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香 港 醫 訊

VOL.22 NO.9 September 2017

Child Psychiatry

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

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#Abilify is indicated for treatment of Tourette's Disorder (6-18 years) in US and Korea[3]

References:
1. Abilify Package Insert **2.** Yoo HK, *et al. J Clin Psychiatry.* 2013 Aug;74(8):e772-780 **3.** Data on file

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ABF 201703 (approved in Aug 2017)

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ABILIFY® (aripiprazole)

Contents

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Disclaimer

The Cover Shot

The photos on the cover catch moments of how kids live their lives in the world. We are inspired by these wonderful children from various places.

① **We love nature**
Many children were playing balloons at the sea front during sunset in Myanmar. They were naked, free of any constraint and playing happily in the water, showing their love of nature and enjoyment of freedom in their childhood

② **Working day and night**
Two Iranian kids were selling gums and snacks to locals and tourists, working day and night

② **We love football**
These Iranian boys were enjoying football even without proper footwear

③ **Playing day and night**
The two kids at Hoonah, Chichagof Island, Alaska were playing at the seashore in the afternoon till sunset in summertime

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Editorial

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Editor

Dr Phyllis Kwok-ling CHAN

Child and adolescent mental health has been the focus of psychiatric service in the past few years. The ever across the board increase in referrals and long waiting time coupled by the media's alarming cluster of student suicides in 2015-16 have put child and adolescent psychiatry in the limelight.

The Report from the expert group, Committee on Prevention of Student Suicide of the Education Bureau (EDB)[1] released in November 2016 has addressed a long list of factors which have interacted and contributed to students' suicidal behaviours, including mental health issues, psychological concerns, family relationship and adjustment problems, peer relationship problems, school adjustment and academic stress.

The position statement of the child and adolescent psychiatry clinical division of the Hong Kong College of Psychiatrists[2] has highlighted the priorities in managing this complex problem.

Adequate resources in current psychiatric services, in tier 2 (out-reach child and adolescent mental health team at school) and also in tiers 3 and 4 (specialist child and adolescent psychiatric out-patient clinic, day hospital and in-patient services) are needed to ensure efficient and effective services for those identified patients who need timely psychiatric intervention.

Currently effort is being put into the pilot "Student Mental Health Support Scheme" in which child and adolescent psychiatric advanced practice nurses (APN) are deployed to provide school based service to both known and unknown mental health cases in collaboration with school professionals like school or family service social workers, school guidance teachers and educational psychologists. This service will be evaluated and hopefully could be rolled out to all the territory wide over 1000 schools in Hong Kong.

Before the titanic change in education and school system as well as mental health policy and service could be made, changes in the mentality of parents, public and all of us on mental illness could be fostered. Destigmatisation of mental illness is the uphill arduous battle we have to fight. It is the main theme of the College's Public Awareness Committee public education work as that could minimise obstacles to access of service, enhance medication adherence and facilitate voluntary hospitalisation of high risk /severe cases. The Hong Kong College of Psychiatrists has launched the "Look at MI" public education programme promoting destigmatisation of mental health among secondary students. Not only attending lectures on mental diseases, they also embark on self-initiated projects with various NGO partners to increase their social contact time and understanding with mental health service users. We hope that mental health education will be integrated into the curriculum for both primary and secondary education with both theory and experiential

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** 59% improvement; 34% stable; 7% deterioration

ABILIFY® (aripiprazole) is indicated for the treatment of irritability associated with autistic disorder in pediatric patients (aged 6 to 17).[3]

PedsQL™ = Pediatric Quality of Life Inventory™ HRQOL = Health-Related Quality of Life

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1. Levy SE, Mandell DS, Schultz RT. *Lancet.* 2009;374:1627-1638 **2.** Varni JW, Handen BL, Corey-Lisle PK, *et al. Clin Ther.* 2012;34:980-992 **3.** ABILIFY® package insert.

For the product's safety, contraindications and side effects or toxic hazards, please refer to the package insert. Detailed information is available upon request.

ABF 201602 (revised in Aug 2017)

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ABILIFY® (aripiprazole)

learning. The young mind is always more open and highly neuroplastic.

In this issue, the child and adolescent psychiatry team of Queen Mary Hospital which takes care of the child and adolescent psychiatric service of both HKWC and HKEC focuses on **child and adolescent depression, deliberate self harm (DSH) and suicide** with real life case report/ illustration, updates and discussion on controversial issues. The CME by Dr C Ho would help clarify concepts and fallacies common in the management of adolescent depression.

