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VOL.20 NO.7 July 2015

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The Cover Shot



This is a photo of the Thorung La Pass in Nepal in the Annapurna Circuit Trek at about 5,416 m above sea level where I and my wife had trekked through years ago, but an avalanche there last year (2014) killed a number of people.



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Editorial

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Consultant, Accident and Emergency Department, North District Hospital

Editor

Dr Chi-biu LO

Hong Kong is a relatively safe place. There were a number of multiple casualty incidents (MCI) in previous decades, when most people can recall the Garley Building Fire in 1996 and the boat collision near Lamma Island in 2012 as notorious examples. There are established mechanisms and procedures in responding to MCIs from various departments, with emergency medical service (EMS) and hospital service being the key agencies responsible for providing treatment to the victims. During an MCI, there is a sudden surge in need for acute care, which often requires alternative arrangement or reprioritisation of work, many a time leading to short-term disruption of regular service. But in general the society's infrastructures are intact and service will resume normal after a period of time. In MCIs, responders will mostly assume their duties in pre-established response plans.

While there is no universally accepted definition for a disaster, it is widely agreed that a society in a disaster would have entered a difficult state of inability to cope or needing external assistance.^{1,2} A phenomenon that often, though not necessarily, occurs in a disaster is the provision of foreign aid to the country in disaster. Foreign medical teams (FMT) from several countries were quickly spotted in Nepal shortly after the recent earthquake on 25th April 2015. How to make the best use of the FMT is another issue to address. One week after the shock in Nepal, roads to some remote areas were still blocked and a more accurate assessment of the local situation was still pending, not to mention bringing aid to the affected.

No two disasters are alike and disasters can come in many forms, challenges faced for responding to an Ebola outbreak, a tsunami, an earthquake, or a super-strong typhoon such as Haiyan, will be very different. Even for earthquakes, difficulties faced in Haiti's earthquake were different from that of in Sichuan (2008) or Nepal (2015), as going to villages at high altitudes required acclimatisation. Other than the infection risk, workers in Ebola care centres in West Africa have to face the risk from hyperthermia and dehydration when gowned up and work in hot climate. In some parts of the world hospitals can become targets of attacks and health care workers are not immune to these attacks.

In recent years a number of organisations including the World Health Organization (WHO) have published documents governing standards for responding to disasters, such as the "Classification and Minimum Standards for Foreign Medical Teams in Sudden Onset Disaster", "WASH" (which stands for water, sanitation and hygiene) and the Cluster Approach for responding to disasters.^{3,4,5} Practices, however, may have to be modified according to cultural differences and local situations. In clinical practice we often mention about evidence-based practice, but in disaster medicine, as repeatedly emphasised in the recent World Congress on Disaster and Emergency Medicine (WCDEM) in Cape Town, it is more appropriate to use an evidence-aided approach as it is simply not possible to carry out control trials in disasters.



In this issue of the Hong Kong Medical Diary we are honoured to have a number of authors to provide a diversity of perspectives on disaster management, from local MCI management to disaster relief work outside Hong Kong. Also in recent years there are increasing concerns on the psychological impacts to both victims and rescuers and there is an article discussing on this topic.

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*SU: sulfonylurea. †ACS: acute coronary syndrome.

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Prof Stephen WK CHENG
(Division Chief, Serena H C Yang Professorship in Vascular Surgery, Department of Surgery, Queen Mary Hospital)
- **Management of Advanced Valvular Heart Diseases**
Dr CHAN Kam-tim
(President, Hong Kong College of Cardiology)

Session II – Advanced Respiratory Diseases

Chairpersons: Dr Jane CK CHAN & Dr NG Chun-kong

- **Established and Emerging Indications of Non-invasive Ventilation**
Dr CHU Chung-ming
(Consultant Physician, Department of Medicine and Geriatrics, United Christian Hospital)
- **Advances in the Management of Obstructive Lung Diseases**
Dr David CL LAM
(Clinical Assistant Professor, Department of Medicine, Queen Mary Hospital)

Lunch Symposium – Management of Pain for Advanced Diseases

Chairperson: Dr CHAN Sai-kwing

Speaker: **Dr Steven HS WONG**
(President, The Hong Kong Pain Society)

Session III – Geriatrics & Psychiatry

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Prof Timothy CY KWOK
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Prof SW TANG
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Dr Mario WK CHAK
(Associate Consultant, Department of Paediatrics and Adolescent Medicine, Tuen Mun Hospital)

Session V – Oncology and Palliative Medicine

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Disaster Medicine: Introduction and the Challenges in Hong Kong

Dr Axel YC SIU

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Dr Axel YC SIU

Introduction

A disaster is defined by natural or manmade events that result in an imbalance between the supply and demand in the existing infrastructure of the community.¹ Most of the time, disasters come without any warning and will result in catastrophic effects to the health, social and economic systems. Disasters can be categorised by various characteristics. (Table 1)² In some situations, the impact may be one-off though the magnitude of the destruction from the primary insult may be already great enough to overwhelm the current responding system. However, in some occasions, the damaging process may be continuous and results in prolonged devastating effects to the whole community.

Table 1: Classification of disaster²

Classification	Category	Examples
Cause	Man-made Natural	War, terrorism attack Typhoon, earthquake
Predictability	Fairly predictable Unpredictable	Flood Earthquake
Onset	Gradual Sudden	Typhoon Earthquake
Duration	Brief Prolonged	Urban fire Influenza pandemic
Frequency	Common Rare	Major traffic accident Nuclear plant accident
Location	Single location Multiple location	Collapse of building Wildfire
Occurrence	Single occurrence Multiple occurrence	Airplane crash Earthquake and aftershock
Extent of Damage	Small scale Large scale	Major traffic accident War

Disaster Response Management

There are 4 phases of disaster response management which include preparedness, response, recovery and mitigation. (Fig. 1)

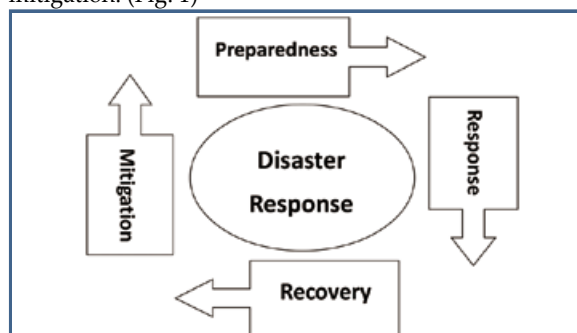


Fig. 1: Four Phases of Disaster Response Management

Preparedness

Preparedness includes the plans and actions to help the community to prepare for the impact from the potential disaster. It aims to reduce the loss of life and property and minimise the disturbance to the community due to the disaster. It involves the development of disaster action response, training of the personnel who may be involved in disaster preparedness and response. It takes place before any disaster happens.

Response

Response is the emergency action conducted during or immediately after the impact of the disaster. It aims at reducing the harmful effects that the disaster has already developed. It usually involves various disciplines to handle different needs of the community, e.g. rescue staff to save the victims from a landslide or the wreckage of an airplane, hospital disaster response to handle a major flux of injured patients and police to maintain order of the disaster scene and keep members of the public as safe as possible.

Recovery

Recovery includes all the actions that aim to restore the normal function of the community as soon as possible. Examples include temporary housing for the victims and financial assistance and psychological support to those in need. In a small scale disaster, recovery can be completed in terms of days if not weeks. However, in a major scale disaster, it may not be finished in years, e.g. the Great East Japan Earthquake.

Mitigation

Mitigation is the actions to prevent future emergencies and to minimise their effects. It can be done before or after a disaster happens. Mitigation can be structural, e.g. reinforcing a dam to prevent future flooding and can be non-structural, e.g. safety policy in prevention of mass casualties incidents in the sinking of a ferry.

History of Disaster Preparedness and Response in Hong Kong

In the past century, Hong Kong had encountered many large scale disasters in different aspects: The great plague in Hong Kong in 1894³, the deadliest typhoons in 1906 and 1937⁴, the Shek Kip Mei fire in 1953, the Garley Building fire in 1996 and SARS in 2003. These disasters overwhelmed the capacity of the community to handle the emerging number of casualties in both the physical and social needs.



In Hong Kong, disasters are mainly handled by various departments, including: Hong Kong Police, Hong Kong Fire Services Department, Hong Kong Hospital Authority, Home Affairs Department, etc. The Hong Kong Government usually takes up the central role of communication, coordination and liaison. Sometimes, we may need to handle disasters outside Hong Kong that involve Hong Kong citizens, e.g. the Hong Kong tour bus crash in Egypt in 2006 and the Manila hostage crisis in 2010. Hong Kong also had experienced in participating in overseas disaster relief, e.g. the tsunami in South-east Asia in 2004 and the Sichuan earthquake in 2008. Non-governmental organisations, e.g. the Hong Kong Red Cross, had a long history of deploying volunteers to overseas in disaster management.

In the past, disaster management in Hong Kong emphasised on the aftermath management on how to recover from the damages resulted from the disaster. However, in recent decades, the Hong Kong Government has established a lot of plans in response to different potential disasters that can happen in Hong Kong, including the Daya Bay Nuclear Plant Response Plan and the Influenza Response Plan etc. These plans have depicted the responsibility of different stakeholders and their appropriate actions at different stages of a disaster.

Current Challenges

In Hong Kong, most of the knowledge on disaster preparedness is based on the experience of previous disasters happened locally. However this kind of mitigation can only help us to reduce the future hazards of the same type of disaster. Upon the challenge of emerging risks of different kinds of disasters that may happen in Hong Kong, there is an urge of more local experts on disaster preparedness.

Disaster medicine is currently not included in the curriculum of the undergraduate medical training or in the post-graduate specialist training. Disaster medicine is not considered as a sub-specialty in any of the colleges under the Hong Kong Academy of Medicine. Most of the medical professionals have little experience on handling disasters in different phases. The lack of experience in the leadership for disaster response will make us vulnerable if there is any major disaster occurring in Hong Kong. In future, we definitely need more physicians who have exposure and training in disaster medicine to fulfil the emerging needs of the community.

The Road Forwards

The establishment of the Hong Kong Jockey Club Disaster Preparedness Research Institute (HKJCDPRI) in August 2014 has marked another significant milestone for Disaster Medicine in Hong Kong. The use of advanced technology and integrated teaching would benefit the candidates in understanding the various scopes of disaster medicine. Overseas experts will be invited to teach and share their experience in handling disasters from preparedness, immediate response and management during the recovery period. The local participants should be able to acquire the essential knowledge and skills to cope with the future challenges.

Looking forwards, elements of disaster medicine can be incorporated into the current curriculum for the medical undergraduate so that they can have some exposure on the current perspective of disaster medicine. Education funds can be developed to facilitate trainees to receive further on this new horizon and they can apply their knowledge on the development of disaster medicine in Hong Kong and hopefully disaster medicine will become one of the subspecialties under the Hong Kong Academy of Medicine in the near future.

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Pre-hospital Management of Casualties in Disaster

Mr Kwok-leung SHUM

Assistant Director (Ambulance), Hong Kong Fire Services Department



Mr Kwok-leung SHUM

This article has been selected by the Editorial Board of the Hong Kong Medical Diary for participants in the CME programme of the Medical Council of Hong Kong (MCHK) to complete the following self-assessment questions in order to be awarded 1 CME credit under the programme upon returning the completed answer sheet to the Federation Secretariat on or before 31 July 2015.

Prologue

Situated at the South-eastern coast of the China Mainland, Hong Kong is fortunately free from many types of natural disasters such as earthquakes, tsunamis, flooding, extreme weather or attacks by tornadoes. Nevertheless, densely populated by more than 7 million people, the modernised tiny city has heavy traffic and lots of human activities. There are therefore high chances for the occurrence of some large-scale incidents involving multiple casualties. Large-scale blazes, gas explosions, building collapse, and traffic accidents on land and sea did happen in the past 20 years, costing numerous human lives.

Role of the Hong Kong Fire Services Department

The Hong Kong Fire Services Department (HKFSD) is the only government department with her statutory duty to deal with disasters and handle casualties therefrom. The Department defines incidents involving eight or more casualties or multiple casualties with an unknown number as Multiple Casualties Incidents (MCI). Different resources of the Department including commanding officers, fire engines and, of course, ambulances will be dispatched by the Fire Services Communication Centre (FSCC) to the scene for rescue, casualty triage, treatment and further transport to hospitals. The following paragraphs will elaborate the preparedness and response by the Ambulance Command of the Department in casualty handling during MCI.

