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Palliative Medicine

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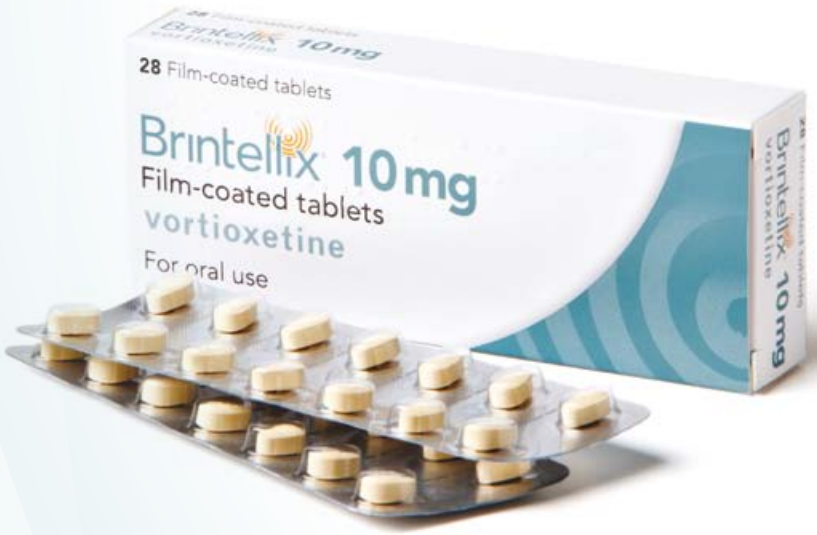

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The Cover Shot

Peach Blossom in Full Bloom
Botanical Garden in Beijing

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Editorial

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Editor

Dr Raymond SK LO

Palliative Medicine has come of age, and it is most timely to dedicate an issue of Medical Diary to this vital clinical specialty. Following the momentum of the Federation 50th Anniversary Scientific Meeting on care for advanced diseases, it is particularly worthwhile to pursue with the sharing of expertise from fellow colleagues on the science and art of palliation. We hope this issue can engage health care professionals from all specialties, as care for the dying transcends all fields of clinical care.

Since the establishment of Palliative Medicine as a specialty by Royal College of Physicians in United Kingdom in 1987, and the endorsement of palliative care approach by World Health Organisation in 1990, much progress has been made in the field locally in Hong Kong. While the care for advanced diseases has undoubtedly improved in recent years, much effort still needs to be devoted in the following four directions in future. Firstly, the internationally accepted notion of the specialty needs to be more broadly promoted: palliative care should be offered at any stage once an advanced incurable illness is diagnosed, if there is a need. Cure and care are not mutually exclusive. Secondly, the equity and access to palliative care have to be enhanced in hospital settings, both public and private, as well as in the community including residential care homes for elderly. Thirdly, professional training should be in place, not just on concepts of palliative approach, but also on wider aspects of humanity including life and death education for all health disciplines. Fourthly, the general public needs to be better informed on the positive benefits of palliative care, and on their options and rights to receiving such services.

As the United Kingdom Department of Health has stated in the National End of Life Care Strategy in 2008, how we care for the dying is an indicator of how we care for all sick and vulnerable people. It is a measure of society as a whole, and it is a litmus test for health and social care services. The Economist Intelligence Unit has conducted the first survey on countries across the world, and generated an international quality of death index in 2010. The survey explored stakeholders views on four indicators: quality of end-of-life care, availability of end-of-life care, basic end-of-life care health environment, and costs of care. Hong Kong ranked 20th on this international rating in 2010, with areas requiring improvement as follows: availability of hospices and palliative care services per million population aged 65 and over; number of hospices and palliative care provision, end-of-life care policy provision, and existence of government-led national palliative care strategy. The results of a second survey have just been published in October 2015, with ranking of Hong Kong now lower at 22nd. While the results of any such comparative studies of course need to be interpreted with caution, the survey did nonetheless help highlight aspects where improvement is likely to be needed locally. With the excellent health care services and guidance from our service leaders and policy makers, Hong Kong certainly has the vast potential to ascend on the ladder of quality care for our citizens at end of life. Patients and public are increasingly health literate, and the voices of the advocates need to be heard.

In this issue of Medical Diary, we are delighted to share with you articles on the key aspects of palliative care, in cancer and non- cancer conditions, in paediatric and elderly age groups, and advance care planning. We hope you will find this issue an interesting read, with a more insightful understanding of the specialty, as well as inspirations in help promoting palliative approach for better care at end of life.

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- To understand the concept of mediation, win-win and interest-based resolution
- To communicate better with patients, relatives and colleagues

Date	Topics	Speakers
5 Nov	Negotiation skills and empowerment	Mr. LAI Tsz Kin Jacky 黎子健 Barrister-at-law 大律師 Accredited Mediator 認可調解員
12 Nov	Reframing and facilitative skills	Dr. ONG Kim Lian 王金蓮 Consultant 顧問醫生 Accredited Mediator 認可調解員
19 Nov	Perception check, paraphrasing and summarizing skills	Dr. DAI Lok Kwan David 戴樂群 Consultant 顧問醫生 Accredited Mediator 認可調解員
26 Nov	Listening skills and use of body language	Prof. LAI Bo San Paul 賴寶山 Professor 教授 Accredited Mediator 認可調解員
3 Dec	Deadlock and impasse	Dr. CHAN Lap Wa 陳立華 Consultant 顧問醫生 Accredited Mediator 認可調解員
10 Dec	Mediation and healthcare	Dr. TSOI Chun Hing Ludwig 蔡振興 Senior Medical Officer 高級醫生 Accredited Mediator 認可調解員

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Contraindications: Patients with uncontrolled hypertension or known hypersensitivity to the active substance or to any of the excipients.

Warnings & Precautions: Evaluate iron status for all patients prior to and during treatment and administer supplementary iron therapy if necessary to ensure effective erythropoiesis. The most common reasons for incomplete response to ESAs are iron deficiency and inflammatory disorders. Consider diagnosis of Pure Red Cell Aplasia (PRCA) if all the possible causative factors excluded. Discontinue Mircera and do not switch to another ESA in case PRCA is diagnosed. PRCA caused by anti-erythropoietin antibodies has been reported in association with ESAs and these antibodies have been shown to cross-react with all ESAs. Epoetins are not approved in the management of anaemia associated with hepatitis C. In patients with chronic kidney disease, maintenance Hb concentration should not exceed the upper limit of the target haemoglobin concentration. Adequately control blood pressure in all patients before, at initiation of, and during treatment with Mircera. Consider dose reduction or withheld treatment if high blood pressure is difficult to control by drug treatment or dietary measures. As with all growth factors, there is a concern that ESAs could stimulate the growth of any type of malignancy. Caution in patients with haemoglobinopathies, seizures or with platelet levels > 500 x 109/l. Misuse of Mircera may lead to an excessive increase in Hb. This may be associated with life-threatening cardiovascular complications.

Drug Interactions: No interaction studies have been performed. Clinical results do not indicate any interaction of Mircera with other medicinal products.

Use in Pregnancy & Lactation: There are no adequate data on the use of Mircera in pregnant women and caution should be exercised when prescribing to pregnant women. It is unknown whether methoxy polyethylene glycol-epoetin beta is excreted in human breast milk. Risk-benefit ratio should be considered when use in nursing mothers.

Undesirable effects: *Common:* hypertension. *Uncommon:* vascular access thrombosis, headache. *Rare:* hypersensitivity, hypertensive encephalopathy, rash (maculo-papular, serious).

Date of preparation: June 2012

Full prescribing information should be viewed prior to prescribing.

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Palliative Care for Patients with Advanced Cancer: Principles and Practice

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The Origin of Palliative Care

Cicely Saunders, the pioneer of modern palliative care movement, observed the phenomenon of "total pain" through systematic attention to patient narratives in terminally ill patients and by listening carefully to stories of illness, disease and suffering. The concept of total pain moved beyond the physical to encompass the social, emotional and spiritual aspects of suffering. She also pioneered the research on the use of powerful analgesics regularly based on the conviction that "constant pain needs constant control". In 1967, she founded St Christopher's Hospice in South London, the first modern hospice combining excellent clinical care, education and research. This has inspired health care workers around the world to look for ways to relieve suffering of dying patients and palliative care continues to flourish in many parts of the world.[1]

In Hong Kong, the first palliative care team was piloted at Our Lady of Maryknoll Hospital in 1982. The first independent hospice, the Bradbury Hospice, was opened in 1992. In 1993, the Hospital Authority (HA) Hospice Care Service Development and Coordinating Committee described the philosophy, objectives, and scope of service, including inpatient care, day-care, home-care, outpatient care, and bereavement care policies.[2] Initially, most care is directed towards cancer patients. In recent years, services are developed for patients with non-cancer diseases as well. Today, there are sixteen services in HA that provide palliative care.

The Essence of Palliative Care

Palliative Care is "an approach that improves the quality of life of patients and families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment of pain and other problems, physical, psychosocial and spiritual." It provides relief from pain and other distressing symptoms, and integrates the psychological and spiritual aspects of patient care. In offers a support system to help patients live as actively as possible until death, and to help the family to cope during the patients' illness and in their bereavement process. It affirms life and regards dying as a normal process, intending neither to hasten nor to postpone death. It is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.[3]

Palliative care focuses on the person rather than the disease. It targets on the suffering experienced by whole persons, who have many aspects beyond the physical dimension. Suffering can be defined as "the state of severe distress associated with events that threaten the intactness of person", and a person perceives the threat of an advanced illness in his/her own way.[4] To diagnose suffering, clinicians need a high index of suspicion, and patients must be directly questioned on patients' subjective experience of suffering. It requires methods of empathic attentiveness and non-discursive thinking on the part of clinicians.[5]

The presence of an advanced illness already adversely affects a patient's quality of life after its diagnosis. In addition, with newer treatment like targeted therapy, newer chemotherapeutic agents and hormonal therapy, the disease courses of cancer have been prolonged for certain types of cancer. The old model that palliative care is instituted only after life-prolonging or curative treatment should be revised. A newer integrated model that both palliative care and life-prolonging care are provided throughout the course of disease should be adopted.[6]

Figure 1 : Integrated Palliative Care

The Multidimensional Needs of Advanced Cancer Patients: Physical, Psychological, Social and Spiritual

The quality of life of advanced cancer patients is determined to a large degree by the presence and intensity of the symptoms of their disease. In a systematic review including 50 studies on symptom prevalence, five symptoms including fatigue, pain, lack of energy, weakness and appetite loss occurred in more than 50% of patients with incurable cancer.[7] A local study showed that fatigue, cachexia and anorexia were the three most distressing symptoms in the last week of life of advanced cancer patients.[8] The progressive functional decline in the last few months of life adds to the suffering.

The physical burden of cancer is compounded by psychological distress. Advanced cancer patients grieve about their continual losses and fear about the multitude of uncertainty in their future. A meta-analysis revealed that approximately 30% of patients in palliative care settings experience some combination of depression, anxiety and/or adjustment disorder.[9] Such psychological morbidity not only adversely affects their quality of life but also predisposes their informal caregivers to a higher likelihood of psychiatric disorders.[10]

Both the patients and their families face a myriad of social adjustments. The change in roles in the family, social isolation, actual caregiving needs, and financial burden associated with loss of income and costs of medical treatment and caregiving all add to the burden to patients and families. The sense of burden perceived by patients adds to their psychological distress and suffering. In a Canadian study of 52 advanced cancer patients, 19% experienced a moderate to extreme level of self-perceived burden, while 48% of respondents reported it as their single most distressing social concern.[11] A local study found that 95.2% of primary informal caregivers of patients with terminal cancer in a hospice home service perceived difficulties in rendering care, and identified four main kinds of difficulties: relationship with the care receiver, emotional reactions to caring, physical demands, and restricted social life.[12]

Measures of spirituality and spiritual well-being correlate with quality of life in cancer patients, cancer survivors and caregivers. Studies exploring the spiritual concerns of palliative care patients have identified several domains which reflect their existential concerns: domain of identity / worth / dignity / value ("What is my place in the world?"); domain of hope ("What can I hope for?"); domain of meaning / purpose ("What is most important in life?"); and domain of relatedness / connectedness ("Who can I count on?").[13] Patients experiencing crisis in these domains may experience loss of dignity, hopelessness, meaninglessness, helplessness and loneliness, with a resultant poor quality of life.

