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Why You Should Have a Family Doctor

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Specialist in Family Medicine

Editor

Dr Donald KT LI

Most colleagues know what Family Medicine is about and would wonder why I choose to write on this "boring" subject again. Yes, you will say, we know the 5 Cs, all medical students have been taught these – the Context of care provided by the family doctor is evidence-based. The care provided is Continuous Comprehensive and patient Centred. Moreover the family doctor Coordinates care and Integrates complex care.

But what does this really mean? Health is about people – beyond the glittering surface of modern technology, the core space of every health system is occupied by the unique encounter between people who need medical services and those entrusted to deliver them. The patient seeks care from doctors when not feeling well. When a patient consults a doctor, he or she is looking for knowledge and predictions: What is the diagnosis and with or without treatment, will the disease go away? The Family Doctor takes into consideration the effect of bio-psycho-social factors, family environment factors on illness and provides appropriate treatment according to problems identified. Only when necessary, the Family Doctor will make the appropriate referral. But we respect patient culture and expectations. Rules are often broken, provided "we do no harm". I once argued with an external examiner from the UK who failed a candidate because he honoured the request of the patient to have a blood count because he has had a fever for a week. This is extravagance in the National Health System but probably a necessity when money follows patients. A good family doctor should realise we are practising Western Medicine in the context of a different race with different culture. And so should our external examiner.

A well trained family physician will have good communication skills and can develop rapport with the patient by asking the right questions, and is astute and observant. He exhibits optimal ethical and professional standards and is skilled in accurate diagnosis at the point of first contact whilst having a failsafe diagnostic strategy. Holistic medicine is balancing the science and the art of medicine: away from being too reliant on science, technology and medicines, and towards focusing on the person as a whole.

The essence of family medicine is relation and trust. A relation which the patient would like to build with someone he or she can confide in; someone who totally understands about his or her health and well being. Why are they called family doctors? Because the patient views them as part of their "family". The Family Doctor also recognises the impact of illness on the family and will respect your wishes regarding privacy and confidentiality.

My fellow specialist colleagues, you too should have a family doctor. More and more we are seeing cases of self neglect amongst doctors with late diagnosis of serious illness which could have been managed more optimally at an early stage. Your family doctor will support a life course approach to screening and prevention and hopefully be one of your best friends. I always like to joke: a Family Doctor is someone you want to see all the time. After being operated on by a surgeon, you wish you will never have to see him again.

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Managing Multi-morbidity: the Important Role of the Family Doctor

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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 November 2014.

Background

Multi-morbidity, the presence of two or more chronic conditions in a person, has become an important health service and research topic for both primary care and public health. Studies have shown that people with multi-morbidity have a poorer quality of life and health outcomes when compared to those without.[1] Moreover, it is a common problem in the primary care setting and people with multi-morbidity tend to have a high utilisation of health services.[2] In addition to being associated with high health care costs, people with multi-morbidity also require more informal caregiving from their families and friends due to their complex health care needs. For health care providers, the care of patients with multi-morbidity often requires spending a longer time with the individual patient. In addition to their physical problems, evidence also shows that they are more likely to suffer from psychological distress and functional problems.[1]

Epidemiology

Although only limited research has been conducted to study the epidemiology of multi-morbidity, a recent large epidemiological study in general practice shows that age and social deprivation are related to the occurrence of multi-morbidity. In the study which involves medical data from more than 17 million registered general practice patients in Scotland, Barnett *et al*[3] shows that about a quarter of people in primary care practice suffer from more than 2 chronic conditions. For those aged 65 years or above, more than half of them suffer from two or more chronic conditions.[3] In addition to showing that there is a higher prevalence of people with multi-morbidity in the older populations, this study also shows that nearly two thirds of physical and mental health comorbidity occur in people who are less than 65 years of age and that people who are more socially deprived or of a younger age group have a higher prevalence of multi-morbidity.

Issues faced by people with multi-morbidity

Several health services related issues specifically affect people with multi-morbidity. For example, studies show that people with multi-morbidity receive more fragmented care when compared to the care received by people with a single chronic condition. This is often due to the lack of an overall coordination of their care and the need for them to attend multiple disease specific clinics.[4] Similar to the coordination of care, the lack of interpersonal continuity of care is also an issue for this population. No health care provider can take care of the overall coordination of care and hence the continuity of care for these patients. Not surprisingly, studies have also shown that people with multi-morbidity have higher consultation rates but have less continuity of care when compared to people without mutli-morbidity.[2] The poor continuity and coordination of care among people with multi-morbidity is particularly problematic as these attributes of care have been shown to be most valued by people with multi-morbidity. In a qualitative study that explored the health care needs of patients with multi-morbidity, Bayliss *et al*[5] have identified that in addition to accessibility, the support that people with multi-morbidity receive for care coordination and the presence of a caring health professional who looks after their care over time are described as two of the most important features they desire for their care.[5] Indeed, the provision of continuous, coordinated care for people with multiple medical conditions is one of the big challenges presenting to any health care system nowadays which aims to provide a high quality of care for this population.

Unfortunately, these challenges to the provision of high quality care may be exacerbated when there is a lack of a well-established primary care structure[6] in a given health system.

Another problem related to coordination and continuity is the often unaddressed issue of competing goals or treatments received from different disease specific care providers. For chronic conditions such as diabetes mellitus or cardiovascular diseases, this situation may present less of a problem since these chronic conditions share similar treatment strategies but the problem of conflicting goals and treatments may occur when competing treatment goals are present such as in the management of chronic obstructive pulmonary diseases, hypertension, asthma and depression. Research has shown that the care of people with these conditions together is often associated with a higher rate of medical errors as well as the presence of inappropriate treatments.[7,8]

As people with multi-morbidity are likely to be prescribed with a considerable number of medications, polypharmacy is very common among them.[8] Although it is well established that polypharmacy is associated with poor medication adherence, this problem appears to be more serious for people with multi-morbidity when compared to those with only a single chronic condition. This is probably due to the fact that in addition to polypharmacy, people with multi-morbidity are at an increased risk for having co-existing mental health problems which can affect their medication compliance.

What can help people with multi-morbidity?

One of the ways to provide a higher quality of care for people with multi-morbidity is to provide more coordinated and longitudinal continuity of care. Family doctors, who are trained to adopt a generalist approach in the care of patients, may be particularly suitable to do this since primary care doctors are more accessible and are trained to address more general health needs with a holistic and patient centred approach and is able to address the overall bio-psycho-social needs of complex patients.[9]

However, with the complex needs of patients with chronic conditions, a single doctor with limited support may not be able to address all their needs. The adoption of a team approach which consists of various health care professionals may be a more reasonable and better approach in the provision of a health care service for this population. In a randomised controlled trial by Katon *et al*[10] (2010), the authors examined the effects of a multi-disciplinary team based intervention to improve patient self-monitoring, medication adherence as well as responsive treatment adjustments among patients with several chronic medical conditions including depression, poorly controlled cardiovascular diseases and diabetes mellitus, they found that those randomised to the team based approach had improved glycated haemoglobin levels, lipid levels, blood pressures as well as depression outcomes, when compared to the usual care group. In addition to these disease specific outcomes, they also found that patients in the intervention group had an improved quality of life and reduced disability.[11]

In the collaborative care team intervention, a nurse care manager was assigned the task of enhancing patient self-management, responsiveness and interpersonal continuity of care with systematic follow up and worked closely with the patients, the patients' caregivers as well as the primary care physicians to achieve better health outcomes. A subsequent study of the same group demonstrated that the mechanisms[12] responsible for the effects observed in the study were likely from better patient self-monitoring, as well as more responsive physician patient treatment adjustment. One of the uniqueness of the intervention is that the nurse care manager worked with both the doctors and the patients and individualised patient centred self-care and clinical target goals were identified and agreed by both the doctors and the patients with regular review to monitor progress by the nurse and primary care physician with necessary treatment adjustments made to achieve the set personalised targets. Thus, health care providers and the patients themselves are working as a team with enhanced continuity and coordination of care which are essential for this group of patients.

With our ageing population and the epidemic of non-communicable diseases in both developed and developing countries, multi-morbidity will likely become more and more common in the community and primary care settings. Research has shown that these people often have poorer coordination of care with little interpersonal continuity. Since these people have a high health service utilisation and complex bio-psycho-social needs, it is likely that their needs would be difficult to be satisfied unless a health care system is re-orientated with more emphasis on the provision of continuing coordinated care that adopts the generalist approach.[13]

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MCHK CME Programme Self-assessment Questions

Please read the article entitled "Managing Multi-morbidity: the Important Role of the Family Doctor" by Prof Samuel YS WONG 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 November 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. People with multi-morbidity have a poorer quality of life when compared to those without.
2. Multi-morbidity is a common condition in primary care.
3. Those with multi-morbidity have a low utilisation of health care services.
4. Multi-morbidity is rarely associated with mental health problems.
5. Multi-morbidity is associated with age and social deprivation.
6. Among those aged 65 years of age or older in primary care, about half of them suffer from multi-morbidity.
7. Multi-morbidity never occurs in people who are younger than 65 years of age.
8. Lack of coordination and continuity of care are two of the major problems facing people with multi-morbidity.
9. Polypharmacy is not common among people with multi-morbidity.
10. Collaborative care team intervention has been shown to be effective to improve the quality of life among people with both physical and mental health problems.

ANSWER SHEET FOR NOVEMBER 2014

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

Managing Multi-morbidity: the Important Role of the Family Doctor

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Childhood Infectious Diseases in the Community

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Introduction

Childhood Infectious Diseases are so common in the community that every family physician will often encounter them in his or her clinical practice. The presentation spectrum could be so broad, ranging from an ailment, e.g. a simple upper respiratory tract infection, to a morbid illness, e.g. meningitis. It can affect any part or any organ of our body, from skin to the brain. It may change a common condition to a serious illness, acting as an opportunistic invader such as developing sinusitis in a child with allergic rhinitis. It may cause unexpected sequelae – patients may continue to suffer from rheumatic heart disease or post-streptococcal glomerulonephritis after their throat infection has been cleared, due to autoimmune reaction to infection of group A streptococci.

Family doctors can help in strengthening the surveillance system

Comprehensive care of children with infectious diseases includes not only the diagnosis and treatment. Early recognition of serious conditions, appropriate management and prevention are all important. Infection can be passed from one child to another, one person to another and may become an institutional outbreak or even an epidemic. Family doctors can help to strengthen the surveillance system by reporting the communicable diseases of public health concern and suspected institutional outbreaks to the Central Notification Office (CENO), which has been set up under the Centre for Health Protection (CHP) in Hong Kong. The reporting process is simple and quick by the on-line system (www.chp.gov.hk/ceno). Family doctors are reminded of their obligation to report the 48 statutory notifiable diseases (Appendix 1). Epidemiological tracking for contagious conditions will help to limit the spread of infection and prevent further outbreaks.