The lifestyle page by Dr Wilfred Wong is a book review of Albert Camus' existential work The Plague. It explores how people reacted differently in face of adversity and the prospect of certain mortality, mirroring the dire setting of Post-war Europe in which the novel was published.

In conclusion, I would like to share with you the story of Mr Bondevik, the Prime Minister of Norway, who have had served in this position for the longest time after World War II. He was diagnosed to have depression in 1998. The vice prime minister had to take over his job for about three weeks during his treatment. After he was cured, he told his citizens about his mental illness. Not only did he receive comfort and support from them, which made him relieved from hiding up his depression, but also he won re-election of prime minister in 2001. We can see that Norwegians were not prejudiced against psychiatric disorders. In fact, the society needs someone who suffers and recovers from psychiatric disorders to share his/her journey of treatments and recovery. Such information could prevent the public from stigmatising psychiatric disorders and enhance the confidence of the patients on their recovery.

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Depression in children and adolescents

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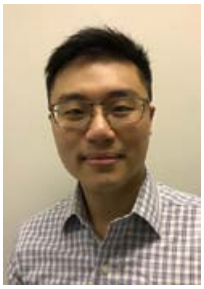

Dr Chung HO Dr Wilfred Shone-horn WONG

This article has been selected by the Editorial Board of the Hong Kong Medical Diary for participants in the CME programme of the Medical Council of Hong Kong (MCHK) to complete the following self-assessment questions in order to be awarded 1 CME credit under the programme upon returning the completed answer sheet to the Federation Secretariat on or before 30 September 2017.

Case illustration:

Ms. Wong was a 16 year-old F4 student who had a history of systemic lupus erythematosus (SLE) for over six years and had symptoms of significant fatigue, bone pain, daily headaches, limb weakness and low grade temperature. As such, she had been missing school 90% of the time for the past 1-2 years.

She complained of a chronic period of on and off low mood since 4-5 years ago. However, she was still able to fairly enjoy herself when she was drawing (a very talented artist), playing music or hanging out with her friends. Since P.4, she was afraid of teachers asking her questions in class and would freeze in class in such situations. There were certain days in which she was particularly anxious before school and for 2-3 hours after the start of school (with symptoms of anxiety and sweating). Whilst being able to attend around 50 percent of her classes in P4-P6, she had only managed to attend 10 percent of them after starting secondary school.

Her mood deteriorated further in the past half a year as it was precipitated by the closing down of her parents' restaurant. Subsequently, they had moved to a much smaller flat. Her financial fund that was set up for her future use was reallocated to support the family instead.

She had difficulty falling asleep in the recent half a year and was only able to manage 2-3 hours of sleep. Her appetite worsened and she was eating only a meal a day. She had a slight drop of weight and felt that her clothes were a bit looser. She had decreased volition in painting, meeting her friends who paint, playing the violin or working with Photoshop. She was still drawing regularly but her mother noticed that her drawings had darker themes than before. She was still attending private tutorial classes everyday. She had low levels of energy and would lounge around at home and did not have much social interaction. She would watch some videos or television at times but was noted to have poor concentration and was at times unable to recall the content of the show. She was not hopeful about the future. Lately, she had become easily irritable and more withdrawn from her extended family. She refrained from meeting her friends and had found them irritating. She had frequent thoughts of self-harm and had thought about jumping from height or drowning herself. She had not had any concrete plans or committed any tangible act of self-harm.

She was diagnosed to have moderate to severe depressive episode after thorough assessment by the child and adolescent psychiatrist. The management options and plan were discussed with the patient and her parents. They agreed to start Fluoxetine at 10mg daily with a plan to titrate further depending on clinical response. She was also arranged to have follow up sessions with a clinical psychologist. The long-term plan would include reintegrating the patient into more social support once her mood improves. The patient might be encouraged to participate more in regular drawing classes that would help her develop her talents and friendships. Regular follow-ups at the psychiatric out-patient clinic would be arranged for her.

Introduction

Depression, whilst often recognised in the adult population, is often under-recognised in the child and adolescent population. It is often misunderstood by the general public and even some medical professionals that this clinical entity does not occur in patients of a tender age. Some attribute depressive symptoms as merely "going through a phase" or simply a normal reaction to the pressures of society at large. On the other hand, the presentation of depressive symptoms in this population varies from that of the adult population, further impeding early recognition of a mood disorder in some cases.