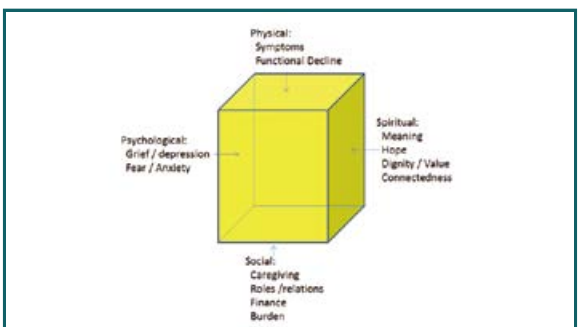

Figure 2 : The multidimensionality of quality of life

The Delivery of Palliative Care: Team work, Continuity of Care and Communication

The essential elements in the delivery of palliative care include an interdisciplinary team approach, coordinated services enhancing continuity of care, and truthful communication and advance care planning.

With the multidimensional nature of quality of life and suffering, a team of physicians, nurses, physical and occupational therapists, social workers and counsellors, psychologists, chaplains and volunteers in various combinations work closely together to support patients by symptom assessment and control, psychological and spiritual care, rehabilitation measures to enhance their functional state and daily living, provision of tangible resources and aid, and support to the family caregivers and the bereaved.

Continuity of care cannot be overemphasized. The provision of inpatient services, outpatient services, day care, home care, and bereavement services should ideally be coordinated under the care of the same team of health care professionals so that the needs of the patient and family are known and communicated across various sectors of the health care system.

An essential element of palliative care is communication. With the quality of life of patients and their families as the center of care, palliative care workers should understand their awareness of the diagnosis and prognosis, perception on the illness experience and suffering, goals and values, preferred place of care and dying, and preferences on life sustaining treatment. Advance care planning is the process of communication among patients with advanced progressive disease, their health care providers, their families, and important others regarding the kind of care that will be considered appropriate when the patient cannot make decisions. With a proactive communication process, the patients' quality of life will be enhanced by provision of care in line with their goals and values.

Effectiveness of Palliative Care

Have palliative care services fulfilled their mandate of improving patient's quality of life? A retrospective study involving 494 patients dying of cancer in four hospitals in Hong Kong revealed that patients who had received palliative care services and died in palliative care wards had fewer admissions to acute care wards and intensive care units, and shorter duration of stay in acute care units in the last six months of life compared with those who had not received any palliative care service. In the last two weeks of life, the former group had more symptoms documented, a higher likelihood to use analgesics, adjuvant analgesics, and sedatives, and fewer interventions initiated. The latter group had less "do-not-resuscitate" order documented and more died after a cardiopulmonary resuscitation. This study reflected that involvement of palliative care had an impact on optimum usage of health care resources appropriate to patients' needs, attention to symptoms and distress, and involvement of patients and families in advance care planning.[14]

A systematic review in 2008 on randomized controlled trials studying the impact of specialized palliative care on quality of life, satisfaction with care and economic costs consistently showed improvement in family satisfaction but mixed results on quality of life and cost saving. However, most studies are limited by methodological shortcomings and carefully planned trials are called for.[15]

Subsequent better designed studies have proven the effectiveness of palliative care in cancer care. A nurse-led, palliative care-focused intervention addressing physical, psychosocial, and care coordination provided concurrently with oncology care had higher scores on quality of life and mood compared with those receiving usual oncology care.[16] A landmark study on patients with metastatic non-small-cell lung cancer showed that patients who had early palliative care had better quality of life and mood, had less aggressive care at the end of life but a longer survival.[17] A cluster-randomized controlled trial comparing early palliative care interventions and standard oncology care showed a significant difference in quality of life, satisfaction with care and prevalence of severe symptoms at four months favoring the palliative care group. The palliative care interventions include coordinated outpatient care, inpatient care and home care and adopted a multidisciplinary approach, addressing physical, psychological, social and spiritual needs.[18]

The Future of Palliative Care

With evidence supporting the value of early specialty palliative care, there is a movement in the United States to call for early integration palliative care in oncology practice.[19] The European Declaration on Palliative Care 2014, grounded on evidence-based recommendations by two EU funded projects, calls upon policy and decision makers at regional, national and international level to adopt a public health approach on the delivery of and access to high quality palliative care, establish palliative care policies, promote basic palliative care skills for all health care professionals, promote public awareness through community level approaches, develop mechanisms to ensure access to specialist multidisciplinary palliative care services or teams, support inter-professional and multidisciplinary collaboration, and promote palliative care education and research.[20] The Global Atlas of Palliative Care at the End of Life describes palliative care provision at three levels: a "palliative care approach" adopted by all health care professionals, provided they are educated and skilled through appropriate training; "General palliative care" provided by primary care professionals and those treating patients with life threatening diseases, with a good basic knowledge of palliative care; and "Specialist palliative care" provided by the specialized teams for patients with complex problems.[21]

I envision oncologists and palliative care specialists "co-managing" patients with advanced cancer, with the primary oncology team providing the oncological treatment as well as assessing pain or other symptoms and inquiring about patients' understanding of their diseases and their goals of care, while specialty palliative care provides extra support by helping with more challenging symptom management, psychosocial support, complex decision-making, advance care planning, and transitions in care.

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Extending Palliative Care for Non-cancer Conditions

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Dr Alice Ka-wai MOK

Introduction

Hong Kong prides herself as being a place with one of the longest life expectancies in the world. It is anticipated that by 2030, more than 30% of the population will be over 65 years of age[1]. Chronic progressive diseases typically strike hardest at the older individuals. It can be anticipated that many of them will be living with multiple diseases. Medical advances have enabled patients with chronic diseases to live beyond what would have been impossible half a century ago. Over the past years, deaths from chronic diseases have consistently out-numbered that of cancers, with heart failure, chronic lung diseases, and chronic kidney diseases making up the majority of these non-cancer diseases[2]. It is therefore imperative that our medical plan should encompass the needs of those suffering and dying from advanced non-cancer diseases.

According to the World Health Organization[3], palliative care is "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems – physical, psychosocial, and spiritual". This philosophy of holistic care is by no means diagnosis specific, nor does it imply a limitation to any stage of a disease. A few decades have passed since the establishment of palliative care service in Hong Kong. Like in many places around the world, the traditional palliative care model focusing on the needs of cancer patients has begun its evolvement into the realm of non-cancer diseases.

Trajectory of disease – cancer vs. non-cancer

One of the greatest challenges to the provision of palliative care in non-cancer diseases is the unpredictable disease trajectories. Cancer patients are often able to sustain a period of good functional level when they may or may not be receiving oncological treatment. As the disease progresses or becomes refractory to treatment, these patients undergo an accelerated decline in the last weeks or months. This course of decline with the final death is relatively predictable.

Patients with chronic progressive diseases, on the other hand, can exhibit a roller-coaster pattern of clinical course that is far less predictable as compared to that of cancers. Patients with end-organ failures often experience recurrent episodes of exacerbations over the background of a slow decline that spans many years[4,5]. Patients may become critically ill at certain points and still could find the possibility of recovering, but only to a functional level that is a step lower than that before the exacerbation. These episodes of exacerbation occur at more and more frequent intervals as disease advances, with perhaps the need of introducing interventional support such as the non-invasive ventilator at some point. Even with the same disease, the disease progression rate and the exacerbation intervals can be highly variable depending on other factors such as the patient's lifestyle control, concurrent illnesses etc. Exacerbations often result in patients' being in and out of hospitals until the last episode when death occurs. One of the aims of palliative care then is to minimize emergency department attendance through an early detection and control of exacerbation. It is also important to enhance patient's coping in situations when the symptom intensity increase was simply reactive and transient.

Palliative needs of patients with advanced non-cancer diseases

Symptoms management is one of the main foci in palliative care and the work of palliative care team in this area is well recognized[6]. Studies suggested that patients with non-cancer diseases experience a considerable number of symptoms. Patients with advanced heart failure suffer from marked dyspnea, fatigue, and symptoms related to end-organ hypoperfusion[7]. The dyspnea and pain in chronic lung diseases were found to be as significant as those in lung cancer[8]. Similar high prevalence of pain was found in cancer, dementia and patients with chronic obstructive pulmonary diseases[10]. Patients dying from motor neuron disease or other neurodegenerative conditions can have as many symptoms as those dying from cancer[11]. A local study on end-stage renal failure patients found a mean number of 20 symptoms during the last month of those who did not undergo renal replacement therapy[12]. Nearly all studies that focus on symptoms related to advanced diseases add to the evidence that these patients suffer from a symptom burden that is comparable to, if not more substantial than, that of patients with cancer.

In addition to physical symptoms, patients with chronic illnesses have psychosocial needs that are easily left unattended. In their last months when physical symptoms can be significant and debilitating, a majority

of these patients become either homebound or they are admitted to an old-aged home because caring at home is met with difficulties due to their functional decline. The high level of distress these patients experience was associated with poor quality of life and social isolation[9]. They face the psychological and spiritual sufferings as all those who face death and dying do, with anxiety and depression being identified as some of the unmet needs in them[13,14].

When pain and symptoms management takes its high priority in cancer care, there is no reason why patients who will be facing their end of life with non-cancer conditions should be denied an adequate symptoms control. Knowing the prevalence of multiple symptoms in this group of patients, clinicians should proactively look for the presence of symptoms to ensure a thorough assessment, taking note that the chronicity of them does not diminish the urgency of control. Same rigor should apply in assessing and managing the psychospiritual needs as one would in seeing any patients with life-limiting diseases.

Model of palliative care

The Gold Standards Framework[15], with its surprise question asking whether one 'would be surprised if this patient were to die in the next 6-12 months', serves as a reminder to clinicians on the palliative care needs of their patients. Yet palliative care is more than just end-of-life care. Nor should it be seen as lying on one end of a dichotomous care model to be triggered when 'no further active treatment can be offered'.

Palliative care is about the relief of sufferings, maximizing quality of life and empowering patients and families to make their choices in the face of a life-threatening disease. Palliative care can be appropriate early in the course of an illness. Active and palliative treatment may run concurrently over the continuum of the disease trajectory, each assuming a different proportion of care at different points of time according to the needs of the patient. The proportion of palliative care usually increases with time until when the end of life approaches, it becomes fully responsible for the care of the patient.

The aim of palliative care for patients with non-cancer diseases can only be achieved through a multidisciplinary effort and in collaboration across different specialties. In Hong Kong, a territory-wide program of palliative care for end-stage renal failure patients was started in 2010. The program is run in collaboration with specialists in nephrology. Patients suffering from renal failure and who decided not to receive renal replacement therapy will be referred to the palliative care team. The palliative care team comprises of palliative doctors and nurses, physiotherapists, occupational therapists, social workers, clinical psychologists, and pastoral care workers. Together the team works towards patient's symptoms relief, offer support in psychosocial and spiritual aspects, facilitate discussions in advance care planning, prepare the patients and families for the end of life, and follow through with their bereavement.

Advance care planning

It is known that clinicians are often over-optimistic in their prognostication of cancer survival until the time when death is close[15]. The inherent uncertainties in the trajectory of chronic diseases only make this prognostication task even more challenging. It is difficult to predict which of the exacerbation episodes will be the patient's last, especially when many of the aged group of patients have multiple comorbidities that can all contribute to an episode of exacerbation. Decisions on interventions are becoming complex as more and more life-sustaining treatment options are now available.

These uncertainties, however, should not preclude the opening of an honest conversation about the limits of medicine. Previous studies revealed that the majority of healthcare workers did not communicate end of life issues with their patients[16,17], and patients were left unaware that they might die from the diseases[18]. A recent study showed that end-of-life care communication in chronic organ failure was still poor[19]. Patients and families should be told about the terminal nature of the diseases, for the acknowledgment of the advanced stage of disease is the basis of further discussions on the appropriate goals of care.