Aetiology

Childhood Infectious Disease is caused by a variety of organisms either a virus, bacterium, fungus, parasite, … etc. Different organisms need different or even very specific medications for treatment. Small bite, big threat – slogan of the World Health Day 2014 - mosquitoes, flies, ticks and bugs will transmit infection to children and family members at home and when travelling. Therefore, do not neglect a small mosquito bite which may cause dengue fever, malaria and even Japanese B encephalitis. Explorations on travel history, contact tracing, possibility of a vector's transmission, personal and environmental hygiene, appear to be mandatory in every consultation of illness related to infectious diseases.

Fever is the commonest presentation and its appropriate management

Clinical presentation of infectious diseases in childhood can be very variable, depending on the type of infection, severity of infection, site of infection and the age of the child. Those less than 2 years old will present with very nonspecific symptoms and signs such as irritability, poor appetite and gastro-intestinal upset. A bulging anterior fontanelle (provided the child is not crying and is in an upward posture) may be the only sign of an early stage of meningitis in an infant.

Fever is the commonest presentation of childhood infectious illnesses. The body temperature will be higher after exercise, after playing in a hot day without taking enough water or just after taking hot food / fluid. When and how the temperature was taken, whether a rectal temperature, a tympanic temperature or an axillary temperature should be recorded (Appendix 2). The possibility of overheating from being dressed too warmly or embraced tightly by the mother should be observed. The information may help the doctor to confirm and to relieve the parent's anxiety in whether the child is really having a fever. However, infection must be excluded in any case of genuine fever.

High grade fever is always scary for parents despite your reassurance on diagnosing Roseola infantum (a suspected viral infection with high fever of >39.5°C or >103°F for a few days, fever will come down after eruption of the rash). Febrile seizures may occur with high fever especially when the temperature is rising rapidly. A temperature over 41°C (106°F), although quite rare, can itself be dangerous. General management of fever, such as tepid sponging, wearing less clothing, drinking adequate water and taking antipyretics should be taught to caregivers of children. Aspirin[1] is no longer used for lowering fever in children because it will cause Reye syndrome[2] (or Reye's syndrome) which is a potentially fatal syndrome with hypoglycaemia, liver damage and severe encephalopathy, especially in the presence of influenza[3] or chickenpox. The commonest antipyretic used in children is still paracetamol. Paracetamol is prescribed according to the body weight (15 mg per kg of body weight per dose, and no

more than 90 mg per kg in a day).[4] Paracetamol is an 'over-the-counter' medicine and is sometimes kept by parents as a standby drug. Nevertheless, always advise caregivers to seek medical consultation for the feverish child, who is less than six months old or has warning features (see below).

Warning symptoms and signs are causes for concern (Appendix 3)

The height of the fever does not necessarily indicate how serious the aetiology is, nor is it related to the severity of the illness. Infections in neonates may present with hypothermia. Other symptoms, such as poor feeding, lethargy, lack of interest in playing, poor sleep, chills and rigor, are more important. Older children may complain of intense headache (may indicate increase in intracranial pressure), stiff neck (may indicate meningeal irritation) or neurological symptoms such as photophobia, diplopia, and muscle paralysis. Symptoms such as difficulty in breathing, confusion, drowsiness and seizure would provide a much better indication of the illness severity than temperature would do.

Always listen to and pay attention to a carer (parent, grandparent or even the maid who takes care of the child) on what they have observed about the child, such as "the child is looking tired", "is less playful today" (may indicate a viraemia or septicaemia), or "having some bizarre behaviour" (may indicate a focal neurological sign or seizure).

A persistent fever lasting for more than 5 days without obvious symptoms, whether high grade or low grade, warrants further investigations to exclude urinary tract infection (UTI), or more serious conditions such as occult abscess, pneumonia, or Kawasaki disease. Tuberculosis infections, immunocompromised status and autoimmune diseases have to be considered if recurrent fever lingers on for an unexplained long period.

Clinical judgement is the golden guideline

The doctor's own observation and physical examination are of paramount importance. Signs such as an ill appearance, lethargy, listlessness, and inconsolability are important observations. If you are familiar with the child, you will be alerted by the change in the child's usual behaviour particularly how the child responds to being examined whether he/she is listless or extremely irritable.

The physical examination will depend on the complaint. Examinations of the throat, nose and ear (ENT), chest and abdomen seem to be our general routine. Nevertheless, examination for neck rigidity, lymphadenopathy (cervical, axillary and groin regions) and generalised skin scanning, will give us a peace of mind in daily practice.

Some signs will immediately raise the alertness of family physicians. A golden discharge will indicate staphylococcus infection in impetigo or infected eczema. Any petechial or purpuric rash must ring a bell for meningococcaemia, necrotising fasciitis, scarlet fever, thrombocytopenia or bleeding tendency (drug induced or infection induced). These cases need urgent referrals to hospitals especially if the child looks toxic –– ABCD for a "toxic child" are as follow:
Alertness, arousal and activity decrease
Breathing difficulties with or without stridor
Colour (pallor or cyanosis hue), circulation (poor capillary refill >2 sec)
Drowsiness, decreased fluid intake or urine output

The site of infection is of important concern especially those near the vital areas, such as the base of the brain might be involved during orbital cellulitis. A toxic child with high fever, saliva drooling and stridor will prohibit us in doing a throat examination which might induce a sudden airway close down in epiglottitis. Any uncommon site of infection, repeated wound infections with or without bruises, multiple bleeding sites or unexplained vaginitis in children with or without UTI, may not be just simply related to infection. Non-accidental injuries or child sexual abuse must be excluded. Psychosocial intervention may be required.

Appropriate investigation is required

Whether further investigations are needed depends on the likely cause of the fever and the age of the child. Any infant under 3 months[5,6] of age with a temperature of 38° C (100.4° F) or higher needs further evaluation. Children aged more than 3 months with fever who have no symptoms suggesting a specific disorder but looking ill or have a temperature of 39° C (102.2° F) or higher need to be observed and followed up closely. Broad spectrum antibiotics will be started after sepsis work up if the child looks ill. Culture results will take a few days, but white blood cell (wbc) count and differential count results will return within one day. A high wbc count might give us more ground to start antibiotics. Even if the wbc count is within the normal range, clinical judgement is more important. If the baby looks sick especially those less than 2 months old, more vigorous treatment might have to be started because the wbc count takes time to rise. In neonates, infection spreads fast and the baby goes downhill very quickly. More sensitive markers such as procalcitonin (PCT) and C-reactive protein (CRP) levels which rise within a few hours of bacterial infection are needed. PCT level is more sensitive than CRP level for differentiating bacterial from noninfective causes of inflammation. One study[7] showed that the sensitivity for differentiating bacterial from viral infections is higher for PCT markers. The diagnostic accuracy of PCT markers was higher than CRP markers among patients hospitalised for suspected bacterial infections.

Practice evidence based medicine

Even though there are numerous guidelines from different authorities throughout the world, guidelines from the Hong Kong Hospital Authority (HA) will suit local situation if it is applicable to your clinic setting and will save your time and energy in literature searching of updates and reviews. Just to quote an example on "Updates – 1st issue – Management of UTI distributed on 11 Aug 2014 from the Department of Paediatrics and Adolescent Medicine, Tuen Mun Hospital, Hong Kong". It recommends «*no routine voiding cysto-urethrogram (VCUG)* or antibiotic prophylaxis. Similar to the NICE[8], Italian and Australian Guidelines, the HA guideline

recommends VCUG if ultrasonogram (USG) is abnormal or UTI recurs. It also suggests to "consider" *VCUG if risk factors are present. Antibiotic prophylaxis would be "considered" in patients with grade III vesico-ureteral reflux (VUR)*[9]*, and "recommended" if such patients have UTI recurrence (second episode)…»*

Basic preventive care

Many of these childhood infectious illnesses are preventable. Children are often at an increased risk to infection as their immune systems are still developing. *Well balanced nutrition, good sleep and appropriate exercise* will aim at rearing healthy children and healthy living in the community.

Environmental hygiene and personal hygiene are the "key" ways of controlling and reducing the spread of infection in the community. Practising good *"cough etiquette"* to avoid disseminating infectious respiratory droplets by teaching the children to cover their mouths when they cough, and wash their hands with soap and water afterwards is important. Parents act as a role model and encourage their children to wear face masks whenever they are sick or on exposure to high risk environment, especially cross- infection in school, in over-crowded places.

The efficiency of *Childhood Immunisations* is well documented. Nearly everyone had measles before there was a vaccine, and hundreds died from it each year. Today, many doctors have never seen a case of measles or polio. Smallpox had disappeared from all countries in the world. According to the WHO news on 25 April 2014 — Immunisation prevents an estimated 2-3 million deaths every year. Yet 1 in 5 children are still missed out.

The Department of Health, Hong Kong, provides free vaccines from birth to adolescence, including BCG, vaccines to cover Hepatitis B, Diphtheria, tetanus, whooping cough, polio, pneumococcus (Prevenar 13), measles, mumps, rubella (MMR) and chickenpox. Private doctors will reinforce implementation of the government vaccination programmes (Appendix 4) and will provide vaccines which are not yet available in the government schedule, e.g. Haemophilus influenza b (HIB) vaccine, meningococcal vaccine, Japanese B vaccine and human papilloma virus (HPV) vaccine. When these vaccines become widely used, the incidences of these diseases will decline. Herd immunity will protect our children from being infected.

Role of family doctors in the control of childhood infectious diseases

We aim at prevention. Family doctors have the advantage of establishing a long term relationship, continuous care, rapport and trust with patients and their families. Family doctors are public health educators and role models to our patients who will be more compliant to our advice. Another cost-effective way to disseminate our messages is by setting up stalls and displays. Distributing pamphlets and innovative materials to patients will increase visibility and reinforce messages. Community outreach services including scheduled presentations at schools can directly affect the behaviour of children and the public through local interaction. We can also educate the children and the public about prevention of infectious disease using respected and locally relevant channels of communication, such as newspaper, radio and television (TV).

The family doctor is the gate keeper, the first contact person of patients in the community. We have the role of early intervention in detecting and managing any infectious disease to protect the child from developing any complication and to avoid outbreak or to prevent further outbreak in the community. We value the close collaboration with the Centre for Health Protection (CHP), Department of Health, Hong Kong Government by reporting the communicable diseases and keep ourselves updated on potential local outbreaks as announced by CHP.

While the commonest childhood infectious disease in the community is upper respiratory tract infections, the diagnosis, treatment, and prevention of infectious diseases can be very challenging. Symptoms and signs of many illnesses can be flu-like at first, such as the recent outbreak of Ebola virus in West Africa. We have to remain vigilant, and keep updating our knowledge, information and resources, and be prepared for appropriate referrals if necessary.

