum markers) and the 20weeks foetal anatomy ultrasound examination. Risk assessment is performed in the first antenatal visit but mainly based on maternal history and characteristics to categorise the pregnancies into high or low risk. High risk pregnancies would be followed up in specialist antenatal clinics such as Twin clinic, GDM clinic, Joint Medical clinic, Prenatal Diagnosis clinic, IUGR clinic, etc. Low risk pregnant women would have antenatal care in Maternal & Child Health Centres (MCHC) or midwifery-led antenatal clinics. The number of antenatal clinic visits for low risk women has been reduced from 12 (traditional pyramid) to 8 (such as 11-13, 20, 24, 28, 32, 36, 38, 40 weeks – more like a "rectangle"), but not as drastically reduced to 4 visits as described like an inverted pyramid. We should not underestimate the value of these low risk antenatal visits, although apparently without predefined medical objectives, but are good platforms for building up trust between the pregnant women with midwives and / or obstetricians, for questions & answers, and for education & counselling. Furthermore, in Hong Kong, there is a strong element of public-private interface in the antenatal care, and the number of antenatal clinic visits in total (public + private) for an average pregnant woman is usually more than expected.

Sophisticated algorithms including various biophysical and biochemical markers are seldom used except under research settings in the university obstetric units. More studies are required to demonstrate their performance in the local pregnant population. Before that, just 4 antenatal visits might not be safe enough even for so called low risk pregnancies.

Conclusion

Inverting the pyramid of antenatal care is an interesting concept and possibly the future of obstetric practice. The current pattern of antenatal care in Hong Kong has already been changed into a rectangle. Large-scale demonstration trials are required to show whether we could move towards an inverted pyramid.

Useful websites

- http://fetalmedicine.org/pyramid-of-care
- http://fetalmedicine.org/aspre-1
- http://www.rcog.org.uk/noninvasive-prenatal-diagnosis-using-cell-free-dna-maternal-blood
- http://www.rcog.org.uk/womens-health/clinical-guidance/cervical-cerclage-green-top-60

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Partial Retraction Notice

Re: Partial retraction of figure 2 and figure 3 on p.16 and p.17 of volume 19, No.7 July 2014 of the Medical Bulletin of the Hong Kong Medical Diary

As requested by Dr. Nicola PY Chan, this is to announce that the removal of figure 2 and figure 3 of Dr. Nicola PY Chan's article, titled "Transcutaneous Intense Focused Ultrasound for Non-invasive Skin Tightening", published on p.16 and p.17 in volume 19, No.7 July 2014 of the Medical Diary.

Please note that the above two figures from the internet copy will be removed accordingly.

MCHK CME Programme Self-assessment Questions

Please read the article entitled "Inverting the Pyramid of Antenatal Care?" by Dr Wing-cheong LEUNG 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 30 September 2014. 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. In the traditional pyramid of antenatal care, increasing number of antenatal visits occurs in the third trimester of pregnancy.
2. The basic assumption for the inverted pyramid of antenatal care is that pregnant women can be classified into high vs. low risk after an assessment at 20 weeks.
3. Down syndrome screening at 11-13 weeks by maternal age, foetal NT, free beta-hCG & PAPP-A, can detect 90% of foetuses with trisomy 21 for a false-positive rate of 10%.
4. Non-invasive prenatal testing (NIPT) using maternal plasma foetal DNA can detect > 99% of Down syndrome with a false-positive rate of 0.1%.
5. Pre-eclampsia affects 10% of pregnancies.
6. Low-dose aspirin taken since early pregnancy could potentially halve the incidence of PET.
7. Algorithms combining maternal characteristics, biophysical & biochemical tests at 11-13 weeks could detect 90% of early PET (<34 weeks), with a 5% false-positive rate.
8. Tocolytic medications can delay preterm deliveries for 2 weeks.
9. Most studies on cervical length measurements in predicting preterm deliveries were performed at 11-13 weeks.
10. The antenatal care model in Hong Kong has already changed into an inverted pyramid.

ANSWER SHEET FOR SEPTEMBER 2014

Please return the completed answer sheet to the Federation Secretariat on or before 30 September 2014 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

Inverting the Pyramid of Antenatal Care?

Dr Wing-cheong LEUNG

MBBS (HK), MD (HKU), FRCOG, FHKAM (O&G), Cert RCOG (Maternal and Foetal Med)

Consultant Obstetrician & Chief of Service, Department of Obstetrics & Gynaecology, Kwong Wah Hospital, HKSAR
Senior Vice President, Hong Kong College of Obstetricians & Gynaecologists

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.:_____ MCHK No.: _____ (for reference only)

Answers to August 2014 Issue

Examining the Link between Irritable bowel syndrome and Common Mental Disorders – from Aetiology to Treatment.

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

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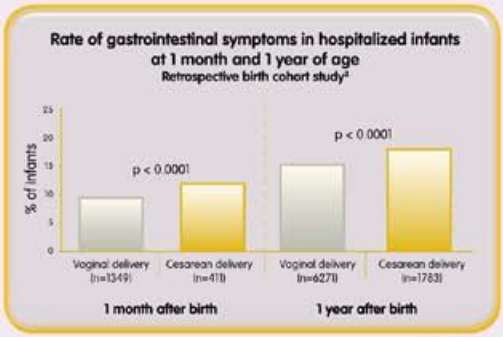
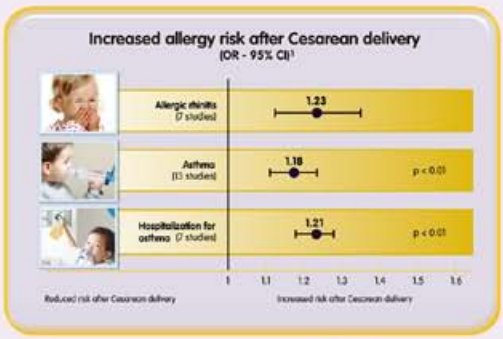


A meta-analysis confirms that Cesarean delivery is a specific risk factor for allergies[1]

up to 23% more risk



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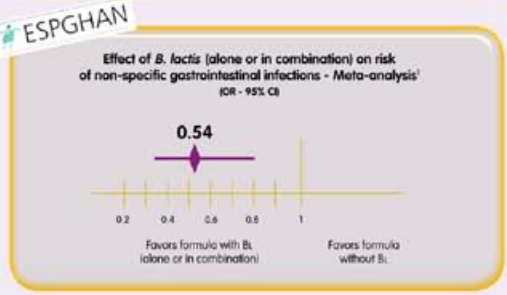

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In the Era of 3D for Laparoscopy

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The development of laparoscopic surgery, also known as 'key-hole' surgery, has enabled a wide variety of surgical procedures to be performed in a minimally invasive approach. In laparoscopic surgery, the image is typically captured by a video camera through minimal access ports and transmitted real-time to a 2-dimensional (2D) screen. The surgeon then performs the operation using long instruments via these working channels. The loss of tactile sensation and depth perception are known drawbacks in 2D laparoscopy, which although can be overcome by adaptation to the 2D view through training, could result in a prolonged learning curve for many beginners, as well as an increased cost of surgery and operation time for the patient.

3D Lap

3-dimensional (3D) laparoscopy has been developed in an attempt to overcome the problems with traditional 2D imaging technology. Developed in the 1990s, 3D laparoscopy has yet to gain widespread popularity. Earlier studies comparing 2D and 3D laparoscopies had shown conflicting results in terms of benefits of 3D over 2D. The main problems with these studies were the diverse imaging systems used, different laparoscopic skill tests involved and lack of standardisation in outcome measurements. The benefits of early 3D laparoscopy were also limited by the quality of the image, with 40% of participants reporting a 'less clear' and 'dimmer' image associated with 3D laparoscopy in one study, and 10% complaining of dizziness or eyestrain after the performance of the required tests[1].

More recently, with the improvement of the 3D imaging system, studies have shown superior task efficiency, shortened operating time and reduced number of errors when 3D laparoscopy was compared to 2D[2-5]. The use of 3D laparoscopy may be of benefit to non-advanced laparoscopists during the initial learning process or when starting to perform complicated cases[6]. Although the improvement may be less marked in experienced laparoscopists who have already adapted to the 2D images[3,6], the importance of precision and fine manipulative skills may become more important as surgeons start to perform increasingly complex laparoscopic procedures. Regardless of the objective performance of 3D laparoscopy, participants appear to have a subjective impression of better spatial orientation for 3D[4,5].

The 3D imaging technology, although more available and less costly than the robotic system, is nevertheless more expensive than the 2D laparoscopy. Sun et al demonstrated a significant decrease in performance time at the second attempt of laparoscopic task, reflecting the importance of the learning process in laparoscopic surgery[7]. The use of 3D might be of less importance when performing simple tasks, which make up the majority of the daily workload, or when the learning curve is steep, such that the increased cost is not justified. Moreover, the ability to adapt to stereoscopic vision differs from person to person, and some individuals may simply not be able to visualise 3D images.

Most studies involve short tasks performed on a pelvic trainer using both 2D and 3D visual modalities[2-8]. However, studies on clinical settings comparing 2D versus 3D laparoscopy are still limited. A Cochrane review comparing 2D and 3D laparoscopies for cholecystectomy, which included only one prospective randomised trial of 60 patients, did not show a significant benefit in 3D laparoscopy[9]. Another study, which used a newer 3D imaging system, showed that 3D reduced operation time without associated increase in the complication rate[10]. Surgeons in the study also reported a better depth perception and that determination of anatomic structures was easier and safer[10].

In Hong Kong, 3D laparoscopy is available in several private and public hospitals. In our department, we had conducted a prospective, randomised controlled study involving 30 doctors performing 3-4 simple tasks on a pelvic trainer using both 2D and 3D laparoscopies. The tasks chosen were peg transfer, pattern cutting, suturing (for intermediate and advanced participants), and duct cannulation (for beginners and intermediate participants). 3D laparoscopy, although preferred by

more participants, did not seem to give better objective performance in the completion of the selected tasks except for duct cannulation[11].

In the era where 3D technology is available in theatres and even in home entertainment systems, it is surprising that we are still performing surgery on 2D flatscreens. Is 3D laparoscopy the future of surgery that can offer a reduced learning curve and improved precision, or merely a gimmick that would pass as the excitement of this glimmering technology fades? More studies, especially in a clinical setting, are needed to answer this question.

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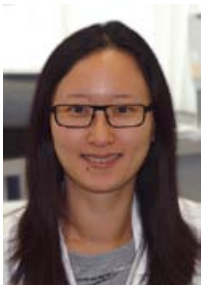
Is it a Time for Universal Human Papillomavirus Vaccination in Young Women?