The point prevalence of depression increases as the age of a child increases, increasing from 0.5 percent (3-5 years of age) to 3.5 percent (12-17 years of age).[1] The same study showed that there was a one year prevalence of 8 percent (12-17 years of age). Another study measured a lifetime prevalence of 11 percent (also in adolescents).[2]

In children, depression seems to be more common in boys than girls.[3] In adolescents, females seem to outnumber males by 2:1 in developing major depressive episodes.[4]

1 *Perou R, Bitsko RH, Blumberg SJ, et al. Mental health surveillance among children--United States, 2005-2011. MMWR Suppl 2013; 62:1.*

2 *Avenevoli S, Swendsen J, He JP, et al. Major depression in the national comorbidity survey-adolescent supplement: prevalence, correlates, and treatment. J Am Acad Child Adolesc Psychiatry 2015; 54:37.*

3 *Douglas J, Scott J. A systematic review of gender-specific rates of unipolar and bipolar disorders in community studies of pre-pubertal children. Bipolar Disord 2014; 16:5.*

Presentations, Symptoms and Diagnosis

According to the DSM-5 criteria by the American Psychiatric Association, a Major Depressive Disorder is diagnosed when a patient presents with five (or more) of the following symptoms (with at least one of the symptoms being depressed/irritable mood or loss of interest/pleasure). The symptoms are usually present nearly every day and are in some cases present throughout most of the day during the same 2-week period:

1) Depressed or irritable mood
2) Markedly diminished interest of pleasure in daily activities
3) Significant weight loss (or make weight gain in children)
4) Sleep disturbance (insomnia/hypersomnia)
5) Psychomotor agitation/retardation
6) Fatigue or loss of energy
7) Feeling of worthlessness or inappropriate guilt
8) Difficulty in concentration
9) Recurrent thoughts of death or suicidal ideation.

Depressed mood is often the very first indicator in adult populations when it comes to the recognition of a depressive disorder. Patients may feel low, sad or helpless and hopeless about their situation. However, it has been found that this condition can be masked instead as irritable mood in children because of a lack of ability in organising their emotional experiences.[5] A child who is irritable might be constantly easily annoyed by siblings, parents, schoolmates or teachers. They might become argumentative and would pick verbal or even physical fights in some cases. Temper tantrums are also commonly seen. It can be understood that parents of such children might easily dismiss this symptom as that of a child who is spoilt or in need of discipline instead of a case in which medical help might need to be sought. However, it is known that depressed mood rather than irritable mood still seems to be the more common type of presentation. A large prospective study of a paediatric population with depressive disorders showed that 58 percent of children presented with depressed mood, whilst 36 percent presents with a combination of depressed and irritable mood.[6] In contrast, only 6 percent of the cases presented with a solely irritable mood. Despite this, it must be considered that those who present with only an irritable mood might be under-diagnosed.

Whilst adults presenting with a loss of appetite might present with a noticeable loss of weight or change in clothing sizes, some children present with a failure in achieving weight/height gain as expected. At times, these children would present to primary care or paediatricians as a case of growth stunt.

Children or adolescents presenting with a sense of worthlessness can be difficult since some have difficulty expressing or even understanding such negative thoughts. It may instead manifest itself in ways such as reluctance to try something new, excessive guilt about a failed parental marriage, a difficulty in identifying their own strengths or being overly critical of themselves (and thus pushing themselves to achieve more academically or otherwise).

Impaired concentration can often be masked and some parents would even consider whether their child has suffered from an attention disorder. Similar to ADHD, these patients would present with procrastination or a poor ability in completing their homework on time or study for their classes. It is very common to see a noticeable decline in school grades when compared to a premorbid level. When compared with ADHD, the problem in concentration and attention can be seen to be manifested after the onset of mood problems instead of being present throughout most of the child's lifetime.

The qualifier in DSM-5 states that the above symptoms cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning". In children and adolescents, this is often manifested as problems at home and at school. Schoolwork might decline, relationship with peers and teachers might deteriorate and extra-curricular activities might suffer. At home, this might cause tension between the child and his/her parents or his/her siblings. At this crucial time point of their lives, children/adolescents are actively building up new friendships and relationships and are robustly developing an evolving and vibrant personality/persona. Mood problems at any point could jeopardise their ability to continue friendships or continue thriving academically (perhaps via an injured self-esteem). Some might develop as school anxiety or even school refusal.

Early detection, recognition and risk profiling are the very important cornerstones in the management of depression in children and adolescents.