Appendix 1

48 statutory notifiable diseases

Notification of suspected or confirmed cases of these diseases is required by law.
First Schedule to the Prevention and Control of Disease Ordinance (Cap 599).

1. Acute poliomyelitis	25. Middle East Respiratory Syndrome
2. Amoebic dysentery	26. Mumps
3. Anthrax	27. Novel influenza A infection
4. Bacillary dysentery	28. Paratyphoid fever
5. Botulism	29. Plague
6. Chickenpox	30. Psittacosis
7. Chikungunya fever	31. Q fever
8. Cholera	32. Rabies
9. Community-associated methicillin-resistant Staphylococcus aureus infection	33. Relapsing fever
10. Creutzfeldt-Jakob disease	34. Rubella and congenital rubella syndrome
11. Dengue fever	35. Scarlet fever
12. Diphtheria	36. Severe Acute Respiratory Syndrome
13. Enterovirus 71 infection	37. Shiga toxin-producing Escherichia coli infection
14. Food poisoning	38. Smallpox
15. Haemophilus influenzae type b infection (invasive)	39. Streptococcus suis infection
16. Hantavirus infection	40. Tetanus
17. Japanese encephalitis	41. Tuberculosis
18. Legionnaires' disease	42. Typhoid fever
19. Leprosy	43. Typhus and other rickettsial diseases
20. Leptospirosis	44. Viral haemorrhagic fever
21. Listeriosis	45. Viral hepatitis
22. Malaria	46. West Nile virus infection
23. Measles	47. Whooping cough
24. Meningococcal infection (invasive)	48. Yellow fever

Appendix 2

Temperature measurement in paediatrics

Body temperature in children can be taken by several methods, namely by mouth (oral), anus (rectal), armpit (axillary), or ear (tympanic). Body temperature readings vary depending on which one you use. Their exact correlation has not been determined by medical research. However, the general correlation is tabulated as follow:

Method	Normal Temperature Range	Remark
oral	35.5°C to 37.5°C (95.9°F to 99.5°F)	
Rectal	36.6°C to 38°C (97.9°F to 100.4°F)	0.5°F (0.3°C) to 1°F (0.6°C) higher than an oral temperature.
Ear (tympanic)	35.8°C to 38°C (96.4°F to 100.4°F)	0.5°F (0.3°C) to 1°F (0.6°C) higher than an oral temperature.
armpit (axillary)	34.7°C to 37.3°C (94.5°F to 99.1°F)	0.5°F (0.3°C) to 1°F (0.6°C) lower than an oral temperature.

Rectal Temperature is still the Gold Standard for determining the presence or absence of fever. Rectal temperatures are generally thought to be the most accurate for checking a young child's temperature.

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Appendix 3

Warning symptoms and signs are causes for concern. They include:

1. Any fever in infants less than 2 months old, immuno-compromised children and children with chronic disease.
2. Lethargy or listlessness, not playful, poor feeding.
3. ILL appearance.
4. Difficulty in breathing, any cyanosis, pallor or poor air entry.
5. Bleeding in the skin, appearing as tiny reddish purple dots (petechiae) or splotches (purpura).
6. Continuous crying in an infant or toddler (inconsolability).
7. Headache, neck stiffness, confusion, or a combination in an older child.
8. Neurological deficit, partial or generalized seizure.
9. Change in level of consciousness or drowsiness.
10. Any symptom of recent onset and rapid progressive increase in severity.

Children with fever should be evaluated by a doctor right away if they have any above warning signs or are less than 2 months old.

Appendix 4

Childhood Immunisation Programme (Department of Health, Hong Kong)

AGE	Immunisation RECOMMENDED
Newborn	B.C.G. Vaccine Hepatitis B Vaccine - First dose
1 month	Hepatitis B Vaccine - Second dose
2 months	DTaP-IPV Vaccine - First Dose Pneumococcal Vaccine - First Dose
4 months	DTaP-IPV Vaccine - Second Dose Pneumococcal Vaccine - Second Dose
6 months	DTaP-IPV Vaccine - Third Dose Pneumococcal Vaccine - Third Dose Hepatitis B Vaccine - Third Dose
1 year	MMR Vaccine (Measles, Mumps &Rubella) - First Dose Pneumococcal Vaccine - Booster Dose Varicella Vaccine - First Dose
1 1/2 year	DTaP-IPV Vaccine - Booster Dose
Primary 1	MMRV Vaccine (Measles, Mumps, Rubella & Varicella) - Second Dose DTaP-IPV Vaccine - Booster Dose
Primary 6	dTap-IPV Vaccine - Booster Dose

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Reference: HK LPD version November 2013 **Date of preparation:** MAY 2014 **Identifier number:** PR13-0514_Hong Kong **FULL PRESCRIBING INFORMATION IS AVAILABLE UPON REQUEST.**

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Long Live Medical Professionalism

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As we recollect the influences on our identity as a doctor, there are undoubtedly some teachers whom we regard as role models, and whose words, actions or ideas have made a profound impact on the values we hold and which underpin the way we have chosen to practise medicine. In this article, we will discuss the importance of the doctor-teacher to the survival and flourishing of medical professionalism in the 21st century.

What is medical professionalism?

Sir William Osler, who is widely regarded as the 'father of modern medicine', once said: "the practice of medicine is an art, not a trade, a calling, not a business." This emphasised the view that the practice of medicine is a way of life with moral values[1] which link medical practice to an ethical ideal without which it cannot exist. In fact, this is consistent with the definition of the word 'profession' found in the Oxford English Dictionary which means an "open declaration, avowal, [or] public declaration." [2] As a member of the medical profession, that promise is made by every doctor to every patient who comes seeking his/her acknowledged expertise during a clinical consultation. "That promise entails competence and putting that competence in the service of the patient even if it means some degree of sacrifice on the part of the physician" [3] and manifests the moral essence of medical professionalism. The same idea is echoed in the Medical Council of Hong Kong's Code of Professional Practice which states in its introduction that, "medicine as a profession is distinguished from other professionals by a special moral duty of care to save lives and to relieve suffering." [4]

This view of medical professionalism has been in existence since the Hippocratic Oath was written around 400 BC. However, in a provocative editorial, physician and prominent American bioethicist Edmund Pellegrino challenged his fellow doctors to consider the relevance of moral values in guiding the profession given that the practice of medicine in modern times has undergone changes reflective of the social and political changes in society.[3] He describes the erosion of medical ethics exemplified by insurance fraud or research conflicts of interest, medical care treated as a commodity which is increasingly commercialised, and a climate of care in which the working hours and lifestyles of doctors have been reconfigured in favour of work-life balance. He cites the free market economy as being a key driver in these shifts which legitimises profit, competition and self-interest. This results in the physician's loyalties being divided between the organisation and the patient, and between self-interest and patient care. Some may take the pragmatic view that medicine is an occupation like any other and that it is unrealistic to demand more of physicians than others in our society as we are all subject to the temptations of self-interest, power, prestige, pride, profit, and privilege that beset all humans in all ages.[3]

Despite this reality check, numerous conceptualisations of medical professionalism have been proposed with moral values at its heart to support the view that "a profession without its own distinctive moral convictions has nothing to profess." [5]

For instance, medical professionalism has been described as having a "foundation of clinical competence, communication skills, and ethical and legal understanding, upon which is built the aspiration to, and wise application of, the principles of professionalism: excellence, humanism, accountability, and altruism" [6] (Figure 1).

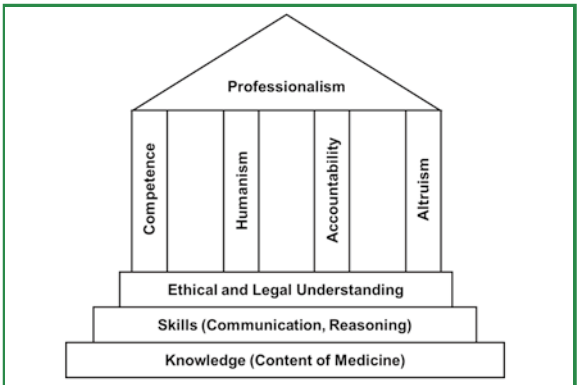

Figure 1, Conceptualisation of professionalism (Arnold and Stern, 2006)

The Royal College of Physicians has linked these qualities with the social contract the medical profession has with the public by articulating professionalism as "a set of values, behaviours and relationships that underpin the trust the public has in doctors." [7]

The doctor as teacher: moral values and the tenets of medical professionalism

To counter the 'deprofessionalisation' of the profession and to reaffirm its moral underpinnings and values, the obligation lies with each of us and the lessons we choose to teach the next generation of doctors. As doctors, our

identity is historically connected to the origins of our title, "doctor," which is derived from the Latin verb "docēre" which means "to teach". We teach patients about their medical conditions and how to empower themselves; we teach ourselves and colleagues through continuing professional development; and, we teach students – either directly as part of a curriculum or indirectly through our interactions with them in grand rounds, in passing in the corridor, when they come as patients, through our reputations as heard through the grapevine or through the filtered lens of media reports. Thus, teaching is fundamental to who we are as a profession and key to our individual responsibilities as medical doctors.

Sandy Buchman, the President of the College of Family Physicians of Canada in 2012, discussed transformative teachers as being those who were "authentically present" during their interactions with students meaning they had a strong sense of personal identity and integrity, and whose power "…lies not in what they teach, but in their capacity to awaken in the learner the essence of being a physician." [8] The essence of being a physician, or what it means to be a doctor, goes to the crux of the meaning of professionalism. American physician Daniel Stern reflected on an occasion when he was a resident on call in the nephrology ward when he called the consultant at 1:30 am to discuss a new admission. He was stunned when the consultant, who was the patient's primary care physician, showed up at 2:30 am having driven to the hospital from his suburban home to see his patient.[9]

To learn and experience "professionalism in practice," medical students at the University of Hong Kong attach to family doctors in the community once per year over the first three years of medical school and return to the academic department for a debriefing session at the end of each year.[10] During one such debriefing, a student shared an incident when he was driving with his preceptor to visit a patient. Suddenly, to the student's surprise, the preceptor stopped the car to go to the assistance of a pedestrian who had fallen on the sidewalk.

That night on call at 2:30 AM, Daniel Stern learned the meaning of responsibility, duty and what it meant to be a primary care physician. He said that lesson had a direct effect on how he chose to care for his patients subsequently though he did not know if the consultant had intended that lesson to be learned or what he would have learned had the consultant not come on that night. The University of Hong Kong medical student asked his preceptor why he stopped to help the pedestrian; the response was simply that it was the right thing to do, not necessarily as a doctor but as a human being. The student learned that aspect of professionalism of being a doctor which overlaps with the common courtesies, respect and altruism we hope to see in all people, but perhaps more so in doctors.