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Introduction

Cervical cancer is the fourth most common cancer in women globally and there were about 528,000 new patients and 266,000 deaths in 2012[1]. In Hong Kong, its incidence dropped from the seventh highest in 2007 to the ninth in 2011 among all female cancers[2], which may be attributed to the implementation of cervical smear screening. Nevertheless, the age-standardised rate of mortality remains static at 2.1 – 2.6 per 100,000 women over the recent decade. In the United Kingdom, the European age-standardised incidence rate dropped by 49% from 1985 – 87 to 2003 – 05[3]. However, the incidence rose again by 8%, and the trend was even more prominent in those aged 25 – 34 years. This rather unexpected rise might be due to the increase in public awareness of the disease leading to more diagnoses, increased HPV infections and increased smoking prevalence. With the rebound phenomenon in the United Kingdom, it is clear that cervical cancer still poses a threat to the world. The medical professionals and policy makers in Hong Kong should also be cautious because the existing cervical smear screening system is still not comprehensive enough, where currently only about 70% of women in a survey have ever had a cervical smear and nearly 40% did not have a smear within the recent three years[4]. Therefore, other preventive measures are definitely needed to further reduce the incidence of cervical cancer and its precursors.

Human papillomavirus (HPV) is well known to be the main causative agent of cervical cancer. It is present in about 90% of high-grade cervical intraepithelial neoplasia (CIN) and cervical cancer[5] and 70 - 80% are related to HPV-16 and 18[6,7]. Other than cervical cancer and CIN, HPV is also associated with vulval, vaginal, penile, anal and oropharyngeal neoplasia, as well as recurrent respiratory papillomatosis and genital warts. It is noteworthy that genital warts are a significant medical problem and the incidence in Hong Kong is about 204 per 100,000 person-years which is higher than other Western countries[8].

There are two HPV vaccines available in the world. The bivalent vaccine targets at HPV-16 and 18 and is used to prevent cervical cancer and its precursors in females at 9 to 45 years old. The quadrivalent vaccine is approved to prevent HPV-6, 11, 16 and 18-related diseases, including cervical, vulval and vaginal cancers and their precursors, as well as genital warts for females at 9 – 45 years old and males at 9 – 26 years old. Up to date, the HPV vaccine is not incorporated into the routine vaccination programme in Hong Kong. In this article, the efficacy, cross-protection, safety, cost-effectiveness and acceptability will be discussed with a focus on cervical cancer. Male vaccination and the differences between the two vaccines will not be elaborated.

Efficacy

There have already been various phase III trials demonstrating the efficacy of the two vaccines. An analysis combined the data of four similar studies including the Females United to Unilaterally Reduce Endo/Ectocervical Disease (FUTURE) I[9] and II[10] studies and evaluated the efficacy of the quadrivalent vaccine in preventing HPV-16/18-related CIN 2-3, adenocarcinoma in-situ (AIS) in those aged 16 - 26 years after a 3-year follow-up[11]. In the per-protocol susceptible group (i.e. those who had no previous infection with HPV-16/18 as shown on DNA or serologic tests at enrollment, received all the doses within one year without protocol violations, and remained DNA-negative for the specific HPV types through one month after the administration of the last vaccine or placebo), the overall efficacy against the lesions related to HPV-16/18 was 99% (95% confidence interval (CI) 93 – 100%), while it was 44% (95% CI 31 – 55%) in the intention-to-treat group (ITT) (i.e. including those with previous infection). An 18% reduction (95% CI 17 – 29%) of CIN 2 or worse regardless of the HPV type was also observed in the ITT group.

On the other hand, the PApilloma TRIal against Cancer In young Adults (PATRICIA) study also showed that the efficacy of the bivalent vaccine was up to 90.4% (97.9% CI 53.4 – 99.3%; p <0.0001) against CIN 2 or 3, AIS and invasive carcinoma associated with HPV-16 and 18 in the total vaccinated cohort (TVC)–naïve group (i.e. those who were DNA negative and seronegative at entry) after an average follow-up of 14.8 months[12]. Using CIN 3 and AIS or worse as end-points, the immediate precursors of malignancy, the four-year end-of-study of the PATRICIA trial showed that the efficacy against those lesions related to HPV-16 / 18 was 100% (95% CI 85.5 – 100%) in the TVC-naïve group and 45.7% (95% CI 22.9 – 62.2%) in the TVC group (i.e. those who received at least one vaccine dose including those who were sexually active irrespective of baseline HPV status)[13]. Vaccine efficacy against AIS irrespective of the HPV type was also 100% (95% CI 31- 100%) in the TVC-naïve and became 76.9% (95% CI 16 – 95.8%) in TVC. The HPV vaccine also reduced the number of colposcopy referrals by 29.0% (95%CI 21.6 – 35.8%) and 14.8% (95% CI 8.9–

20.3%), and cervical excisional procedures by 70.2% (95% CI 57.8–79.3%) and 33.2% (95% CI 20.8–43.7%) in the TVC-naïve and TVC, respectively.

Other than high-grade CIN, the quadrivalent HPV vaccine also provides good protection against high-grade vaginal (VAIN) and vulval (VIN) intraepithelial neoplasia. Pooled analysis of phase II/III trials (protocol-007[14,15], FUTURE I and II) showed 100% (95% CI 82.6 - 100%) efficacy against VAIN or VIN 2-3 associated with HPV 6, 11, 16 or 18 in the per-protocol population and 79.0% (95% CI, 56.4 - 91.0%) in the ITT population after a mean follow-up of 42 months[16]. Combining the data of the FUTURE I and II trials after an average of 3.6-year follow-up, it was shown that the quadrivalent vaccine could reduce HPV-6/11-related genital warts by 97.1% (95% CI 92.4 - 99.2%) in those negative to the 14 HPV types at entry, and 79.3% (95% CI 72.7 – 84.5%) in the ITT population[17].

In addition, it was evident that low-grade lesions could be prevented by HPV vaccines based on the combined data of the FUTURE I and II trials[18]. In the per-protocol susceptible group, the vaccine efficacies against HPV-6, 11, 16 and 18 were 96% for CIN I (95% CI 91 - 98%), 100% for both VIN I (95% CI 74 - 100%) and VAIN I (95% CI 64 - 100%), and 99% for condyloma (95% CI 96 - 100%). These results were similar to the PATRICIA trial, which also showed modest efficacy against CIN 1 or worse caused by HPV 16 and 18 (89.2%, 97.9% CI 59.4 – 98.5%; p <0.0001)[12].

In the 28th International Papillomavirus Conference in 2012, Nygård M et al presented that the immunogenicity to HPV-1, 11, 16 and 18 remained high 9 years following the use of the quadrivalent HPV vaccine, and Kjaer SK reported that there was no breakthrough cases of HPV 16/18-related CIN2 or worse up to 8 years after using the same vaccine.

Cross-protection

There are at least 15 types of HPVs that can lead to cervical cancer. Together with HPV-16 and 18, other HPV types like HPV-31, 33, 35, 45, 52 and 58 constitute about 90% of all HPV-related cervical cancers[19]. Therefore, cross-protection against these non-vaccine oncogenic HPV types can potentially maximise the chance of success in preventing cervical cancer. It has been shown that 12-month persistent infection with HPV-33, 45 and 52 could be prevented by 45 – 62% using the bivalent HPV vaccine[12]. The end-of-study analysis of the PATRICIA study after 4 years of follow-up evaluated the efficacy of the bivalent vaccine in its cross-protection against HPV- 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, and 68[20]. The efficacy against 6-month persistent infection with HPV-31 was 76.8%, 77.1% and 46.3% in according-to-protocol cohort for efficacy (ATP-E, i.e. those who were HPV DNA negative at enrollment and at 6 months for the specific HPV type being analysed, adhered to the protocol and had a normal or low-grade baseline cytology), TVC-naïve (i.e. those who received at least one vaccine dose and HPV DNA for all 14 HPV types and seronegative for HPV-16 and 18 and had a negative baseline cytology) and TVC, and that with HPV-33 was 44.8%, 43.1% and 26.3% respectively. For CIN 2+ lesions excluding HPV-16 / 18 infection, a consistent protective effect was observed in HPV-31 in all cohorts and was up to 84.3% (95% CI 59.5 – 95.2) in the ATP-E and 83.4% (95% CI 43.4 – 96.9) in the TVC-naïve. Efficacy against HPV-33 was also noted in the ATP-E (59.4%, 95% CI 20.5 – 80.4) and TVC-naïve (76.3%, 95% CI 35.5 – 93.0). On the other hand, the quadrivalent HPV vaccine could reduce HPV-31 / 45 infection by 40.3% (95% CI 13.9 – 59.0%) and CIN 1-3 or AIS by 43.6% (95% CI 12.9 – 64.1%) in a group of patients negative for 14 non-vaccine HPV types[21]. Similar to the bivalent vaccine, the most remarkable protective effect was observed in HPV-31.

Although some have shown that the bivalent vaccine seems to offer better protection against HPV-31, 33 and 45 compared to the quadrivalent vaccine, direct comparison is difficult due to the difference in study design and cohorts. The cross- protective effect also seems to fade away with time[22].

Safety

HPV vaccines are relatively well tolerated. Most of the symptoms are self-limiting and related to the injection causing fever, pain, erythema, pruritus and swelling. Those receiving vaccines tend to have more fatigue, headache and myalgia within seven days of vaccination than the control group[12]. Serious complications related to the vaccine occurred only in <0.1% [12,13,23]. Adverse pregnancy events like spontaneous miscarriage and abnormal infants were observed in 9 – 10% and 1 – 1.2% respectively in the vaccination group, which were comparable to those without vaccination[12,13].

Cost-effectiveness

A literature search yielded no local study on the cost-effectiveness of HPV vaccination. Despite the heterogeneity of different studies utilising different parameters, assumptions and mathematical models, most concluded that HPV vaccination is cost-effective especially in young girls before sexual debut and in middle-low and low-income countries where there is a high burden of cervical cancer and the screening system is not well established[24-30]. A recent study funded by the WHO evaluated the cost-effectiveness of HPV vaccination of 12-year-old girls before sexual debut across 179 countries[31]. It was estimated that vaccination of 58 million girls could prevent 690000 cases of cervical cancer and 420000 deaths during their lifetime at a net cost of US$ 4 billion. By comparing the cost per disability-adjusted life-years (DALYs) averted with the gross domestic product (GDP) per capita, HPV vaccination was considered to be very effective in 156 (87%) countries.

Herd protection from male vaccination, protection against non-cervical diseases, reduction of abnormal cervical smear results and hence colposcopic examinations and excisional procedures, and the possible introduction of a nanovalent HPV vaccine, may further reduce the medical expenses and their impacts are out of the scope of discussion in the current article. In addition, the Strategic Advisory Group of Experts on Immunisation (SAGE) has recently concluded that the two-dose schedule given within a minimum of 6-month interval is not inferior to the conventional

3-dose schedule (at 0, 1-2, 6 months)[32]. The reduction from three to two doses can potentially lower the cost of vaccination and reduce the number of visits. However, its cost-effectiveness needs to be further evaluated.