Advance Care Planning (ACP), with communication being at its core, is a dynamic process that focuses on patient's values and choices in relation to future care plan. Apart from the common issues of resuscitation, ventilator support, artificial nutrition and hydration etc, issues specific to a particular condition such as the deactivation of defibrillator, the withdrawal of dialysis etc. should also be addressed. An understanding of the preferences of patients and families will direct our care decisions to ensure that they match to patients' wishes. More often than not, the ACP serves as a platform where difficult conversations on death and dying can take place. Uncertainties can be brought to the open and emotions such as fear and anxiety addressed. Evidence has found that with communications in ACP, hope can be sustained[20].

Conclusion

Despite the advances in medicine and the availability of life-prolonging treatment, the mortality of patients with chronic progressive diseases is still higher than their age-matched population. Many of these are elderly patients whose course of illness is further compounded by the co-occurrences of more than one chronic diseases and their functional decline by an ageing physical body. Evidence showed that patients with non-cancer diseases have physical and psychosocial needs that are comparable to those with cancers.

Palliative care, with its focus on the quality of life and relief of sufferings, is an approach to support the needs of these patients through the work of a multidisciplinary team and in collaboration with other specialties. Ongoing communication is encouraged among patients, families and healthcare professionals in terms of discussing prognosis and end of life issues as well as setting the goals of care that are in line with patient's and family's values and preferences.

In recent years palliative care in Hong Kong has begun to move beyond the paradigm of cancer care to patients with advanced non-cancer conditions. Much yet is still to be learned in this development, but experiences have affirmed the value of palliative care in showing that improving quality of life in the presence of a progressive organ failure can be achieved.

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2. Molecular pathways, classification & basic principles in targeted drugs in cancer treatment
3. Basic radiobiology principles in cancer radiotherapy, conventional & modern radiotherapy equipment
4. Clinical efficacy of targeted drugs & radiotherapy in different cancers & recent clinical trials

Date	Topics	Descriptions	Speakers
16 Nov	**Molecular cancer diagnostic tests**	PCR, in situ hybridization, gene chip, DNA sequencing tests, etc.	Dr. Chris L.P. WONG
23 Nov	**Molecular pathways in cancer development**	Oncogenes, tumor suppressor genes, cancer cell cycle, DNA methylation, programmed cell death etc.	Dr. Timothy T.C. YIP
30 Nov	**Classification & mechanism of action of targeted drugs**	AKT, MAPK & EGFR pathways in drug development, monoclonal antibody & chemical inhibitor types of targeted drugs, siRNA, nano-particles	Dr. Timothy T.C. YIP
7 Dec	**Clinical advances in cancer targeted therapy**	Clinical use of targeted drugs in cancer management, their efficacy and side-effects from landmark clinical trials	Dr. Joseph S.K. AU
14 Dec	**Conventional & modern cancer radiotherapy equipment**	Physical advances in linear accelerator, after-loading brachytherapy, stereotactic radiosurgery, intensity modulated radiation therapy (IMRT), tomography	Dr. Ben S.K. YU
21 Dec	**Radiobiology principles in cancer treatment**	Biological mechanism in daily fractionated radiotherapy (4Rs in radiobiology etc.) affecting treatment efficacy	Dr. Timothy T.C. YIP
28 Dec	**Clinical advances in cancer radiotherapy**	Clinical use of external beam irradiation & brachytherapy in treating different cancers, when to use RT, toxicity, new advancement in RT	Dr. Roger K.C. NGAN

Introductions of the Speakers

Dr. Timothy T.C. YIP (BSc, PhD)
Radiobiology & Cancer Research Unit i/c
Department of Clinical Oncology, Queen Elizabeth Hospital &
Honorary Associate Professor, SPACE, University of Hong Kong;
Visiting Professor, University of Missouri-Columbia, USA.

Dr. Chris L.P. WONG (BSc, PhD)
Laboratory Director,
Hong Kong Molecular Pathology Diagnostic Centre Limited
Adjunct Assistant Professor, University of Macau
Chair, International Affair Committee,
Association for Molecular Pathology

Dr. Joseph S.K. AU (MBBS, PhD, FRCR, FHKAM)
Clinical Consultant
Department of Clinical Oncology, Queen Elizabeth Hospital &
Honorary Associate Professor, University of Hong Kong
Chairman, Research Committee, Kowloon Central Cluster,
Hospital Authority

Dr. Roger K.C. NGAN (MBBS, FRCR, FFRRCSI, FHKAM)
Clinical Consultant and Chief of Service, Department of Clinical Oncology
Honorary Clinical Associate Professor, University of Hong Kong
Director, Hong Kong Cancer Registry

Dr. Ben S.K. YU (BSc, PhD)
Senior Medical Physicist
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Palliative Care in Children

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Dr Chi-kong LI

Background

Palliative care for children with life-limiting conditions is an active and total approach to care, embracing physical, emotional, social and spiritual elements. It focuses at enhancing quality of life in the face of an ultimately terminal condition, and also supporting the family. The management includes relief of distressing symptoms, provision of respite and care through death and bereavement. The causes of death in children are substantially different from the cause of death in adults, and the palliative guidelines for adult may not be appropriate for children. Parents are the main carers of the sick children, the care providers must respect the child's and family's wishes. Paediatric palliative care (PPC) service is less well developed and is a relatively new subspecialty. Royal College of Paediatrics and Child Health in UK published the first guideline on "Withholding or Withdrawing Life Sustaining Treatment in Children: A framework for Practice" in 1997. American Academy of Pediatrics formulated the first statement on "Palliative Care for Children" in 2000. One of the reasons for the slow development of PPC is the small number of children dying that makes the development and maintenance of expertise difficult. There are also many rare conditions which are only encountered in paediatric practice. Over the years, it attracts more attention on the development of PPC service in most western countries. Many non-government organisations have active participation in education, fund-raising to support non-hospital service including hospice care. In UK, there are now over 50 hospice centres serving children with various life-limiting and life-threatening conditions. PPC is now also a formal subspecialty in both UK and US.

Why PPC in children is different from adults

The causes of death in children are very different from adults. In Hong Kong every year there are about 200 deaths in children under age of 15 years. About half of the deaths occur before age of 1 year, and mostly during the neonatal period. Prematurity and congenital malformations are the common causes of mortality in neonates. After infancy, non-medical related conditions including injury and poisoning accounts for 25% of the death. Cancer is the commonest medical illness contributing the death in children after infancy, about 25%. Infection related death is becoming less common with advances in medical care. However there are children having conditions that are life limiting, i.e. mostly will not survive to adulthood, and have the chronic disabilities for many years before they finally succumb. There are four groups of conditions that will benefit from PPC: (1) conditions where potentially curative treatment has failed, e.g. refractory leukaemia resistant to all salvage therapy; (2) conditions where intensive treatment may prolong life but premature death occurs, e.g. mucopolysaccharidosis Type 1 treated with enzyme replacement therapy and aggressive cervical spine surgery; (3) progressive conditions where treatment is exclusively palliative, e.g. Duchenne Muscular Dystrophy putting on assisted ventilation; (4) non-progressive neurological conditions which result in an increased susceptibility to complications and premature death, e.g. cerebral palsy child may require tracheostomy, gastrostomy and intensive physiotherapy, and stable for many years but may deteriorate rapidly after an episode of infection and die within short period. These non-cancer patients require PPC for prolonged duration, some may start from infancy and can be more than 10 years. In adult palliative care, the duration from referral to death is usually in the range of 1-2 months, whereas PPC may be extended over years. In overseas experience, the non-cancer cases constitute over 70% of the referrals for PPC. The involvement of parents as care givers and decision-makers sometimes increases the complexity of care. The parents have to spend many years of great effort to give the best care to their children with life-limiting conditions. The trauma experienced by parents, siblings and other family members from the death of a child can be profound. These family members may suffer from complicated grief reactions and impaired long-term adjustment. Thus the PPC would provide help not only to the child but also to the family. At the same time, children are growing in many dimensions thus the developmental, ethical and physiological aspects must be well taken care of.

When to start palliative care

There are myths about palliative care, such as 'palliative care is end of life', 'palliative care starts when curative treatment stops'. One of the special features of PPC is the patients being served have great diagnostic diversity and prognostic uncertainty. It is difficult to identify a point at which treatment becomes exclusively palliative. It is always preferred to introduce PPC early in the phase of the treatment. Some parents however may not accept the idea of PPC at the time they still have high hope on the cure of the disease, and they may consider 'PPC is doing nothing'. In some countries like

Canada, the PPC team is named as Pediatric Advanced Care Team (PACT) and may be more easily accepted by parents, and they do receive more referrals in recent years. Thus a mixed model of care in which facets of palliative care and cure-oriented or life-prolonging treatment is integrated, e.g. a child with advanced neuroblastoma arranging for autologous stem cell transplantation and at the same time receive maximal symptom management and support in coping with the uncertainty and possibility or probability of death. The PPC team will support the family to 'hope for the best but prepare for the worst'. At a point when transition to PPC is clear, the staff should help the family to gradually accept the change of their focus from cure to palliation. The process of having consensus on the goal of care needs delicate balance between maintaining hope and addressing reality. The clear message of active approach to symptom control and quality of life would help the parents to overcome the emotional disturbance, and can arrive at the decision which is of best benefit to the child.

Symptom control in PPC

Children with life-limiting and life-threatening conditions also develop symptoms similar to adult patients. Dyspnoea and pain are the commonest symptoms in PPC, the other common symptoms include nausea and vomiting, constipation, anxiety and anorexia. Pain is especially common in malignant conditions and pain assessment in children needs special tools as young children may not be able to express their complaints. Pain may be due to neuropathic, bone-related, muscle spasm or cerebral irritation. It is important to find out the nature of pain and then provide specific treatment to control pain. The severity of pain in older children can be self-reporting, use of visual analog scale or face pain scale is commonly adopted. Parental report is very useful as they understand their children best. Sometimes parents may have underestimation of pain due to various reasons, such as fear of opiod use. WHO guideline (2012) on the pharmacological treatment of persisting pain in children with medical illnesses is a useful guide for paediatricians. The two-step approach has now replaced the three-step approach. Paracetamol and NSAIDs are the recommended non-opiod analgesics as starting medications. For moderate and severe pain, strong opiod is recommended to provide effective analgesic control. The previous recommendation of using codeine as second-step of the three-step ladder is now stopped. Codeine is a weak opiod that is a prodrug requiring conversion to the active metabolite morphine by the enzyme CYP2D6. There is variable expression of the enzymes involved in the biotransformation of prodrugs to active metabolites. Children under age of five years may only have 25% of the enzyme activity of adults. On the other hand, some individuals may have rapid metabolise of codeine that have risk of severe opiod toxicity. Neuropathic pain should be managed with gabapentin, and the use of antidepressants such as tricyclic depressants and selective serotonin reuptake inhibitors need further research in children. Ketamine may be used as adjuvant to refractory neuropathic pain. The use of adjuvants and non-pharmacological measures to relieve pain should be considered as well. Education of staff in timing administration of sufficient analgesics to control the distressing pain is necessary. Use of opiods is very effective in relieving the dyspnea, and adding benzodiazepine may improve symptom control.