These two examples demonstrate the profound impact that experiences with role models can have on student learning of professional values and simultaneously how such learning takes place both in the formal (planned) curriculum and in the informal (ad hoc) curriculum.[11] It also underscores the importance of not just role modelling and expecting learning to take place by osmosis, but by having explicit discussions with medical students about good and bad observed behaviours and real-life events that challenge ideas of what it means to be a doctor.[12] Coupled with a checklist of attributes or behaviours which can be observed and assessed, the complexity and contextual nature of professionalism necessitates its exploration within the lived experience through experiential learning or through exposure to stories or narratives of physicians and patients. After all, "becoming a physician involves witnessing, and not just behaving." [13] In a review of the state of medical education in the United States, a focus on the learning of professionalism through explicit instruction, role modelling, and socialisation were identified as priorities in preparing physicians for the 21st century.[14] Locally, in the MCHK guidance document "Hong Kong Doctors" outlining the attributes and skills expected of medical graduates, the objectives for the undergraduate medical curriculum included "to produce doctors who are honest and trustworthy, and act with integrity." [15]

Family doctors in particular, are well placed to help medical students learn medical professionalism for reasons laid out by Professor Amanda Howe, the 2010 Hong Kong College of Family Physicians Visiting Professor and the Professionalism and Fitness to Practice Lead for the medical curriculum at the University of East Anglia. In her presentation to Family Medicine teachers[16], she suggested that:

- Patient contact is the key to learning professionalism, especially respect, and the family practice setting is ideal as it is where there is volume and diversity of patients providing more opportunities for observation and interaction.
- Role models of doctor-patient relationships are strongly professional in family practice as the focus is more about values and communication and less on the biomedical.
- Community practices may also be a "safer" environment in which to explore professionalism as the teachers are geographically and perceptually removed from the more intense and formal medical school environment.
- If placements are prolonged, definite evidence of professionalism of learners can be collected and sound formative advice offered.

As doctor-teachers in family medicine as well as across all disciplines, we need to be aware of the moral values inherent in our profession, conscious of how we influence the coming generation of doctors among us, and commit ourselves to "awakening in the learner the essence of being a doctor," as tacit acknowledgement of the effect our own teachers have had on our own professional development.

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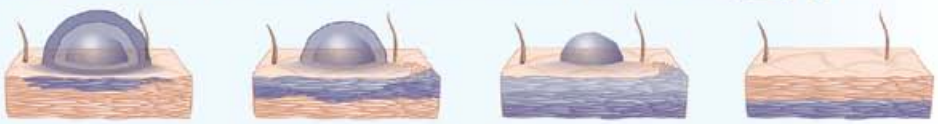

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UPDATE ON PREVENTION
- An Introduction to Quaternary Prevention

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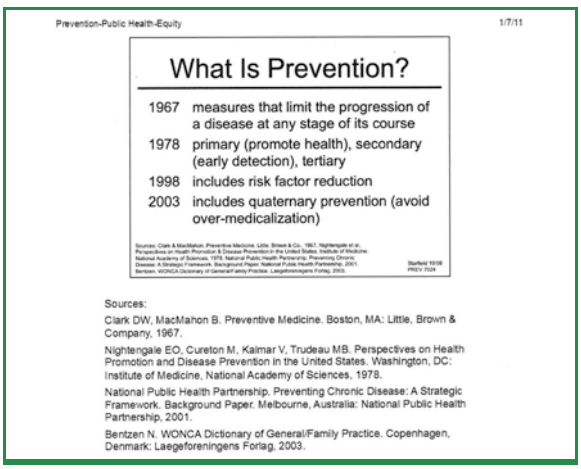
Immediate Past President, HKCFP
Honorary Treasurer, WONCA Asia Pacific Region

Background

Clinical Prevention has been organised in a chronological manner since the middle of the 20th century. A paradigmatic shift from a chronological to a relationship-based prevention organisation offers new insights into the work and, specifically, into the preventive activities of doctors, and brings to light the concept of *quaternary prevention*, a critical look at medical activities with an emphasis on the need not to do harm.



Definition of Quaternary Prevention (QP)

"Action taken to identify a patient or a population at risk of over-medicalisation, to protect them from invasive medical interventions, and provide them with care procedures which are ethically acceptable"

This definition was adopted by the Wonca International Classification Committee (WICC) during its Durham meeting in 1999. It has been published in the Wonca Dictionary for General Practice/Family Practice. A website was developed by the WICC for "Primary Health Care Classification Consortium" (PH3C) on QP activities globally. WICC members within the group will circulate information and movement about QP from all over the world. Members' participation on the website were most active from South America, continental and northern Europe.

Simple definitions for prevention by late Prof. Barbara Starfield in which Quaternary Prevention were also included.

The principle is the same as in other versions proposed by different authors. Prof. Starfield was internationally famous for her research in the Primary Care Assessment Test. She had prominent influence in the academic field of primary care in America. Nevertheless, activities of QP have not been as robust in the States as compared with South America and Europe. Hong Kong and the Asia Pacific Region are also very much lagging behind.

Who will practise QP?

When I started medical practice in Hong Kong more than 30 years ago, patients were mainly seeking for episodic treatment. Words of wisdom such as *"Prevention is better than cure"* was a popular slogan. Clinical prevention was meant for preventing progressive deterioration, recurrence or complications of diseases diagnosed (tertiary prevention). Textbooks on topics for General Practice were few in the local book-stores. I bought some books back from London. One of them was "Preventive Medicine in General Practice", first published in 1983, because the topic on prevention had not been taught formally in my undergraduate years. There were different chapters dealing in details with the principles and practice of preventive medicine, definitions of primary, secondary and tertiary prevention, as well as anticipatory care. There was no such term as Quaternary Prevention at that time.

With the arrival of internet communication, a huge volume of health information and activities of QP circulate everyday on the PH3C website. The quantity is enormous, the contents are broad and stimulating, at times provoking. Sometimes one may be dragged into more philosophical thinking such as the real contribution of modern medicine to people's health problems.

However, information and messages about QP are no longer restricted to academic medical journals for doctors. It has been spreading widely and quickly in major newspapers and media to the public. This is an important development for QP because it has become a topic of public interest.

The most striking incident about QP was the public announcement by the movie star Angelina Jolie's decision to have prophylactic double mastectomy because she was found to carry the BRCA gene. The impact was especially far-reaching because of her celebrity effect. It has made tremendous repercussions within the medical profession, not only those interested in QP, but also women all over the world.

In a health care system which is primary care led, the Family Physician is the first point of contact for patients with sickness, or healthy people for health issues. Our roles are many, as a healer, a coordinator of health care for patients, a health advocate as well as an educator to the public. Naturally, Quaternary Prevention has become one of the explicit roles of a Family Physician.

Interaction between clinical practice and prevention

The following quotations are taken from a paper by Dr Marc Jamoulle *"The relational view fits perfectly within the Wonca definitions of prevention"*

There is a diagrammatic model from the article illustrating the relationship view of QP with the three other fields.

Figure 1. Four fields of the patient-doctor encounter based on relationships. The doctor looks for diseases. The patient could feel ill. Timeline is obliquely oriented from left to right, from alpha to omega, from birth to death. Anyone will become sick and die, doctors as well as patients. (Jamoulle 1986)

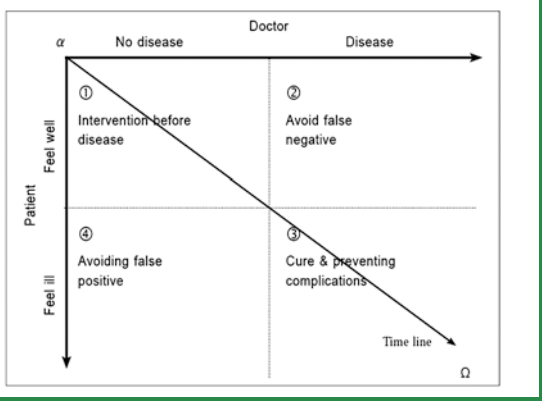
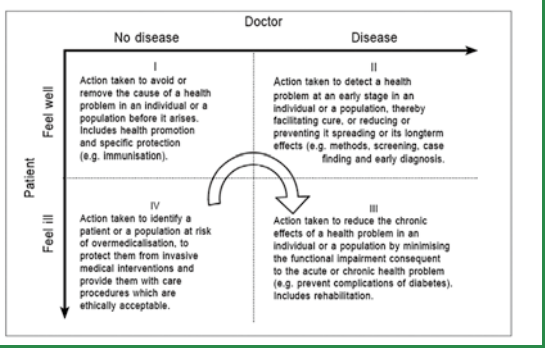


Figure 2: The patient-doctor relationship is at the origin of the four types of activities. The arrow shows that the P4 attitude is impacting all the activity.



And I quote his words:

"QP is a field of intervention, based on relationships, includes scrutinising all the continuous interventions doctors make to treat their patients, as well as to control their own anxiety and lack of knowledge."

Family Physicians know very well that we all have anxiety when faced with our patients presenting with some non-specific complaints such palpitation, chest discomfort, giddiness, drowsiness or even black-out. The action and reaction of a doctor at the consultation reflects the amplitude of clinical competency as well as the level of tolerance to uncertainty for that particular doctor.

"They also have to learn that sometimes, even though it may be difficult, it is better to do nothing rather than to pursue useless investigations trying to find a rare condition (the rule-out syndrome) or an emerging catastrophe. Hence, QP is a new term for an old concept and update to the motto: <u>First, do no harm</u>."

It is important to appreciate that our consultations will frequently overlap between clinical practice and preventive practice. I am going to share some common scenarios frequently encountered in general practice for the above statement.

1. We know that the chance of encountering a new patient with very high blood pressure due to phaeochromocytoma is extremely low in general practice. Therefore, one usually will not investigate in that direction to rule out this rare cause of hypertension. If it turns out subsequently that the patient was diagnosed with phaeochromocytoma by some other doctors, one should not feel guilty about missing this rare diagnosis.

2. Patients with chest discomfort are common in general practice. ECG would be ordered for the patients and frequently done in the clinic immediately. Usually there are no positive findings. Therefore, if the doctor suspects ACS in the patient, his decision to refer to a cardiologist, or his advice on more investigations, is a result of his clinical judgement, irrespective of the ECG findings. The decision-making and referral rate are dependent on the clinician's experience and tolerance to uncertainty. The risk and damage to those patients without cardiac problems but are referred to undergo more invasive investigations such as cardiac catherisation should not be under-estimated.

3. However, if one suspects a patient may be suffering from AMI in one's clinic, which carries a high mortality rate, ordering a clinic ECG instead of calling an ambulance for urgent transfer to hospital might cause irreparable damage to the patient due to the delay in treatment. This is clinical mis-judgement which may have medico-legal implications. Therefore, it is important to distinguish between the essence of QP from the daily clinical practice.