Comorbidity

Comorbid diagnoses and developmental, psycho-social and educational problems should be thoroughly assessed and managed. Psychiatric comorbidity is very prevalent amongst children and adolescents who present with depression.

The most common comorbidities include Attention Deficit Hyperactive Disorder, Anxiety Disorder, Oppositional Defiant Disorder and Substance abuse. Children with ADHD often have a chronic difficulty in executive functioning and ability to concentrate academically. These can easily lead to self-esteem issues amid criticisms from themselves, teachers or their parents. As such, this can potentially lead to mood disorders. Anxiety disorders that are present in social situations or school situations are also quite common in patients with depression. Whilst substance abuse can lead to the onset of depression, it should be acknowledged that some adolescents turn to drugs, alcohol or tobacco in order to self-medicate and this might also lead to a long-term problem.

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5 *Cicchetti D, Toth SL. The development of depression in children and adolescents. Am Psychol 1998; 53:221.*

6 *Stringaris A, Cohen P, Pine DS, Leibenluft E. Adult outcomes of youth irritability: a 20-year prospective community-based study. Am J Psychiatry 2009; 166:1048.*

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20 Sep	Chronic pulmonary infection (TB/Non-tuberculosis mycobacterium)	Dr Ida WONG AC (Med), HHH
27 Sep	Non-invasive ventilation, Acute vs Chronic	Dr PS CHEUNG AC (Med), UCH
11 Oct	Palliative care for patients with advanced Respiratory disease	Dr Jeff NG AC (Med), HHH Ms TC NG (APN), HHH
18 Oct	Multidisciplinary approach to Pulmonary rehabilitation	Dr Thomas MOK COS (RMD), KH Mr Eddy CHEUNG PT, KH
25 Oct	Diagnostic investigations and Pharmacotherapy for chronic airway disease	Dr Maureen WONG COS (MG/ICU), CMC

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Management and Treatment

The treatment of depression in children and adolescents requires an input and cooperation between a plethora of agents. Family members are obviously important as they provide invaluable insight into the patients' presenting symptoms and functional status at home. They are also important as their cooperation and understanding of the patients' condition directly influence the compliance to treatment or even the default rate on follow-up. Familial stressors frequently play a big part on the patients' psychological well-being and conflicts or parental discord can often lead to depression. On the other hand, the school is also another invaluable resource. School social workers, teachers or other school personnel can often inform us of the patients' academic performance and social well-being at school. A hostile or unforgiving schooling environment could also lead to significant mood disorders. Therefore, collaboration between the health provider, the patient, the family and the school could greatly influence the outcome of a patient's treatment.

For patients with moderate to severe depression, the current recommendation would be a combination of pharmacotherapy and psychotherapy. In light of the significant psychosocial aspects of depression, the combination of medications and psychological intervention could help enhance the patients' cognitive and behavioural skills. Cognitive Behavioural Therapy is most often used for psychotherapy in the treatment of children and adolescents with depression. Sole pharmacotherapy is still efficacious when used alone for reasons including the unavailability of service or during severe depressive episodes unamenable to psychotherapy.[7] Other meta-analysis and studies also suggest that combination therapy is superior to sole pharmacotherapy in terms of functioning of decrease in suicidal ideation.[8,9]

The first line medication used for depression in children and adolescents is usually a Selective Serotonin Reuptake Inhibitor (SSRI). The most commonly used SSRI in this population is Fluoxetine. It is the most studied SSRI in the paediatric population and its safety profile has been most investigated. It is also seen to be the most efficacious. Sertraline is another reasonable choice, especially in patients who do not respond to Fluoxetine. Other choices include escitalopram, citalopram or venlafaxine. Generally, a period of 6-12 weeks should be allowed for observation of effects.

In general, treatment should continue for 6-12 months after a patient's depressive symptoms have resolved. At that point, the clinician would have to determine whether treatment should be continued or not. It is often a decision that has to be made between the psychiatrist, the patient and the family members. For cases with recurrent depressive episodes or severe episodes, it might be safer to maintain the treatment for a longer period of time.

In 2004, the FDA has asked manufacturers of antidepressants to include a warning stating that antidepressants may increase the risk of suicidal ideation in children and adolescents. It has been rather difficult to prove any association but there appears to be a very slight increase in the risk of suicidal ideation when compared with placebo alone. However, considering that pharmacotherapy is effective in treating depression, the consensus is that the benefit of using pharmacotherapy outweighs the risk. The rate of response to medication vs. a suicidal decent is around 11:1. Despite this, it is recommended that the child and adolescent psychiatrist should discuss this issue with family members before prescription of antidepressants. If a child or young person is started on antidepressants treatment, they and their parents should be informed about the rationale for the drug treatment, the time course of treatment and the possible side effects/risks.