Preparedness and Response

Ambulance Command

The Ambulance Command of HKFSD is responsible for the administration, management and quality assurance on paramedic ambulance service provided to the public. The paramedic service is of Emergency Medical Assistant level II (EMA II) standard, which is equivalent to Advanced Emergency Medical Technician (AEMT) level in the United States, or Primary Care Paramedic (PCP) in British Columbia of Canada. The 1400 EMA II (in which around 1200 being frontline personnel) have to be re-certified every 3 years and also have to attend Continuing Medical Education (CME) at intervals so

as to upkeep their knowledge and skills. Handling of multiple casualty incidents is surely a topic to be taught and refreshed in different training occasions

About 300 ambulance resources are operating every day to provide service to the Hong Kong territory. Such resources include Emergency Ambulances (Amb), Hospital Transfer Fleet (HTF), EMA motorcycles (EMAMC), Rapid Response Vehicles (RRV) manned by Ambulance Officers, one Paramedic Equipment Tender (PET) as well as 4 Mobile Casualty Treatment Centres (MCTC).



Photo 1: An emergency ambulance of HKFSD



Photo 2: Emergency Medical Assistant Motorcycle

Dispatch and Response

Concerning MCI management, there are internal orders, guidelines and contingency plans in HKFSD to govern the response action of ambulance resources in case of an MCI. As stated previously, whenever an incident

involving eight or more casualties or an incident with an unknown number of casualty occurs, it will be treated as an MCI. FSCC will dispatch ambulances and fire resources to the scene according to the Standard Attendance Schedules, which set out the mandatory minimum Fire Services resource requirement for response to calamities like fire or MCI. Reinforcement for more manpower or other resources might be requested upon the arrival of the first batch of resources.

FSCC will also notify the Hospital Authority Head Office Duty Officer (HODO) who, in consultation with hospitals adjacent to the scene of an MCI, will decide on the type and number of casualties to be diverted to different destination hospitals.

Scene and Casualty Management

Upon arrival at the scene, the supervisor of the first arrived ambulance / EMAMC / RRV will assume the role of the Ambulance Incident Officer (AIO) who will start the ambulance operation according to the mnemonic: CSCATTT: Command & Control; Safety; Communication, Assessment; Triage; Treatment and Transport.

Command & Control

Good command and control are cornerstones in major incident management. It requires good and smooth communication horizontally to other rescue sectors or posts, and also vertically to more senior commanding officers as well as to subordinates who will follow instructions to carry out the rescue, casualty triage, treatment and conveyance.

Safety

It concerns with safety of the scene, the casualties, and of course, the ambulance personnel at the scene. In complicated MCIs such as those involving fire, gas leakage, building collapse, serious traffic accidents or even Chemical/Biological/Radiation/Nuclear (CBRN) incidents, fire fighters would at the same time carry out rescue and fire suppression operation in the "hot zones", whilst ambulance personnel will receive the casualties and perform patient care and treatment in the "warm" and "cold zones".

Communication

Effective and reliable communication is normally done through handheld type radio-telephones (RT, also known as "walkie-talkies"). Involved parties such as the Command Post, AIO, Triage Officer (TO), Ambulance Loading Officer (ALO), Medical Control Officer (MCO), FSCC, HODO and such other emergency service providers must maintain effective communication with a view to enhance a smooth rescue operation.

Assessment

The initial appraisal of the disaster scene certainly affects the later operation. The AIO will act according to the mnemonic: ETHANE to assess the situation:

Exact location

Type of incident - e.g. traffic accident, fire, etc.

Hazards - Current and potential

Access (route to scene)

Number of Casualties - and their severity / type

Emergency services - present and required

Triage-Treatment-Transport

After having been rescued from the "hot zone", such as the wreckage in a traffic accident, casualties are prioritised to receive treatment and subsequent conveyance to hospitals. This is known as field triage. Unlike at the Accident & Emergency Departments (A&E) of local hospitals, ambulance personnel at scene will employ a simpler way to triage the patients. The method being employed is known as START: Simple Triage And Rapid Treatment.

During triage, four factors of the casualties are considered. They include physiological factors, anatomical factors, co-morbid factors and the mechanism of injury. Casualties are then triaged into four categories:

- Top Priority (coloured RED) = require immediate lifesaving procedures
- 2nd Priority (coloured YELLOW) = require intervention within 4-6 hours
- Walking Wounded (coloured GREEN) = less serious, do not require treatment within the times given above
- Dead (coloured BLACK)



Photo 3: A triage tag

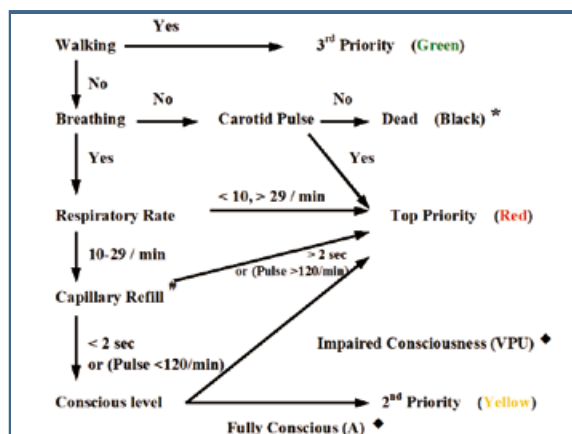


Photo 4: The triage steps

After being triaged, casualty treatment is done at the Casualty Clearing Station (CCS). Emergency treatment such as maintaining airway in unconscious patients, control of severe haemorrhage and/or some other critical interventions, must be carried out at scene



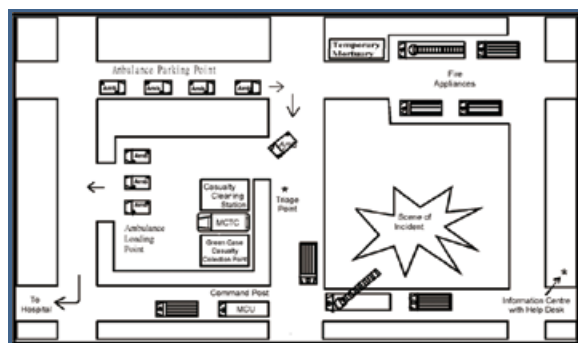
immediately. The treatment should be just enough for a safe conveyance to hospitals. Efforts would not be spent on meticulous care of minor wounds. Apart from treatment, reassessment/re-triage of casualties are also done here. Casualties would wait for ambulances being arranged for further conveyance to hospitals.

MCTC would be reserved for particular cases when the medical team at scene (which is dispatched from a hospital on the request from at-scene officers and at the decision by the Hospital Authority) decides to use the medical or surgical equipment stored on board the MCTC for certain medical procedures e.g. insertion of chest drain, ET tube intubation etc.

Ambulances, on their arrival, will be parked at the Ambulance Parking Point (APP). On the instruction of the AIO or ALO, ambulances will be manoeuvred to the Ambulance Loading Point (ALP) where transport of casualties to hospitals will commence and carry on as an on-going process. In order to enable receiving hospitals to cope with the influx of casualties, both the rate of transport and the extent of diversion of casualties must be closely controlled and coordinated by the ALO. Ambulances, including those of auxiliary services e.g. Auxiliary Medical Services, St. John Ambulance etc., should NEVER convey casualties to hospitals without going through the ALP or without notifying the ALO.

FSCC will notify the Hospital Authority Head Office Duty Officer (HODO) who, in consultation with hospitals adjacent to the scene of an MCI, will decide on the type and number of casualties to be diverted to different destination hospitals. This may also be decided by the Medical Control Officer (MCO) at the scene if dispatched. Nevertheless, in the event that HODO needs time to coordinate and to decide on the diversion plan, or if there is no MCO at scene, the casualties would not be kept at the scene merely for such instructions from the HODO or arrival of the MCO. The AIO will arrange ambulances to convey casualties to adjacent hospitals according to a pre-set quota as agreed between HKFSD and HA. In short, 4 serious (red) and 16 minor (yellow & green) casualties could be received by major hospitals at one time, whilst 2 serious (red) and 8 minor (yellow & green) casualties could be received by minor hospitals.

The following diagram illustrates how ambulance operation goes in an MCI:



Measures to improve HKFSD operation in MCI

As a matter of fact, it is always uneasy to handle an MCI especially when there are other factors affecting the operation, such as adverse weather or unreachable locations. In the past few years, the Ambulance Command of HKFSD has made improvements in certain areas with a view to effect smoother operation during MCIs. The below shows some examples:

Identification of AIO and Communication

In a bid to let both HKFSD members and emergency responders of other government departments or organisations to easily identify the AIO in an MCI, an AIO vest was manufactured and put to general use by ambulance personnel. Responding parties could speedily locate the AIO whilst the latter could expeditiously deploy the personnel and resources at the scene to manage different sectors of the MCI operation.

For better communication among different parties of HKFSD during an MCI, a new trunk radio was put into operation. With the new radios, less busy, clearer and better communication could be yielded.



Photo 5: The AIO vest for easy identification



Photo 6: Radio telephone currently used by HKFSD

Operational Instruments and Vehicles

In an MCI, the number of casualties could range from 8 to several hundreds. With a large number of casualties scattering elsewhere of the disaster scene, ambulance personnel would encounter difficulties in triage and treatment as well as head counting of the casualties. In a bid to exercise better control, triage mattresses were equipped on ambulances so that casualties of different triage categories (red, yellow, green) could be grouped together for easier identification. Ambulance personnel and other emergency responders could be easily deployed to handle the different categories of casualties.



Photo 7: Colored triage mattresses used in a MCI drill

More importantly, new vehicles including new MCTCs and a new Paramedic Equipment Tender (PET) were available to respond MCIs in an attempt to provide full support to the MCI operation and casualty treatment.



Photo 8: Paramedic Equipment Tender (PET)



Photo 9: New Mobile Casualty Treatment Centre (MCTC)

Ambulance Personnel

Responding ambulances, during the provision of treatment to casualties of an MCI, may be required to convey casualties to hospitals. As such, the number of available ambulance personnel at the scene to look after casualties as well as to prepare for the ever-changing circumstances of the MCI would thus be reduced.

In view of the difficulties encountered during MCIs, HKFSD has therefore established a special team named the Special Support Unit (SSU). One of the major roles of the SSU is to augment normal ambulance crews during MCIs. SSU ambulances would be dispatched to the scene of MCIs throughout the territory. On arrival, the ambulance crews would be deployed to man different posts such as triage, CCS or ambulance loading point. Normally, SSU ambulances would not be tasked to convey casualties from the scene to hospitals. Therefore ambulance personnel of SSU are available to oversee the changing circumstances of the MCI scene as well as to take care and provide treatment to those casualties still awaiting for conveyance at scene.

Apart from SSU, Rapid Response Vehicles (RRV) manned by Ambulance Officers also play indispensable roles in daily ambulance operations, MCIs, quality assurance as well as personnel management during their daily work. Lately in early 2015, RRV service is further strengthened so that 24 hours service could be provided. During MCIs no matter occurring day or night, RRV officers will be dispatched to the scene to take up the leader's role and to execute a smooth and effective MCI operation.



Photo 10: Rapid Response Vehicle (RRV) providing 24-hours service

The Way Forward

When an MCI especially a large-scale one happens, it would certainly involves a large number of ambulance personnel and fire-fighters of HKFSD to execute the rescue operation. In some occasions, emergency responders of other government departments or voluntary organisations may also attend the scene. Lack of coordination, cooperation and communication among different parties might become the hurdles to block achieving a smooth operation. As such, drills and regular exercises involving multiple agencies, no matter of local community scale or of territory-wide scale must be conducted regularly.

Preparedness is always of utmost importance. Management levels of involved organisations such as HKFSD or HA should carry on with all current discussions and also forecast future developments so that a robust mechanism e.g. a quick and accurate alert system to hospitals, in handling MCIs could be put in place.

Lastly, frontline work directly affects casualties' conditions. Improvement in equipment, vehicles and other adjuncts used in MCIs would benefit casualties in their treatment and even their subsequent recovery process. As an emergency organisation, HKFSD will go in great lengths in getting itself well-equipped and well-prepared to any disaster or MCI happening during day or night in this tiny but busy city, bearing in mind the mission of HKFSD: To serve Hong Kong by making it a safe place to live and work.