"In this sense, QP is aimed more at the doctor than the patient."
"QP involves the need for close monitoring by the doctor himself, a sort of permanent quality control on behalf of the consciousness of the harm they could, even unintentionally, do to their patients."

Public education and change in clinical practice

"Measures need to be taken in order to avoid patients slipping into the fourth field. Poor information from the internet is a source of anxiety and unjustified demand for care. Screening for prostate or breast cancer can throw patients into the fourth field if he or she becomes cancerophobic. A puzzling note in a treatment protocol can also trigger patient anxiety"

In the past, before the advance of FNAC, young women with a fibroadenoma will always be advised by surgeons to have excisional biopsy, despite the fact that malignant changes are rare. I had a young patient in the 20s who has had 2 excisional biopsies before she married. She consulted me before the 3rd planned episode as whether the procedure was a must.

What will you do?

1. I could say go ahead because one could not be 100% sure just by palpation. It is simple and easy, risk free for the doctor.

Or

2. I could explain to her the natural course of fibroadenomata, and give her the option for putting the fibroadenoma on observation. That meant doing nothing.

What would be the risk that I would have to shoulder on behalf of the patient if I told her not to take it out, against the opinion of a Surgeon?
What if a small cancer did develop a few years later just sitting close to the fibroadenoma?

Luckily, my patient is now happily married with 2 healthy children and both of them were breast-fed by her.

Knowledge, skills and attitude

Patient anxiety is always there if there are some health issues of concern. A doctor's reaction, facial expressions, body language or the way of talking may trigger more worries. This is especially true for cancer patients when they are faced with suggestions from oncologists as whether post-OP chemo, RT or a combination would be the best option to take? Does the oncologist mean that the cancer has spread?

Family Physicians should possess a set of skills which is essential when handling these situations. Sensitivity to a patient's feeling, good communication and rapport, attentive listening, empathy, long-lasting and mutually trusting relationship with the patient and the family are all important in order to provide integrated care to patients. Patients' autonomy and their right to refuse treatment, after having been fully informed of their choices, should be well-respected when we are offering our professional advice and treatment. The paternalistic style of medical practice has gone with the evolution of modern health concepts and the promulgation of patients' right to choose.

The above is an introduction of QP mainly in the context of prevention at the personal level which is one of the two categories in the definition of QP. I shall share with you my own reflection and thinking, after 2 years' of exposure to the scope and global movement of Quaternary Prevention.

Overmedicalisation and disease mongering

The other category in the definition of QP is the prevention for the population at large, which is more a public health issue, much broader, sometimes controversial and political. The goal is the avoidance of overmedicalisation.

The term "overmedicalisation" may sound vague to many. I will not elaborate with specific clinical scenarios. Nowadays, when we talk about end of life issues, a lot of people say that if they could have a choice, they would prefer to have a quick-fix, say AMI and die within a few days, rather than a long battle such as cancer accompanied with painful treatments; or being bed-ridden for years after a stroke with the body full of tubings. I personally feel such an attitude, apart from religious or philosophical thinking about life and death, is a reflection of an inherent fear of overmedicalisation.

People are more concerned with the quality of life especially at the terminal stage. Is modern medicine heading in the right direction to address these issues, or whether science has over-shadowed the humanitarian aspect of Medicine?

Population screening programmes will invariably involve public funding which is always precious and capped by government budget. Policy makers will need to balance the interests and demands from various groups of health care recipients. Opinions from health care providers are important and it has to be evidence-based with positive health outcomes supported by different measurements and statistics.

Disease Mongering is a derogatory term commonly used in the world of QP. There have been a striking diagnostic inflation and a corresponding increase in the use of psychotropic drugs during the past 30 years. The newly launched DSM-V has been accused of financial association with the pharmaceutical industry among the Panel members. The sheer blatancy of disease mongering activities with the latest edition of DSM-V, Big Pharma and corrupted marketing strategy,.. etc. have been exposed and widely reported in the media.

I would not quote specific reports of the above allegations. I am sure if readers are interested, you can easily find them in major newspapers or search in the internet.

Critical reading vs Scepticism

One could not help but ask questions such as:

1. Can patients still entrust the medical profession when dealing with their health problems?

2. Can we still believe those biased, pharmaceutical companies sponsored researches designed for marketing?

3. How can we practise medicine ethically?
The definition of QP has incorporated the ethical issue.
Who could set the standards of medical ethics?
Could it be taught or trained?

Fellow Family Physicians, I have some important questions which remain unanswered:

1. Are we organised and well-prepared for the task within our own discipline of Family Medicine?

2. Have we got proper training for the necessary knowledge and skill?

3. How much do we differ among ourselves in our attitude towards health, diseases and illness, risk tolerance; and our value for life and death?

Conclusion

I hope you will agree with me that most of us (I mean all Doctors) are practising Quaternary Prevention to some extent. It is just as simple as saying "No" to a patient requesting some kind of investigations due to fear or innocence.

We need collective effort and input to achieve a critical mass of Family Physicians sharing the same platform for the practice of Quaternary Prevention. We must understand and emphasise the importance of practising QP in a pragmatic way with local relevance. We should prepare to accept criticisms, but encourage intellectual, inter-professional exchange of views and opinions in various prevention issues, update clinical practice, proper public education on health informatics. We should be open-minded, try to foster multi-specialty collaboration rather than being over-sceptical with an antagonistic gesture.

We should remember the theme of the Hong Kong Primary Care Conference 2014– ***with the patients, for the patients.***

Dermatological Quiz

Dr Ka-ho LAU

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

Dr Ka-ho LAU

This 55-year-old man noticed this non-itchy skin eruption at his forearm for a few years (Fig.1) He noticed that the lesion had a slightly raised border surrounding the edge and progressively increased in size centrifugally up to 2.5cm x 2cm. He received oral and topical antifungal treatment from his family doctor with no improvements. A skin biopsy confirmed the clinical diagnosis.

Questions:

1. What is your clinical diagnosis or differential diagnoses?
2. What are the characteristic histological changes?
3. How will you manage this man?

(See P.32 for answers)

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Cesarean Delivery vs Vaginal Delivery - Are There Any Differences?

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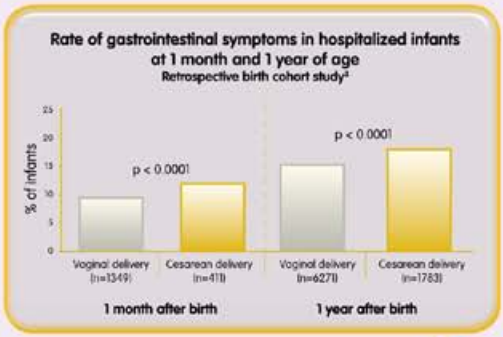
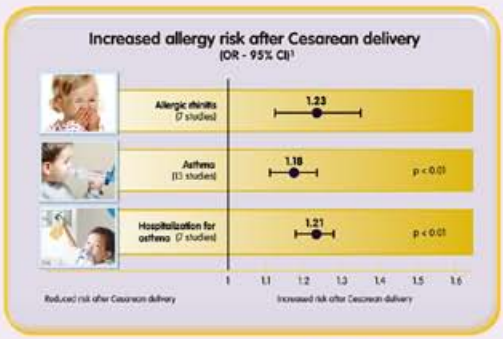
up to 1 year of age



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

up to 23% more risk



ESPGHAN recognizes the efficacy of *B. lactis* for the prevention of gastrointestinal infections[1]

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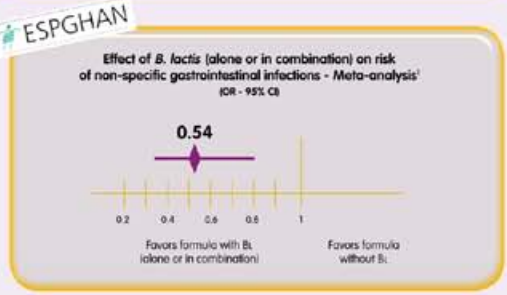

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Source Euromonitor International Limited, company shares by global brand owner, per milk formula definitions, retail value rsp, 2013

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REFERENCE:
1. Chang JH, Hsu CY, Lo JC, Chen CP, Hwang FY, Yu S. Comparative analysis of neonatal morbidity for vaginal and caesarean section deliveries using hospital charge. Acta Paediatr 2006; 95(12): 1561-6.
2. Bager P, Wohlfahrt J, Westergaard. Caesarean delivery and risk of atopy and allergic disease: meta-analyses. Clin Exp Allergy 2008; 38(4): 634-42.
3. Braegger C, Chmielewska A, Decsi T, Kolacek S, Mihatsch W, Moreno L, Piescik M, Puntis J, Shamir R, Szajewska H, Turck D, van Goudoever J. Supplementation of Infant Formula With Probiotics and/or Prebiotics: A Systematic Review and Comment by the ESPGHAN Committee on Nutrition JPGN 2011; 52: 238-50.