Conclusion

Depression in the child and adolescent population is often overlooked and under-diagnosed. With proper training and understanding, such cases could be identified by teachers, parents and other school-based health care providers. Timely bio-psycho-social interventions could greatly improve the quality of life of both the patients and their carers. With normalisation of school life and family life, lifelong impairment and repercussions on work and social life could be avoided. With your help, we are not merely treating children; we are building better pillars for the future.

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9 *Dubicka B, Elvins R, Roberts C, et al. Combined treatment with cognitive-behavioural therapy in adolescent depression: meta-analysis. Br J Psychiatry 2010; 197:433.*

MCHK CME Programme Self-assessment Questions

Please read the article entitled "Depression in children and adolescents" by Dr Chung HO and Dr Wilfred Shone-horn WONG and complete the following self-assessment questions. Participants in the MCHK CME Programme will be awarded CME credit under the Programme for returning completed answer sheets via fax (2865 0345) or by mail to the Federation Secretariat on or before 30 September 2017. 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. **Depression is often under-recognised in children and adolescents.**
2. **Depression in children and adolescents is more common in boys than girls.**
3. **According to the DSM-5 criteria, depressive symptoms should be present nearly every day or most of the day during the same four-week period.**
4. **Depression may present as irritable mood in children and adolescents.**
5. **Depression in children and adolescents may present as failure in achieving expected weight or height gain.**
6. **Children or adolescents with depression may develop anxiety symptoms related to school or even school refusal problems.**
7. **Psychiatric comorbidity is rare in children and adolescents suffering from depression.**
8. **Pharmacotherapy is contra-indicated in the treatment of depression in children and adolescents and should not be used in all cases.**
9. **The benefit of using pharmacotherapy in the treatment of moderate to severe depression in children and adolescents outweighs the risk.**
10. **In general, for the first depressive episode, anti-depressant medication should continue for 6-12 months after the patient's depressive symptoms have resolved.**

ANSWER SHEET FOR SEPTEMBER 2017

Please return the completed answer sheet to the Federation Secretariat on or before 30 September 2017 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

Depression in children and adolescents

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Answers to August 2017 Issue

Diagnostic Approaches to Common Head & Neck Masses

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

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* MADRS - Montgomery-Åsberg Depression Rating Scale

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Dermatological Quiz

Dr Lai-yin CHONG

MBBS(HK), FRCP(Lond, Edin, Glasg), FHKCP, FHKAM(Med)
Specialist in Dermatology & Venereology

Dr Lai-yin CHONG

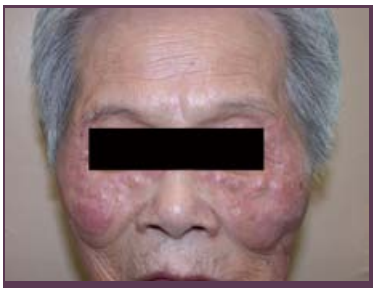

Fig.1: Erythematous indurated plaques over both periorbital areas and cheeks

A 61-year-old lady complained of itchy, non-tender, indurated erythematous plaques over her periorbital areas and cheeks (Fig.1) for ten years. There was no ulceration or erosion over the lesions and no regional lymphadenopathy or organomegaly. She had a concomitant history of idiopathic thrombocytopenia for many years. Her lipid profile only showed a slightly raised cholesterol level. All other biochemical tests including thyroid function were normal. No paraprotein could be found.

A skin biopsy had been performed which showed diffuse dermal infiltrate of histiocytes that ranged from spindle-shaped cells, to oval cells and to large foamy cells. Touton giant cells together with admixed inflammatory components consisting of eosinophils, plasma cells and lymphocytes were also present. However, typical hyaline necrobiotic changes were not detectable.

Questions

1. What is your diagnosis based on the clinical and pathological pictures?
2. What are the other differential diagnoses?
3. What are the important associated systemic diseases that must be watched out for?