PPC in Hong Kong

There is no epidemiological study in Hong Kong on PPC. The prevalence of children with life-limiting and life-threatening conditions requiring PPC in western countries is estimated to be 1 in 1000 children. Based on this projection, there would be about 1500 children in Hong Kong who may benefit from PPC. Cancer is the commonest cause of death in the post-infancy period and PPC is better developed in this field. Paediatric oncologists have close collaboration with Children's Cancer Foundation (CCF) and established the PPC for cancer children for over 15 years. Paediatric oncologists have also prepared a manual of Symptom Control for staff as reference for managing the distressing symptoms. CCF has set up a team of palliative care nurses to provide the community based service. The four nurses are now paying home visits, providing nursing care and psychological and emotional support to the patients and their families. Pain control at home by intravenous infusion of morphine and patient-controlled analgesic infusion pump facilitates the patients staying at home as long as possible. Palliative care nurses will report to paediatric oncologists for dose adjustment and achieve maximal pain control. CCF is also arranging an annual overseas visit to a theme park in Asia and this is most welcome by the children and families receiving PPC as this is likely the last trip for these children. They also continue the care after the death of these children, bereavement is an essential part of the service. There are also supported by other professionals of CCF, including counsellors of social worker background, child life specialists with training in play therapy, clinical psychologist and occupational therapist. The CCF Rehabilitation bus allows the transport of disabled patients back home, and returning to hospitals for follow-up or treatment. The number of children dying from cancer is about 40-50 per year, some patients may have PPC service more than a year due to the slow progression of disease, while some may die from complications of treatment which PPC is not planned. As there is far more non-cancer conditions that will benefit from PPC, CCF also piloted the service to non-cancer cases in the past few years. About 50 such cases have been served and the palliative care nurses face the challenges on caring these children as the underlying disease and disease presentation or symptomatology is quite different from oncology cases.

Future development of PPC in Hong Kong

Hospital Authority had conducted a commissioned training course on PPC in the first week of September 2015. Three overseas experts from Wales and Toronto delivered a series of lectures and participated in the in-depth discussion of the local case presentations. The training courses attracted a large number of doctors, nurses and allied health workers attending the sessions. The training will stimulate colleagues to think more about the palliative care approach for patients under their care with life-limiting conditions. However Hospital Authority must start planning a service model

for children who need PPC, Hong Kong Children's Hospital is a good opportunity for setting up a territory-wide service for these unfortunate children and their families. Engaging the NGOs in non-hospital service is extremely important as they have the resources and experience in running the service, the community and home based service is the service direction. In Hong Kong, the model of hospice care should be evaluated, but respite care is definitely necessary for families with children requiring long term intensive home care.

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(n=1,160,088)

LOS reduced by 2.3 days

6.7%
decrease
in probability of
30-day readmission†
(n=862,960)

ONS = oral nutritional supplement
Effect of ONS use (on LOS, probability of readmission and episode cost) significant at the 1% level. Instrumental variables regression analysis was used to account for selection bias.

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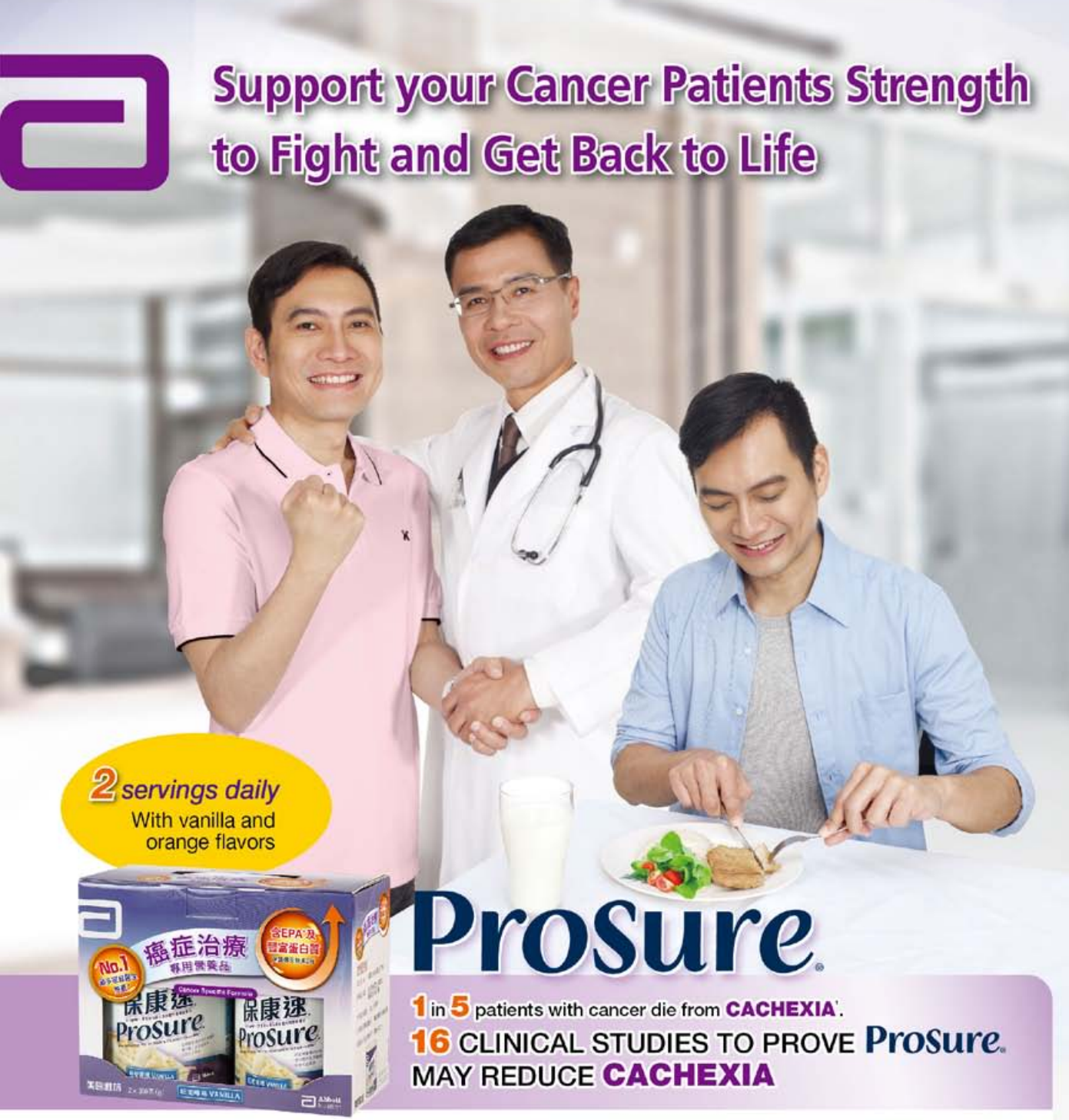

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Palliative Care for the Aged

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This article has been selected by the Editorial Board of the Hong Kong Medical Diary for participants in the CME programme of the Medical Council of Hong Kong (MCHK) to complete the following self-assessment questions in order to be awarded 1 CME credit under the programme upon returning the completed answer sheet to the Federation Secretariat on or before 30 November 2015.

No ageism in palliative care

Ageing society poses various challenges to health care services worldwide. Older people do bear the brunt of burden of advanced cancer and non-cancer conditions, and the need for palliative services is likely to escalate with the rapidly growing elderly population. Cancer is a disease of the aged. End stage organ failure and neurodegenerative conditions are more prevalent as age increases. Efforts clearly need to be devoted to ensure there is no ageism in the delivery of palliative care. Various myths of care for elderly at the end of life still exist, e.g. older people don't feel much pain; older people if in pain cannot be treated; older people are less affected by cumulative loss; older people cannot make advance care planning for themselves. In addition, any of the following profile of elderly with palliative care conditions should alert us for more care and attention: frailty syndrome, cognitive impairment, language barrier, single or widowed, recent bereavement, poor family or social support, institutionalisation, difficult symptoms, and stigmatising diseases.

World Health Organisation Regional Office for Europe published a global policy in 2011 to promote better palliative care practices for older people.[1] It is emphasised that palliative care for older people is an urgent public health priority. Whole system approach is needed in improving palliative care, while national awareness and educational interventions should be promulgated. Care for older people in hospitals needs to be enhanced. In the community, palliative care for elderly at home ought to be provided, whereas training and education with outreach of care should be extended to nursing and residential care homes. Dementia is a condition highlighted especially in need of attention. Family caregivers are part of the treatment unit of palliative care not to be neglected. Advance care planning and integrated care pathways are processes of care to be incorporated. Research is most warranted.

Principles of symptoms management of elderly palliative care patients

It is essential to bear in mind that the multi-dimensional nature of symptomatology applies equally if not more to our older population in need of palliative care. The concept of total pain, encompassing physical, psychological, social, and spiritual dimensions is a good illustration. The same is also broadly relevant for other symptoms. For example, dyspnoea can lead to fear which further aggravates dyspnoea. Nausea or vomiting can be purely due to anxiety or nervousness. The undiagnosed is not the same as the irremediable, and blanket treatment is to be avoided in managing symptoms. Physical pain for example can have a range of different causes each requiring different treatment. In the palliative setting, elderly may have nociceptor pain from tumour or metastases which responds very well to opioids. They may also have neuropathic pain due to nerve compression or infiltration from benign or malignant causes, which would be better treated by anticonvulsants or antidepressants. More typically, they may have musculoskeletal pain from atrophied muscles or stiffened joints due to frailty and prolonged immobility, which benefit more from regular exercise and physiotherapy. Psychospiritual distress presenting as atypical somatic pain can be easily overlooked. The multidimensional causality of pain typically found in elderly at palliative care setting is summarised in table 1.

Table 1 Potential components of total pain in elders (different components may overlap)

Physical pain	Psychological pain	Social pain	Spiritual/ existential pain
Pain from cancer	Worry	Poor living conditions	Indignity
Pain from metastases	Anxiety	Financial hardship	Meaning of suffering
Pain from treatment	Fear	Inadequate communication	Meaning of life
Pain from joints	Negativity	Inadequate information	Purpose of life
Pain from trauma	Low self- esteem	Loneliness	Value of life
Pain from wound	Despair	Isolation	Sanctity of life
Pain from sores	Depression	Neglect	
Pain from immobility	Demoralisation	Abuse	
Pain from poor oral/dental hygiene	Derealisation	Burden on family/carers	
		Family disharmony	
		Discharge placement	

The World Health Organisation analgesic ladder approach has been well established for treating physical cancer pain for many years.[2] It is found to be safe too in elderly population. Step one utilises non-opioids with paracetamol and/or non-steroidal drugs; step

two recommends weak or moderate strong opioids such as tramadol together with non-opioids; and step three with strong opioids such as morphine with non-opioids. At each step, the use of adjuvant therapy, both pharmacological and non-pharmacological, should be considered for the underlying cause of pain. Interventional procedures such as nerve blocks may be employed when indicated. Oral route of analgesia is the best route, and analgesics should be prescribed round the clock for adequate pain relief. The principle of start low and go slow is judicious in frail old patients, though of course acute pain such as pathological fracture needs to be promptly treated. Regarding the use of opioids, several misconceptions can be clarified. Constipation can be prevented by applying laxatives before starting opioids, and increasing laxatives when opioids are titrated up. A combination of stimulant and osmotic laxatives is particularly effective. Not every patient will develop nausea and vomiting after opioids, and the side effect is usually transient and responds well to anti-emetics. Sedation and confusion usually will subside after a few days, and often respond to psychostimulants and antipsychotics respectively as an interim, and with the opioid dose suitably tailed down when necessary. Respiratory depression is rarely encountered, as long as the opioid dose is carefully increased.

Quite often, much of the symptoms are iatrogenic and can be attributed to the polypharmacy resulting from multiple co-morbidity in elderly. In relation to the use of drugs in terminal setting, less is more and none is the best, which can certainly be achieved in suitable scenarios when opportunity arises. In addition, the use of non-pharmacological measures should be actively considered, eg diversional therapy, massage, passive limb mobilisation, transcutaneous electrical stimulation and acupuncture etc in alleviating pain. With dyspnoea, energy conservation, relaxation and the use of fan providing fresh air flow across the face, can much improve the dyspnoea sensation. With fatigue, the use of gradual tailor-made exercise can actually improve exercise tolerance and reduce the tiredness, opposite to commonly held patient misbeliefs. With cognitively impaired elderly, pain can still be readily recognised by noticing any increased restlessness, fidgeting, or verbal outbursts, and non-pharmacological modalities like comfort environment, soothing touch, pleasant imagery can all help towards analgesic effect.