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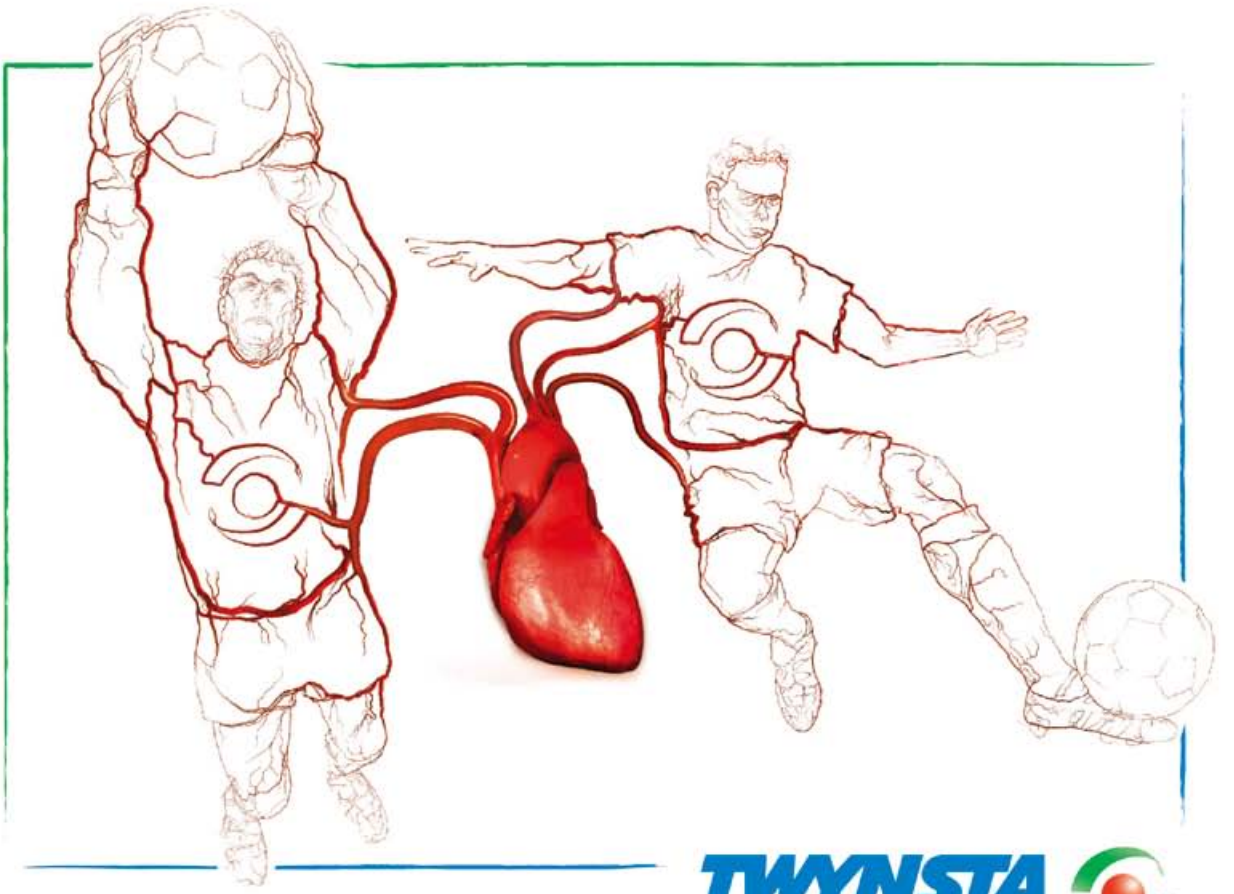

* Mean systolic BP reduction of hypertensive patients (n=14, baseline systolic BP 165 - 199 mmHg) received the single-pill combination of telmisartan/amlodipine 80 mg/10 mg after 8 weeks

Δ 24-h mean SBP < 130 mmHg or reduction ≥ 15 mmHg

BP: blood pressure; ARB: angiotensin II receptor blocker; CV: cardiovascular

References: 1. Guthrie RM, et al. Efficacy and tolerability of telmisartan plus amlodipine in added-risk hypertensive patients. CHRO. 2011;27:1995-2008. 2. Neutel JM, et al. Single-pill combination of telmisartan 80 mg/amlodipine 10 mg provides superior blood pressure reductions in patients with severe hypertension: TEAMSTA Severe HTN Study. 2010. 25th Annual Scientific Meeting of the American Society of Hypertension, New York, USA. Poster LB-PO-10. 3. White WB et al. Effects of telmisartan and amlodipine in combination on ambulatory blood pressure in stages 1-2 hypertension. Blood Press Monit. 2010;15:205-212. 4. Micardis prescribing information, Boehringer Ingelheim.

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TWY64-2014-01

A Piece of Americana – the Road Trip

Dr Kenneth YK LEUNG

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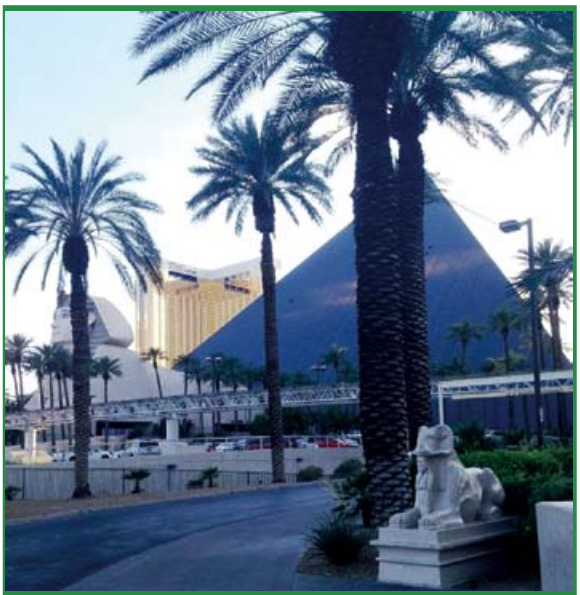
Dr Kenneth YK LEUNG

Earlier this year I wanted to try something that has fascinated me for a long time – the American road trip. Driving an automobile on the never-ending roads in the United States has an enchanting appeal, with the freedom and wonder enticingly portrayed in so many Hollywood movies.

Replica of the Eiffel Tower

So I packed my bags and headed off to my first stop: Las Vegas. Although the city is closely associated with gambling, there is more to Sin City than blackjack tables and slot machines. I found myself awing at the spectacle of the casinos themselves. How can you build a replica of the Eiffel Tower and the Sphinx in the middle of the desert? Only in Vegas could anyone do that. There are many entertainment shows in Las Vegas to choose from, with every taste catered for. I chose to watch the magic skills of Penn and Teller, still going strong after nearly 30 years in the conjuring business. Their show varies every night and they are fantastic to their fans as well, staying after the show ends to sign for autographs and pose for photos. Although less well known around the world, Terry Fator is a multitalented performer – ventriloquist, singer, impressionist and comedian. His routines are very funny and varied. Yet, these shows can be pale in comparison to the best part of my Las Vegas leg. I took a helicopter ride to see the natural beauty of the nearby Grand Canyon. The view from the air makes you appreciate the magnificence of the canyon itself, made even more so when you land and take in the wonder.



Replica of the Sphinx

Grand Canyon

After Las Vegas, I headed southwest to San Diego. The city is a must for wildlife lovers. The SeaWorld San Diego aquarium lets you get up close and interact with the park's inhabitants. It's a bit weird (and slimey!) feeling the manta rays when they come up to you for food. It's also a good place to see a sea lion dance to "Gangam Style"! The next day was filled at the San Diego Zoo, one of the world's biggest zoos. Highlights of my trip to the zoo include seeing a peacock roam free near the entrance oblivious to all the tourists taking photos or videos of him strutting around and spotting a sign about a lesser spot-nosed guenon (a type of monkey) stating, "Did you know… I'm a diabetic monkey. Like diabetic people, I follow a special diet to stay healthy. Please help me stay healthy by not feeding me."

After a quick detour to Los Angeles to watch an ice hockey game, my road trip entered the most anticipated part. The Pacific Coast Highway (or California State Highway 1) has some of the most scenic views imaginable. From Dana Point in the south to Leggett in the north, the highway passes along the California coast and gazes across the Pacific Ocean. One of the nuggets in my trip was found along the Pacific Coast Highway at Hearst Castle. There is a beach there with hundreds and hundreds of elephant seals just lying there. Most of them are just sunbathing, although there are some elephant seals arguing with each other for no apparent reason. The best views of the Pacific Coast Highway are along the winding segments between San Luis Obispo and Carmel. The road is sandwiched between luscious green hills and blue ocean waters. Just remember to take your camera along.

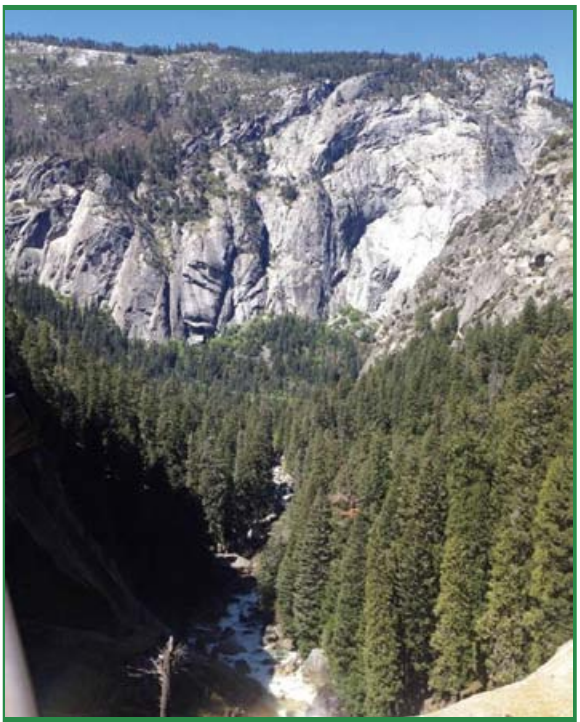
San Diego Zoo


The Orca / Killer Whale at the SeaWorld San Diego Aquarium

Another detour was taken, this time to Yosemite National Park. If you love nature and hiking, as I know a lot of Hong Kong people do, then it is worth the trip to see the chipmunks, squirrels, deer and grizzly bears roaming the forests. There are many hikes to go on, including going up the Vernon Falls and looking down on the park's forests and lakes.

My journey ended in San Francisco and a chance to truly unwind, having spent two weeks in USA and one week of that on the road constantly driving. If there is one thing to be learnt on this trip, the main lesson is to bring somebody else along on a road journey. They can share the burden of driving, which can be arduous at times and even if they cannot drive, they can keep you awake, help alleviate boredom by talking to you and help take photos of the beautiful scenery you are passing by.


Elephant seals at the beach along the Pacific Coast Highway


Yosemite National Park

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Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						★ Mastering Professional Interactions 1
2	3	★ HKMA Council Meeting ★ FMSHK Officers' Meeting 4	★ HKMA Shatin Doctors Network - Adult Female Acne ★ Cardiovascular Disease & Hypertension ★ Mastering Adverse Outcomes - 3 hours 5	6	★ Joint Surgical Symposium - Intra-Operative Intralesional Embolization for Tumour Excision ★ HKMA Shatin Doctors Network - Update Management in Cataract and Glaucoma 7	★ Refresher Course for Health Care Providers 2014/2015- Work stress management workshop ★ Mastering Adverse Outcomes - 2 hours 8
★ HKMA Yau Tsim Mong Community Network – Community Service Day 9	10	★ HKMA Kowloon West Community Network - Is There Any Role for Early Combination Therapy in the Management of Patients with T2DM? ★ HKMA Yau Tsim Mong Community Network - Topical Management of Atopic Eczema 11	★ Hong Kong Neurosurgical Society Monthly Academic Meeting – Surgical approaches to para-spinal tumor 12	★ HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2014 – Management of Acute Stroke ★ FMSHK Executive Committee Meeting ★ FMSHK Council Meeting ★ FMSHK Foundation Meeting 13	★ Oxfam Trailwalker 2014 14	★ Oxfam Trailwalker 2014 15
★ Lantau Hiking Team (Pui O to Mui Wo) ★ Oxfam Trailwalker 2014 16	17	★ HKMA Tai Po Community Network - Reference Framework for Preventive Care for Older Adults in Primary Care Settings ★ HKMA Kowloon West Community Network - Significance of Tailored Osteoporosis Treatment Strategy for Better Patient Compliance 18	★ HKMA Central, Western & Southern Community Network - Review on Topical Treatment for Acne Vulgaris 19	★ KECN/UCH – Certificate Course for GPs 2014 - Update on COPD Management ★ HKMA New Territories West Community Network - The Role of the Incretin Axis in Type 2 Diabetes Management 20	★ HKMA CME - Antibiotics in COPD exacerbations 21	★ Mastering Your Risk Workshop 22
★ HKMAPS 4th Seasonal Competition and Subcommittee Meeting 23 ★ HKMA Family Sports Day 2014 30	24	25	★ HKMA Shatin Doctors Network - Common Ear Pathologies and Associated Mental Health Problems 26	★ HKMA Hong Kong East Community Network - Practical Management in the Use of Novel Oral Anticoagulants (NOACs) in Stroke Prevention in AF Patients ★ The Hong Kong Medical Association Community Network Exercise Prescription Certificate Courses 27	28	29