(See P.35 for answers)

Deliberate Self Harm (DSH) in children and adolescents

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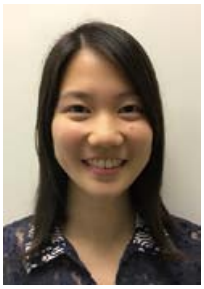

Dr Joyce Sing-yan LAU Dr Sarah Theresa CHUNG

Introduction

"Deliberate Self Harm (DSH)" is defined as an intentional act of self-injury or self-poisoning, irrespective of the motivation or the severity of the suicidal intent (Hawton 2003). It includes acts with real intentions to die, those without suicidal intent such as to release stress or communicate distress and those with mixed motivation (Hjelmeland 2002; Scoliers 2009). It is a major health care and social problem worldwide and has strong associations with suicide (Hawton 2012). Non-suicidal self-injury has been discussed to be included in the DSM-V as a separate diagnostic entity as well, as it is often present in patients with borderline personality disorder.

Epidemiology of Deliberate Self Harm (DSH) in children and adolescents

The accurate statistics for DSH are difficult to establish as most figures are derived from hospital admission records in which the definition may vary. Moreover, a considerable number of people are seen in primary care or may not seek for any treatment. Only around one in eight adolescents in the community who self-report engaging in DSH ever presents to the hospital (Hawton 2002; Ystgaard 2009; McMahon 2014).

Its prevalence ranges from 3.7% to 23.5% in young people worldwide. (Law BM 2013, Tormoen 2013, Liang S 2014). In Hong Kong, a study involving a large sample of Grade 8 students showed that 23.5% had engaged in self-harm behaviours in the past 12 months (Law, 2013). It is much more common in female than male adolescents (Evans 2005). DSH becomes more frequent in girls by twelve years old. The female to male ratio reaches five or six to one from twelve to fifteen years old. (Hawton 2003). It is likely explained by the increased prevalence of alcohol use and depression in young females. (Patton 2007). It is more common among adolescents from the lower socioeconomic class (Burrows 2010).

Methods of Deliberate Self Harm (DSH)

The majority of children and adolescents presenting to hospitals for DSH are involved in self-poisoning, most commonly overdosing analgesics such as Panadol (Hawton 2012b; Sheen 2002). Whereas for repeaters and older people, overdosing of antidepressants and tranquillisers were more common. The above difference might be explained by the differential availability of the medications.

The second most common method for teenagers who present to the hospital is self-cutting. Self-cutting is classified as superficial, deep or self-mutilation. Self-mutilation involves pricking at a wound or carving on skin. Patients who had self-mutilation were more likely to suffer from dysthymia, depression or oppositional defiant disorder. Deep cuts involving tendons, blood vessels or nerves were associated with higher suicidal intents.

In Hong Kong, the most common form of DSH among adolescents is related to inflicting wounds by direct cutting or scratching, whereas self-hitting is the most prevalent among adolescents in the China Mainland (Law 2013). Common areas for cutting include the wrists, lower arms and thighs. They may sometimes cut the shoulders, chest, abdomen or inner thighs to hide up the scene and occasionally cutting the neck.

Aetiology of Deliberate Self Harm (DSH)

The causal mechanisms leading to DSH are usually multifactorial, involving biological, psychological, social and cultural factors.

Some reports mentioned that patients who were admitted for DSH, especially those who used violent methods had low levels of cholesterol (Alvarex, 2000; Kim & Myint, 2004), yet other studies were unable to reproduce the same results (Diesenhammer, 2004). It was hypothesised that lipid levels were involved and there is a serotonin-mediated link between suicidality and lower cholesterol. It was also found that these patients had low levels of 5-hydroxyindoleactic acid (5-HIAA) in the cerebrospinal fluid, which served as an index for serotonin release and turnover (Mann & Malone, 1997).

Adolescents commonly suffer from disturbed relationship with family members or receive low level of support from parents. In older adolescents, relationship problems with partners are more common. (Hawton 2012). Bullying, including cyberbullying may also increase the risk of DSH (Hinduja 2010).

Adolescents who have DSH and present to the hospital commonly have formal psychiatric diagnosis which included depression, anxiety, conduct disorder, attention deficit hyperactive disorder, eating disorder, early onset of psychotic illness and drug misuse (Apter & Freudenstein 2000; Hawton 2013). They may also have a history of childhood physical, psychological or sexual abuse (Madge 2011). Adolescents may show evolving personality traits which assimilate borderline personality disorders in adults. (Crowell 2012). Poor emotional regulation and problem solving skills may increase

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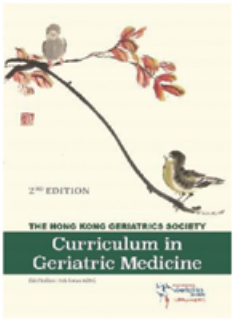

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the risk of DSH in this population (Speckens 2005; Mikolajczak 2009). These youngsters tend to have low self-esteem, no sense of belonging, feelings of entrapment and hopelessness. (O'Connor 2012; Hawton 2012)

Adolescents tend to be impressionable and may be vulnerable to the influence of family members, friends and the mass media, especially the internet or social networking (Hawton 2002; McMahon 2013; Daine 2013; O'Connor 2014).