MCHK CME Programme Self-assessment Questions

Please read the article entitled "Pre-hospital Management of Casualties in Disaster" by Mr Kwok-leung SHUM and complete the following self-assessment questions. Participants in the MCHK CME Programme will be awarded CME credit under the Programme for returning completed answer sheets via fax (2865 0345) or by mail to the Federation Secretariat on or before 31 July 2015. Answers to questions will be provided in the next issue of The Hong Kong Medical Diary.

Questions 1-10: Please choose the best answer.

1. The first goal of the first ambulance personnel arrives at an MCI scene should be:

- a, Take the first patient he meets and rush that patient to hospital.
- b, Carry out a detailed assessment and treatment of the first patient he meets.
- c, Establish command and control of the MCI scene.
- d, Rush into the hot zone of the MCI scene and find out the most seriously injured patients amongst the others and provide treatment.
- e, Help the fire-fighters to fight any on-going risk such as a fire.

2. The TTT in CSCATTT stands for (choose one of the following):

- a, Triage, treatment, transport.
- b, Transport, triage, treatment.
- c, Trauma, triage, transport.
- d, Triage, transfuse, transport.
- e, Trauma, triage, treatment.

3. In the MCI triage process, a patient who cannot walk with an injured lower limb but has normal vital signs, should be triaged to the following colour (choose one of the following):

- a, Black.
- b, Yellow.
- c, Red.
- d, Green.
- e, Blue.

4. In the MCI triage process, a patient with a wound on the head and responds only to pain stimulus, has normal BP and normal respiration, should be triaged to the following colour (choose one of the following):

- a, Black.
- b, Yellow.
- c, Red.
- d, Green.
- e, Blue.

5. The first arrived ambulance personnel at an MCI scene will assume the role of (choose one of the following):

- a, Medical Control Officer (MCO).
- b, Ambulance Incident Officer (AIO).
- c, Ambulance Loading Officer (ALO).
- d, Ambulance Communication Officer (ACO).
- e, Head Office Duty Officer (HADO).

6. Which of the following is NOT in the elements of MCI scene assessment:

- a, Number of casualties.
- b, Type of incident (e.g. traffic accident, fire, etc.).
- c, Route of access to the scene.
- d, Number of rescuers at scene.
- e, Number of bystanders at scene.



7. Fire Services Communication Centre (FSCC) will notify which of the following persons to decide on the type and number of casualties to be sent to different destination hospitals:

- a, Duty Officer of Department of Health.
- b, Director of Department of Health.
- c, Hospital Authority Chief Executive.
- d, Hospital Authority Head Office Duty Officer.
- e, Director of Fire Services.

8. Mobile Casualty Treatment Centre (MCTC) is used by which one of the following:

- a, Fire team.
- b, Ambulance team.
- c, Medical team.
- d, Communication team.
- e, Search and rescue team.

9. The main tool for communication used by Ambulance personnel during MCI is:

- a, Mobile phone.
- b, SMS.
- c, Pager.
- d, Radio.
- e, Landline telephone.

10. The smooth operation during an MCI depends on the following EXCEPT:

- a, Communication.
- b, Coordination.
- c, Rapid clearing up of the MCI scene.
- d, Adherence to the MCI response plan.
- e, Maintain good command and control.

ANSWER SHEET FOR JULY 2015

Please return the completed answer sheet to the Federation Secretariat on or before 31 July 2015 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

Pre-hospital Management of Casualties in Disaster

Mr Kwok-leung SHUM

Assistant Director (Ambulance), Hong Kong Fire Services Department

1 2 3 4 5 6 7 8 9 10

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

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

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

Answers to June 2015 Issue

Sodium-Glucose Co-Transporter 2 Inhibitors: A Novel Glucose Control Mechanism Independent of Pancreatic Reserve

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



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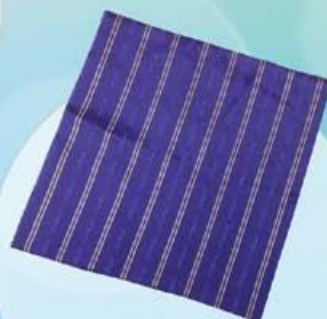
Pin
(Butterfly)
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Cap
\$70



Cufflink
\$80/pair



Pocket square
\$80



Tie
\$160



Bowtie
\$200

堅守民康五十載 醫聯同心志未改

An aid worker's diary

Ms Esther YIU



Ms Esther YIU

Brief bibliography: Esther, Nurse Midwife trained from Hong Kong Government Hospitals of Nursing in the 80's. She was awarded the HK Humanity Award 2011 and Outstanding Nurse 2013 after joined the Humanitarian sector with the Red Cross Movement and Medecins' Sans Frontieres since 2002. She was involved in missions in Lokichokio of Kenya, Peshawar of Pakistan; Leogane & Port au Prince of Haiti, Jogykarta of Indonesia, Mindanao of the Philippines, Sichuan Province of China and various emergency exploration missions in China. After her MPH from the Mahidol University of Thailand, she worked for the School of Public Health of CUHK and currently she is practising as an Advanced Practice Nurse at the HK Polytechnic University, University Health Service for Disease Control & Preventive Medicine.

1. The Children

K was only 5. He didn't speak my language nor did I speak his. But we communicated well with gestures and smiles. Under his genuine baby face with big dark eyes thick curly hair shadowed with his half grown half gone teeth. His smiles brought the fond love from all the staff. He was in fact very shy – shy to talk and shy to ask for help; and he was shy to show what he actually needed till the day I left, that was the only time he asked for something from me, at his age of 5.

He was adorable to his grandpa who stayed in the tent with him day and night. K never picked on food nor cried for any procedure we had to do on him. He went by his days without many activities, as there were no schooling, no playmates and not many toys. And he couldn't get out of his bed by himself. He would play with one old car toy and pretended he could go somewhere with his smile. And grandpa was his best companion.

K's parents were blasted dead during a sudden attack in a village near the border of Peshawar, where the militants and the combatants were fighting since God-knows-when and for what and why. K was injured at the same time and got a messy lower limbs trauma. Fortunately it was not life threatening. But the injury was so bad that both tibias and fibulas were not salvageable. Above knee amputations were done to both his lower limbs in a local institution with subsequent infected wound and hence he was sent to us, the International Committee of the Red Cross (ICRC) surgical hospital where medical care was free and teamed with expatriate medical people. He was by then operated a few times for wound debridement till

the infection was clear and then secondary closure was done. The management was based on the ICRC surgical protocol. Not until all the wounds were completely healed then an in town prosthesis fitting would be arranged, with staging of fitting for various limb sizes and the fitting had to be repeated every half yearly as he was growing to match the corresponding length and stump diameter. K was in the hospital for more than 2 months already.

K was probably not old enough to ask for what he didn't have, probably he did not know what he was supposed to have. It was only on the last day of my departure from this field hospital, K kept knocking on his thigh and kept saying a word which I could not understand – with the help of an interpreter, I realised he was saying "my legs", he was asking for a pair of legs; he was asking if I could give him the prosthetic legs before I left, in his usual big smile from where I couldn't even look into his eyes straight nor could I smile back.

As a health care personnel like myself who was supposed to aid the wounded, to heal the sick and to alleviate the pain in suffering, I would question on what do people actually fight for to bring in so many human suffering, injuries and harm to mankind. This kind of 'didn't know why and how' remains to be one key challenge as a field health care worker. While we were trying to do the healing and repair job and there was so many out there who did the shooting and bombing, it was really hard. Children are always the most vulnerable as they suffer the most, from the loss of parents or families, loss of health, loss of their futures and loss of opportunities. And there is not any single prosthesis that can fit into such a loss.



Figure 1 - K was drawing on a picture book I brought from the town of Peshawa



2. The woman

JM was a 17 years old 'woman'. She was married 2 years previously and had a 16 months old boy. She was well and 'satisfied' till the day she got bomb-blasted in town. Girls in the country got marry at very young age and mostly they did not practise contraception and became a mom young. As married women there, they were not able to make an independent medical decision about their own body. It was either the husband or the father who made the decision, whether it was a social or medical decision. The men had all the say. Every single time when there was an indication for a surgical procedure that required consent, it could take days or even weeks for coming up with a consented decision from all. Ultimately, there could be a delay in treatment, subsequently with delayed intervention and delayed healing.

JM's situation was exactly like that. She had an open fracture, multiple laceration wounds and minor abdominal injury. The open fracture of the right femur was operated a few times and the minor abdominal wound was repaired. It was initially decided that her injured limb should be amputated due to the massive injury, however, the husband disapproved the operation as he did not want to have a 'handicapped' wife. Hence JM was not able to agree to any medical proposal from the surgeon. Due to the lack of health care facility and support, external fixation was then the only available option for the fracture and extensive wound. A series of debridement and surgical wound cleaning were carried out under Ketamine, which was the only choice in limited resources.

JM was slim, thin and timid. She sought assistance from her mom for daily care. But with her inability to mobilise, a 2nd degree deteriorating to 3rd degree bed sore developed and was soon followed by cystitis. On top of the Penicillin and oral Septrin, she required an urinary catheter due to the inability to void. The hip wound was at the same time infected with pseudomonas and was aggravated by her pre-operative lack of nutritional support.

JM was breast-feeding her boy despite she could hardly produce any milk. Nevertheless, they enjoyed the mother-child close bonding. JM's mother was by then the carer to both during her hospitalisation and such support was in fact very crucial. JM would cry in agony during a dressing change but she could be calmed down by a doll or a pink ribbon for her hair; she was like a big kid herself. However, it always took the entire ward staff's effort to reposition her in bed to avoid further bed sores and to maintain the standard of care. JM was picky and fussy on what to eat, what to do and what not to do. Her compliance to nursing care and procedures was not remarkable. She often ate very little, of which it was not helpful at all to the healing as she got nothing else to eat. The hospital diet was calculated based on calories but the varieties of food choice were not fancy. With an unhappy stay at this surgical tent, JM had urged to be discharged home after a long journey of struggle in the treatment modality and medical care, the bargain of keeping her seriously injured leg had in fact brought her potential risks in the long run. She was sent home based on the strong request from the husband who exercised the power on her and a

borderline effective surgical management available for her situation. It was very uncomfortable to see her fate of life being manipulated by a man who did not decide on her best interest, and the man had hardly showed up to support her through this hardship of life course but urged her to give up instead.



Figure 2 - JM was discharged in bed-ridden condition as per family request

3. The trust of care

Typhoon Pablo hit Mindanao hard in December 2012. It was the century's worst typhoon to the area without much warning. A few counties in this very south part of the Philippines where constant conflict took place were totally torn, and of course health care facilities were not excluded. Being one of the emergency response delegates in the team, I was deployed with the ICRC health care team together with others, the relief, water sanitation, the reporting team etc. to be on ground the week after. The team arrived via Davao from Manila, took the road leading to Baganga by car was the only transport mode, taking 14-18 hours with a few checkpoints of 'friendly' rusted AK 47. The day of arrival was late in the evening. We all settled to a temporarily shelter where there were probably around 40 persons sharing 2 bedrooms, 1 common room and one bathroom. The temperature was at 35° C and it was humid. Many of us set up self-brought tents outdoors just to get some sleep and be ready for the next day's exploration. On the next day the primary health care centre – a white tent, was set up on gravel floor with wooden palette. This was done by local workers led our team leader who was a Japanese. The temporary basic health care was ready to greet the daily hundred patients, from the proximal or distal areas.



Figure 3 - destroyed town of Baganga, Mindanao

In Baganga, once the local population realised that there were expatriate health people on ground, they flooded in to be seen, whether it was for real or for ideal, they came early in the morning to get the appointment tickets and waited patiently for hours. I met a granny who brought her grandchild in due to fever for a few days; in her neck she got an unknown creature bottled, trusting the creature would take away the sickness from the child; I saw a congenital hydrocephalus 10 months old baby whose parents could not afford to send him to hospital care previously; I saw a premature infant who was only 10 days old weighing less than 2 kg, breathing and alive; but he was not the smallest - the smallest one was a 700 gm baby who was sleeping in the arms of his teenage mother, with an oral tube for feeding but not an endotracheal tube, breathing nicely and quietly at the corner of the destroyed hospital at Cateel; I saw a unrepaired cleft palate cleft lip girl who gave you a big smile but no chance to be operated on in that particular social or health environment.