Acceptability

Public awareness and acceptability of HPV vaccination are crucial to make a vaccination programme successful. Ever since the introduction of the HPV vaccine in Hong Kong in 2006, there had been various local studies examining the knowledge and acceptability of HPV vaccination in adolescents, their parents and the health care professionals[33-43]. For example, a questionnaire study conducted in 2007 on 1450 Chinese women aged >=18 who attended the Family Planning Association showed that only 38% of women had heard of HPV, and 48% were aware that HPV vaccine could prevent cervical cancer[35]. Half of the women thought that they would be stigmatised if they had HPV infection. Besides, 65% thought that the infection was transmitted from their partners and 42% of them might even end their relationship. 88% of the participants wished to be vaccinated but 27% thought that those who were sexually naïve should not be vaccinated as most thought that the vaccine was indicated only to those who were sexually active or those with multiple partners. Another recent questionnaire study involving 1022 mothers with daughters aged =<18 in 2008 and another 1005 mothers in 2013, as well as 2252 secondary school students aged 11 – 21, showed that only 2.4% (95% CI 1.8 – 3.2%) and 9.1% (95% CI 7.0 – 11.6%) schoolgirls had received HPV vaccination in 2008 and 2013 respectively[39]. 68.5% (95% CI 65.5 – 71.3%) mothers in 2012 had heard of HPV, in comparison of 40.5% (95% CI 37.5 – 43.6%) in 2008. However, due to unexplained reasons, fewer mothers in 2012 had heard of HPV vaccines than mothers in 2008 (43.7% Vs 68.3%; p <0.01). 44.6% and 66.7% of mothers in 2008 and 2012, respectively, were willing to vaccinate their daughters regardless of the vaccine price ($p < 0.01$), reflecting a gap between the acceptability and actual uptake of the HPV vaccination. With regard to vaccination at the market price, the acceptability of mothers was low in general, being 27.5% (95% CI 24.8 – 30.4%) and 37.6% (95% CI 34.5 – 40.8%) in 2008 and 2012 ($p < 0.01$). Besides, the median price that the mothers were willing to pay for vaccinating their daughters was HK$1000 (50% central range = HKU 500 – 1500). Factors that might negatively influence the acceptability include vaccine cost, low family income, low maternal education level, uncertainty about the effective duration, low perceived risk of HPV infection, anticipated family or peer disapproval, fear of pain and lack of support from the family care providers and the government [34,36,39,40,42,43]. And some had shown that the intention of the adolescents to receive HPV vaccination and the acceptability of the mothers could be improved by enhancing their knowledge through information pamphlets and education programmes[33,36,38].

Conclusion

The incidence of cervical cancer has been decreasing in Hong Kong. However, once occurs, this will pose substantial physical and psychological stress to the patients and their families. In fact, the mortality rate remains static despite the advances in investigation and treatment. Since there is a strong association between HPV and cervical cancer, the latter may potentially be preventable by protecting women against HPV. There has been robust evidence that HPV vaccines are efficacious, safe and cost-effective especially in sexually naïve girls. Improving the knowledge of the adolescents and their parents can further enhance its acceptability and hence overall uptake of the vaccine though its cost remains a major hindrance. While more than 40 countries now have implemented a national HPV vaccination programme[44], it is still provided mainly in individual health centres or by private practitioners on a self-financed basis in Hong Kong. More published data on the long-term efficacy and safety of the HPV vaccines, together with studies relevant to the local context such as the epidemiology of HPV infection, cost-effectiveness of the vaccines and public attitude, are needed to facilitate the government in integrating HPV vaccination into the universal vaccination programme[45].

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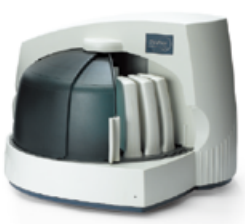

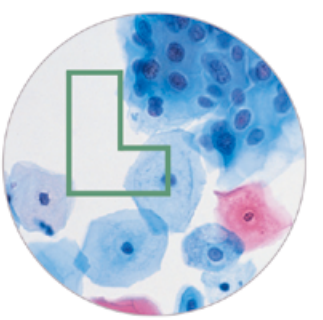

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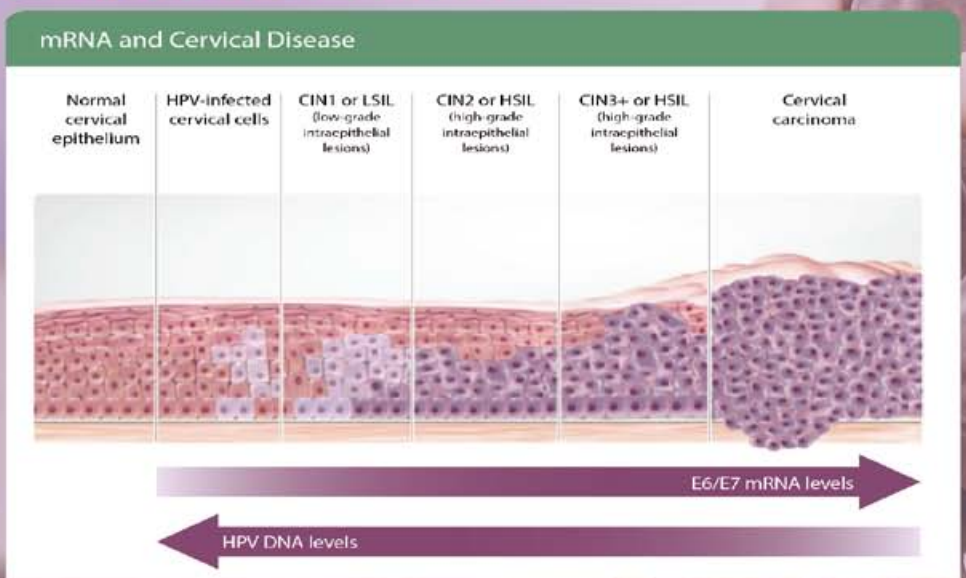

"The optimal screening strategy should identify those cervical cancer precursors likely to progress to invasive cancers (maximizing the benefits of screening) and avoid the detection and unnecessary treatment of transient HPV infection and its associated benign lesions that are not destined to become cancerous (minimizing the potential harms of screening)." — Am J Clin Pathol 2012; 137:516-542

Current Medical Management of Endometriosis-Associated Pain

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Specialist in Obstetrics and Gynaecology

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Pelvic endometriosis is a chronic inflammatory condition defined by the presence of endometrial glands and stroma outside the uterine cavity. It occurs in 7% to 10% of all women of reproductive age. Pelvic pain is a typical presenting symptom. The pain may be in the form of dysmenorrhoea, dyspareunia or chronic pelvic pain. This present article will discuss on the medical treatment of endometriosis-associated pain and will not touch on surgical treatment or on the treatment of endometriosis-associated infertility. References have been made to the guidelines of the European Society of Human Reproduction and Embryology (ESHRE) and the Royal College of Obstetricians and Gynaecologists (RCOG).

1. Empirical Treatment with NSAIDs

NSAIDs are commonly prescribed as a first-line treatment to women suffering from pelvic pain with a high index of suspicion of endometriosis even without a prior definitive diagnosis by laparoscopy. This is especially common in adolescents and young women without the desire for pregnancy. In two Cochrane Reviews in 2009[1] and 2010[2], NSAIDs are more effective in the treatment of pelvic pain and dysmenorrhoea than paracetamol. However, there is inconclusive evidence to show which (if any) individual NSAID is the safest or most effective. There was one study on the effective use of rofecoxib, a COX II inhibitor in endometriosis pain, but the drug was withdrawn in many countries due to sever side effects on long term usage. However NSAIDs have a favourable effect on primary dysmenorrhoea and should be used as first line treatment after other causes of pelvic pain symptoms have been excluded. Women should be warned about the side effects of NSAID including inhibition of ovulation, risk of gastric ulceration and cardiovascular disease on long term treatment. It is also clearly a paradox that by recommending empirical treatment in symptomatic young women, this may delay the diagnosis of pelvic endometriosis in their later life.

2. Hormonal Contraceptives

Combined oral contraceptives (OC) were shown to be effective in treating pain in women with endometriosis. OCs inhibit ovulation, substantially reduce the volume of menstrual flow and hypothetically interfere with implantation of refluxed endometrial cells. In a meta-analysis involving 18 studies in 2010[3], it was shown that the risk of endometriosis was reduced in current OC users (RR 0.63, 95% CI 0.47-0.85). With the introduction of the ultra low dose oestrogen/progestagen pills and new OCs using the natural 17-beta oestradiol instead of ethinyl oestradiol, OCs are becoming more safe for long term use with fewer side effects. There are other practical advantages of OC usage including contraceptive protection, long term safety and control of menstrual cycles.

Combined OCs can be used continuously for endometriosis-associated recurrent dysmenorrhoea that does not respond to a cyclic regimen[4]. A low dose (0.02 mg ethinyl oestradiol) combined OC used continuously for 24 months resulted in over 50% reduction in the visual analogue pain scale and 80% of patients were satisfied with the treatment. Total amenorrhoea occurred in 38% of patients, spotting in 36% and breakthrough bleeding in 26%. The author had personal experience in using a continuous 2 or 3 monthly regime of low dose combined OCs in patients with refractory endometriosis or uterine adenomyosis with satisfactory results. This treatment regime reduces the endometriosis-associated pain cycle to every two to three months and is particularly useful in women near the age of menopause who had repeated recurrences with or without surgeries. The side effects of breakthrough bleeding and irregular spotting are well accepted by patients.

3. Progestagens

Progestagens including oral or depot medroxy-progesterone acetate (MPA), dienogest, norethisterone acetate or danazol had been used to reduce endometriosis-associated pain. In a Cochrane Review[5], there was no evidence of any benefit with depot-MPA versus other treatments but with more side effects.

Dienogest is a relatively new synthetic oral progestagen highly selective for the progestagen receptor. It displays strong progestational effects and moderate anti-gonadotrophic effects, but no androgenic, glucocorticoid or mineralocorticoid activity. These properties give dienogest a selective effect on the endometrium to create a psuedopregnancy state in long term treatment of endometriosis-associated pain. Dienogest is not associated with significant androgenic side effects such as acne, weight gain, alopecia and hirsutism. In randomised clinical trials, a dienogest 2 mg daily dose effectively reduced pelvic pain in patients confirmed with endometriosis. The clinical efficacy was sustained during long term treatment for over 18 months[6]. In clinical trials comparing dienogest with GnRH agonists

up to 24 weeks, the efficacy of dienogest 2 mg/day is comparable to leuprorelin 3.75 mg injections every four weeks or intranasal buserelin spray 300 ug three times daily in treatment of endometriosis. It is because dienogest only moderately suppresses oestradiol levels, it appears to have fewer hypo-oestrogenic side effects than the GnRH agonists especially on the bone health of patients in long term treatment. .A cost analysis in Germany[7] comparing dienogest and GnRH agonist treatment; a substantial saving to the National Health Service (over Euro 4.98 million) was shown after 5 years of introduction of dienogest treatment. Similar to other progestagen treatment, dienogest was associated with abnormal bleeding patterns (amenorrhoea 28%, infrequent bleeding 24%, irregular bleeding 22%, prolonged bleeding 4% and normal bleeding 23%). The abnormal bleeding intensity and frequency tend to decrease with time of treatment and these are generally well tolerated with few patients discontinuing therapy.