Psychospiritual well-being and quality of life of elderly at the end of life

It used to be thought that Chinese elderly may not relate to psychospiritual issues as much as those in the West, and the quality of life concept is not applicable in our Chinese culture. Evidence is accumulating that the psychospiritual issues faced by elderly at end of life is universal, regardless of race, culture and religion. Local studies have shown that the existential domain is the most important domain in predicting overall quality of life in local Chinese palliative care patients.[3] Elderly often express that they are not in fear of dying. They often accept to let nature take its course, though are concerned about prolonged distress and suffering. Suffering often is in the realms of psychological and spiritual domains. Common aspects such as finishing unfinished business, relieving burden on families with facilitation of support, reconciliating differences with harmony, are frequent issues expressed by elderly. Depression is not the sole reason for an elderly wanting to give up one's life. Meaning and purpose of life are not beyond comprehension, and the perceived lack of which frequently lead to suicidal thoughts and euthanasia requests. Cases have been seen where elderly rediscovers meaning in life by allowing students to examine and learn from their disease. More commonly, cases are seen where elderly feel fulfilled with validation of their self esteem and reaffirmation of their achieved life goals. Decision of organ and body donation itself may actually reinforce the elderly value of life and contribution of self. To explore our patients' concerns, an active, individualised, whole person-centred care is essential. This exemplifies the hospice standard, and should be the gold standard of all branches of modern medicine. Trans-disciplinary approach is encouraged with adoption of the hospice culture: a respect culture, a listening culture, a caring culture, an empathic culture, a learning culture, a support culture and just culture. Science, art and compassion in their synergy embodies the humanity of health professionals in caring for the vulnerable and dying.

Care for caregivers is most important, as goal of care endorsed by World Health Organisation includes quality of life not just for patients but also families. More often than not, the patients' psychospiritual suffering can be much relieved, once they see that the caregivers worry, anxiety and burden are suitably addressed and cared for. Author's experiences have found that a targeted structured programme can improve caregivers' state of well-being and quality of life significantly. The strategy and approach in caring for caregivers, both formal and informal, deserve a separate article. At individual case level, good communication and support from health professionals for families is mandatory, especially in dealing with critical or life threatening situations. Bereavement support is a significant part of palliative care for patients and families. Good anticipatory grief support for both patients and relatives can much ease emotions and facilitate coping, and themes with model of support are emerging.[4] Bereavement can be easily overlooked, and many bereaved clients are elderly themselves. Bereavement needs not be medicalised, and collaborative support from health services, social sector and non-governmental organisations are essential. The Federation charity programme for bereaved children support is one example, in arousing society awareness and support for those in need. Staff support equally merits our attention, as how well professionals can look after dying patients, depend very much too on how well the professionals can look after themselves.

Dying with dignity in a place of choice

Much has been said about dignity preservation at end of life. Regarding dignity issues in facing death and dying for older people, more research needs to be devoted in understanding and managing related concerns. Dignity-related distress is not uncommon, and issues such as symptom distress, existential suffering, dependency are prevalent. While dignity may be affected differently in different individuals, a broad repertoire with its key determinants can be incorporated as part of an

individualised regular assessment.[5] Further, related constructs such as autonomy and advance care planning also deserve special mention. It is fully acknowledged that in Chinese culture family members' viewpoints are important and should always be taken into account. Though older persons of the modern society are increasingly knowledgeable and can have clear preferences of how they should be treated in dying phase. Advance care planning is needed in order to respect our older patients' choices and autonomy. When facing advanced incurable conditions, advance care planning or advance directive can be made in the following decisions, e.g. cardiopulmonary resuscitation, invasive interventions, assisted ventilation, artificial nutrition and hydration, blood transfusions and use of antibiotics. Older patients' autonomy should be respected.

Dying in a place of choice is another issue concerning comfort, peace of mind and dignity for our older population. There may be multiple barriers and hurdles in facilitating an older person to die at own home, with logistics concerns stemming from family readiness, home environment, palliative and other services support, procedures with certifying death, legal requirements, ambulance and mortuary arrangement etc. While local culture and setting may not yet encourage our elderly to put dying at own home as the top preference, yet if a patient does express such a wish, then it is a litmus test on how responsive and patient-centred our services and society are in supporting the dying. Death indeed need not be medicalised too. If dying at own home is not immediately available as a ready option, then efforts should be made in allowing the elderly to remain at home as much as possible with full support to maximise quality of life. As quite a proportion of our elderly in community are residing in residential care homes, palliative and supportive care should be rightly extended to those in need. Culture, knowledge, attitude and skills in care at the end of life are all the required attributes identified in old age home setting,[6] where palliative care physicians should work closely together with geriatricians and family physicians, in dissemination and promotion.

Opportunities and challenges in enhancing palliative care for an ageing population

It is most timely now to seize the opportunities abound, in enhancing the palliative care approach for the increasingly prevalent advanced incurable conditions faced by our ageing society. Palliative medicine is a fully established specialty with training pathway and curriculum both locally and abroad. More importantly, with the accumulation of specialist knowledge and experience, palliative care colleagues are ready to share and disseminate the approach for fellow professionals. The need for person-centred care is more and more recognised globally, prompting the delivery of palliative care at end of life. Further, the increasingly accepted paradigm of extending comfort and palliation for anyone who is critically ill, enables a wider coverage of patients at different stages of incurable illnesses. Older people are progressively more aware, and ready to accept the hospice philosophy and palliative approach. Evidence is accumulating, proving that quality of life can be maintained at end of life.[7]

However, there are still many challenges that remain to be overcome. The latest Economist Intelligence Unit Report on international quality of death index published in October 2015, ranked Hong Kong at 22nd, two places lower than in 2010. Five years ago, the report stated that Hong Kong needed improvement in availability of hospices and palliative care services per million population aged 65 and over, number of hospices and palliative care provision, end-of-life care policy provision, and government-led national palliative care strategy. The 2015 index evaluated 80 countries using 20 quantitative and qualitative indicators across five categories: the palliative and healthcare environment, human resources, the affordability of care, the quality of care and the level of community engagement.8 Coping with the increasing palliative need and service demand in a rapidly ageing population certainly will not be easy in the years to come. There will be an escalating volume of patients with malignant and non-malignant advanced conditions. Equity and coverage of hospice and palliative care for all disease types will have to be enhanced. Uniting and synergising the medical and social dimensions of care is an urgent goal for a seamless provision of care for the dying. Engaging and integrating a multi-specialty and multi-disciplinary collaboration to adopt the bio-psycho-spiritual model in caring for advanced diseases will take time. Care should be taken not to err in sub-optimally supported attempts, as seen unfortunately in the promulgation of Liverpool Care Pathway for end of life in United Kingdom. Both government-led policies and community engagement are much needed.

Notwithstanding the challenges, we remain hopeful that palliative care for the dying can be further promoted for our older adults locally in Hong Kong. This can be better achieved, through synergistic directions suggested in the opening at the Federation 50th Anniversary Scientific Meeting on Care for Advanced Diseases : "Cure and care; science and art; high technology and high touch; primary and tertiary services; public and private; government and non-government organisations; patients and professionals, to be united together for pursuing the common goals."

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MCHK CME Programme Self-assessment Questions

Please read the article entitled "Palliative Care for the Aged" by Dr Raymond SK LO and complete the following self-assessment questions. Participants in the MCHK CME Programme will be awarded CME credit under the Programme for returning completed answer sheets via fax (2865 0345) or by mail to the Federation Secretariat on or before 30 November 2015. Answers to questions will be provided in the next issue of The Hong Kong Medical Diary.

Questions 1-10: Please answer T (true) or F (false)

1. Palliative care for older people is an urgent public health priority.
2. Elderly may have nociceptor pain from tumour or metastases which responds very well to opioids.
3. Adjuvant therapy with both pharmacological and non-pharmacological modalities can be considered in each step of the analgesic ladder.
4. Psychospiritual distress may present as atypical somatic pain.
5. Constipation cannot be prevented in elderly taking opioids.
6. The use of non-pharmacological measures should be actively considered for symptom relief.
7. Loss of meaning in life can lead to suicidal thoughts and attempts.
8. Care for caregivers is not part of the goal of palliative care.
9. Older patients' autonomy need not be respected in Chinese culture.
10. Equity and coverage of hospice and palliative care for all disease types need to be enhanced.

ANSWER SHEET FOR NOVEMBER 2015

Please return the completed answer sheet to the Federation Secretariat on or before 30 November 2015 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

Palliative Care for the Aged

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Answers to October 2015 Issue

Chapter 1 Non-invasive prenatal testing – a breakthrough in prenatal diagnosis

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

Advance Care Planning and Advance Directives in Hong Kong: Development and Challenges

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Chairman, Hospital Authority Clinical Ethics Committee

Dr Chun-yan TSE

With contemporary development in medical technologies, many life-sustaining treatments can still be offered near the end of life. However, some of these only prolong the dying process, doing more harm than good, and are against the patient's wish. It is generally agreed that such futile treatments may be withheld or withdrawn in suitable situations.[1] When the patient is competent, the decision not to receive a life-sustaining treatment (LST) must be respected. When the patient is incompetent, the healthcare team should build consensus with the family members as to what is in the patient's best interests. However, these decisions often involve complex legal and ethical considerations. If the prior preferences or values of the incompetent patient are not known, there could be difficulties for the healthcare team and family members to reach consensus.

Such difficulties could be alleviated if the patient, while competent, has made an advance decision refusing certain LST. Legally, a valid and applicable advance refusal of LST must be respected. The person may specify what LST one does not want under what situations (e.g. terminally ill or irreversible coma). In Hong Kong, the term Advance Directive (AD) usually refers to this. In some other countries, such advance refusal is called a "living will", and the term AD may also include appointment of a proxy decision maker on healthcare issues. However, a proxy directive on healthcare issues currently does not have legal status in Hong Kong.

AD was seldom discussed among healthcare professionals or among the public in Hong Kong until 2004, when The Law Reform Commission of Hong Kong (LRC) issued a public consultation paper on AD. In 2006, LRC released her report on the issue,[2] recommending AD to be promoted under the existing common law framework instead of by legislation. LRC further proposed a model AD form, the scope of which is limited to the terminally ill, irreversible coma, and persistent vegetative state. But it is not the only format of AD that can be used under common law. In 2009, Health and Food Bureau of the Government of HKSAR issued the *Introduction of the Concept of Advance Directives in Hong Kong Consultation Paper*.[3] In the paper, the Government expressed no intention to advocate the public to make AD, but suggested to provide more information to the public about the concept of AD, and to have guidelines for professionals. Furthermore, the Paper considered whether to promote the concept of advance care planning (ACP) in Hong Kong.

In 2010, the Hospital Authority of Hong Kong (HA) issued the *Guidance for HA Clinicians on Advance Directives in Adults, and has the Guidance* revised in 2014.[4] The HA AD form was modified from the LRC model form. In its 2010 version, the scope of the HA AD form was limited to the terminally ill, irreversible coma, and persistent vegetative state. Upon revision in 2014, a new category "other end-stage irreversible life-limiting condition" was added. According to the Guidance, the validity of an AD may be doubted if the AD is ambiguously drafted, not properly signed or witnessed, or there is reason to suspect that the patient was not competent or was not properly informed when the AD was made. An AD becomes applicable when the patient suffers from the pre-specified condition, and is no longer competent.

The approach to the use of AD varies among different countries. Currently in HA, AD are usually made by patients with advanced irreversible illnesses via advance care planning (ACP). ACP is often defined as a process of communication among patients, their health care providers, their families, and important others regarding the kind of care that will be considered appropriate when the patient cannot make decisions.[5] Some places adopt a broader definition and include discussion with family members of incompetent or minor patients within the scope of ACP.[6]

In September 2015, HA issued an updated *Guidelines on LST in the Terminally Ill*, and added a new section on ACP.[7] The updated Guidelines recommend that the ACP process may be initiated following the diagnosis of a life limiting condition with rapid downhill course, early cognitive decline in dementia, significant disease progression, discontinuation of disease targeted treatments, transition to palliative care, recovery from an acute severe episode of a chronic disease, following multiple hospital admissions, or when the patient becomes institutionalized. However, the approach must be individualized, and it is important to assess whether the patient is suitable for such a discussion before embarking on it. The discussion should be made sensitively with good communications skill. A rigid, routinized or checklist approach is not recommended. The scope of the discussion may include anticipated progression and prognosis of the illness, treatment options available and the benefits and risks, the patient's preferences and values regarding medical and personal care, and views and concerns of family members. Outcome of ACP includes decisions on preferences for future medical or personal care, making an AD, and assigning a family member for future consultation.