Figure 4 - 700 gm boy wrapped in a blanket sleeping with mom



Figure 5 – grandma said the bottle had a blessing with the small creature that cures all sickness

As a midwife supporting maternal and child health and not to exclude general health care, my duty would mostly be checking on pregnant women who were previously cared by local birth attendants or midwives now all busily engaged with the destroyed clinic. Children under 5 and their mothers or grandmothers were also the key 'clients' to be seen at this centre. Apart from assessment, consultation, health education and clinical teaching, psychosocial support to meet their vague physical complaints were also crucial and essential. Many came in with non-specific complaints or some would want certain medications for 'stand-by' as they felt very insecure after the massive typhoon swept. Health education and teaching to the carers were very significant as many patients had very little understanding of the symptoms and signs we tried to elicit. Most of the consultations were actually dealing with primary and preventive care. There were many children with upper respiratory tract infections that were initiated from cross infection in a family; the spread of head lice or scabies due to poor personal hygiene and living condition; skin infections due to the lack of clean water for washing; gastro-intestinal related problems that came from improper food handling resulted from lack of clean water and proper shelter. Hence the consultations required the health care team to address more root cause issues, and not only to the illnesses. This 'medical sociology' issue was a real challenge.



Figure 6 - the girl with cleft palate and cleft lip, suffered from pneumonia

The impact from the destruction of various natural or man-made disasters remains a huge challenge for human kind. There is no doubt that many would use some sort of scales to measure the impact from a disaster, and to see if the response from government, international aids, and subsequent mitigation measures are sufficient. The effectiveness of such responses requires various skills and a vast spectrum of specialists or professionals from national to international horizon. As a health care aid worker, there are so little that can be done and yet, the trust that the patients put on us are somehow huge and not to be belittled. And it does not end in here.

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Hong Kong Urological Association

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To let participants to have an understanding of the latest advancement and trend in the management of some common urological diseases.

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24 Aug	Prostate Cancer 前列腺癌	Dr. P.C. TAM 談寶雛醫生 Hong Kong Urology Clinic 顧問醫生
31 Aug	Urinary Stone Disease 尿路結石	Dr. CHAU Hin 鄒衍醫生 聯合醫院副顧問醫生
7 Sep	Female Urinary Incontinence 女性尿失禁	Dr. C.H. CHENG 鄭長興醫生 屯門醫院副顧問醫生
14 Sep	Renal Tumors 腎臟腫瘤	Dr. Joseph H.M. WONG 黃翰明醫生 威爾斯親王醫院副顧問醫生
21 Sep	Bladder Cancer 膀胱癌	Dr. W.K. MA 馬偉傑醫生 瑪麗醫院副顧問醫生

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References: 1. Lok SF and McMahon BJ. Hepatology 2009;50:1-36 2. EASL. Journal of Hepatology 2012;57:167-185 3. Liaw YF. et al. Hepatol Int'l 2012;6:531-561 4. Marcellin P et al. 64th Annual Meeting of AASLD 2013. Poster 926 5. Marcellin P et al. The Lancet. vol.381. issues 9865. Feb 2013. pp.468-475



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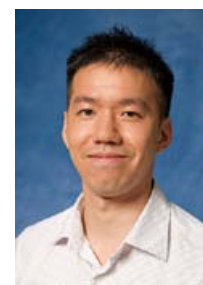
Putting Sendai Framework into Action: How Hong Kong Could Be Better Prepared for Disasters

Ms Agatha KY LIN

RN, MPH

Dr Kevin KC HUNG

MBChB, MPH



Ms Agatha KY LIN

Dr Kevin KC HUNG

Introduction

The Sendai Framework for Disaster Risk Reduction 2015-2030 was adopted at the third United Nations World Conference on Disaster Risk Reduction (WCDRR) in March, 2015. 187 participating states had promised to make the world a safer place through implementation of the new DRR framework in the coming 15 years. Four priorities for action include understanding disaster risk, strengthening disaster risk governance to manage disaster risk, investigating in disaster risk reduction (DRR) for resilience and enhancing disaster preparedness for effective response, and 'Build Back Better' in recovery, rehabilitation and reconstruction¹.

This article seeks actions Hong Kong could adopt to enhance disaster risk reduction strategies. Firstly, we suggest that disaster loss database and comprehensive risk assessment are essential to understand local disaster risk. Secondly, we emphasise a multi-sectoral approach in managing DRR as a solution to strengthen the existing mechanism. In the last section, we will highlight the importance of community engagement in mainstreaming DRR.

Understanding Local Disaster Risk

Historical events provide insights for planning and development. Collecting disaster loss data allows both policy makers and the community to understand the impact of disasters. Back in the early 80s, international society realised the need of disaster loss data collection, different sectors including governments, research institutes and reinsurance companies started to collect disaster loss data which assisted the planning of disaster prevention and response. Two major issues were identified from the current disaster loss data. First, there are currently no single authoritative disaster loss databases that could provide loss data for all sectors. Secondly, there are scarce subnational disaster loss data for local governments where planning is needed the most.

Currently, there are three global multi-peril databases well known to the DRR community. They are the Emergency Events Database EM-DAT, NatCatSERVICE and Stigma. Definition of disasters and loss data varies based on the purpose being served. EM-DAT, developed by the Centre for Research and the Epidemiology of Disasters (CRED) at Louvain University² mainly captures human loss, including casualties and deaths based on natural and technological disastrous events.

EM-DAT is especially important for disaster relief and recovery planning while reinsurance companies develop catastrophes databases e.g. NatCatSERVICE and Stigma. By collecting and analysing disaster loss data, they enable the companies to assess insurance risks and facilitate risk management³. These databases provide detailed economic losses for the insured and uninsured properties attributable to catastrophic events. The different interpretations of disaster and the related loss made the data difficult to be integrated. This poses a great challenge for DRR policy making.

Another issue concerning the existing global databases is that most of them only provide a national resolution of historical loss data. These global databases provide a basis for DRR strategies. However, they fail to cater to the needs of policy makers e.g. Hong Kong, to develop an appropriate disaster management plan. In recent years, governments of some disaster-prone countries such as Indonesia and Sri Lanka had set up country-customised disaster loss databases to facilitate the policy makers to make informed decisions⁴. A national or subnational disaster loss database with the objective to review both the direct and indirect impacts of disasters in society might be a solution to fill the current gap.

Disaster loss might not necessarily reflect the disaster risk of the community. For instance, from 1900 to 2009 in Haiti, earthquakes killed less than 10 people in the country, while in 2010, one single earthquake had caused more than 200,000 fatalities⁵. Therefore, it may be misleading to measure the disaster risk by previous loss data while not taking into account of hazards, exposure and vulnerability.

Disaster risk is the probability of hazards causing damage to a society. The degree of damage depends on the characteristics and likelihood of different hazards; human, system and economic exposure; and the susceptibility of assets loss caused by the hazards. Disaster risk assessment is the understanding of the interaction among these three components. It is undoubtable that the hazard, exposure and vulnerability is shifting. Climate change impacts greatly on the risk. It is predicted that the maximum wind speed of tropical cyclones will increase in the coming 50 years⁶. It implies that coastal metropolitan cities such as Hong Kong will face a greater risk of metrological hazards. The 2015 Global Assessment Report on Disaster Risk Reduction estimated that the tropical cyclone annual average loss (AAL) of Hong Kong was 1.5% of the city's capital investment annually, which ranked 6th globally (excluding small island developing states). Apart from



climate change, other social factors such as unplanned urbanisation and an ageing population also affect the disaster risk of Hong Kong.

A systematic, localised risk assessment evaluating both potential short and long term human and economic loss would be needed to facilitate Hong Kong policy makers and related stakeholders to identify priorities in DRR. The disaster risk assessment would also be able to provide insights on how to integrate DRR into existing systems and cultural context.

Enhancing Disaster Risk Management (DRM) through Multi-sectorial Involvement in Hong Kong

Besides understanding local disaster risks, an inclusive environment is vital for successful DRR. DRM involves coordination among public authorities, civil servants, media, private sector and civil society⁷. A good DRM ensures the community to have sufficient resources as well as capacity to mitigate, prepare, respond and recover from disasters. There is no single recipe available for a good DRM. Each country should have a unique DRM approach based on the local disaster risks, political economic factors and relationship of stakeholders.

DRM in Hong Kong is mostly government-centred. The Hong Kong SAR Government (HKSARG) plays a central role in coordinating disaster preparation, response, recovery, and the mitigation process. Disaster response planning has been a major focus of HKSARG. A three tier emergency response system, 5 contingency plans with defined roles and responsibilities of different stakeholders are in place⁸. The Security Bureau (SB) leads the development of disaster plans and coordination of crisis and emergency management. The Hong Kong Observatory (HKO) and Information Services Department are responsible for information dissemination, HKO is particularly responsible for issuing early warnings of natural hazards like tropical cyclone and rainstorms. The Hong Kong Police Force and Fire Services Department are involved in emergency and disaster response. Other departments such as the Social Welfare Department, Drainage Services Department (DSD) and Civil Engineering and Development Department (CEED) would be involved in the recovery process based on the needs and nature of the disaster⁹. A range of auxiliary services groups, non-governmental organisations in the response system will come in according to the needs in the disaster response and recovery phase⁸. For risk mitigation, CEED and DSD take the lead to mitigate natural hazards such as landslides and flooding through implementation of safety standards and regular maintenance^{10,11}.

The government-centred approach enables implementation of DRR to be consistent and coherent. Centralised management is particularly effective when disaster strikes as to ensure coordination of effective and rapid response. With limited stakeholder and community involvement, DRM faces challenges to create an enabling environment to mobilise the community and other key stakeholders in disaster risk mitigation and preparedness activities¹².

Various countries acknowledged the limitation of government-centred approach and attempted different means to create opportunities for multi-stakeholders participation in managing disaster risks. The Philippines adopted a community-led approach where NGOs and civil society were formally involved in DRM activities, for instance, NGOs comprised 20% of the members of local development councils¹³ while some municipalities in Japan tried to adopt a more inclusive management style through subsidising grassroots NGOs and providing guidelines for community disaster risk reduction activities. Corpus Christi city in Texas, the United States, attempted to decentralise DRM responsibilities to different stakeholders in the society by using a partnership approach to financing local-level risk reduction measures¹⁴. A platform drawing multi-stakeholders together for DRM enhanced the comprehensiveness of the existing disaster management mechanism while at the same time empowered different stakeholders. The private sector, health care industries and research institutes should share the responsibility of DRM with the government¹⁵.

Community Engagement: Mainstreaming Disaster Risk Reduction

To facilitate the integration of DRR in social development, the concept of community engagement should be embedded in every stage in DRR. In Hong Kong, a mechanism is in place to allow the community to participate in the disaster response process through joining auxiliary services such as the Auxiliary Medical Service and Civil Aid Service. Members of these auxiliary service teams receive disaster and emergency response trainings and will be deployed to the field during disasters when HKSARG so requests^{16,17}. Apart from disaster response, more opportunities could be created to engage the community in other aspects of DRR, such as risk mitigation.

Community engagement can be seen as a collective behavioural change process. The Theory of Planned Behaviour articulated that behavioural change intention is affected by¹⁸,

- i. subjective norms,
- ii. perceived behavioural control,
- iii. behavioural attitude

Figure 1 illustration on how community engagement in DRR can be achieved through changing an individual's perceptions. Raising the disaster risk awareness is the first step of community engagement. Awareness raising campaigns aim to provide community a chance to reflect on the current disaster management in Hong Kong and the individual's perception of Hong Kong disaster risk and self-management (subjective norms & attitude). It involves enhancing disaster related knowledge, being aware of local disaster risks and in relating to daily life, it aims to facilitate a change in attitude of disaster management and encourage community involvement. Saijo City in Japan demonstrated how to engage different community groups in risk awareness raising through 'Mountain-watching' and 'Town-watching' programmes for school children to enhance local relationship and risk awareness¹⁹. Public

health interventions, e.g. hand hygiene promotion and breastfeeding, provided evidence that no single campaign could achieve awareness raising. It is a process that requires multi-methods in order to achieve an effective attitude change across the community. Awareness raising alone could not create a behavioural intention (an intention to be proactively involved in DRM). Knowledge sharing and skill-based training are essential to enhance one's perception on behavioural control.

It is foremost important to recognise that changes in behavioural intention is the synergy of the above three components. Community engagement in DRR is a prolonged process. It requires the strong commitment from both the government and related parties.