Clinicians can consider prescribing a levonorgestrel-releasing intrauterine system (LNG-IUS) (Mirena IUCD) as one of the options to reduce endometriosis-associated pain[8]. This also has a favourable effect on the lipid profiles as compared with the anti-oestrogenic side effects of long term GnRH agonist treatment.

4. GnRH Agonist

GnRH agonists (nafarelin, leuprolide, buserelin, goserelin or triptorelin) are useful options for treating endometriosis-associated pain. They create a pseudomenopausal endocrine state leading to regression of endometriotic nodules. The traditional regime involves a four-weekly injection for six months, thus creating total amenorrhoea and a pain free period up to 8 to 9 months. However, evidence is limited regarding the dosage or duration of treatment[9]. In a local study, GnRH agonist injections had been given at six-weekly intervals for a total of four doses with similar effects. This would mean a substantial cost reduction to the patients and the health authority. Hormone add-back therapy should be considered to prevent bone loss and hypo-oestrogenic symptoms during treatment, especially in women at risk of developing osteopenia.

5. Aromatase Inhibitors (AI)

Aromatase inhibitors (anastrozole and letrozole) had been used in treating endometriosis-related pain symptoms in premenopausal women. This was based on the observations of increased expression of aromatase P450 in endometriotic tissues. In a systemic review including 10 publications, AIs (letrozole 2.5 mg/day or anastrozole 1.0 mg/day) combined with either progestagens or oral contraceptive pills reduce the severity of pain symptoms and improve the quality of life[10]. Adverse effects include arthralgia and myalgia which may reduce patient compliance. Furthermore, long term treatment with AIs in premenopausal women may affect their bone health negatively. The ESHRE Guidelines advise that due to the severe side effects, AIs should only be prescribed in women with pain from rectovaginal endometriosis refractory to other medical or surgical treatments.

Conclusion

Endometriosis is a chronic, benign disease causing symptoms of pelvic pain, dysmenorrhoea and dyspareunia that often relapse after surgical therapy. Long term medical treatment is often warranted to decrease the symptoms and improve the quality of life. There is no overwhelming evidence to support a particular treatment over others. Clinicians are recommended to take the patients' preferences, side effects, efficacy, costs and availability into consideration when choosing the appropriate treatment for endometriosis-associated pain.

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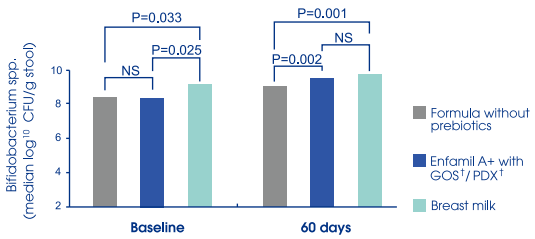

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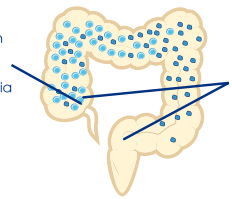

PDX†: More complex carbohydrate that feeds beneficial bacteria throughout the large intestine[3]

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^^ A bifidogenic effect is defined as growth stimulation of bifidobacteria

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Dr Cecilia WC CHEON

MBChB, FRCOG, FHKCOG, FHKAM (O&G)

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Introduction

Urinary incontinence is said to exist when involuntary loss of urine is a social or hygienic problem and is objectively demonstrable. It is a common complaint among females affecting approximately 35% to 40% of the adult population. It has much negative impact on the quality of life to sufferers with embarrassment, reduction in self esteem, impairment in emotional / psychological well-being and poorer sexual relationships with partners. A thorough assessment of the patients is essential since there are many causes and a large variety of treatment options available. Management should be individualised.

Diagnosis

A history and physical examination are important in making a relevant diagnosis, to establish rapport with the patient, understand the severity of the incontinence / degree of social incapacitation and guide to the choice of treatment.

Investigations include mid stream urine for microscopy and culture, frequency- volume chart and urodynamic studies if indicated.

The aim of the urodynamic study is to provide a urodynamic diagnosis in an objective manner and therefore guide to the type of treatment. It also assists in pre-operative counselling for the patients especially on the chance of success of surgery and complications. For examples, in patients with urodynamic stress incontinence going to have anti-incontinence surgery, the chance of success will be less if she has co-existing detrusor overactivity (DO) than if she has not. For patients with voiding dysfunction, the risk of long term catheterisation should be stressed before undergoing surgery. Disadvantages and limitations include the requirement of the patient's co-operation, causing mild discomfort to the patient and the chance of urinary tract infection. It is performed in an artificial setting which may be different from the real situation. Abnormalities such as DO may be masked in some patients.

Management of urodynamic stress incontinence (USI)

Urodynamic stress incontinence is the involuntary loss of urine when the intravesical pressure exceeds the maximum urethral pressure but in the absence of detrusor activity. Aetiology of USI is multifactorial with ageing, parity, menopausal status and difficulties in vaginal delivery being of relevance. Treatment of USI needs to be tailored to individual patients. Even when the patient's only symptoms is stress incontinence, pre-operative urodynamics should still be performed since DO may still be present in 20% of patients! Decision on the choice of management needs to take into account the severity of the patient's symptoms, fitness for operation, the wish of the patient, the presence or absence of other pathology and the efficacy and complications from conservative or operative treatment. Conservative treatment includes pelvic floor exercises (PFE) which strengthen the striated muscles to occlude the urethra during episodes of increased abdominal pressure. It is actually indicated for all patients with USI because it is a simple and non-invasive procedure. The short term subjective cure rate is high. One can always resort to operation if PFE fails. There is no benefit when interferential therapy, electrical stimulation or vaginal cones are added. Symptoms recur after PFE stops. Oestrogen can be given in the form of HRT with doubtful efficacy. If surgery is required, the choice of treatment depends on whether the procedure is primary or secondary (first operation offers the best chance); presence of other pathology (fibroids, prolapse, etc); presence of co-existing voiding problems; presence of intrinsic sphincter deficiency and mobility of bladder neck (colposuspension requires a mobile bladder neck); the patient's choice and medical fitness for operations. Types of surgical procedures for USI include anterior colporrhaphy with bladder buttress, colposuspension (open and laparoscopic), tension free vaginal tape, bladder sling procedure and transurethral collagen injection. They are indicated when conservative treatment fails. Midurethral sling / tension free vaginal tape is still by far the most preferred operation and should be the first choice. It also replaces the Burch colposuspension and is considered to be the gold standard in the treatment of USI. As compared with colposuspension, it is easier to perform and superior in terms of better long term cure rates, reduced operation time, post-operative pain, and hospital stays. There is no statistical significant difference between inside-out and outside-in procedures. According to a Cochrane Review, Novara, et al, 2010, the tension free vaginal tape-retropubic approach (TVT) has long term evidence of sustained benefits when compared with the tension free vaginal tape-transobturator approach (TOT). Therefore, for primary USI, TVT may be more appropriate for younger patients while TOT may be more indicated for older patients. At the same time, TVT may be better for patients with recurrent USI

and intrinsic sphincter deficiency. Mini slings have inferior subjective and objective cure rates on short-term follow up, their use should be discouraged in clinical practice. Pre-operative counselling is important in order to explain the nature and possible outcomes of the operation, operative risks including injury to bladder / ureter, De Novo DO, voiding difficulty possibility for post-operative catherisation and chance of recurrence of incontinence over time. Emphasis should be given to ensure that the patients accept the possible complications since continence operations are procedures for improving quality (not quantity) of life!

Management of Idiopathic Detrusor Overactivity (DO)

DO is diagnosed when the involuntary rise in bladder pressure during the filling phase of a urodynamic study is associated with urgency. Treatment of idiopathic DO is relatively unsatisfactory, mainly because of the fact that the pathophysiology is still not known. It is therefore empirical and based on the assumption that either the brain or the bladder is primarily overactive. It is also important to exclude underlying problems e.g. neuropathy, bladder neck obstruction, urinary tract infection, psychiatric diseases. The choice of treatment includes drug therapy and bladder retraining. Bladder retraining is the most effective conservative treatment available for DO. The basic premise is that DO is the result of frequency and urgency rather than the cause. Correction of the behavioural abnormality is by retraining the bladder to a normal voiding frequency leading to a greater control. One to one relationship between the trainer and the patient is important. Therefore, the patient should be referred to the Continence Nurse Specialists for follow up so that they can monitor the progress accordingly. Long term commitment of patients is important, follow up assessments are therefore encouraged. Failure is usually due to loss of enthusiasm among patients and medical personnel. Commonly used drugs include oxybutynin, imipramine, solifenacin and intravescial Botox. Before starting drug therapy, counselling is important in order to explain the possible side effects and necessity for possible long term treatment. The dosage of drugs should be adjusted in a stepwise fashion and should not be abandoned until it has been given at the maximum tolerated dose. Oxybutynin is still considered to be the first line agent. It is a non-specific muscurinic receptor blocker. The dose range is 2.5 mg QD to 20 mg QD. Side effects include dry mouth, unpleasant food taste, palpitation, blurring of vision. Side effects tend to become less severe with time and variable in degree from patient to patient. It is contraindicated in patients with cardiac arrthymia and glaucoma. Solifenacin has more selectivity to M3 muscurinic receptors. It is a calcium channel antagonist and acts as the modulator of prejunctional receptors of neurons to reduce the acetycholine release. The dose range is from 5 mg to 10 mg daily. The side effect profile is the same as oxybutynin but with much better tolerability due to the more selective nature of the medication. Intravesical Botox injections have been used for treatment of refractory DO. The mechanism of action includes the blockage of release of acetylcholine at neuro-muscular junctions. Its effectiveness can last for 6-9 months. Side effects include a transient increase in post-void residual urine requiring intermittent catherisation. The cost, invasiveness and necessity of repeating treatment one every six to nine months are the problems for Botox injection.

Conclusion

Much advances have been made in the care of patients with female urinary incontinence. Effective treatments are available nowadays which can significantly improve women's quality of life. In many occasions, patients feel embarrassed to voice out their problems and enquiry by direct questioning is required. The concept of the midurethral sling has revolutionised the options of surgical treatment for USI. Its minimally invasive approach and long term success rates have led to a worldwide acceptance of the technique in the recent five to ten years. More long term studies and randomised control trials are still awaited to confirm the proper choices for the various types of midurethral slings available in the market. Patients with urinary incontinence usually require longer term follow up. Drug treatment may be needed to continue for decades. Relapse of symptoms is common if PFE and bladder retraining stop. Recurrence of USI can occur from a few months to more than 10 years after continence surgery. Patience is of paramount importance in order to understand the degree of severity of the incontinence and social incapacitation.