The "Blue Whale Game" is suspected to be an on line challenge that is linked with teen suicides internationally, according to media reports. The term "Blue Whale" is derived from the phenomenon of beached whales, which appeared to have committed suicides. This challenge is believed to be originated from Russia. A former psychology student called Philipp Budeikin, who was being expelled from the university claimed to have invented the game. He stated the purpose of the game was to push anyone who had no value in the society to commit suicide and targeted on youngsters on social media. Teenagers would be assigned multiple tasks throughout a 50-days period, including watching horror movies, waking up at 4:20 in the morning, engaging in self harm behaviours and ultimately taking their own lives in the form of hanging or drug overdosing as their last tasks.

The following case vignette illustrated an adolescent who was involved in the "Blue Whale Game" under peer influence on the social network and engaged in DSH.

Case Illustration

An 11-year-old girl, new to the mental health service, was seen at the emergency department for DSH of slashing her wrist. She was a Primary Six student at a local band 1 school, living with her parents. She presented with three weeks of reactive low mood precipitated by examination stress, teasing by classmates for poor decision making and relationship problems with her best friend and parents.

All along, her interest and energy were well maintained, with no significant biological symptoms. She started to have self-harm behavior of slashing her wrist with scissors in the school toilet after verbal conflicts with her best friend who threatened to cut off their friendship. She expressed wish to release stress and denied any real intention to die.

She was introduced to the "blue whale game" through a friend on the QQ instant messaging service one week prior to her admission to the emergency department. She relished the peer support she received from the other players. On the day of admission, she completed a task assigned by the administrator, which was to slash her wrist and take a photo to prove it. She reported this act to her school social worker and she was brought to the emergency department for further management.

Regarding her personal history, she was born in the Mainland and came to Hong Kong when she was two years old. She had normal developmental milestones and was mainly taken care of by her mother. She had been used to an easy baby but was described to be anxious-prone recently.

At school, she appeared to be obedient and delightful in the lower primary. She used to have fair peer relationship with two to three close friends. She found it hard to sustain their friendship due to change of class by Primary six. The patient started to encounter conflicts with her classmates as they worked on group projects. She was teased for her poor quality of work. She was called names such as "stupid" or "useless" and her groupmates would snatch away her homework. The patient would just bottle up her feelings in face of bullying. Her academic results were below average all along and she ranked bottom three in class every year. She was assessed to have an average intelligent quotient with no learning difficulties. She was required by the school to attend remedial classes twice per week. As she entered Primary six, her academic stress further increased as she had to prepare for the application of secondary school.

There was no family history of mental illness. Her fifty-year-old mother was born in the Mainland and came to Hong Kong twenty years ago. She previously worked as a factory worker and is currently a housewife. She was described to be impatient, controlling and demanding. She would escalate to scolding soon after lecturing for a short while. She threw items on the floor frequently to show her frustration when the patient was unable to follow her command. She denied using any corporal punishment. On the other hand, the patient's father was seventy years old. He was also a mainlander who settled in Hong Kong for more than sixty years. He was primitive, stubborn and out-spoken. He rarely involved in parenting. However, he would scold the patient if the mother ever complained to him about any of her misbehaviour or poor academic results.

In summary, this patient was an eleven-year-old girl who had an anxious-prone personality, poor stress coping ability and suboptimal parenting. She suffered from three weeks of low mood in reaction to academic stress, teasing from classmates and relationship problem with her best friend. She therefore started to engage in DSH on an on line challenge called the "Blue whale game" under peer influence.

Prevention of Deliberate Self Harm (DSH)

The "Blue Whale" phenomenon is observed worldwide and many authorities including China, France, New Zealand and Britain have warned their youngsters against getting involved in the challenge. As illustrated in the above case, even youngsters without a diagnosable mental illness can be easily engaged in these kinds of "games". Adolescents with mental illnesses, not limited to depression or anxiety disorder, are particularly vulnerable. People with autism spectrum disorder may find "friendship" from the game, people with attention deficit / hyperactivity disorder may find "excitement" in the game as well. Therefore, attention should be paid to adolescents with the above listed risk factors, instead of just focusing on whether they have any mental illness. Early recognition of high risk adolescents is the key to prevention and early intervention, via public education, special training to school personnel and family workers, and early availability of medical attention.