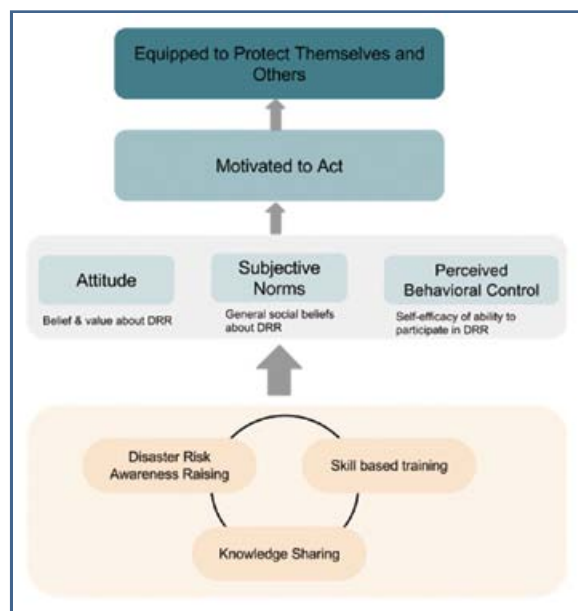


Figure 1. The Theory of Planned Behaviour in Disaster Risk Reduction

Conclusion

An effective DRM ensures a sustainable development of a society. Understanding how disasters have affected a community in the past and assessing current disaster risks help policy makers to set local DRR priorities. At the same time, an inclusive management approach creates an enabling environment for different sectors to participate in setting policy setting and to take up DRR responsibilities. Nevertheless, community engagement should not be neglected in mainstreaming DRR, such engagement is a behavioural change process. It involves attitude changes, knowledge sharing, and skill-based trainings. We believe that making our city a safer place is the mutual goal of every member in the society. Successful and sustainable DRR is a collective effort made by government, every sector and every member in the society.

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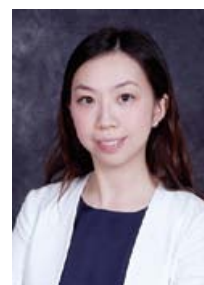


Mental Health and Psychosocial Support in Disasters

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Recent major global disasters and emergencies such as the Ebola outbreak in West Africa, the on-going crisis in Syria, Typhoon Haiyan, and the 2011 Japan earthquake-Tsunami-nuclear crisis have repeatedly demonstrated how disasters might cause significant impact on human lives by bringing multiple losses, destruction, grief, and death.¹⁻⁵ The impact on mental and psychosocial well-being is one of the major consequences in disasters and critical incidents. If people's psychosocial needs are not addressed, even if we can provide blankets, food, water, medicine or shelter to the affected people, we are not bringing them other essentials to safeguard their quality of life, such as sleep, appetite, health, nor a home.

Impact on Survivors

A number of systematic reviews and meta-analyses have well demonstrated the severity of burden associated with mental and psychosocial outcomes of disasters. In general, psychological impact of disasters is usually assessed by the prevalence of post-traumatic stress disorder (PTSD), depression and various types of anxiety disorders in affected areas. According to a systematic review published in 2008, the prevalence of PTSD among direct disaster survivors generally ranged from 30% to 40%, compared to the 5% to 10% range found in the general population.⁶ For example, two months after the 2004 South Asian Tsunami, displaced populations were reported to have rates of symptoms of PTSD at 12%, anxiety at 37%, and depression at 30%.⁷ Three months after the Yushu China earthquake that registered at a Richter Scale of 7.1 in 2010, the prevalence rates of PTSD, anxiety, and depression were 33.7%, 43.8% and 38.6%, respectively.⁸ Responding to the psychological needs among survivors has become an indispensable part of the entire disaster response.

Impact on First Responders

Apart from direct survivors in disaster, previously published research findings have shown that disaster responders also experienced various psychopathologies including post traumatic stress disorder and depression. Self-blame, survivor guilt and frustration were also reported. In the review of more than 60,000 disaster victims from 1981-2001, a usually neglected but alarming fact was highlighted: disaster responders, not just victims, also suffered from various mental detriments because of their duties. Although the prevalence of distress and disorders among responders, which ranged from 10% to 20%, was reported to be lower than direct victims, it was nevertheless higher

than that of the general population. One in every eight disaster responders developed severe to very severe impairment in mental well-being after their duties.⁹ For example, the prevalence of PTSD among firefighters responding to Hurricane Katrina was 22% two to three months after the disaster.¹⁰ The emotional burden among the first responders afflicted by such adverse situations should therefore not be overlooked.

Impact on Community Volunteers

Community volunteers, unlike their professional counterparts, engage in disasters mainly because of their availability on site. They might be the disaster survivors themselves, or people who voluntarily assisted due to an altruistic spirit and willingness to help in times of emergency. A systematic literature review of mental health impact of disasters among community volunteers and professional rescue personnel showed that community volunteers suffered from a higher degree of mental health complaints than that of professional responders and shared similar levels with direct survivors. The post-disaster PTSD prevalence of volunteers ranged from 24% to 46%.¹¹ Due to the ad hoc nature of disaster response, community responders often have much less training and less preparedness to support relief efforts when compared to professional responders. Additional support to this group of community volunteers is therefore crucial in protecting them from further harm and facilitating also their own recovery from the disaster.

Interventions to address Psychological Needs in Disaster

In order to cope with the surging mental health needs, models and tools of psychological interventions have been developed and used as a key component of the overall disaster response preparedness. In 1980s, Mitchell and Everly developed Critical Incident Stress Management (CISM), a comprehensive agency-based multi-component crisis intervention strategy.¹²⁻¹³ This intervention strategy had once been widely used as the model in managing post-disaster psychological needs. The goal of applying CISM was to prevent and mitigate crisis states and the subsequent development of more long-term psychopathologies, including acute stress disorder and post-traumatic stress disorder.¹³⁻¹⁴ Critical Incident Stress Debriefing (CISD), or "psychological debriefing" as described by other researchers, was the most commonly used component in CISM adopted

by community groups and was a 7-phase, structured group discussion, usually being provided hours or days after a traumatic event.¹⁵ It was designed to mitigate acute symptoms, assess the need for follow-up mental health service, and, if possible, provide a sense of post-crisis psychological closure. According to psychological debriefing, participants were encouraged to express and ventilate their emotions and thoughts about the trauma to facilitate reprocessing.

Since its advocacy, debriefing had been offered as a standard measure to address potential mental health needs in a wide variety of traumatic incidents, including policemen involved in shooting incidents, rape victims, road traffic accident survivors, rescue workers helping in natural disasters, and sailors involved in maritime collisions.¹⁶ Although debriefing had been widely applied, with the majority of debriefed survivors having described the experience of debriefing as helpful, no convincing evidence was found in its ability to reduce the incidence of post-traumatic stress disorder. Two meta-analyses found that single session debriefing to intervention groups neither prevented the onset of PTSD nor reduced psychological distress when compared to control groups.¹⁶⁻¹⁷ Some even reported that debriefing may “impede natural recovery from trauma”.¹⁸ Two randomised controlled trials of CIST with longest follow-ups of 13 months and 3 years respectively further reported a higher incidence of negative outcomes in those who received CIST compared with those who did not receive an intervention.¹⁹⁻²⁰ As a result, the National Institute for Clinical Excellence (NICE) guidelines suggested that “single-session debriefing is not recommended”.²¹

Mental Health and Psychosocial Support in Emergency

In its executive board meeting in 2005, World Health Organization (WHO) called for action in implementing programmes, including availability of community volunteers, provision of nonintrusive emotional support, psychoeducation, and encouraging pre-existing positive ways of coping, that can repair the psychological damage of war, conflict and natural disasters.²²⁻²³ The Interagency Standing Committee (IASC) issued an important document to provide guidance for humanitarian actions to plan and execute Mental Health and Psychosocial Support (MHPSS) in emergency settings in 2007. According to the document, the term MHPSS, defined as “any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder”, addresses the pre-existing, emergency-induced and humanitarian aid-induced mental health and psychosocial problems in times of extreme stress.²⁴ This composite term represents the integrative way to address the public mental health needs arisen throughout the various phases in the disaster management cycle of disaster prevention, disaster preparedness, emergency response, and rehabilitation and recovery.²⁵ MHPSS is composed of interventions which are two-folded in that they address both psychological and social needs at the same time. Multi-layered support is important to address the needs of different groups of beneficiaries and an intervention pyramid delineates this concept clearly (see Figure 1). In

principle, higher layers in the pyramid represent more specialised services, which are required by a smaller population among the affected community.



Figure 1. Intervention pyramid for mental health and psychosocial support in emergencies. Adapted from “IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings,” by Inter-Agency Standing Committee (IASC, 2007), Geneva: IASC, p.13.

The first layer, “basic services and security”, addresses the basic physical needs of the beneficiaries in terms of water, sanitation, food, shelter, and health care. It also highlights the importance of the protection of the dignity of beneficiaries and promotion of mental health and psychosocial well-being. The second layer is concerned with the facilitation of population’s access to obtain support from their communities and families. Responses like family reunion, parenting programmes and livelihood activities, for example, are interventions that may enhance the support networks in order to promote mental and psychosocial well-being. The third layer is the support for those who need more focused interventions by trained helpers. Psychological first aid and provision of basic mental health care by primary health care workers fall under this level of non-specialised focused attention and support. The top layer illustrates the specialised care for a small proportion of the population who develops significant distress which impacts their daily functioning. Psychological and psychiatric interventions will be provided by psychologists and psychiatrists when the existing primary health service is not able to address the specialised mental health service needs.

Psychological First Aid

Psychological first aid is listed as one of the major strategies in a comprehensive MHPSS programme. The American Psychiatric Association first defined and referred a range of acute mental health interventions post disaster as “Psychological First Aid” and argued that all disaster workers need to familiarise themselves with the common psychological reactions and ways to address the needs.²⁶ A number of agencies continued to echo the “first-aid” idea of psychosocial intervention in times of emergency.²⁷⁻²⁹

According to the IASC, PFA is a basic form of support to be given to people undergoing acute psychological distress and “can easily be taught to workers who have no previous training in mental health”.²⁴ PFA aims at reducing psychological distress right after the disaster and facilitating long-term adaptive coping. PFA generally consists of a group of skills identified



to provide active listening, assist people to cope with stressful and traumatic events in life, provide practice support, ensure safety, and foster social support and linkages with community resources. Apart from providing PFA to direct survivors of disaster, PFA is also highlighted as one of the essential trainings for aid workers so that they can provide peer support to each other while working under a stressful environment as well as in critical incidents.²⁴

Basic action principles of PFA can be summarised by the acronym A-B-C-D-E:³⁰

1. Assess for safety and comfort and ask the person's urgent needs and concerns;
2. Be attentive, aware and respectful so to know yourself well;
3. Comfort though helping people to cope and through good communication;
4. Do problem solving and link people with their support;
5. End / Exit Strategy.

PFA is an evidence-informed approach which development was based on five underlying principles - hope, calming, safety, connectedness, and self-efficacy & community efficacy - all of which have been demonstrated to be related to short-term adjustment and long-term recovery of affected people in crises.³¹ It is a concept similar to physical first aid, and can be used during or immediately after disaster. People without mental health specialised training, such as public health practitioners, responders in disasters, military personnel and community volunteers, can learn and apply psychological first aid to people in need in emergencies.

Various agencies have developed protocols of PFA, including the WHO, War Trauma Foundation & World Vision International, the National Child Traumatic Stress Network and National Center for PTSD, and the International Federation of Red Cross and Red Crescent Societies.³²⁻³⁴ *The Psychological first aid: Guide for field workers* published by WHO and partner organisations has been translated into at least 15 different languages, including Chinese¹, and is one of the most widely translated and distributed versions of PFA for now.³² Specific PFA guide in response to different disaster settings, for example the provisional Psychological First Aid (PFA) guide (adapted for the Ebola context) that was published by the WHO and partner organisations, was the product of consolidating experiences from the lessons learnt in the field.³⁵

Conclusion

Despite its tragic nature, emergencies also provide us with chances and opportunities to further develop a longer term, community-based mental health and psychosocial support system for all people in need, even during peace time. Good examples of grasping the momentum of change to build capacity of health systems in addressing mental health issues post disaster have been captured in the WHO *Building Back Better* document.³⁶

In this article, disaster impact on psychosocial well-being among direct survivors, first responders, and community volunteers has been discussed. Given the background of development of various psychological interventions, psychological first aid has been regarded as the state of the art in responding to the psychological needs of people affected. It is recommended to all disaster responders to learn about MHPSS, more specifically the skills and techniques of Psychological First Aid, by reading the protocols and attending relevant trainings, to equip ourselves with the effective support to people affected in disasters, including the fellow responders. To conclude, mental health and psychosocial support is not a luxury but a necessity in disaster response and we should not overlook the importance of mental and social well-being of people affected.