Date / Time	Function	Enquiry / Remarks
1 SAT 2:30pm	**Mastering Professional Interactions** Organisers:Hong Kong Medical Association &Medical Protection Society, Speaker:Dr. Lee Wai Hung, Danny,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 2.5 CME Points
4 TUE 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
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
5 WED 1:00pm	**HKMA Shatin Doctors Network - Adult Female Acne** Organiser:HKMA Shatin Doctors Network, Chairman:Dr. MAK Wing Kin, Speaker:Dr. CHIU Lai Shan, Mona,Venue: Jasmine Room, Level 2, Royal Park Hotel, 8 Pak Hok Ting Street, Shatin	Ms. Wendy CHENG Tel: 2824 0333 1 CME Point
1:00pm	**Cardiovascular Disease & Hypertension** Organisers:HKMA-Central, Western & Southern Community Network, Chairman:Dr. TSANG Chun Au, Speaker:Dr. Yip Wai Cheong,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
6:30pm	**Mastering Adverse Outcomes - 3 hours** Organisers:Hong Kong Medical Association &Medical Protection Society, Speaker:Dr. Hung Chi Wan, Emily,Venue: Jordan Room, 2/F, Eaton Hotel	HKMA CME Dept. Tel: 2527 8452
7 FRI 8:00am-9:00am	**Joint Surgical Symposium - Intra-Operative Intralesional Embolization for Tumour Excision** Organisers: Department of Surgery,The University of Hong Kong & Hong Kong Sanatorium & Hospital, Chairman: Dr. Gilberto LEUNG, Speakers: Dr. FAN Yiu-Wah & Dr. TSE Yat-Hang,Venue: Hong Kong Sanatorium & Hospital	Department of Surgery, Hong Kong Sanatorium & Hospital Tel: 2835 8698 1 CME Point (Active)
1:00pm	**HKMA Shatin Doctors Network - Update Management in Cataract and Glaucoma** Organiser:HKMA Shatin Doctors Network, Chairman:Dr. MAK Wing Kin, Speaker:Dr. HUI Yung Lam, Jeff,Venue: Fung Lam Restaurant (楓林小館), 45-47 Tsuen Nam Road, Tai Wai	Mr. Philip WONG Tel: 9728 6843 1 CME Point
8 SAT 2:15pm	**Refresher Course for Health Care Providers 2014/2015-** **Work stress management workshop** Organisers:Hong Kong Medical Association, HK College of Family Physicians & HA-Our Lady of Maryknoll Hospital, Speaker:Dr. Lam Wing Wo,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
2:30pm	**Mastering Adverse Outcomes - 2 hours** Organisers:Hong Kong Medical Association & Medical Protection Society, Speaker:Dr. Cheng Ngai Shing, Justin,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 2 CME Points
9 SUN 2:00pm	**HKMA Yau Tsim Mong Community Network – Community Service Day** Organiser:HKMA Yau Tsim Mong Community Network,Venue: Hospital Authority Building	Ms. Candice TONG Tel: 2527 8285
11 TUE 1:00pm	**HKMA Kowloon West Community Network - Is There Any Role for Early Combination Therapy in the Management of Patients with T2DM?** Organiser:HKMA Kowloon West Community Network, Chairman:Dr. WONG Wai Hong, Bruce, Speaker:Dr. LEE Yee, Ace,Venue: Crystal Room I-III, 30/F, Panda Hotel, 3 Tsuen Wah Street, NT	Miss Hana YEUNG Tel: 2527 8285 1CME Point
1:00pm	**HKMA Yau Tsim Mong Community Network - Topical Management of Atopic Eczema** Organiser:HKMA Yau Tsim Mong Community Network, Chairman:Dr. WONG Yuk Wing, Larry, Speaker:Dr. CHAN Yung,Venue: Jade Ballroom, Level 2, Eaton, Hong Kong, 380 Nathan Road, Kowloon	Ms. Candice TONG Tel: 2527 8285 1CME Point
12 WED 7:30am	**Hong Kong Neurosurgical Society Monthly Academic Meeting – Surgical approaches to para-spinal tumor** Organiser: Hong Kong Neurosurgical Society, Chairman: Dr. SUN Tin Fung David, Speaker: Dr. HO Lok Yan, Faith, Venue: Seminar Room, Ground Floor, Block A, Queen Elizabeth Hospital	Dr. LEE Wing Yan, Michael Tel: 2595 6456 1.5 points
13 THU 2:00pm	**HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2014 – Management of Acute Stroke** Organisers:Hong Kong Medical Association & Hong Kong Sanatorium & Hospital, Speaker:Dr. Li Chung Ki, Patrick,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 1CME Point
7:00pm	**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
8:00pm	**FMSHK Council 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
9:15pm	**FMSHK Foundation 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
14 FRI 8:00am *(15,16)*	**Oxfam Trailwalker 2014** Chairmen:Dr. CHOW Yuen Hon, Francis; Dr. TSANG Wing Hang, Janice,Venue: Sai Kung	Mr. Andie HO Tel: 2527 8285
16 SUN 10:00am	**Lantau Hiking Team (Pui O to Mui Wo)** Organiser:The Hong Kong Medical Association, Chairmen:Dr. HO Chung Ping;Dr. SIN Pui Yee, Helena,Venue: Lantau Island	Mr. Benjamin CHAN Tel: 2527 8285
18 TUE 1:00pm	**HKMA Tai Po Community Network - Reference Framework for Preventive Care for Older Adults in Primary Care Settings** Organiser:HKMA Tai Po Community Network, Chairman:Dr. FU Kam Fung, Kenneth, Speaker:Prof. WONG Chi Sang, Martin,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	Miss Hana YEUNG Tel: 2527 8285 1 CME Point

Calendar of Events

Date / Time	Function	Enquiry / Remarks
18 TUE 1:00pm	**HKMA Kowloon West Community Network - Significance of Tailored Osteoporosis Treatment Strategy for Better Patient Compliance** Organiser:HKMA-KLN West Community Network, Chairman:Dr. TONG Kai Sing, Speaker:Dr. Yip Wai Man,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
19 WED 1:00pm	**HKMA Central, Western & Southern Community Network - Review on Topical Treatment for Acne Vulgaris** Organisers:HKMA Central, Western & Southern Community, Chairman:Dr. CHAN Hau Ngai, Kingsley, Speaker:Dr. CHAN Yung,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
20 THU 1:00pm	**KECN/UCH – Certificate Course for GPs 2014 - Update on COPD Management** Organisers:HKMA Kowloon East Community Network & United Christian Hospital, Chairman:Dr. Gary AU, Speaker:Dr. LEUNG Wah Shing,Venue: East Ocean Seafood Restaurant, 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 New Territories West Community Network - The Role of the Incretin Axis in Type 2 Diabetes Management** Organiser:HKMA New Territories West Community Network, Chairman:Dr. MOK Kwan Yeung, Matthew, Speaker:Dr. TSANG Man Wo,Venue: Maxim 's Palace Chinese Restaurant (美心皇宮), Tuen Mun Town Hall, 3 Tuen Hi Road, Tuen Mun	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
21 FRI 1:00pm	**HKMA CME - Antibiotics in COPD exacerbations** Organiser:Hong Kong Medical Association, Speaker:Prof. Michael Philip Habib,Venue: Pearl Ballroom, Eaton Hong Kong Hotel, 380 Nathan Road, Kowloon	HKMA CME Dept. Tel: 2527 8452 1 CME Point
22 SAT 2:30pm	**Mastering Your Risk Workshop** Organisers:Hong Kong Medical Association & Medical Protection Society, Speaker:Dr. Cheng Ngai Shing, Justin,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 2.5 CME Points
23 SUN 2:00pm	**HKMAPS 4th Seasonal Competition and Subcommittee Meeting** Organiser:HKMA Photographic Society, Chairman:Dr. PANG Lai Man, Amy,Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong	Mr. Ian KWA Tel: 2527 8285
26 WED 1:00pm	**HKMA Shatin Doctors Network - Common Ear Pathologies and Associated Mental Health Problems** Organiser:HKMA Shatin Doctors Network, Chairman:Dr. MAK Wing Kin, Speaker:Dr. HO Nga Yi, Fiona; Ms. Celine LAI,Venue: Jasmine Room, Level 2, Royal Park Hotel, 8 Pak Hok Ting Street, Shatin	Ms. Stella FOK Tel: 2193 5905
27 THU 1:00pm	**HKMA Hong Kong East Community Network - Practical Management in the Use of Novel Oral Anticoagulants (NOACs) in Stroke Prevention in AF Patients** Organiser:HKMA Hong Kong East Community Network, Chairman:Dr. GOH Kim Yeow, Speakers:Dr. HO Hung Kwong, Duncan,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
1:30pm	**The Hong Kong Medical Association Community Network Exercise Prescription Certificate Courses** Organiser:The Hong Kong Medical Association Community Network, Speaker:Prof. Ip Wing Yuk,Venue: Lei Garden Restaurant, Shop No. L5-8, apm, Kwun Tong, No. 418 Kwun Tong Road, Kowloon	HKMA CME Dept. Tel: 2527 8452 2 CME Points
30 SUN 1:30pm	**HKMA Family Sports Day 2014** Organiser:The Hong Kong Medical Association, Chairman:Dr. HUI Yat Ming, Johnson,Venue: Stanley Ho Sports Centre, 10 Sha Wan Drive, Sandy Bay, Hong Kong	Mr. Ian KWA Tel: 2527 8285

Federation News

"ADHD from Childhood to Adulthood" Symposium

On 22 September 2014, a lunch symposium on Attention Deficit Hyperactivity Disorder (ADHD) was held at the Eaton Hong Kong, Kowloon. The symposium was well attended by doctors, nurses, paediatricians and allied health professionals.