While the HA guidelines may facilitate the use of AD and ACP in the Hospital Authority, many questions are

often asked by professionals and members of the public regarding AD and ACP. I would like to discuss a few of these questions below:

Q1: Without specific legislation on AD in HK, is AD legal in HK?

According to the Law Reform Commission report of 2006, under the existing common law, a valid and applicable AD refusing medical treatment has the same effect as a contemporaneous oral instruction.[8] Thus, such a refusal must be respected.

Q2: What should the healthcare team do if there is doubt about the validity or applicability of an AD?

The healthcare team should continue to provide clinically indicated emergency LST, while waiting for clarification. Such treatment may be withdrawn after the validity and applicability of the AD becomes clear.

Q3: Assessment of the validity and applicability of an AD is sometimes not easy. Would it be simpler to have AD legalized by specific legislation?

In UK, with the Mental Capacity Act in force since 2007, doctors still have to assess the validity and applicability of an advance refusal of LST before following it.[9]

Q4: Can family members override a valid and applicable AD?

Under the common law framework, family members cannot override a valid and applicable AD.

Q5: Does this mean that legislation on AD is not necessary in HK?

Under Section 59ZF of the Hong Kong Mental Health Ordinance Cap 136, a doctor may provide life-sustaining treatment to an incompetent patient without consent if this is in the best interests of the patient. In the great majority of cases, because the patient's prior wish is a very important factor in the consideration of the patient's best interests, there should not be conflict between the patient's advance refusal and the patient's best interests. However, I personally think that it will be useful to have legislation to clarify the relationship between this section of the Ordinance and an AD, to avoid controversies in difficult cases.

Q6: Talking about death is taboo in Chinese society. Are there problems in discussing death issues with patients and family?

Studies have shown that chronically ill patients and elderly patients often accept discussion of death issues, if approached sensitively.[10,11] Problem more often occurs with family members of patients with acute irreversible illnesses or newly diagnosed terminal illnesses, when the family are unable to accept the poor prognosis.

Q7: Should ACP/AD be widely promoted among healthy members of the public?

Different countries have different approaches to this, ranging from wide promotion among the public in USA,[12] to a more judicious approach in UK. I think there could be problems in wide promotion among the healthy public. To cover a range of possible scenarios that may happen in future, the information needed may be overwhelming and distressing.[13] There could be harm to the person if a rigid, prescriptive or routinized approach is used.[14] Furthermore, a healthy person's perception on hypothetical illness states may be worse than the perception of a chronically ill patient.[15] This implies that a person's preference for treatment may change when the person actually becomes ill. It will be more problematic if the illness in the specified condition in the advance refusal is not advanced nor irreversible, e.g. simply because of old age. Respecting Choices of Gundersen Health System in USA, a major advocate of ACP, considers that it may not be appropriate to plan for everything that may affect a person in future.[16] Respecting Choices recommends in her "1st step" of ACP for healthy people over age 55 that, other than appointing a surrogate decision maker, advance refusal in this "1st step" would be limited to the goals of care in the event of permanent severe neurological injury only.

Q8: How can an AD be respected in an emergency situation?

This is not easy. There could be difficulty to judge whether an AD is valid and applicable in an emergency situation, especially if there is out-of-hospital cardiac arrest. To overcome this difficulty, many states in USA developed the "Physician Order for LST" (POLST) system.[17] In UK, guidelines and procedures have been developed to enable compliance to a Do-Not-Attempt Cardiopulmonary Resuscitation (DNACPR) form by other health care providers, including ambulance staff.[18] In Hong Kong, the HA DNACPR form for non-hospitalized patients promulgated in 2014 is along this direction.[19] Unfortunately, the approach is not yet accepted by the ambulance crew, because of the concern over the "duty to resuscitate" in the Fire Services Ordinance.

Q9: What should be done to reduce difficulties in end of life decisions in HK?

My personal view is that AD should be promoted in patients with advanced incurable illnesses, as part of ACP, involving the family early. At a macro level, there is a need of a government policy on end-of-life care, revising/enacting relevant legislations as necessary. There should be more education among healthcare professionals about end of life issues. For the general public, more death education should be promoted. It is important for the elderly members of the public to understand the meaning of LST and AD. While they may not necessarily sign an AD before having any serious illnesses, elderly members of the public should be encouraged to discuss with their family about preparation of death, and to express personal values and preferences about end of life care.

After all, death is the common destiny of all human beings. It will be good if we can have some say about how to travel through this last journey of our life peacefully, and leave a fond memory among those we treasure in our life.

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Dermatological Quiz

Dr Chi-keung KWAN

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

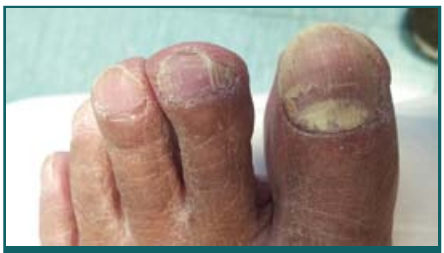

Fig.1 Nail dystrophy of our patient

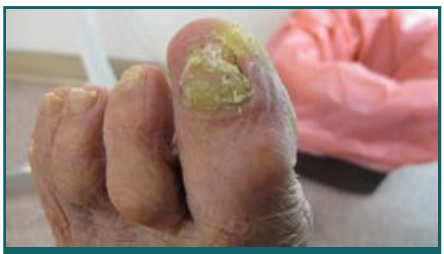

Fig.2: Nail dystrophy of other patient

This 45-year-old gentlemen complained discolouration of his left big toe nail for 2 years. The area involved was gradually increased. He did not remember any history of injury or precipitating cause. The lesion was asymptomatic without any pain or other discomfort. Physical examination reviewed a yellowish discolouration on the proximal part of his left big toe nail near the nail bed (Fig. 1). The distal part of the nail was relatively well looking.

Questions:

1. What is the diagnosis of his nail lesion?
2. What investigations may help you to arrive the diagnosis?
3. What other history or investigation do you want take?
4. How do you treat this patient?

(See P.36 for answers)

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Central and Western District Health Festival 2015/16

The annual Central and Western Health Festival, organised by the Central and Western District Council, was held successfully on 29-30 August 2015 at the Smithfield Sports Centre. Same as in past few years, the HKFMS Foundation Limited continued to support this event and was one of the supporting organisers. This year, 8 health talks and 4 health booths were organised by the Federation, composing of dental checks, eye test and games for the citizens. Over 800 citizens visited our booths and joined the health checkup. We would like to express our sincere thanks to the following speakers and member societies, namely Dr Sau-kwan CHU, Dr Wai-man HUNG, Dr Chi-wai MAN, Dr Chun-kong NG, Dr Sau-yan WONG, Dr Kenneth WU, Dr Pui-pui YIP, Ms Zanonia CHIU, Ms Sally POON, the Hong Kong Society of Professional Optometrists and the Hong Kong Occupational Therapy Association. In addition, we would like to thank the following sponsors for their gifts and support: Bausch + Lomb, Mekim Limited and Oral-B.


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Maserati Exclusive Test Drive Day

On 17 May 2015, the members and Executive Members of the Federation of Medical Societies of Hong Kong were invited by Maserati for its new sport car model launch. During the test drive day, there were some fabulous show booths for families e.g. cartoon portrait sketching, cupcake making class, chocolate & coffee tasting. Our members exchanged driving tips and interest with the hosts and spent an enjoyable afternoon together. The Federation looks forward to further organise different social activities for our members' interest. Members' ideas and suggestions are most welcome.



A New Evidence-based Addition to Your Toolkit: Formula Diets for Weight Loss, Maintenance and Health Improvement

On 7 Sep 2015, a CME lecture on A New Evidence-based Addition to Your Toolkit: Formula Diets for Weight Loss, Maintenance and Health Improvement was held at the Lecture Hall, FMSHK Office. The lecture was well attended by doctors, nurses and dietitians.

The Federation is pleased to have Prof Anthony LEEDS, Visiting Senior Fellow of University of Surrey to be the speaker and Ms Sally POON, chairlady of Hong Kong Practising Dietitian Union to be the chairperson. The lecture aimed to give an overview of the medical and health benefits of a formula diet for overweight and obese patients.



Classified Advertisement

Please contact the Federation Secretariat at 2527 8898 for placement of classified advertisement.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
★ HKMA Swimming Gala 2015 **1**	**2**	★ HKMA Kowloon West Community Network - Postmenopausal Osteoporosis Continuum: Young vs Old Postmenopausal Women Treatment Goal ★ MPS Workshop – Mastering Difficult Interactions with Patients ★ HKMA Council Meeting Organiser ★ FMSHK Officers' Meeting **3**	**4**	★ HKMA Kowloon East Community Network - Herpes Zoster and Post Herpetic Neuralgia – Are They Related? ★ HKMA New Territories West Community Network - Recommendation on Herpes Zoster Vaccination for Adults **5**	★ Joint Surgical Symposium - Minimally Invasive Approach to Ventral Hernia at Difficult Locations **6**	**7**
8	**9**	**10**	★ Hong Kong Neurosurgical Society Monthly Academic Meeting – Advance in Radiosurgery ★ HKMA Central, Western & Southern Community Network - Management of Non-Alcoholic Fatty Liver Disease **11**	★ HKMA Kowloon East Community Network - Update in the Management of Convulsion in Children ★ HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2015 – New Developments in Cardiac Intervention ★ FMSHK Executive Committee Meeting ★ FMSHK Council Meeting ★ FMSHK Annual General Meeting ★ FMSHK Foundation Meeting **12**	**13**	★ CME Lecture - Refresher Course for Health Care Providers 2015/2016 - Common Paediatric Skin Problems **14**
15	**16**	★ HKMA Kowloon West Community Network - Update on the Treatment of Type 2 Diabetes: A Cardiologist's Perspective ★ 1) Novel Biological Therapies for Psoriatic Arthritis 2) Case Presentation **17**	★ 17th Beijing / Hong Kong Medical Exchange **18**	★ KECN-HKCFP-UCH – Certificate Course for GPs 2015 (Session 5) – Stress Incontinence ★ HKMA New Territories West Community Network - Achieving Optimal Glycemic Control: What are the Current Options in Management ★ HKMA Hong Kong East Community Network - Audiology Update; Speech Therapy Update **19**	**20**	★ 7th AASD Scientific Meeting and Annual Scientific Meeting of the Hong Kong Society of Endocrinology, Metabolism and Reproduction ★ Seminar on 'Organ Donation Saves Life - Primary Care Physicians Can Make A Difference' **21**
★ 7th AASD Scientific Meeting and Annual Scientific Meeting of the Hong Kong Society of Endocrinology, Metabolism and Reproduction ★ RSCP Bridge Tournament 2015 **22**	**23**	★ MPS Workshop – Mastering Adverse Outcomes **24**	★ HKMA Central, Western & Southern Community Network - Novel Approach against Refractory Angina and the Role of the Primary Physician **25**	★ HKMA Kowloon East Community Network - First 1000 Days of Life – What Matter Most? **26**	★ HKMA Yau Tsim Mong Community Network - New Horizons for Managing Type 2 Diabetes with High CV Risk cum Annual Meeting **27**	★ MPS Workshop – Mastering Adverse Outcomes – 2 hours **28**
★ Scientific Symposium: Nuclear Medicine- From Organs to Molecules ★ HKMA Family Sports Day 2015 **29**	**30**					