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The Hong Kong College of Paediatricians (HKCPaed) and the Royal College of Paediatrics and Child Health (RCPCH) will be holding a Joint Diploma in Child Health Clinical Examination in Hong Kong in October 2015, awarding DCH (HK) and DCH (International) to successful candidates.

The DCH Clinical Examination will be held on **29th October 2015 (Thursday)**.

The DCH Clinical Examination is open to registered medical practitioners in Hong Kong. Candidates who have already successfully passed the DCH written examination, namely Part 1A since January 2004 or Foundation of Practice since February 2013, are eligible to apply. In addition, candidates who passed the Part 1A examination in May 2005 or thereafter should have at least 6 months of Paediatric practice (resident medical officer or intern within 5 years prior to the date of the DCH Clinical Examination) in a recognized institution with acute hospital admissions. There are no exemptions from the Part 1A or Foundation of Practice examination.

The DCH Syllabus, which has been introduced since November 2009, will serve as the basis for assessments for the DCH Clinical Examination to be held in Hong Kong in October 2015. The Syllabus is available for viewing at the following link on the RCPCH Website:

<http://www.rcpch.ac.uk/training-examinations-professional-development/assessment-and-examinations/examinations/clinical-e-3#DCHSyllabus>

Application:

Candidates who wish to sit the DCH Clinical Examination in Hong Kong **MUST** apply through the Hong Kong College of Paediatricians. Application form, details of application and the format of examination can be found on the HKCPaed website at http://www.paediatrician.org.hk/index.php?option=com_content&view=article&id=45&Itemid=46. Examination Fee is HK\$ 8,500. Available places are limited and will be allocated on a 'first come first served' basis.

Opening date: 22 June 2015

Closing date: 22 July 2015



My Walking Meditation

Dr Chi-biu LO

Consultant, Accident and Emergency Department, North District Hospital



Dr Chi-biu LO

I started regular hiking in Hong Kong since the 70's after I participated in a youth leadership camp (more commonly known as the 'Army Camp' at the time). Hiking is such an activity that one can get a little more serious by having more preparation, such as attaining map reading skill, orienteering skill and planning, especially towards bad weather. In fact hiking, walking, trekking or whatever you wish to call it, with a light daypack is entirely different from hiking with a 10-15 Kg backpack with all your utilities in it for eight hours. Other than the fresh air, the sun and the scene, the feeling of distancing from the crowd, from the busy traffic, from the noise and from the dust is my way of unwinding from work pressure. In Mother Nature's arm, I can feel how minute a single human being is, so why should my relations with other people be so tense. Despite the physical stress, the mind is relaxed. Some people do meditation by sitting in a quiet place. I do meditation through walking – walking meditation.

But Hong Kong is such a small place. I had covered most of the trails in Hong Kong after a number of years. I started to trek abroad in 2001. The first attempt was Mount Kinabalu in Malaysia with my son. The Low's Peak is only 4,095 m tall, but it was quite a challenge for us as a first attempt for heights. We were driven to the National Park entrance (Timpohon Gate, 1,866 m) from the hotel at the seafront, walked to Laban Rata at 3,272 m (the mountain hut where we stayed the evening), arriving there at about 7-8 hours after we left the hotel. After a short sleep we climbed again at 2 am in the morning. When we stepped out of the hut we were astounded by the view of the sky that was completely flooded with stars we had never seen before other than in the Space Museum. The stars were so close to us and we actually saw the Milky Way Galaxy with our naked eyes. We summited the Peak at round 6 am, just around 20 hours after we left the hotel, allowing no time for acclimatisation at all. The route from Timpohon Gate to Laban Rata was not particularly scenic, as mostly we walked through the forest, but the section above the hut, in particular the view from the Low's Peak was really spectacular. I went back to the Low's Peak with my wife about 6 months later.



Fig. 1 The South Peak from the Low's Peak in Mount Kinabalu, Malaysia

Nepal is one of the places I had trekked for a number of times. My experience of trekking in Nepal was very different from trekking in some other countries. It had purification effects on my mind. In 2002, my wife and I trekked to the Annapurna Basecamp (ABC) in Nepal. The whole trip took about two weeks. We each lost about 3-4 Kg afterwards as food supplied en route was not particularly plentiful nor to the favour of an ordinary 'Hongkonger'. Trekking in Nepal is not difficult, even for those not regularly engaged in sports. If you are able to bear the cold, the altitude, the ultra-rustic accommodation, the very basic food, the 'primitive' toilets, the 'modified' way of taking showers, with a little training before taking the trip, trekking in Nepal is a very enjoyable experience. The treks actually consist of walk paths connecting villages. You don't have to carry much loads on your back, there are porters who carry everything you don't want to carry, including an occasional client who happens to get injured. The trekking guide will plan your schedule to reduce the likelihood of high altitude sickness. We usually got up at around 6 am in the morning, took breakfast at around 7 am, started walking at around 8 am, we mostly chose not to spend time for lunch (which could easily take 2 extra hours) so that we could arrive at the teahouse^β to stay the night at around 3 pm. The afternoon tea would serve as a replacement for the omitted lunch. Then it came to shower time. The teahouses used solar energy to heat up water in tanks for customers, whether there was enough hot water for your turn of the shower depended on how sunny the day was and how many persons had done their showers before you. There



were eight in our group, so we took turn to be the first to take shower (hot water most ensured) and whether there was still enough hot water at the 8th round would depend on luck. We usually had dinner at 6 pm and it would be bedtime by 8 pm. There was no TV, no radio, no mobile phone, no internet, no pager, and even for reading one needed to use a headlight. Every day the schedule and the food were much the same, but the scene differed significantly.



Fig. 2 A typical teahouse in Nepal treks

I had to walk slowly due to the scene, the altitude, the ascent and the breathlessness that came with it. It was like meditation, I attended only to breathing, the path and the scene. Each step purified the mind and the spirit bit by bit. Thoughts about work and other things in Hong Kong did flow through the mind, but they appeared far less bothering. We walked through terrace rice fields, villages, streams and hanging bridges. We saw poultry kept by villagers running on ground, we saw young children walking from one village to the next to attend school and we saw yaks and donkeys carrying loads. For a city dweller these served as a call that life could be very simple and basic. Both my wife and myself had a strong feeling that the modern life we led flooded with gadgets and electronic devices could be simplified for at least a bit and we could be happier. We saw young children hopping on rocks as they played (that by Hong Kong standard should already be forbidden or aroused the suspicion of child abuse), they had very simple toys and would get happy with very small things, and a piece of candy would brighten up a day. People we came across were in general polite, modest and honest. A simple 'Namaste' served as a greeting as well as a blessing. When we left the country, we both had a hunch that we left a link there and we could go back to Nepal some time later.



Fig. 3 The Annapurna at sunrise



Fig. 4 Terrace Rice Fields



Fig. 5 Donkeys carrying loads

I did the Lantang trek myself in 2007. In the same year my wife and I did the Everest Base Camp (EBC) trek and we got up to Kala Patthar (5,545m). In 2009 we did the Annapurna Circuit trek through the Thorung La Pass (5,416m). Each time, the call for 'simplicity' came to us again. Each time, the trip purified our minds and we felt totally refreshed when returning to Hong Kong.



Fig. 6 View of the Langtang Valley



Fig. 7 View along the EBC trek



Fig. 8 View of the Sagarmāthā (सगरमाथा अञ्चल, 珠穆朗瑪峰, Zhūmùlǎngmǎ Fēng, Qomolangma, Mount Everest) from Kala Patthar at sunrise



Fig. 9 Heading towards the Thorung La Pass

The 7.8 M_w earthquake in Nepal was really a devastating trauma to the country. Other than the vast number of deaths, casualties and property lost, I felt so sorry to know that some of the places I had trekked before, such as the Langtang Village, were totally wiped out. God knows when the treks are good for use and attract income from tourism to this poor country again, the mitigation phase this country faces is equally, if not more difficult than the responding phase, as rebuilding with stronger establishment needs immense financial support. Other than offering donations, I wish this country could recover soon and to a better state than before.

^β Teahouse refers to the simple accommodation available in Nepal trek which also offers meals.

Dermatological Quiz



Dermatological Quiz

Dr Chi-keung KWAN

MBBS(HK), MRCP(UK), FHKCP, FHKAM(Medicine)
Specialist in Dermatology and Venereology



Dr Chi-keung KWAN



Fig. 1: hyperkeratotic mass protruding from left middle finger

This 67-year-old gentleman complained of a relative rapidly growing mass protruding out from his left middle finger for around 6 months. He did not remember any history of injury or precipitating cause. The lesion was asymptomatic without any itch or pain. It was around 3mm in diameter and the surface was smooth and hard but not warty (Fig. 1). There was no ulcer or erosion on the mass.

Questions:

1. What is the diagnosis of his skin lesion?
2. What are the underlying causes?
3. How do you treat this patient?

(See P.36 for answers)

Certificate Course on Respiratory Medicine 2015



Jointly organised by



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



Hong Kong
Thoracic Society
香港胸肺學會



CHEST
Chinese Health Education Society
for Thoracic Health

Objectives:

To enhance understanding and update the practical management of common respiratory disorders. Practical aspects of non-invasive ventilation, inhaler and oxygen therapy are also included.

Date	Topics	Speakers
9 Sep	Non-invasive ventilation in hospital and home setting	Dr. Chung-ming CHU Consultant (Medicine) United Christian Hospital
16 Sep	Influenza and pneumonia – epidemiology, diagnosis and treatment	Dr. Loletta SO Consultant (Medicine) Pamela Youde Nethersole Eastern Hospital
23 Sep	Management of pneumothorax and pleural diseases	Dr. Johnny CHAN Consultant (Medicine) Queen Elizabeth Hospital
30 Sep	Pharmacotherapy and pulmonary rehabilitation for COPD	Dr. Chi-fong WONG Consultant (Respiratory Medicine) Grantham Hospital
7 Oct	Inhaler therapy: from science to practical aspects	Mr. Wilson LEUNG Senior Pharmacist Queen Elizabeth Hospital
	Principles and practice of oxygen therapy	Dr. Kah-lin CHOO Consultant (Medicine) North District Hospital
14 Oct	Diagnostic approach and advances in treatment of lung cancer	Dr. David LAM Clinical Assistant Professor The University of Hong Kong

Date : 9 September 2015 - 14 October 2015 (Every Wednesday)

Time : 7:00 p.m. – 8:30 p.m.

Venue : Lecture Hall, 4/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong

Language Media : Cantonese (Supplemented with English)

Course Fee : HK\$750 (6 sessions)