The lecture topic was "ADHD from Childhood to Adulthood". The Federation was privileged to have Dr Chung-sing KAN, Specialist in Psychiatry, as our speaker; with Dr Yin-kwok NG, 2nd Vice-President of the Federation of Medical Societies of Hong Kong, as our chairman for the symposium. Dr KAN shared the experience on how to handle ADHD patients on their adolescence to adulthood and provided a comprehensive understanding of adult ADHD in the view of the disease across the lifespan. The lecture ended fruitfully with active questioning from participants. The Federation looks forward to organising further educational activities on various topics for our professionals in the near future.

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IMPROVE™ study[2]

Subgroup analysis of IMPROVE, a 26-week, open-label, non-randomised, international observational study

References: 1. Raskin P *et al*. on behalf of the INITIATE Study Group. Basal insulin or premix analogue therapy in type 2 diabetes patients. *Euro J Int Med 2007*;18:56-62. **2.** Wenying Y *et al*. on behalf of the IMPROVE Study Group Expert Panel. Improved glycaemic control with BIAsp 30 in insulin-naïve type 2 diabetes patients inadequately controlled on oral antidiabetics: subgroup analysis from the IMPROVE study. *Curr Med Res Opin* 2009:25(11):2643-2654.

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Answers to Dermatological Quiz

1. The clinical diagnosis is porokeratosis. It is a chronic progressive disorder of keratinisation, characterised clinically by hyperkeratotic papules or plaques surrounded by a well-defined thread-like elevated border that expands centrifugally as shown in our patient. Differential diagnoses should include actinic keratosis, Bowen's disease, squamous cell carcinoma, granuloma annulare and tinea corporis.

2. Histology showed characteristic changes at the raised and advancing thread-like edge of the lesion, where the skin biopsy was performed in our patient. The stratum corneum is hyperkeratotic. There is a thin column of poorly staining parakeratotic cells, the cornoid lamella, running through the surrounding normal staining cells. Underlying the cornoid lamella, the granular layer is markedly reduced and the underlying keratinocytes are oedematous with spongiosis and shrunken nuclei. A dermal lymphocytic pattern may be present.

3. Lesions of porokeratosis are chronic and slowly progressive. If symptomatic, topical treatments with potent steroids, keratolytic, retinoids, calcipotriol or imiquimod have been tried with variable outcomes. Ablative techniques such as cryotherapy, carbon dioxide laser therapy, dermabrasion and surgical excision have also been used with variable successes. Malignancies, such as squamous cell carcinoma, Bowen's disease and basal cell carcinoma, have been reported in 7-11% of chronic porokeratosis. For asymptomatic patients, intervention may not be necessary but close surveillance and a lower threshold for biopsy of suspicious lesions is warranted.

Dr Ka-ho LAU
MBBS(HK), FRCP(Glasg, Edin), FHKCP, FHKAM(Med)
Private dermatologist

Most Taken and Recommended Statin by HK Physicians[1]

According to 2013 ACC/AHA Guideline, statin therapy should focus on ASCVD risk reduction.[2]

MIRACL[3]	SPARCL[4]	TNT[5]	ASCOT-LLA[6]	CARDS[7]	ARMYDA[8]	PROVE-IT[9]	IDEAL[10]	GREACE[11]
✓	✓	✓	✓	✓	✓	✓	✓	✓

Proven to reduce CV events by up to 50% in multiple major CV outcomes trials.[3-11]

- Efficacious LDL-C lowering[12,13]
- Proven CV outcomes evidence from landmark trials[3-11]
- NO dosage adjustment in patients* with renal impairment[12,14]

*excluding kidney transplant patients

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References 1. Ahead Research Consultants. "HCP's Statin Preference Research Report", 2013 n=120 physicians. 2. 2013 ACC/AHA Guidelines on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. American Heart Association. Circulation. 2013;00:000–000. 3. Schwartz GC, et al. Effects of atorvastatin on early recurrent ischemic events in acute coronary syndromes - the MIRACL Study: A randomized controlled trial. JAMA 2001;285(13):1711-1718. 4. Amarenco P, et al. High-Dose Atorvastatin after Stroke of Transient Ischemic Attack. The Stroke Prevention by Aggressive Reduction in Cholesterol Levels Study (SPARCL). N Engl J Med 2006;355(6):549-59. 5. LaRosa JC, et al. Intensive Lipid Lowering with Atorvastatin in Patients with Stable Coronary Disease. N Engl J Med. 2005;352:1425-35. 6. Sever PS, et al. Prevention of coronary and stroke events with atorvastatin in hypertensive patients who have average or lower-than-average cholesterol concentrations, in the Anglo-Scandinavian Cardiac Outcomes Trial—Lipid Lowering Arm (ASCOT-LLA): a multicentre randomised controlled trial. Lancet 2003;361:1149–58. 7. Colhoun HM, et al. Primary prevention of cardiovascular disease with atorvastatin in type 2 diabetes in the Collaborative Atorvastatin Diabetes Study (CARDS): multicentre randomised placebo-controlled trial. Lancet 2004;364:685–96. 8. Di Sciascio G, et al. Efficacy of Atorvastatin Reload in Patients on Chronic Statin Therapy Undergoing Percutaneous Coronary Intervention: Results of the ARMYDA-RECAPTURE (Atorvastatin for Reduction of Myocardial Damage During Angioplasty) Randomized Trial. JACC 2009;54(6):558-565. 9. Cannon CP, et al. Intensive versus moderate lipid lowering with statins after acute coronary syndromes. N Engl J Med 2004;350:1495-504. 10. Pedersen TR et al. High-dose atorvastatin vs usual-dose simvastatin for secondary prevention after myocardial infarction: the IDEAL study: a randomized controlled trial. JAMA 2005;294(19):2437-45. 11. Athyros V et al. Treatment with Atorvastatin to the National Cholesterol Education Program Goal Versus 'Usual' Care in Secondary Coronary Heart Disease Prevention. The GREek Atorvastatin and Coronary-heart-disease evaluation (GREACE) Study. Curr Med Res Opin 2002;18:220-8. 12. Lipitor® (atorvastatin) Prescribing Information. Pfizer Corporation Hong Kong Limited. Version September 2011. 13. Law MR et al. BMJ 2003;326:1423-1427 14. KDOQI Clinical Practice Guideline For Diabetes and CKD: 2012 Update. Am J Kidney Dis 2012;60(5):850-886.

LIPITOR ABBREVIATED PACKAGE INSERT 1. TRADE NAME: Lipitor® **2. PRESENTATION:** The tablets for oral administration contain atorvastatin calcium equivalent to 10, 20, 40 or 80 mg atorvastatin. **3. INDICATIONS:** Adjunct to diet for the treatment of patients with elevated total cholesterol, LDL-cholesterol, apolipoprotein B, and triglycerides and to increase HDL-cholesterol in patients with primary hypercholesterolemia (heterozygous familial and non-familial hypercholesterolemia), combined (mixed) hyperlipidemia (Fredrickson Types IIa and IIb), elevated serum triglyceride levels (Fredrickson Type IV), and for patients with dysbetalipoproteinemia (Fredrickson Type III) who do not respond adequately to diet. For the reduction of total cholesterol and LDL-cholesterol in patients with homozygous familial hypercholesterolemia when response to diet and other non-pharmacological measures are inadequate. Reduce the risk of myocardial infarction, stroke, revascularization procedures and angina in adult patients without clinically evident coronary heart disease, but with multiple risk factors for coronary heart disease such as age, smoking, hypertension, low HDL-C, or a family history of early coronary heart disease. Reduce the risk of myocardial infarction and stroke in patients with type 2 diabetes, and without clinically evident coronary heart disease, but with multiple risk factors for coronary heart disease such as retinopathy, albuminuria, smoking, or hypertension. Reduce the risk of non-fatal myocardial infarction, fatal and non-fatal stroke, revascularization procedures, hospitalization for CHF and angina in patients with clinically evident coronary heart disease. Atorvastatin is also indicated as an adjunct to reduce total-C, LDL-C, and apo B levels in boys and postmenarchal girls, 10 to 17 years of age, with heterozygous familial hypercholesterolemia if after an adequate trial of diet therapy the following findings are present: a. LDL-C remains ≥ 190 mg/dL or b. LDL-C remains ≥ 160 mg/dL and there is a positive family history of premature cardiovascular disease or two or more other CVD risk factors are present in the pediatric patient. **4. DOSAGE:** The recommended starting dose of Lipitor is 10 or 20mg once daily. Patients who require a large reduction in LDL-C (more than 45%) may be started at 40mg once daily. The dosage range is 10 to 80 mg once daily. After initiation and/or upon titration of atorvastatin, lipid levels should be analyzed within 2 to 4 weeks, and dosage adjusted accordingly. **5. CONTRAINDICATIONS:** Hypersensitivity to any component of this medication, active liver disease or unexplained persistent elevations of serum transaminases exceeding three times the upper limit of normal. Pregnant, breast-feeding, or of childbearing potential who are not using adequate contraceptive measures. Atorvastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards to the fetus. **6. WARNINGS & PRECAUTIONS:** As with other lipid-lowering agents of the same class, moderate (>3 x upper limit of normal [ULN]) elevations of serum transaminases have been reported following therapy with atorvastatin. Liver function tests should be performed before the initiation of treatment and periodically thereafter. Patients who develop any signs or symptoms suggesting liver injury should have liver function tests performed. Patients who develop increased transaminase levels should be monitored until the abnormality (ies) resolve(s). Should an increase in ALT or AST of greater than three times the upper limit of normal persist, reduction of dose or withdrawal of atorvastatin is recommended. Atorvastatin can cause an elevation in transaminases. Atorvastatin should be used with caution in patients who consume substantial quantities of alcohol and/or have a history of liver disease. Myalgia has been reported in atorvastatin-treated patients. **7. INTERACTIONS:** Cyclosporine, fibric acid derivatives, lipid-modifying doses of niacin or cytochrome P450 3A4 inhibitors (e.g., erythromycin, and azole antifungals), clarithromycin, protease inhibitors, diltiazem hydrochloride, itraconazole, grapefruit juice, inducers of cytochrome P450 3A4 (e.g, efavirenz, rifampin), antacids, colestipol, digoxin, oral contraceptives, fusidic acid **8. PREGNANCY and LACTATION:** Atorvastatin is contraindicated in pregnancy and while breast-feeding. **9. SIDE EFFECTS:** Nasopharyngitis, hyperglycemia, pharyngolaryngeal pain, epistaxis, nausea, diarrhea, dyspepsia, flatulence, arthralgia, pain in extremity, musculoskeletal pain, muscle spasms,myalgia, joint swelling, liver function test abnormal, blood creatine phosphokinase increased
Reference: HK PI (SEP2011) Date of preparation: FEB2013 Identifier number: LIP0213 **FULL PRESCRIBING INFORMATION IS AVAILABLE UPON REQUEST.**

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