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6 – 8 NOVEMBER 2014 • HONG KONG

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PRE-CONGRESS WORKSHOPS (5 NOVEMBER 2014)

- Workshop 1 - Fillers
- Workshop 2 - Botulinum Toxin
- Workshop 3 - Non-invasive Body Contouring
- Workshop 4 - Non-invasive Face Lifting and Skin Resurfacing

PROGRAMME HIGHLIGHTS

Aesthetic

- Cosmetic Eyelid Surgery
- Cosmetic Breast Surgery
- Rhinoplasty
- Facelift & Threadlift
- Abdominoplasty
- Liposuction & Body Contouring
- Fat Grafting & Stem Cells
- Skin Laser Surgery
- Toxin & Fillers

Reconstructive

- Head & Neck Surgery
- Facial Skeleton Surgery
- Craniolfacial/Cleft Surgery
- Breast Reconstruction
- Flaps & Microsurgery
- Lymphovasular Anomalies
- Wound & Tissue Repair
- Training in Plastic Surgery
- Advances in Plastic Surgery

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IMPORTANT DATES

Deadline for Abstracts Submission: 10 August 2014
Deadline for Early Bird Registration: 1 September 2014

REGISTRATION

Please register online: www.wapscd2014.org.hk
Doctors of all specialties and nurses are welcome to attend

VENUE

Hong Kong Academy of Medicine Jockey Club Building
99 Wong Chuk Hang Road, Aberdeen, Hong Kong

ENQUIRY

MIMS (Hong Kong) Limited
Tel: (852) 2155 8557 Email: info@wapscd2014.org.hk

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La Vie En Jazz

Dr Nicholas SY CHAO

Consultant Paediatric Surgeon, Kowloon East Cluster / Kowloon Central Cluster

Dr Nicholas SY CHAO

'…Like a bolt out of the blue, fate steps in and sees you through. When you wish upon a star, your dreams come true.' Jiminy Cricket of *'Pinocchio'* (Ned Washington, 1940)

Making a Mo' Better beginning

Good music to me for years in school meant Mozart, Brahms and a few enduring *pop* songs. My musical life changed profoundly when it crossed path with jazz music during medical school. It was one inadvertent Saturday night after watching Spike Lee's *'Mo' Better Blues'* on home video. The fateful outcome was that I became infested with modern African-American cultures and a variety of standard and original African-American music [Fig.1]. Discovering *'Swing'* and the *'Blues'*, feeling the complex rhythms and harmonies, suddenly there are whole new dimensions to sound as an art form, both soul captivating and liberating at the same time.

What is jazz?

The history and origins of jazz, began and evolved where, when and by whom, is a subject of fascinating controversies that deserves an encyclopedic article. Wikipedia and *Ken Burns'* series provide quite comprehensive references. Or if *hip-hop* inclined, a good account can be heard on Guru's lyrics of *'The Jazz Thing'* on *Lee's* film. For many, jazz is the relaxing Latin beats, the smooth saxophone grooves, the lush piano style, and bluesy laidback tunes like *Take Five*. Soothing styles of Jazz are always popular. Many such recordings compile the early collections for enthusiasts. But there is more to jazz than just providing light background music for dining lounges.

Fig. 1&2
The film Mo' Better Blues features a rich variety of African-American music that lured me deep into jazz and African-American cultures. Subsequent discovery of Blue Note recordings, a record label exclusively of jazz music since 1939, helped compile my early archives of music as well as visual arts for jazz.

Listening to different styles

The first jazz sound that inspired me was 'Hard-Bop' of the 1950s and 60s, as heard on *Lee's* film. Their beats and improvisations are sometimes intense. Soon my ears were glued to works of *Miles Davis* and many African-American artists who recorded under the *'Blue Note'* label [Fig.2]. My appreciation diversified into different jazz genres, as *Davis'* own music evolved and changed stylistically through time and place. He started off in the 40s playing *Be-bop*; in the 50s he formed gigs in the west coast that led to the birth of 'Cool'. After his acclaimed *hard bop* and modal experimentations, through the late 60s and 70s *Davis* pioneered jazz fusion, followed by jazz-rock in the 80s, and finally experimented with hip-hopper in the 90s to create one of the earliest jazz-rap record. *Davis* changed *jazz* music and its history many times during tumultuous periods in African-American culture [Fig.3]. His influence contrasts those of post-modernists who re-popularised jazz since the 80s, such as *Wynton Marsalis*, a virtuoso trumpeter of New Orleans tradition, revived traditional jazz of the *pre-Bebop* era. *Marsalis'* works expanded my interests in early jazz and big band music [Fig.4]. They were two great icons, one embracing traditions with charisma and craft, the other being archetypal of the creativity spirit pushing musical boundaries. Their recordings are amongst the most influential. Attending their live gigs would be jazz pilgrimage. *Davis* unfortunately died before my jazz journey started.

Fig. 3&4
Kind of Blue, 1959, was one of Davis' many evolutionary 'experiments' that remains an all-time best-selling and one of the most influential jazz recordings. Marsalis, by contrast, produced multitude of dazzling works after the 80s that influenced the revival of traditional jazz.

Live performances and improvisations

Buying and listening to recordings are big pastimes of jazz audiophiles. One spends fortunes addictively

in compiling old and new recordings, and treasure-hunting rare 'vinyls' from rare shops across the globe. Recordings are invaluable documentations of great music. The essence of jazz however is that of improvised music, spontaneity and hence live performances. The earliest live gigs I attended were in London, NYC and D.C., including legends from the 60s. Those were truly memorable experiences, crowding in small clubs, listening up-close and chatting to great musicians who were also down-to-earth good humoured persons. Often at these clubs, captivating vibes between live audiences and musicians inspire delivery of rhythmic or melodic improvisations not reproducible in studio recordings. Attending live performances and 'jam sessions' to experience the magic of spontaneity becomes regular passion filling the weekend nightlife.

Studying to 'play'

Jazz improvisation is an intriguing art that embodies both technical mastery and the creative soul of the performer. The unique musical form and freedom in jazz enable complex harmonic variations upon which infinite melodic improvisations are possible. Improvising music is not a routine in classical training. Chopin and Mozart were rare geniuses who did. Learning to play jazz felt intimating. But for my deep fascination, with jazz and the jazz trumpet, I willed to study it, and play in a band someday.

The trumpet, robust and versatile, is technically demanding. Receiving only irregular teachings during my undergraduate and junior resident years meant that my trumpet-skills were much self-taught, and progressed intermittently. Nearly ten years elapsed before I finally played in a jazz band. The *Basic Notes*, a local sixteen-piece amateur and semi-professional jazz band had a vacancy in the trumpet section that granted my long time wish. But it was no easy time for the novice amateur. Big band repertoire, from *Swing, Bebop, Latin, Cuban,* to *funk* and *fusion*, demands blasting energy and focus for tight ensemble. But great music gig and high spirits were synergistic. No weekly Friday night rehearsals ended without overdose of euphoria [Fig.5]. *'When You Wish Upon A Star'*, of Disney's Pinocchio, fittingly and magically marked my debut at improvised trumpet solo in the band. For the years of endorphin topping experience from playing big band I was indebted to bandleader Danny, all the band members who coached me, and above all to Francis who introduced me.

Fig. 5
The Basic Notes Jazz Big Band, rehearsing blissfully every Friday night, was where my wish to play and perform jazz came to life

The 'musician-surgeon' constitution

As a practitioner in subspecialty surgery for over a decade, I learn that good surgical practice mandates long years of disciplined study, technical mastery, performance with composure and with heart, in-depth understanding of traditional principles and values, appreciation of new modalities, spontaneity and creativity at the specialty's forefront, and some ability to improvise upon principles at desirable moments, which seem apparently the same attributes in jazz study as I have known it. Has music and surgery influenced one another within my own constitution? My journeys through surgery and jazz span approximately the same years in my curriculum vitae. The two being mutually exclusive constitutions seem an improbable null hypothesis. There can be no controlled trials to prove if my musical pursuit has made me a better surgeon, or *vice versa*. However discovering *jazz* and other great music has certainly blessed my day-to-day existence with vibes, passion and meaning, making each day *mo' better* than otherwise.

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Source: 1. IMS 2010 Cord Blood Bank Market Research in Hong Kong (with Private O&G physicians) 2. Ipsos Healthcare 2009-2013 Cord Blood Bank Survey

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Dermatological Quiz

Dr Lai-yin CHONG

MBBS(HK), FRCP(Lond, Edin, Glasg), FHKCP, FHKAM(Med)
Private dermatologist

Dr Lai-yin CHONG

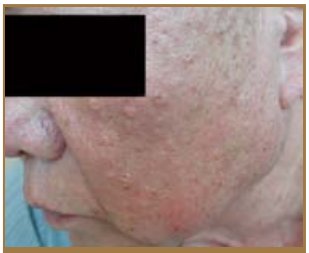

Fig.1a: Multiple papular lesions over the face

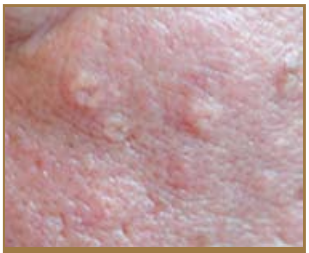

Fig.1b: Close-up of the lesions

This 60-years-old man presented with multiple asymptomatic papules over his cheeks and forehead since middle age (Fig.1a). These lesions gradually increased in number. Close-ups of individual lesions showed central umbilication and a yellowish tint (Fig.1b). He was diagnosed as having molluscum contagiosum by a junior doctor and referred to a dermatologist for treatment.

Questions:

1. What is your diagnosis?
2. What are your differential diagnoses?
3. Which drug may be the attributing cause of these lesions?
4. How do you treat this condition?