Certificate : Awarded to participants with a minimum attendance of 70%

Enquiry : The Secretariat of The Federation of Medical Societies of Hong Kong

Tel.: 2527 8898

Fax: 2865 0345

Email: info@fmshk.org

CME / CNE / CPD Accreditation in application

Application form can be downloaded from website: <http://www.fmshk.org>



Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<p>★ Annual Scientific Meeting and Workshop 2015</p> <p>5</p>	<p>6</p>	<p>★ Medical Teleconference Programme (Neonatology)</p> <p>★ HKMA YTM Community Network - Certificate Course 3) – (1) Musculoskeletal Ultrasound as a Point of Care for Diagnosing and Managing Common Musculoskeletal and Sports Injuries; (2) Fundamentals of Sports and Exercise Nutrition</p> <p>★ HKMA Council Meeting</p> <p>★ FMSHK Officers' Meeting</p> <p>7</p>	<p>★ Hong Kong Neurosurgical Society Monthly Academic Meeting – Brain compliance in Hydrocephalus</p> <p>★ HKMA Central, Western & Southern Community Network - Management of Emergency Conditions in Office Setting</p> <p>8</p>	<p>★ Paediatric Infectious Disease and Immunology Course 2015, Evidence-Based Immunology</p> <p>★ HKMA Hong Kong East Community Network - Update on Management of Fatty Liver Disease</p> <p>★ HKMA New Territories West Community Network - 1. Updates on Drugs Related to PC12 Practical Tips in Managing Elderly Hypertension</p> <p>★ HKMA Structured CME Programme & HKMA Medical Search for the Responsible Bacteria - the Fast Way</p> <p>9</p>	<p>★ Joint Surgical Symposium - An Overview of Heart Transplant and the Hong Kong Experience</p> <p>3</p> <p>★ Paediatric Infectious Disease and Immunology Course 2015, Evidence-Based Paediatric Infectious Diseases and Immunology</p> <p>10</p> <p>★ The 8th Annual Scientific Meeting of the Hong Kong Society for Paediatric Immunology and Infectious Diseases</p> <p>11</p>	<p>★ Annual Scientific Meeting and Workshop 2015</p> <p>4</p> <p>★ Paediatric Immunology and Infectious Diseases Study Day (PID Study Day)</p> <p>★ The 8th Annual Scientific Meeting of the Hong Kong Society for Paediatric Immunology and Infectious Diseases</p> <p>11</p>
<p>★ Tseung Kwan O Dragon Boat Races</p> <p>12</p>	<p>13</p>	<p>★ HKMA Yau Tsim Mong Community Network - West Chinese Herpetosis</p> <p>★ HKMA New Territories West Community Network - Reference Framework for Preventive Care for Older Adults in Primary Care Settings</p> <p>1) Cardiovascular risk factors and mortality in rheumatoid arthritis; 2) Case presentation</p> <p>14</p>	<p>★ Annual General Meeting</p> <p>15</p>	<p>★ KECN-HKCP-UCH – Certificate Course for GPs 2015 (Session 3) – Acute Confusional State in Older Adults: Avoidable Causes</p> <p>★ FMSHK Executive Committee Meeting</p> <p>16</p>	<p>17</p>	<p>18</p>
<p>★ Medico-Legal Issues</p> <p>19</p>	<p>20</p>	<p>★ HKMA Kowloon West Community Network - The Journey to Optimize Type 2 Diabetes Therapy</p> <p>21</p>	<p>★ HKMA Central, Western & Southern Community Network - An Insulin-Independent Approach to Manage Patients with Type 2 Diabetes Mellitus</p> <p>22</p>	<p>★ HKMA Kowloon East Community Network - Dyslipidemia Management with Combination Therapy- Improve Outcomes Further?</p> <p>★ HKMA Hong Kong East Community Network - Management of Dyslipidemia: Do it Better in High Risk Patients!</p> <p>★ HKMA New Territories West Community Network - The Journey to Optimize Type 2 Diabetes Therapy</p> <p>★ FMSHK Foundation Meeting</p> <p>23</p>	<p>24</p>	<p>25</p>
<p>26</p>	<p>27</p>	<p>28</p>	<p>29</p>	<p>30</p>	<p>★ HKMA Yau Tsim Mong Community Network - Use of 3D Mammogram in Symptomatic Patients and Breast Cancer Screening - Principles and Scientific Evidence; Management of Common Breast Symptoms</p> <p>31</p>	



Date / Time	Function	Enquiry / Remarks
3 FRI 8:00 AM	Joint Surgical Symposium - An Overview of Development of Heart Transplant and the Hong Kong Experience Organisers: Department of Surgery of The University of Hong Kong & Hong Kong Sanatorium & Hospital; Chairman: Dr. Clement Shui-wah CHIU; Speakers: Dr. CHENG Lik-cheung and Dr. Cally Ka-lai HO; Venue: Hong Kong Sanatorium & Hospital	Department of Surgery, Hong Kong Sanatorium & Hospital Tel: 2835 8698 Fax: 2892 7511 1 CME Point
4 SAT (5)	Annual Scientific Meeting and Workshop 2015 Organiser: Hong Kong Institute of Musculoskeletal Medicine; Venue: Prince of Wales Hospital on 4 Jul, Clinic in Tsuen Wan on 5 Jul	Meeting Secretariat Tel: 2155 8557
7 TUE 8:00 AM	Medical Teleconference Programme (Neonatology) Organisers: Pamela Youde Nethersole Eastern Hospital & Stanford University School of Medicine; Venue: 1) Seminar Room 1, G/F, HKEC Training Centre, Multicentre Block B, Pamela Youde Nethersole Eastern Hospital 2) Seminar Room, 10/F, Block K, Queen Mary Hospital 3) Multifunction Room, G/F, Block D, Queen Elizabeth Hospital 4) Auditorium, G/F, Main Block, Tseung Kwan O Hospital 5) Seminar Room, 3/F, Block S, United Christian Hospital 6) Training Hall 1A, 1/F, Administrative Building, Kwong Wah Hospital 7) Meeting Room 2, G/F, Block A, Princess Margaret Hospital 8) Seminar Room, Department of Paediatrics, 6/F, Clinical Science Building, Prince of Wales Hospital 9) 6/F, Interview Room, Main Block, Tuen Mun Hospital 10) Room 1103, 11/F, Li Shu Pui Block, Hong Kong Sanatorium & Hospital 11) Training Room, 8/F, MIC, Union Hospital	Mr. KC Cheng (on site support) Tel: 6460 0654; Ms. Choi Sau Sau (PYNEH) Tel: 2595 6410 CME Point (Pending)
1:00 PM	HKMA YTM Community Network - Certificate Course on Sports Medicine (Session 3) - (1) Musculoskeletal Ultrasound as a Point of Care for Diagnosing and Managing Common Musculoskeletal and Sports Injuries; (2) Fundamentals of Sports and Exercise Nutrition Organiser: HKMA Yau Tsim Mong Community Network; Chairman: Dr. CHAN Wai Keung, Ricky; Speakers: Dr. LAM King Hei, Stanley and Ms. Sylvia LAM; Venue: Jade Ballroom, Level 2, Eaton, Hong Kong, 380 Nathan Road, Kowloon	Ms. Candice TONG Tel: 2527 8285
7:30 PM	HKMA Council Meeting Organiser: The Hong Kong Medical Association; Chairman: Dr. SHIH Tai Cho, Louis; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong	Ms. Christine WONG Tel: 2527 8285
8:00 PM	FMSHK Officers' Meeting Organiser: The Federation of Medical Societies of Hong Kong; Venue: Gallop, 2/F, Hong Kong Jockey Club Club House, Shan Kwong Road, Happy Valley, Hong Kong	Ms. Nancy CHAN Tel: 2527 8898
8 WED 7:30 AM	Hong Kong Neurosurgical Society Monthly Academic Meeting – Brain compliance in Hydrocephalus Organiser: Hong Kong Neurosurgical Society; Chairman: Dr. Larry WONG; Speaker: Dr. CHOW Kwan Ho; Venue: M Block Ground Floor Lecture Theatre, Queen Elizabeth Hospital	Dr. LEE Wing Yan, Michael Tel: 2595 6456 Fax: 2965 4061 1.5 CME Points
1:00 PM	HKMA Central, Western & Southern Community Network - Management of Emergency Conditions in Office Setting Organiser: HKMA Central, Western & Southern Community Network; Chairman: Dr. YIK Ping Yin; Speaker: Dr. WAN Kuang An, Ben; 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
9 THU 9:00 AM (10)	Paediatric Infectious Disease and Immunology Course 2015, Evidence-Based Paediatric Infectious Diseases and Immunology Organisers: Hospital Authority Infectious Disease Centre, Department of Paediatrics and Adolescent Medicine, Princess Margaret Hospital, Hospital Authority Infectious Disease Control Training Centre & The Hong Kong Society for Paediatric Immunology and Infectious Diseases; Chairman: Dr. Mike Kwan; Speakers: Prof. Stanley Plotkin (USA), Prof. David Isaacs (Australia), Prof. Bobby Gasper (UK), Prof. Li Min Huang (Taiwan) & Dr. Vas Novelli (UK) and a panel of local experts; Venue: Lecture Theatre, 7/F, Block H, Princess Margaret Hospital	Dr. Mike Kwan Tel: 2990 2872 Fax: 2990 2875 CME Point (Pending)
1:00 PM	HKMA Hong Kong East Community Network - Update on Management of Fatty Liver Disease Organiser: HKMA Hong Kong East Community Network; Chairman: Dr. LEUNG Kwan Kui, Terence; Speaker: Dr. SZE Wan Chee; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong	Ms. Candice TONG Tel: 2527 8285
1:00 PM	HKMA New Territories West Community Network - 1. Updates on Drugs Related to PCI 2. Practical Tips in Managing Elderly Hypertension Organiser: HKMA New Territories West Community Network; Chairman: Dr. TSUI Fung; Speakers: Dr. LEUNG Wai Suen, Albert and Dr. CHAN Chun Chung; Venue: Plentiful Delight Banquet (元朗喜尚嘉喜酒家), 1/F., Ho Shun Tai Building, 10 Sai Ching Street, Yuen Long	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
2:00 PM	HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2015 – Search for the Responsible Bacteria - the Fast Way Chairmen: Dr. CHENG Chi Man, Dr. HO Hung Kwong and Dr. WONG Bun Lap, Bernard; Venue: HKMA Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	Miss Sophia LAU Tel: 2527 8285
11 SAT 8:00 AM	Paediatric Immunology and Infectious Diseases Study Day (PIID Study Day) Organisers: Hong Kong College of Paediatricians & The Hong Kong Society for Paediatric Immunology and Infectious Diseases; Chairman: Dr. Pamela Lee; Speakers: Prof. Bobby Gasper & Subspecialty trainees of Paediatric Immunology and Infectious Diseases; Venue: Jade Room, 6/F, Marco Polo Hong Kong Hotel, Tsimshatsui	Dr. Mike Kwan Tel: 2990 2872 Fax: 2990 2875 CME Point (Pending)
12:30 PM	The 8th Annual Scientific Meeting of the Hong Kong Society for Paediatric Immunology and Infectious Diseases Organiser: The Hong Kong Society for Paediatric Immunology and Infectious Diseases; Chairman: Dr. Mike Kwan; Speakers: (Bill Marshall Memorial Lecture) Prof. Stanley Plotkin and (Ronald Levinsky Memorial Lecture) Prof. Bobby Gasper; Venue: Centenary Ballroom, The Marco Polo Hong Kong Hotel, Tsimshatsui	Dr. Mike Kwan Tel: 2990 2872 Fax: 2990 2875 CME Point (Pending)
12 SUN 9:00 AM	Tseung Kwan O Dragon Boat Races Organiser: The Hong Kong Medical Association; Chairman: Dr. YAM Chun Yin; Venue: 將軍澳東水道	Mr. Ian KWA Tel: 2527 8285
14 TUE 1:00 PM	HKMA Yau Tsim Mong Community Network - A Novel Way in Glucose Homeostasis – Insulin Independent Mechanism Organiser: HKMA Yau Tsim Mong Community Network; Chairman: Dr. FONG Chun Yan, Julian; Speaker: Dr. TSANG Man Wo; Venue: Pearl Ballroom, Level 2, Eaton, Hong Kong, 380 Nathan Road, Kowloon	Ms. Candice TONG Tel: 2527 8285