Date / Time	Function	Enquiry / Remarks
1 SUN 2:00 PM	**HKMA Swimming Gala 2015** Organiser: The Hong Kong Medical Association; Venue: Hong Kong Polytechnic University Swimming Pool	Mr. Ian KWA Tel: 2527 8285
3 TUE 1:00 PM	**HKMA Kowloon West Community Network - Postmenopausal Osteoporosis Continuum: Young vs Old Postmenopausal Women Treatment Goal** Organiser: HKMA Kowloon West Community Network; Chairman: Dr. CHAN Ching Pong; Speaker: Dr. YIP Wai Man; Venue: Panda VIP Room, 7/F., Panda Hotel, 3 Tsuen Wah Street, Tsuen Wan, N.T.	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
6:30 PM	**MPS Workshop – Mastering Difficult Interactions with Patients** Organiser: The Hong Kong Medical Association & Medical Protection Society; Speaker: Dr. Anthony FUNG; Venue: HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road, Central, Hong Kong	HKMA CME Dept. Tel: 2527 8452 2.5 CME Point
8:00 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
5 THU 1:00 PM	**HKMA Kowloon East Community Network - Herpes Zoster and Post Herpetic Neuralgia – Are They Related?** Organiser: HKMA Kowloon East Community Network; Chairman: Dr. MA Ping Kwan, Danny; Speaker: Dr. TONG Ka Fai, Henry; Venue: V Cuisine, 6/F., Holiday Inn Express Hong Kong Kowloon East, 3 Tong Tak Street, Tseung Kwan O	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
1:00 PM	**HKMA New Territories West Community Network - Recommendation on Herpes Zoster Vaccination for Adults** Organiser: HKMA New Territories West Community Network; Chairman: Dr. CHUNG Siu Kwan, Ivan; Speaker: Dr. YIP Wai Man; 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
6 FRI 8:00 AM	**Joint Surgical Symposium - Minimally Invasive Approach to Ventral Hernia at Difficult Locations** Organiser: Department of Surgery, The University of Hong Kong & Hong Kong Sanatorium & Hospital; Chairman: Dr. SIU Wing-Tai; Speakers: Dr. SIU Wing-Tai, Dr. Joe FAN; Venue: Hong Kong Sanatorium & Hospital	Tel: 2835 8698 1 CME Point
11 WED 7:30 AM	**Hong Kong Neurosurgical Society Monthly Academic Meeting – Advance in Radiosurgery** Organiser: Hong Kong Neurosurgical Society; Chairman: Dr YAM Kong Yui; Speaker: Dr CHAN Ngo Lun, Allan; Venue: M Block Ground Floor Lecture Theatre, Queen Elizabeth Hospital	Dr Michael LEE Tel: 2595 6456 1.5 CME Point
1:00 PM	**HKMA Central, Western & Southern Community Network - Management of Non-Alcoholic Fatty Liver Disease** Organiser: HKMA Central, Western & Southern Community Network; Chairman: Dr. YIK Ping Yin; Speaker: Dr. CHEUNG Ting Kin; 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
12 THU 1:00 PM	**HKMA Kowloon East Community Network - Update in the Management of Convulsion in Children** Organiser: HKMA Kowloon East Community Network; Chairman: Dr. MA Ping Kwan, Danny; Speaker: Dr. SIN Ngai Chuen; Venue: V Cuisine, 6/F., Holiday Inn Express Hong Kong Kowloon East, 3 Tong Tak Street, Tseung Kwan O	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
2:00 PM	**HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2015 – New Developments in Cardiac Intervention** Organiser: The Hong Kong Medical Association & Hong Kong Sanatorium & Hospital; Chairman: Dr. WONG Bun Lap, Bernard; Speaker: Dr. CHAU Mo Chee, Elaine; Venue: Function Room A, HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, Hong Kong	HKMA CME Dept. Tel: 2527 8452 1 CME Point
7:00 PM	**FMSHK Executive Committee Meeting** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Council Chamber, 4/F, Duke of Windor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Nancy CHAN Tel: 2527 8898
8:00 PM	**FMSHK Council Meeting** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Council Chamber, 4/F, Duke of Windor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Nancy CHAN Tel: 2527 8898
8:30 PM	**FMSHK Annual General Meeting** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Council Chamber, 4/F, Duke of Windor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Nancy CHAN Tel: 2527 8898
9:15 PM	**FMSHK Foundation Meeting** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Council Chamber, 4/F, Duke of Windor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Nancy CHAN Tel: 2527 8898
14 SAT 2:15 PM	**CME Lecture - Refresher Course for Health Care Providers 2015/2016 - Common Paediatric Skin Problems** Organiser: The Hong Kong Medical Association; Speaker: Dr. Chan Cheong Wai, Stephen; Venue: Training Room II, 1/F, OPD Block, Our Lady of Maryknoll Hospital, 118 Shatin Pass Road, Wong Tai Sin, Kowloon	Ms. Clara Tsang Tel: 2354 2440 2 CME Point
17 TUE 1:00 PM	**HKMA Kowloon West Community Network - Update on the Treatment of Type 2 Diabetes: A Cardiologist's Perspective** Organiser: HKMA Kowloon West Community Network; Chairman: Dr. LEUNG Gin Pang; Speaker: Dr. HUNG Yu Tak; Venue: Crystal Room IV-V, 3/F., Panda Hotel, 3 Tsuen Wah Street, Tsuen Wan, N.T.	Miss Hana YEUNG Tel: 2527 8285
6:00 PM	**1) Novel Biological Therapies for Psoriatic Arthritis 2) Case Presentation** Organiser: The Hong Kong Society of Rheumatology; Chairman: Dr MH Leung; Speaker: Dr HO Tsz Chung; Venue: Hospital Authority Headquarters, Room 205S	Dr Ka Lai LEE Tel: 2595 6111 1CME Point
18 WED	**17th Beijing / Hong Kong Medical Exchange** Organiser: The Hong Kong Medical Association & Chinese Medical Association; Chairman: Dr. IP Wing Yuk; Speaker: Various; Venue: Chongqing Yuelai Wyndham Hotel, PRC	Ms. Candy YUEN Miss Ellie FU Tel: 2527 8285

Date / Time	Function	Enquiry / Remarks
19 THU 1:00 PM	**KECN-HKCFP-UCH – Certificate Course for GPs 2015 (Session 5) – Stress Incontinence** Organiser: HKMA Kowloon East Community Network & Hong Kong College of Family Physicians & United Christian Hospital; Chairman: Dr. AU Ka Kui, Gary; Speaker: Dr. GO Wing Wa; Venue: V Cuisine, 6/F., Holiday Inn Express Hong Kong Kowloon East, 3 Tong Tak Street, Tseung Kwan O	Ms. TAI / Ms. WONG Tel: 3949 3430 / 3949 3087 1 CME Point
1:00 PM	**HKMA New Territories West Community Network - Achieving Optimal Glycemic Control: What are the Current Options in Management** Organiser: HKMA New Territories West Community Network; Chairman: Dr. MOK Kwan Yeung, Matthew; Speaker: Dr. TONG Chun Yip, Peter; Venue: Pearl Ocean (金霞殿), 1/F., Gold Coast Yacht and Country Club (黃金海岸鄉村俱樂部 - 遊艇會), 1 Castle Peak Road, Castle Peak Bay, Hong Kong	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
1:00 PM	**HKMA Hong Kong East Community Network - Audiology Update; Speech Therapy Update** Organiser: HKMA Hong Kong East Community Network;Chairman: Dr. CHAN Hoi Chung, Samuel; Speaker: Ms. LAU Hoi Yan, Ada; Ms. NG Wing Yee, Cymie; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong	Ms. Candice TONG Tel: 2527 8285
21 SAT 9:30 AM	**7th AASD Scientific Meeting and Annual Scientific Meeting of the Hong Kong Society of Endocrinology, Metabolism and Reproduction** Organiser: Hong Kong Society of Endocrinology, Metabolism and Reproduction ; Chairman: Dr June LI; Venue: Hong Kong Convention and Exhibition Centre	Tel: 2559 9973
2:30 PM	**Seminar on 'Organ Donation Saves Life - Primary Care Physicians Can Make A Difference** Organiser: The Department of Health and the Hong Kong Medical Association; Speakers: Dr. LAM Tsz Sum; Dr. HO Chung Ping; Ms. CHEUNG Suk Man and Dr. CHAK Wai Leung; Venue: Lecture Theatre, G/F, Centre for Health Protection, 147C Argyle Street, Kowloon	Miss Joey LEE Tel: 2527 8452 2 CME Point
22 SUN 9:00 AM	**7th AASD Scientific Meeting and Annual Scientific Meeting of the Hong Kong Society of Endocrinology, Metabolism and Reproduction** Organiser: Hong Kong Society of Endocrinology, Metabolism and Reproduction ; Chairman: Dr June LI; Venue: Hong Kong Convention and Exhibition Centre	Tel: 2559 9973
1:00 PM	**RSCP Bridge Tournament 2015** Organiser: The Hong Kong Medical Association; Venue: Mariners' Club	Mr. Ian KWA Tel: 2527 8285
24 TUE 6:30 PM	**MPS Workshop – Mastering Adverse Outcomes** Organiser: The Hong Kong Medical Association & Medical Protection Society; Speaker: Dr. Emily HUNG; Venue: Eaton, Hong Kong, 380 Nathan Road, Kowloon	HKMA CME Dept. Tel: 2527 8452 2.5 CME Point
25 WED 1:00 PM	**HKMA Central, Western & Southern Community Network - Novel Approach against Refractory Angina and the Role of the Primary Physician** Organiser: HKMA Central, Western & Southern Community Network; Chairman: Dr. TSANG Chun Au; Speaker: Dr. GOH King Man, Victor; 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
26 THU 1:00 PM	**HKMA Kowloon East Community Network - First 1000 Days of Life – What Matter Most?** Organiser: HKMA Kowloon East Community Network; Chairman: Dr. SHIU Ka Lok, Ivan; Speaker: Dr. CHOW Pok Yu; Venue: V Cuisine, 6/F, Holiday Inn Express Hong Kong Kowloon East, 3 Tong Tak Street, Tseung Kwan O, Sai Kung, N.T.	Miss Hana YEUNG Tel: 2527 8285 1 CME Point
27 FRI 1:00 PM	**HKMA Yau Tsim Mong Community Network - New Horizons for Managing Type 2 Diabetes with High CV Risk cum Annual Meeting** Organiser: HKMA Yau Tsim Mong Community Network; Chairman: Dr. LAM Tzit Yuen, David; Speaker: Dr. TONG Chun Yip, Peter; Venue: Jade Ballroom, Level 2, Eaton, Hong Kong, 380 Nathan Road, Kowloon	Ms. Candice TONG Tel: 2527 8285 1 CME Point
28 SAT 2:30 PM	**MPS Workshop – Mastering Adverse Outcomes – 2 hours** Organiser: The Hong Kong Medical Association & Medical Protection Society; Speaker: Dr. Justin CHENG; Venue: Holiday Inn Golden Mile, 50 Nathan Road, Kowloon	HKMA CME Dept. Tel: 2527 8452 2 CME Point
29 SUN 11:40 AM	**Scientific Symposium: Nuclear Medicine- From Organs to Molecules** Organiser: Hong Kong Society of Nuclear Medicine and Molecular Imaging; Speakers: Prof Henry BOM, Prof Jun HATAZAWA, Prof Yaming LI, Prof John BUSCOMBE; Prof Wen Sheng HUANG, Prof David YEUNG; Venue: Ball Room, Hyatt Regency Hong Kong	Mr Mike HUNG Tel: 2339 7430 3 CME Point
1:30 PM	**HKMA Family Sports Day 2015** Organiser: The Hong Kong Medical Association; Venue: Stanley Ho Sports Centre	Miss Ada SIU Mr. Ian KWA Miss Denise KWOK Miss Hei Man CHAN Tel: 2527 8285

Upcoming Meeting

4/12/2015	**HKPGA Capacity Conference cum Annual General Meeting 2015** **Pre-conference Workshop on Mental Capacities** Organiser: Hong Kong Psychogeriatric Association; Speakers: Prof Sanford I. FINKEL, Prof Camelle PEISAH, Ms Olivia SM LEUNG; Venue: Thornton Room & Huthart Room I, 3/F, South Tower of the YMCA-The Salisbury Hotel	Ms Jossy TIN Tel: 2516 6128 Website: www.hkpga.org/main.php?id=141
31/12/2015	**FMSHK Annual Dinner 2015** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Run Run Shaw Hall, The Hong Kong Academy of Medicine Jockey Club Building, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong	Ms Eva TSANG Tel: 2527 8898

Certificate Course for Medical Practitioner, Nurse, Health Care Providers & Allied Health Workers
General Public is also welcome if interested

Course No. C273
CME/CNE Course

Certificate Course on
Wilderness Medicine

Title : Wilderness Medicine: An adventure of Emergency Physicians & Practitioners in the wild
野外醫學: 急診醫生及醫療專業人員的野地歷險記

Jointly organised by

The Federation of Medical Societies of Hong Kong

Hong Kong Society for Emergency Medicine and Surgery

Objectives:

Wilderness activities have rapidly grained an increase in popularity among Hong Kong citizens in recent years. However wilderness environment possess a totally different type of threats and dangers to those participants that are involved in wilderness activities. This course aims at providing the basic medical knowledge on wilderness medicine and specific practical information related to the medical problems that might arise in wilderness environment.