(See P.36 for answers)

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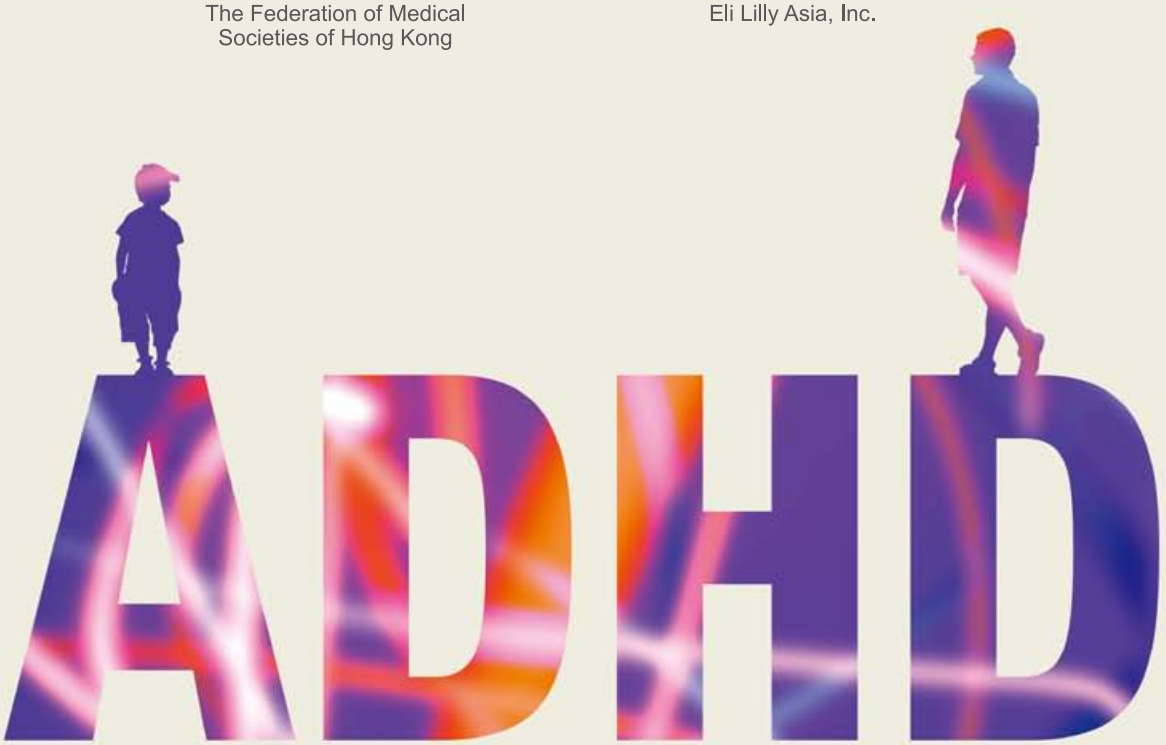

ADHD from Childhood to Adulthood

Dates : 22 Sept 2014 (Monday)
Time : 12:45pm – 3:00pm
Venue : Jordan Room, 2nd Floor, Eaton Hong Kong, 380 Nathan Road, Kowloon

- **Speaker:** Dr. KAN Chung-sing
  Specialist in Psychiatry
- **Chairman:** Dr. NG Yin-kwok
  2nd Vice-President of the Federation of Medical Societies of Hong Kong
- **Rundown :** 12:45 Reception
  13:00 ADHD from Childhood to Adulthood Symposium
  14:00 Lunch
- **Capacity :** 50 *(Priority will be given to doctors on first-come-first serve basis)*

Registration: Interested parties please complete the application form and fax to 2865 0345 or email to ellen.wong@fmshk.org on or before **15 Sept, 2014 (Monday)**
Enquiry: Ms. Ellen Wong of the Secretariat at 2821 3515

CME has been applied and pending confirmation
Application form can be downloaded from website: http://www.fmshk.org

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	★ A Big Prostate and A big Stone **1**	★ HKMA Tai Po Community Network – Incretin Base Management of T2DM ★ FMSHK Officers' Meeting ★ HKMA Council Meeting **2**	★ HKMA Community Network Exercise Prescription Certificate Courses **3**	★ KECN/UCH – Certificate Course for GPs 2014 (Session 4) – An Update on Scabies ★ HKMA Hong Kong East Community Network – BPH Screening & Diagnosis ★ HKMA Central, Western & Southern Community Network - Certificate Course on Psychiatry (Session 1) - Update on Management of Common Anxiety Disorders ★ HKMA New Territories West Community Network – Evidence–based Management for Type 2 Diabetes Mellitus **4**	★ Joint Surgical Symposium ★ HKMA Kowloon City Community Network – Reference Framework for Preventive Care for Older Adults in Primary Care Settings **5**	★ MPS – HKMA Medical Experts Training Course in Hong Kong – 2014 **6**
★ MPS – HKMA Medical Experts Training Course in Hong Kong – 2014 **7**	**8**	**9**	★ Hong Kong Neurosurgical Society Monthly Academic Meeting –Assessment and treatment of diplopia secondary to cranial nerve palsies ★ HKMA Community Network Exercise Prescription Certificate Courses **10**	★ HKMA Hong Kong East Community Network – The Pain of Osteoarthritis Management ★ HKMA New Territories West Community Network – 5th Annual Meeting cum CME Lecture on "Complaints against GP" ★ HKMA Kowloon East Community Network – A Rational Approach to Diabetes Management ★ HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2014 – Endolaproscopic Surgery for GI Disease **11**	★ HKMA Shatin Doctors Network – Improving CV Outcome in CAD Patients with Elevated Heart Rate **12**	★ HKMA & Kowloon Hospital Alumni Society – Seminar of Care for the Elderly ★ Refresher Course for Health Care Providers 2014/2015 – ENT update – Management of Salivary Gland Diseases and Thyroid Nodules **13**
★ HKMA Badminton Tournament **14**	**15**	★ HKMA Yau Tsim Mong Community Network – Diagnosis and Treatment of Axial–Spondyloarthropathy (Axial–SpA) ★ HKMA Kowloon West Community Network –5th Annual Meeting cum CME Lecture on "Postmenopausal Osteoporosis Continuum: How do We Choose between SERMs and Bisphosphonates for Different Patients?" ★ HKMA Tai Po Community Network – A Focus on Management of Atherogenic Dyslipidemia **16**	★ HKMA Central, Western & Southern Community Network - Certificate Course on Psychiatry (Session 2) - Management of Depression – New and Challenge ★ HKMA Community Network Exercise Prescription Certificate Courses ★ HKMA Golf Tournament 2014 **17**	★ HKMA Hong Kong East Community Network – BPH Treatment Options and Management ★ HKMA New Territories West Community Network – Current Management on Rhinitis ★ FMSHK Executive Committee Meeting **18**	**19**	★ HKMA Dragon Boat Team Celebration Dinner **20**
★ HKMA Badminton Tournament **21**	**22**	★ HKMA New Territories West Community Network – BPH Screening & Diagnosis ★ HKMA Tai Po Community Network – Diagnostics of HPV and Prevention **23**	★ CUHK Sleep 2014 Comprehensive Polysomnography Workshop, Psychotherapy for Insomnia Workshop and Conference ★ HKMA Community Network Exercise Prescription Certificate Courses **24**	★ CUHK Sleep 2014 Comprehensive Polysomnography Workshop, Psychotherapy for Insomnia Workshop and Conference ★ HKMA Hong Kong East Community Network - Update on the Management of Hypertension ★ HKMA Kowloon East Community Network – New Era for COPD Management – Dual Bronchodilation **25**	★ CUHK Sleep 2014 Comprehensive Polysomnography Workshop, Psychotherapy for Insomnia Workshop and Conference ★ HKMA Shatin Doctors Network – Management of Urinary Tract Infection **26**	★ CUHK Sleep 2014 Comprehensive Polysomnography Workshop, Psychotherapy for Insomnia Workshop and Conference ★ HKMA Yau Tsim Mong Community Network – Certificate Course on Bringing Better Health to Our Community (Session 5) ★ 16th Beijing / Hong Kong Medical Exchange **27**
★ CUHK Sleep 2014 Comprehensive Polysomnography Workshop, Psychotherapy for Insomnia Workshop and Conference ★ 16th Beijing / Hong Kong Medical Exchange ★ RSCP Badminton Tournament **28**	**29**	★ HKMA Kowloon West Community Network – New Era of Seasonal Influenza Prevention **30**				