Date / Time	Function	Enquiry / Remarks
14 TUE	<p>1:00 PM HKMA New Territories West Community Network - Reference Framework for Preventive Care for Older Adults in Primary Care Settings Organiser: HKMA New Territories West Community Network and Primary Care Office of the Department of Health; Chairman: Dr. CHEUNG Kwok Wai, Alvin; Speaker: Dr. MOK Chun Keung, Francis; Venue: Plentiful Delight Banquet (元朗喜尚嘉喜酒家), 1/F., Ho Shun Tai Building, 10 Sai Ching Street, Yuen Long</p> <p>6:00 PM 1) Cardiovascular risk factors and mortality in rheumatoid arthritis; 2) Case presentation Organiser: The Hong Kong Society of Rheumatology; Chairman: Dr. KY Ma; Speaker: Dr. Yeung Wan Yin; Venue: Hospital Authority Headquarters, Room 205S</p>	<p>Miss Hana YEUNG Tel: 2527 8285 1 CME Point</p> <p>Dr. Lee Ka Lai Tel: 9229 4616 1 CME Point</p>
15 WED	<p>9:00 PM Annual General Meeting Organiser: The Hong Kong Medical Association; Chairman: Dr. LAM Tzit Yuen, David; Venue: HKMA Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central, Hong Kong</p>	<p>Ms. Christine WONG Tel: 2527 8285</p>
16 THU	<p>1:00 PM KECN-HKCFP-UCH – Certificate Course for GPs 2015 (Session 3) – Acute Confusional State in Older Adults: Avoidable Causes Organiser: HKMA Kowloon East Community Network & Hong Kong College of Family Physicians & United Christian Hospital; Chairmen: Dr. AU Ka Kui, Gary and Dr. LEUNG Man Fuk; Speaker: Dr. SHA Kwok Yiu, Edmund; Venue: V Cuisine, 6/F., Holiday Inn Express Hong Kong Kowloon East, 3 Tong Tak Street, Tseung Kwan O</p> <p>8:00 PM FMSHK Executive Committee Meeting Organiser: The Federation of Medical Societies of Hong Kong; Venue: Council Chamber, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong</p>	<p>Miss Hana YEUNG Tel: 2527 8285</p> <p>Ms. Nancy CHAN Tel: 2527 8898</p>
19 SUN	<p>2:00 PM Medico-Legal Issues Organiser: Hong Kong College of Paediatricians; Chairmen: Dr. Chan Hin Biu Bill and Dr. Cheung Kam Lau; Speakers: Prof. Fok Tai Fai, Dr. Dai Lok Kwan David and Prof. Lau Yu Lung; Venue: M Block, Ground Floor, Lecture Theatre, QEH</p>	<p>Ms. Lily Lin Tel: 2871 8752 Fax: 2785 1850 3 CME Points</p>
21 TUE	<p>1:00 PM HKMA Kowloon West Community Network - The Journey to Optimize Type 2 Diabetes Therapy Organiser: HKMA Kowloon West Community Network; Chairman: Dr. LEUNG Kin Nin, Kenneth; Speaker: Dr. TONG Chun Yip, Peter; Venue: Crystal Room I-III, 30/F., Panda Hotel, 3 Tsuen Wah Street, Tsuen Wan, N.T.</p>	<p>Miss Hana YEUNG Tel: 2527 8285 1 CME Point</p>
22 WED	<p>1:00 PM HKMA Central, Western & Southern Community Network - An Insulin-Independent Approach to Manage Patients with Type 2 Diabetes Mellitus Organiser: HKMA Central, Western & Southern Community Network; Chairman: Dr. LAW Yim Kwai; Speaker: Dr. MA Pui Shan; Venue: HKMA Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central, Hong Kong</p>	<p>Miss Hana YEUNG Tel: 2527 8285 1 CME Point</p>
23 THU	<p>1:00 PM HKMA Kowloon East Community Network - Dyslipidemia Management with Combination Therapy- Improve Outcomes Further? Organiser: HKMA Kowloon East Community Network; Chairman: Dr. MA Ping Kwan, Danny; Speaker: Dr. TSANG Man Wo; Venue: V Cuisine, 6/F, Holiday Inn Express Hong Kong Kowloon East, 3 Tong Tak Street, Tseung Kwan O, Sai Kung, N.T.</p> <p>1:00 PM HKMA Hong Kong East Community Network - Management of Dyslipidemia: Do it Better in High Risk Patients! Organiser: HKMA Hong Kong East Community Network; Chairman: Dr. LI Keung; Speaker: Dr. Norman CHAN; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong</p> <p>1:00 PM HKMA New Territories West Community Network - The Journey to Optimize Type 2 Diabetes Therapy Organiser: HKMA New Territories West Community Network; Speaker: Dr. CHAN Chun Chung; Venue: Pearl Ocean (金霞殿), 1/F., Gold Coast Yacht and Country Club (黄金海岸鄉村俱樂部-遊艇會), 1 Castle Peak Road, Castle Peak Bay, Hong Kong</p> <p>8:00 PM FMSHK Foundation Meeting Organiser: The Federation of Medical Societies of Hong Kong; Venue: Council Chamber, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong</p>	<p>Miss Hana YEUNG Tel: 2527 8285 1 CME Point</p> <p>Ms. Candice TONG Tel: 2527 8285</p> <p>Miss Hana YEUNG Tel: 2527 8285 1 CME Point</p> <p>Ms. Nancy CHAN Tel: 2527 8898</p>
31 FRI	<p>1:00 PM HKMA Yau Tsim Mong Community Network - Use of 3D Mammogram in Symptomatic Patients and Breast Cancer Screening - Principles and Scientific Evidence; Management of Common Breast Symptoms Organiser: HKMA Yau Tsim Mong Community Network; Chairman: Dr. LEE Wai Lun; Speakers: Dr. LUI Chun Ying and Dr. HUNG Wai Ka; Venue: Pearl Ballroom, Level 2, Eaton, Hong Kong, 380 Nathan Road, Kowloon</p>	<p>Ms. Candice TONG Tel: 2527 8285</p>

The Hong Kong Society of Paediatric Surgery

The Hong Kong Society of Paediatric Surgery is formed by a group of paediatric surgeons. The main objectives are to enhance the professionalism and competence of paediatric surgeons and child health related professionals and to consolidate comradeship.

The Society was inaugurated on 20th March 2015. We had the honour of having Dr Wing-man KO, Secretary for Food and Health, Dr the Honourable Ka-lau LEUNG, Legislative Councillor, Prof Prem PURI, President of the National Children's Research Centre of Ireland, Mr Alan DICKSON, Consultant Paediatric Urologist of the Royal Manchester Children's Hospital and many other distinguished guests to attend the meeting and ceremony.

Our council consists of Dr Kelvin K W LIU (President), Dr Peter Y H TAM (Vice-President), Dr Kenneth L Y CHUNG (Hon. Secretary), Dr Jennifer D Y SIHOE (Hon. Treasurer), and Dr Michael W Y LEUNG, Dr Edwin K W CHAN, Prof Kenneth K Y WONG and Dr Ivy H Y CHAN as Council Members.

Our Society is committed to provide a platform for promoting the highest ethical and clinical standard in paediatric surgery. A series of activities and educational meetings have been planned. A website will soon be developed to provide updated information regarding our society.



DCH (Diploma in Child Health Examination) Written Examination (MRCPCH Foundation of Practice) 2015

The Hong Kong College of Paediatricians (HKCPaed) and the Royal College of Paediatrics and Child Health (RCPCH) will hold a Joint Diploma in Child Health Examination in Hong Kong in 2015 awarding DCH (HK) and DCH (International) to successful candidates.

The DCH Examination is divided into two parts, written (MRCPCH Foundation of Practice (formerly known as Part IA) and clinical. The written examination is the same as the MRCPCH Foundation of Practice Examination, which is held three times a year in Hong Kong. The next DCH written examination will be held on **Tuesday, 6 October 2015**. The examination fee is **HK\$4,500** for Foundation of Practice. Candidates who wish to enter the examination must hold a recognized medical qualification in Hong Kong.

Application: Candidates **must apply online** using the RCPCH website via the **member sign in** area <https://www.rcpch.ac.uk/user>. In order to access the online application form, you need to be a registered user. If you do not have an RCPCH online account, you will be required to create one using the following link: <https://www.rcpch.ac.uk/user/signup>. Applications for all exams will open at 9.00am UK local time on the first day of the advertised application period and close at 4.30pm UK local time on the last day.

Please note that application is **NOT confirmed** until payment of examination fees is received **in Hong Kong**.

Candidates who wish to sit the examination in Hong Kong **MUST ALSO** submit paper application to the Hong Kong College of Paediatricians (HKCPaed) by completing Form B (Application for entry to the MRCPCH Foundation of Practice & Theory and Science Examinations-Overseas Centres). For application details, please visit the HKCPaed website at http://www.paediatrician.org.hk/index.php?option=com_content&view=article&id=45&Itemid=46 or call the College Secretariat at 28718871.

Application Period: 20 July 2015 (Monday) – 31 July 2015 (Friday)

Important Notice

Clinical Examination format for DCH from April 2011

Details of the DCH Clinical examination format and other relevant information can be viewed on the RCPCH website at:

<http://www.rcpch.ac.uk/training-examinations-professional-development/assessment-and-examinations/examinations/clinical-e-3>

Certificate Course on Sports Medicine and Emergencies

Title: Emergency Sports Medicine Files 運動醫學急症檔案

Jointly organised by



The Federation of Medical Societies of Hong Kong



Hong Kong Society for Emergency Medicine and Surgery

Objectives:

Sport Injury is a common presentation to the Emergency Department. Different sports have their own pattern of injury. In "Emergency Sports Medicine Files", type of injuries and emergency conditions from six popular sports will be discussed. You will learn specific sports related emergency situation, preventive measures and their emergency management in this course. This knowledge is essential for those engaged in these sports.

因運動損傷而到急症室求診是非常普遍。不同的運動會有自己獨特的受傷模式。在“急症運動醫學檔案”中，將討論六種時下流行運動的受傷種類及緊急情況。在這課程中您將學習到與該運動相關的具體緊急情況，預防措施和應急處理。這方面的知識是從事這些運動的人士所必需的。

Date	Topics	Speakers
4 Sep	File 1 : A Scuba Diver 活在水世界 - Diving related injuries and their management	Dr. Man-Kam HO FHKCEM 何文錦醫生 香港急症科醫學院院士
11 Sep	File 2: A Rugby Player 短兵相接 - Contact Sports related injuries and their management	Dr. Kenneth Wing-Cheung WU FHKCEM 胡永祥醫生 香港急症科醫學院院士
18 Sep	File 3: A Skier and Snowboarder 雪嶺雄峰 - Skiing related injuries and their management	Dr. Elvis Ying-Leung MAK FHKCEM 麥應良醫生 香港急症科醫學院院士
25 Sep	File 4: A Bicycle Rider 千里單騎 - Cycling related injuries and their management	Dr. Francis Yip-Kwong LAU FHKCOS 劉業光醫生 香港骨科醫學院院士
2 Oct	File 5: A Sudden Collapsed Field Player 球場上的最後戰士 - Medical Emergency in Sports, their recognition and management	Dr. Willis Wing-Hong KWOK FHKCEM 郭永康醫生 香港急症科醫學院院士
9 Oct	File 6: A Trail Walker and Marathon Runner 毅行耐走 - Endurance Sports injuries and their management	Dr. Kam-Leung LAW FHKCEM 羅金亮醫生 香港急症科醫學院院士

Dates : 4 September 2015 – 9 October 2015 (Every Friday)

Time : 7:00 pm – 8:30 pm

Venue : Lecture Hall, 4/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong

Language Media : Cantonese (Supplemented with English)

Course Fee : HK\$750 (6 sessions)

Certificate : Awarded to participants with a minimum attendance of 70%

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Answers to Dermatological Quiz

Answer:

- Cutaneous Horn**
The diagnosis is cutaneous horn. It is a clinical diagnosis only describing the morphology of the lesion that a hard cone-like mass projecting above the skin surface. The lesion is formed by accumulation of keratin in an elongated manner. It composes of variable acanthosis with hyperkeratosis and parakeratosis. It is commonly found in the sun-exposure areas such as face, nose, pinna, forearms and dorsum of hands.
- Sebacous keratosis, Actinic keratosis, Squamous cell carcinoma (SCC)**
Cutaneous horn is commonly arisen from benign lesions such as sebaceous keratosis, keratoacanthoma, hyperkeratotic actinic keratosis and wart. However, atypical keratinocytes may be found if the lesion is due to actinic keratosis and up to 20% of cutaneous horns may be arisen from in-situ or even invasive squamous cell carcinoma (SCC).
- Surgical Excision**
As mentioned, the lesion may have malignant potential especially underlying SCC and histopathological examination is necessary. Therefore, complete surgical excision is the mainstay of treatment. Other treatment modalities such as cryotherapy, electrocauterisation or surgical shaving alone may not completely cure the lesion because the base of the cutaneous horn, where the main pathology is located, may not be adequate treated.

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*Specialist in Dermatology and Venereology***The Federation of Medical Societies of Hong Kong**
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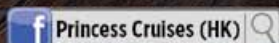
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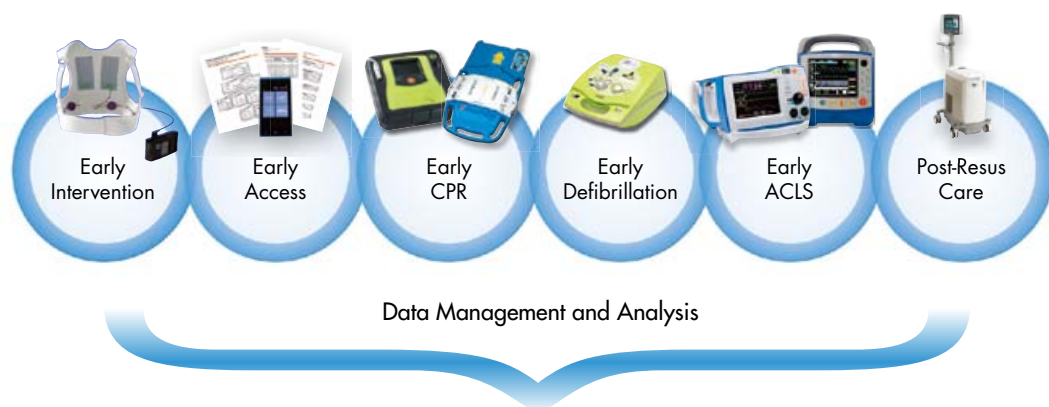


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