野外活動過去幾年在香港迅速普及。但野外環境對於野外活動的參與者，會造成完全不同類型的威脅和危險。本課程旨在提供基本的野外醫學知識、及對在野外環境中可能出現的醫療問題之相關實用處理技巧。

Date	Topics	Speakers
11 Nov	Introduction to wilderness medicine & wilderness medicine for backcountry 野外醫學及偏遠地區的野外醫學介紹 Lightning injury in wilderness environment, its prevention & management 在野外環境的雷擊傷害，其預防與處理	Dr. Chee Pay Yun, Peter 池丕恩醫生 香港急症科醫學院院士
18 Nov	Problems related to heat and cold in wilderness environment, its prevention & management 在野外環境因高溫及低溫所引發的問題，其預防與處理	Dr. Law Kam Leung 羅金亮醫生 香港急症科醫學院院士
25 Nov	Poisonous stings and bites in wilderness; First aid and management in wilderness situation 在野外被毒物蜇咬的急救與處理	Dr. Ng Wah Shan 伍華山醫生 香港急症科醫學院院士
2 Dec	High altitude related problems in wilderness, its prevention and management 野外高海拔所引發的相關問題，其預防與處理	Dr. Ho Man Kam 何文錦醫生 香港急症科醫學院院士
9 Dec	Management of accident & trauma in wilderness environment, wound care and fracture management in wilderness situation 野外事故及意外創傷，傷口及骨折在野外情況的處理	Dr. Siu Yuet Chung, Axel 蕭粵中醫生 香港急症科醫學院院士
16 Dec	Helicopter SAR (Search And Rescue) for Wilderness victims, Experience from AMNO in GFS 對於在野外傷者的直升機搜尋和救援 政府飛行服務隊航空醫療護士的經驗體會	Mr. Kwok Shing Lam 郭成霖先生 政府飛行服務隊 航空醫療護士 急症室護士長

Dates : 11 November 2015 – 16 December 2015 (Every Wednesday)
Time : 7:00 pm – 8:30 pm
Venue : Lecture Hall, 4/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong
Language Media : Cantonese (Supplemented with English)
Course Fee : HK$750 (6 sessions)
Certificate : Awarded to participants with a minimum attendance of 70%
Enquiry : The Secretariat of The Federation of Medical Societies of Hong Kong
Tel: 2527 8898 Fax: 2865 0345 Email: info@fmshk.org

CME / CNE / CPD Accreditation in application
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Answers to Dermatological Quiz

Answer:

1. Onychomycosis
   The diagnosis is onychomycosis that is a fungal infection of nails. It can involve any component of the nail unit including nail matrix, bed and plate. Other differential diagnoses are psoriasis involved nails, lichen planus, nail dystrophy due to trauma and sometimes malignant melanoma if the discolouration is dark.

2. Clipping the nail for microscopy, fungal culture, histopathological examination
   Direct microscopy examination of the clipping nail with 20% potassium hydroxide (KOH) may see fungal hyphae. Fungal culture may help to identify the species of fungus and sometimes histopathological examination with Periodic-Acid-Schiff (PAS) stain may also help to identify the presence of fungus in the nail. A negative mycological result does not rule out the diagnosis as 10% and 30% of cases are negative in direct microscopy examination and in fungal culture respectively[1].

3. Sexual History and HIV Test
   Onychomycosis can be broadly classical into three clinical types: (1) Proximal Subungual Onychomycosis (PSO) – Fig 1. from our patient; (2) Distal Lateral Subungual Onychomycosis (DLSO) – Fig 2. from other patient and (3) Superficial White Onychomycosis (SWO). DLSO is commonly seen which affects the distal and lateral part of the nail as Fig 2 shown. However, PSO mainly affects the proximal part of the nail, though not pathognomonic, it is more commonly found in immunocompromised patients. Therefore, sexual history and HIV test are important in our patient and he was found to be HIV positive.

4. Systemic Antifungal Treatment
   Systemic antifungal is the mainstay of treatment such as terbinafine and itraconazole in our patient. Both may cause liver function derangement. Itraconazole is metabolized through cytochrome P-450 so drug interaction should also be alert. Topical treatment should be limited to patients with mild disease or unable to tolerate systemic treatment only. Combined systemic and topical treatment may increase the successful rate.

Reference

[1] Lilly KK, Koshnick RL, Grill JP, et al. Cost-effectiveness of diagnostic tests for toenail onychomycosis: a repeated-measure, single-blinded, cross-sectional evaluation of 7 diagnostic tests. J Am Acad Dermatol. 2006 Oct;55(4):620-6.

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Specialist in Dermatology and Venereology

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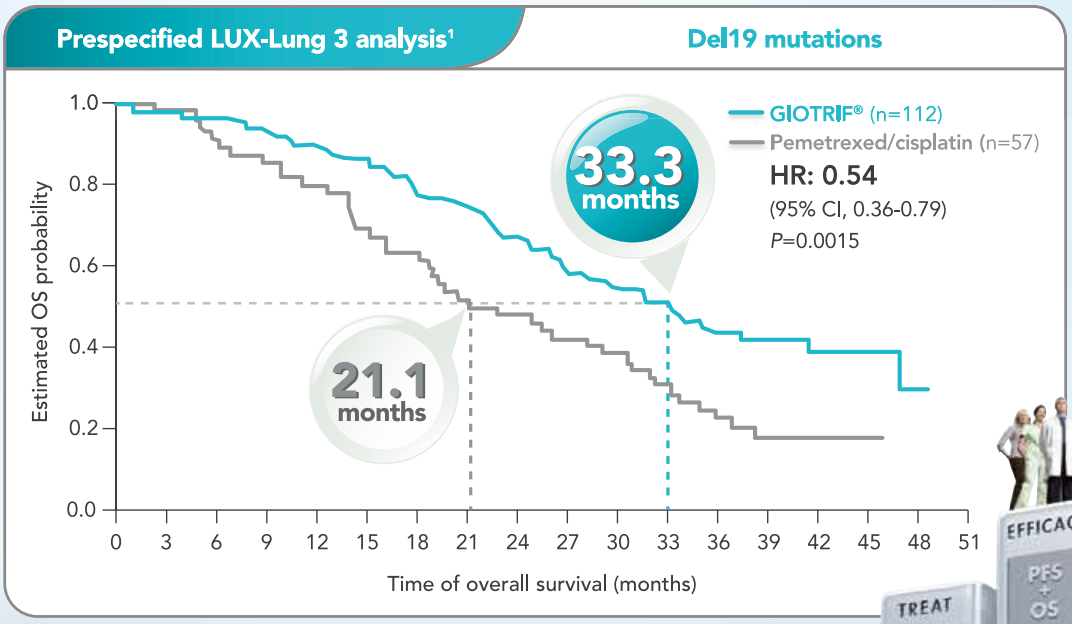
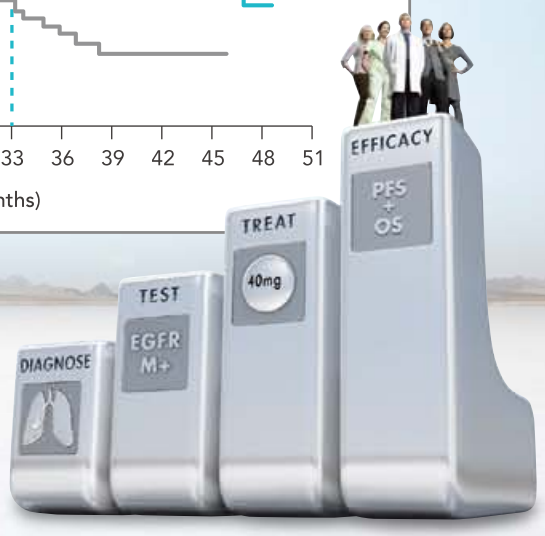
A light of hope in overall survival for EGFR M+ advanced NSCLC

Pronounced first-line OS* benefit in del19 patients, with over 1 year extended survival vs pemetrexed/cisplatin in LUX-Lung 3[1]





- 46% reduction in risk of death in del 19 mutation[1]. (HR:0.54, P=0.0015)
- Giotrif medium overall survival reached 33.3 months vs chemotherapy 21.1 months[1].

* OS – overall survival

Reference: 1) Yang J, et al. *Lancet Oncol.* 2015 Feb;16(2):141-51.

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Dose and Administration: 40 mg once daily. Symptomatic adverse reactions (e.g. severe/persistent diarrhoea or skin related adverse reactions) may be successfully managed by treatment interruption and dose reductions or treatment discontinuation. Not recommended in patients with severely impaired renal function (< 30 ml/min creatinine clearance) and severe hepatic impairment. Tablets should be swallowed whole with water or dispersed in water and consumed immediately. Tablets should be taken without food. Food should not be consumed for at least 3 hours before and at least 1 hour after taking GIOTRIF.

Contraindications: Hypersensitivity to afatinib or to any of the excipients.

Warnings and Precautions: Diarrhoea, including severe diarrhoea, has been reported most frequently within the first 6 weeks of treatment. Severe diarrhoea may require interruption and dose reduction or discontinuation of therapy. Rash/acne has been reported which may occur or worsen in areas exposed to the sun. Severe skin reactions may require temporary interruption of therapy, dose reduction, additional therapeutic intervention and referral to a specialist. Closer monitoring in female patients, patients with lower body weight and those with underlying renal impairment is recommended. Treatment should be interrupted if ILD is suspected. If ILD is diagnosed GIOTRIF should be permanently discontinued and appropriate treatment initiated. Pre-existing liver disease: periodic liver function testing is recommended. Worsening of liver function: dose interruption may become necessary. If severe hepatic impairment develops, treatment should be discontinued. Acute or worsening eye inflammation, lacrimation, light sensitivity, blurred vision, eye pain and/or red eye: refer promptly to an ophthalmology specialist. If ulcerative keratitis is confirmed, treatment should be interrupted or discontinued. Use with caution in patients with a history of keratitis, ulcerative keratitis or severe dry eye. Cardiac risk factors, conditions that can affect LVEF and those who develop cardiac signs/symptoms during treatment: cardiac monitoring including LVEF assessment should be considered. Ejection fraction below the institution's lower limit of normal: cardiac consultation and treatment interruption or discontinuation should be considered.

Interactions: Administer strong P-gp inhibitors using staggered dosing, preferably 6 hours or 12 hours apart from GIOTRIF. Strong P-gp inducers may decrease exposure. Afatinib may increase the bioavailability of orally administered BCRP substrates (e.g. rosuvastatin and sulfasalazine).

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