Date / Time	Function	Enquiry / Remarks
1 MON 7:30pm-8:30pm	**A Big Prostate and A big Stone** Organiser: Hong Kong Urological Association, Chairman: Dr C L Cho, KWH, Speaker: Dr Clarence Leung, KWH, Venue: Multi-disciplinary Simulation and Skills Centre, 4/F, Block F, QEH	Ms. Tammy HUNG Tel: 9609 6064 1 CME Point
2 TUE 1:45pm	**HKMA Tai Po Community Network – Incretin Base Management of T2DM** Speaker: Dr. TSANG Man Wo, Venue: Chiuchow Garden Restaurant (潮江春), Shop 001–003, 1/F, Uptown Plaza (新達廣場), No. 9 Nam Wan Road, Tai Po	Mr. Francis LEUNG Tel: 5362 6843 1 CME Point
8:00pm	**FMSHK Officers' Meeting** Organiser: The Federation of Medical Societies of Hong Kong, Venue: Gallop, 2/F., Hong Kong Jockey Club Club House, Shan Kwong Road, Happy Valley, Hong Kong	Ms. Nancy CHAN Tel: 2527 8898
8:00pm	**HKMA Council Meeting** Organiser: The Hong Kong Medical Association, Chairman: Dr. SHIH Tai Cho, Louis, Venue: HKMA Head Office, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong	Ms. Christine WONG Tel: 2527 8285
3 WED 1:30pm	**HKMA Community Network Exercise Prescription Certificate Courses** Organisers: Hong Kong Medical Association & Department of Health, Speaker: Prof. IP Wing Yuk, Venue: Jasmine Room, 2/F, Royal Park Hotel, 8 Pak Hok Ting Street, Shatin	HKMA CME Dept. Tel: 2527 8452 2 CME Points
4 THU 1:00pm	**KECN/UCH – Certificate Course for GPs 2014 (Session 4) – An Update on Scabies** Organisers: HKMA Kowloon East Community Network and United Christian Hospital, Chairman: Dr. David CHAO, Speaker: Dr. LUK Chi Kong, David, Venue: East Ocean Seafood Restaurant (東海海鮮酒家), Shop 137, 1/F, Metro City Plaza 3, 8 Mau Yip Road, Tseung Kwan O, Kowloon	Ms. Polly TAI Tel: 3513 3430 Ms. Cordy WONG Tel: 3513 3087 1 CME Point
1:00pm	**HKMA Hong Kong East Community Network – BPH Screening & Diagnosis** Organiser: HKMA Hong Kong East Community Network, Chairman: Dr. KONG Wing Ming, Henry, Speaker: Dr. CHAN Wai Hee, Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong	Ms. Candice TONG Tel: 2527 8285 1 CME Point
1:00pm	**HKMA Central, Western & Southern Community Network - Certificate Course on Psychiatry (Session 1) - Update on Management of Common Anxiety Disorders** Organisers: HKMA Central, Western & Southern Community Network, Chairman: Dr. YIK Ping Yin, Speaker: Dr. KWOK Wai Ming, Henry, Venue: HKMA Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
1:00pm	**HKMA New Territories West Community Network – Evidence–based Management for Type 2 Diabetes Mellitus** Organiser: HKMA New Territories West Community Network, Chairman: Dr. LEE Huen, Speaker: Dr. CHEUNG Fu Keung, Venue: Plentiful Delight Banquet (元朗喜尚嘉喜酒家), 1/F, Ho Shun Tai Building, 10 Sai Ching Street, Yuen Long	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
5 FRI 8:00am-9:00am	**Joint Surgical Symposium** Organisers: Department of Surgery,The University of Hong Kong & Hong Kong Sanatorium & Hospital, Chairman: Professor William Wei, Speakers: Professor William Wei & Professor Simon Law, Venue: Hong Kong Sanatorium & Hospital	Department of Surgery, Hong Kong Sanatorium & Hospital Tel: 2835 8698 1CME Point (Active)
1:00pm	**HKMA Kowloon City Community Network – Reference Framework for Preventive Care for Older Adults in Primary Care Settings** Organiser: HKMA Kowloon City Community Network, Chairman: Dr. CHIN Chu Wah, Speaker: Dr. LEE Siu Yin, Ruby, Venue: Spotlight Recreation Club (博藝會), 4/F, Screen World, Site 8, Whampoa Garden, Hunghom	Ms. Candice TONG Tel: 2527 8285 1 CME Point
6 SAT 1:00pm (7)	**MPS – HKMA Medical Experts Training Course in Hong Kong – 2014** Organisers: Hong Kong Medical Association & Medical Protection Society, Speaker: Various, Venue: HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21–22 Connaught Road Central, Hong Kong	HKMA CME Dept. Tel: 2527 8452 3 CME Points each day
10 WED 7:30am	**Hong Kong Neurosurgical Society Monthly Academic Meeting –Assessment and treatment of diplopia secondary to cranial nerve palsies** Organiser: Hong Kong Neurosurgical Society, Chairman: Dr Gilberto LEUNG, Speaker: Mr. CHAN Tan Wah, Stephen, Venue: Seminar Room, Ground Floor, Block A, Queen Elizabeth Hospital	Dr. LEE Wing Yan, Michael Tel: 2595 6456 1.5 CME Points
1:30pm	**HKMA Community Network Exercise Prescription Certificate Courses** Organisers: Hong Kong Medical Association & Department of Health, Speakers: Prof. Stanley S.C. HUI;Mr. Sam W.S. WONG, Venue: Jasmine Room, 2/F, Royal Park Hotel, 8 Pak Hok Ting Street, Shatin	HKMA CME Dept. Tel: 2527 8452 2 CME Points
11 THU 1:00pm	**HKMA Hong Kong East Community Network – The Pain of Osteoarthritis Management** Organiser: HKMA Hong Kong East Community Network, Chairman: Dr. TSANG Kin Lun, Speaker: Dr. LAW Yee Cheong, Wally, Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong	Ms. Candice TONG Tel: 2527 8285 1 CME Point
1:00pm	**HKMA New Territories West Community Network – 5th Annual Meeting cum CME Lecture on "Complaints against GP"** Organiser: HKMA New Territories West Community Network, Chairman: Dr. CHEUNG Kwok Wai, Alvin, Speaker: Dr. CHOI Kin, Venue: Pearl Ocean, 1/F., Gold Coast Yacht and Country Club, 1 Castle Peak Road, Castle Peak Bay, Hong Kong (黃金海岸鄉村俱樂部–遊艇會一樓金霞殿)	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
1:00pm	**HKMA Kowloon East Community Network – A Rational Approach to Diabetes Management** Organiser: HKMA Kowloon East Community Network, Chairman: Dr. MA Ping Kwan, Danny, Speaker: Dr. IP Tai Pang, Venue: East Ocean Seafood Restaurant (東海海鮮酒家), Shop 137, 1/F, Metro City Plaza 3, 8 Mau Yip Road, Tseung Kwan O, Kowloon	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
2:00pm	**HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2014 – Endolaproscopic Surgery for GI Disease** Organisers: Hong Kong Medical Association and Hong Kong Sanatorium & Hospital, Speaker: Dr. LI Ka Wah, Michael, Venue: Function Room A, HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21–22 Connaught Road Central, Hong Kong	HKMA CME Dept. Tel: 2527 8452 1 CME Point
12 FRI 1:00pm	**Hong Kong Neurosurgical Society Monthly Academic Meeting –Assessment and treatment of diplopia secondary to cranial nerve palsies** Organiser: HKMA Shatin Doctors Network, Chairman: Dr. MAK Wing Kin, Speaker: Dr. LI Siu Lung, Steven, Venue: Chairman Room, Level 2, Royal Park Hotel, 8 Pak Hok Ting Street, Shatin	Ms. Ivy CHAN Tel: 9733 7883

Date / Time	Function	Enquiry / Remarks
13 SAT 12:45pm	**HKMA & Kowloon Hospital Alumni Society – Seminar of Care for the Elderly** Organisers: Hong Kong Medical Association & Kowloon Hospital Alumni Society,Speakers: Mr. CHAN Hon Wai;Ms. CHOW Kit Ying, Kathy; Dr. FUNG Pui Man, Mandy;Ms. KAM Yee Ling, Eleanor;Dr. POON Ting Keung, Venue: Conference Rooms 1&2, 2/F., Main Building, Kowloon Hospital, 147A Argyle Street, Kowloon	Ms. Philippa LO Tel: 9667 5600 2.5 CME Points
2:15 pm	**Refresher Course for Health Care Providers 2014/2015 – ENT update – Management of Salivary Gland Diseases and Thyroid Nodules** Organisers: Hong Kong Medical Association,HK College of Family Physicians & HA – Our Lady of Maryknoll Hospital, Speaker: Dr. NG Siu Kwan, Venue: Training Room II, 1/F, OPD Block, Our Lady of Maryknoll Hospital, 118 Shatin Pass Road, Wong Tai Sin, Kowloon	Ms. Clara TSANG Tel: 2354 2440 2 CME Points
14 SUN 1:00pm	**HKMA Badminton Tournament** Organiser: The Hong Kong Medical Association, Chairman: Dr. CHEUNG, Michelle, Venue: MacLehose Medical Rehabilitation Centre (MMRC), 7 Sha Wan Drive, Pokfulam, Hong Kong	Mr. Ian KWA Tel: 2527 8285
16 TUE 1:00pm	**HKMA Yau Tsim Mong Community Network – Diagnosis and Treatment of Axial–Spondyloarthropathy (Axial–SpA)** Organisers: HKMA Yau Tsim Mong Community Network and Hong Kong Society of Rheumatology, Chairman: Dr. LAM Yick Wang, Clement, Speaker: Dr. CHAU Shuk Yi, Lucia, Venue: Jade Ballroom, Level 2, Eaton, Hong Kong, 380 Nathan Road, Kowloon	Ms. Candice TONG Tel: 2527 8285 1 CME Point
1:00pm	**HKMA Kowloon West Community Network –5th Annual Meeting cum CME Lecture on "Postmenopausal Osteoporosis Continuum: How do We Choose between SERMs and Bisphosphonates for Different Patients?"** Organisers: HKMA Kowloon West Community Network, Chairman: Dr. TONG Kai Sing, Speaker: Dr. YIP Wai Man, Venue: Panda Grand Ballroom B, 5/F, Panda Hotel, 3 Tsuen Wah Street, Tsuen Wan, NT	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
1:45pm	**HKMA Tai Po Community Network – A Focus on Management of Atherogenic Dyslipidemia** Organiser: HKMA Tai Po Community Network, Speaker: Dr. MA Pui Shan, Venue: Chiuchow Garden Restaurant (潮江春), Shop 001–003, 1/F, Uptown Plaza (新達廣場), No. 9 Nam Wan Road, Tai Po	Ms. Joyce TSUNG Tel: 2664 3808 1 CME Point
17 WED 1:00pm	**HKMA Central, Western & Southern Community Network - Certificate Course on Psychiatry (Session 2) - Management of Depression – New and Challenge** Organiser: HKMA Central, Western & Southern Community Network, Chairman: Dr. LAW Yim Kwai, Speaker: Dr. TING Sik Chuen, Venue: HKMA Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
1:30pm	**HKMA Community Network Exercise Prescription Certificate Courses** Organisers: Hong Kong Medical Association& Department of Health, Speaker: Mr. Sam W.S. WONG, Venue: Jasmine Room, 2/F, Royal Park Hotel, 8 Pak Hok Ting Street, Shatin	HKMA CME Dept. Tel: 2527 8452 2 CME Points
	HKMA Golf Tournament 2014 Organiser: The Hong Kong Medical Association, Chairman: Dr. HOU Lee Tuen, Laurence, Venue: Old Course, Hong Kong Golf Club, Fanling, NT	Mr. Andie HO Tel: 2527 8285
18 THU 1:00pm	**HKMA Hong Kong East Community Network – BPH Treatment Options and Management** Organiser: HKMA Hong Kong East Community Network, Chairman: Dr. LI Keung, Speaker: Dr. CHAN Wai Hee, Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong	Ms. Candice TONG Tel: 2527 8285 1 CME Point
1:00pm	**HKMA New Territories West Community Network – Current Management on Rhinitis** Organiser: HKMA New Territories West Community Network, Chairman: Dr. TSUI Fung, Speaker: Dr. TANG Kwong Chi, Venue: Plentiful Delight Banquet (元朗喜尚嘉喜酒家), 1/F, Ho Shun Tai Building, 10 Sai Ching Street, Yuen Long	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
8:00pm	**FMSHK Executive Committee Meeting** Organiser: The Federation of Medical Societies of Hong Kong, Veune: Council Chamber, 4/F, Duke of Windor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Nancy CHAN Tel: 2527 8898
20 SAT 6:30pm	**HKMA Dragon Boat Team Celebration Dinner** Organiser: The Hong Kong Medical Association, Venue: HKMA Central Premises, 2/F, Chinese Club Building, 21–22 Connaught Road Central, Hong Kong	Mr. Andie HO Tel: 2527 8285
21 SUN 1:00pm	**HKMA Badminton Tournament** Organiser: The Hong Kong Medical Association, Chairman: Dr. CHEUNG, Michelle,Venue: MacLehose Medical Rehabilitation Centre (MMRC), 7 Sha Wan Drive, Pokfulam, Hong Kong	Mr. Ian KWA Tel: 2527 8285
23 TUE 1:00pm	**HKMA New Territories West Community Network – BPH Screening & Diagnosis** Organiser: HKMA New Territories West Community Network, Chairman: Dr. TSANG Yat Fai, Speaker: Dr. CHAN Tsz Yeung, Marco, Venue: Pearl Ocean, 1/F., Gold Coast Yacht and Country Club, 1 Castle Peak Road, Castle Peak Bay, Hong Kong (黃金海岸鄉村俱樂部–遊艇會一樓金霞殿)	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
1:45pm	**HKMA Tai Po Community Network – Diagnostics of HPV and Prevention** Organiser: HKMA Tai Po Community Network, Speaker: Dr. Francois FONG, Venue: Chiuchow Garden Restaurant (潮江春), Shop 001–003, 1/F, Uptown Plaza (新達廣場), No. 9 Nam Wan Road, Tai Po	Ms. Fei MAK Tel: 8200 9592 1 CME Point
24 WED 9:00am-5:00pm *(25-28)*	**CUHK Sleep 2014 Comprehensive Polysomnography Workshop, Psychotherapy for Insomnia Workshop and Conference** Organisers: Department of Psychiatry and Paediatrics, The Chinese University of Hong Kong, Chairmen: Prof. Wing Yun Kwok and Prof. Albert Martin Li, Speakers: Prof. Phyllis C Zee and Prof. Mary A. Carskadon, Venue: Postgraduate Education Centre, Prince of Wales Hospital, Shatin	Ms. Mandy YU Tel: 2636 7593
1:30pm	**HKMA Community Network Exercise Prescription Certificate Courses** Organiser: The Hong Kong Medical Association, Speaker: Mr. Eyckle WONG, Venue: Jasmine Room, 2/F, Royal Park Hotel, 8 Pak Hok Ting Street, Shatin	HKMA CME Dept. Tel: 2527 8452 2 CME Points
25 THU 1:00pm	**HKMA Hong Kong East Community Network - Update on the Management of Hypertension** Organiser: HKMA Hong Kong East Community Network, Chairman: Dr. LEUNG Kwan Kui, Terence, Speaker: Dr. HO Hung Kwong, Ducan, Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong	Ms. Candice TONG Tel: 2527 8285

Date / Time	Function	Enquiry / Remarks
25 THU 1:00pm	**HKMA Kowloon East Community Network – New Era for COPD Management – Dual Bronchodilation** Organiser: HKMA Kowloon East Community Network, Chairman: Dr. MA Ping Kwan, Danny, Speaker: Dr. TAI Kian Bun, Venue: East Ocean Seafood Restaurant (東海海鮮酒家), Shop 137, 1/F, Metro City Plaza 3, 8 Mau Yip Road, Tseung Kwan O, Kowloon	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
26 FRI 1:00pm	**HKMA Shatin Doctors Network – Management of Urinary Tract Infection** Organiser: HKMA Shatin Doctors Network, Chairman: Dr. MAK Wing Kin, Speaker: Dr. WONG Chun Wing, Simon, Venue: Jasmine Room, Level 2, Royal Park Hotel, 8 Pak Hok Ting Street, Shatin	Ms. Scarlett WONG Tel: 2868 9075 1 CME Point
27 SAT 1:00pm	**HKMA Yau Tsim Mong Community Network – Certificate Course on Bringing Better Health to Our Community (Session 5)** Organisers: HKMA Yau Tsim Mong Community Network Kowloon Central Cluster & Hong Kong College of Family Physicians, Speakers: Dr. CHAN Hau Ngai, Kingsley; Dr. John CHAN, Venue: Block M, Lecture Theatre, Queen Elizabeth Hospital, 30 Gascoigne Road, Kowloon	Ms. Noel AU YEUNG Tel: 2958 8608 Ms. Mandy LEUNG Tel: 2958 8613 Miss Candice TONG Tel: 2527 8285
(28)	**16th Beijing / Hong Kong Medical Exchange** Organisers: The Hong Kong Medical Association & Chinese Medical Association, Chairman: Dr. TSE Hung Hing, Speaker: Various, Venue: 7/F, Langham Place, Monkok, Hong Kong	Miss Sukey CHENG Tel: 2527 8285 5 CME Points 27/9 3 CME Points 28/9
28 SUN 12:00nn	**RSCP Badminton Tournament** Organiser: Recreation & Sports Club for Hong Kong Professional Bodies, Venue: Sun Yat Sen Memorial Park Sports Centre	Mr. Ian KWA Tel: 2527 8285
30 TUE 1:00pm	**HKMA Kowloon West Community Network – New Era of Seasonal Influenza Prevention** Organiser: HKMA Kowloon West Community Network, Chairman: Dr. WONG Wai Hong, Bruce, Speaker: Dr. SO Man Kit, Thomas, Venue: Crystal Room I–III, 30/F, Panda Hotel, 3 Tsuen Wah Street, Tsuen Wan, NT	Miss Hana YEUNG Tel: 2527 8285 1 CME Point

Upcoming Meeting

4-5/10/2014	**The 8th Hong Kong Allergy Convention (HKAC 2014) – Novel Revelations in Allergies** Organiser: Hong Kong Institute of Allergy, Chairman: Dr Robert Tseng, Venue: Hong Kong Convention and Exhibition Centre Online Registration: www.allergy.org.hk, Enquiry: HKAC 2014 Secretariat Tel: 2559 9973 Fax: 2547 9528, CME/CPD points application in progress

Society News

The Hong Kong Pain Society

The Hong Kong Pain Society is a multidisciplinary society with representation from different medical specialties and healthcare disciplines with interest in research and management of pain. We were founded in 2006 with the following objectives:

- to promote exchange of knowledge among professionals
- to promote public education on pain and its management
- to promote research in science and practice relevant to pain medicine
- to advise relevant regional agencies on advances in pain medicine

Our membership is open to all practicing medical and allied health professionals with interest in pain research and management. Regular members enjoy the benefit of attending the events of the society at a special discount rate and receipt of regular newsletters. From time to time, the society also invites our members to apply for conference grants to attend local and overseas conferences.

We organize regular scientific meetings, symposiums, workshops and educational series on various topics in pain management. An annual scientific meeting is held each year, with a comprehensive programme by expert local and overseas speakers.

The Hong Kong Pain Society was recognized as a chapter of the International Association for the Study of Pain in 2011. We share a common goal in advocating that "Relief of pain should be a human right". Every year, we launch the "Global Year Against Pain" programme on a particular type of pain. Year 2013 is the "Global Year Against Visceral Pain".

You are welcome to visit our website www.hkpainsociety.org for information on membership and our coming programmes.

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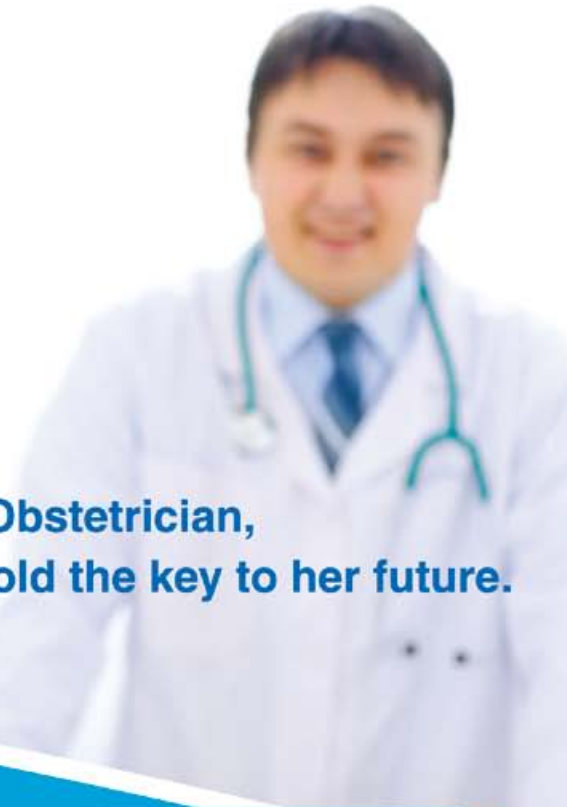

Dear Obstetrician,
You hold the key to her future.

Unlock her world to more medical alternatives with cord blood.

Cord blood, a proven source substitute to bone marrow for haematopoietic stem cells (HSC), can support the treatment of certain cancers such as leukaemia and lymphoma, blood disorders, inborn errors of metabolism and immunodeficiencies. Current areas of active research and clinical trials include stroke, cerebral palsy and cartilage regeneration.

With 1 in 217 people[1] estimated to require a HSC transplant in their lifetime, you can help your patients secure more medical treatment options today. Help them know more about the benefits of cord blood stem cells.

For more supporting literature, please contact us at **physician@hk.cordlife.com** or call **3980 2888**.

Important Facts

Cord Blood
A rich source of haematopoietic stem cells (HSCs)

No significant difference
between outcomes of cord blood and bone marrow transplantation[2]

1 in 217 people[1]
needs HSC transplant in his/her lifetime

Reference:

1. Nietfeld JJ, Pasquini MC, Logan BR, Verter F, Horowitz MM. Lifetime Probabilities of Hematopoietic Stem Cell Transplantation in the U.S. *Biology of Blood and Marrow Transplantation* 2008;14:316-322.
2. Rocha V., Labopin M., Sanz G., Arcese W., Schwerdtfeger R., Bosi A., et. al. Transplants of Umbilical-Cord Blood or Bone Marrow from Unrelated Donors in Adults with Acute Leukemia. *N Engl J Med* 2004; 351: 2276-85

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Answers to Dermatological Quiz

1. The morphology of the lesion is characteristic of sebaceous hyperplasia.
   Sebaceous hyperplasia is a common, benign condition of the sebaceous glands in middle aged or elderly adults. Lesions can be single or multiple, usually appear as discrete, small, yellowish and soft papules on the face. Typically an individual lesion has a central umbilication which corresponds to a central follicular infundibular ostium. The forehead, cheeks and nose are the common sites of distribution.

2. The differential diagnoses include basal cell carcinoma, molluscum contagiosum, milia and xanthoma. Some papules of sebaceous hyperplasia may have features similar to basal cell carcinoma, such as a central depression, an elevated edge and overlying telangiectasia.

3. It had been observed in the past that sebaceous hyperplasia has an increased frequency in patients with heart or renal transplants. It is now believed that it is due to cyclosporine taken in these patients. Cyclosporine induced follicular abnormalities include hypertrichosis, folliculitis, sebaceous hyperplasia, keratosis pilaris, follicular infundibular cyst and folliculodystrophy.

4. The clinical appearance is usually sufficient for a correct diagnosis. However, a biopsy should be done if basal cell carcinoma is a concern. Treatment options include carbon dioxide laser surgery, topical trichloroacetic acid, cauterisation and curettage. However the recurrence rate is high after treatment because of the depth of the lesion. Oral isotretinoin had been tried in patients with extensive lesions, but the result was inconsistent. Lesions often recur upon discontinuation of therapy. The side-effects of oral retinoid also will not justify its long term use for a condition of benign nature.

Dr Lai-yin CHONG
MBBS(HK), FRCP(Lond, Edin, Glasg), FHKCP, FHKAM(Med)
Private dermatologist

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References:
1. Ignaut DA, Schwartz SL, Sarwat S and Murphy HL. *Diabetes Educ* 2009;35:789-798.
2. Ignaut DA, Opincar M and Lenox S. *J Diabetes Sci Technol* 2008;2:533-537.

Further information is available upon request.

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Reference:
1. YAZ® Package Insert, BHC Hong Kong (May 2013)

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