A number of countries have put emphasis on improvement in management of patients with DSH

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- **From Clinical to Real World: Updates of Cardiovascular Data in Novel Diabetes Mellitus Drugs**
  Prof. YU Cheuk-man
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  Dr. LEE Ka-kui
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  Prof. CHANG Wing-chung
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  Honorary Associate Consultant, Department of Psychiatry, Queen Mary Hospital
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  Prof. Sandra CHAN
  Associate Professor, Department of Psychiatry, The Chinese University of Hong Kong

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  Dr. SIU Kwai-ming
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behaviour in their suicide prevention strategies (World Health Organization 2014). Special attention has been offered to DSH patients as a high risk group in the National Suicide Prevention Strategy for England and United States. This is due to the high level of psychopathology and significantly increased suicide risk.

About fifteen to twenty-five percent of adolescents return to the same hospital for repeated DSH within one year (Hawton 2008). For adolescents who do not present to clinical care, repetition may also be common (Hawton 2002). Despite much effort spent in the treatment, compliance to the recommended treatment after DSH was observed to be relatively poor. Between twenty five to fifty percent of adolescents did not attend any follow-up sessions (Granboulan 2001; Taylor 1984).

Management of DSH

Currently, only a few studies investigate into the effects of interventions for children and adolescents who engage in DSH. Thus, not much evidence is available for conclusions to draw on. The treatment for DSH in children and adolescents may involve pharmacological, psychological interventions or a combination of both.

Pharmacological interventions

Due to the prevalence of depression in children or adolescents who engage in DSH, pharmacological treatment may include antidepressants. Other drugs may include anxiolytics. (Hawton 2013). However, psychosocial interventions are preferred over drug treatment, partly due to concerns about the increased risk of suicidality (Miller 2014). Treating the comorbidities may help in reducing the frequency of self-harm as it helps in reducing the stress level of the children or adolescents.

Psychosocial interventions

Psychological approaches typically involve brief individual or group-based psychological therapy such as cognitive behavioural therapy or problem solving therapy, family therapy, and contact interventions. Most of them targeted at reducing the risk factors for DSH. Currently, there is no standard psychosocial treatment for DSH in children and adolescents. Availability of psychological services also varies greatly among different countries.

In high income countries, treatment generally consists of a combination of assessment, support, involvement of family and individual psychological sessions. In Hong Kong, this treatment model involves a multidisciplinary team including a medical doctor, a clinical psychologist, social workers (including school and family), and other therapists. At the moment, there are some limited positive findings regarding dialectical behavioural therapy, mentalisation and therapeutic assessment. However, these approaches require further evaluation before any definitive conclusions could be made regarding their clinical use.

Conclusion

In summary, DSH is common in children and adolescents and is caused by the interplay of biological, psychiatric, psychological, social and cultural factors. It is closely linked to future risks of suicide and is causing a considerable burden to the health care system. It is not limited to people with a mental disorder as well. Currently, there is only limited evidence on the effect of interventions for DSH in this population. Future studies on strategies to prevent and manage DSH in children and adolescents are deemed necessary.

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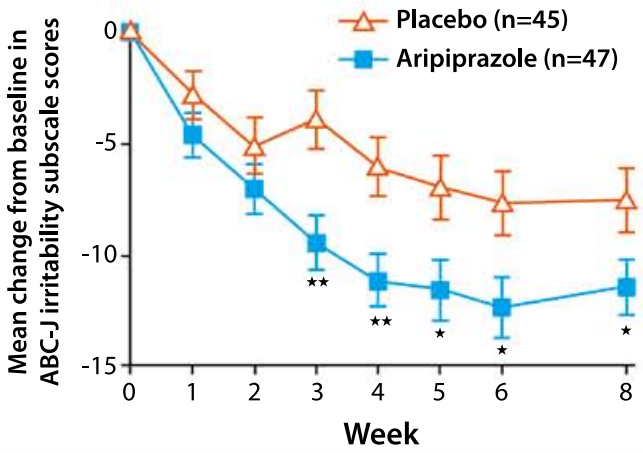
An effective management on irritability for Asian children with Autism[1]

ABILIFY® shown significant favorable TDs in ABC-J irritability subscale from week 3 through endpoint in comparison with placebo[1]

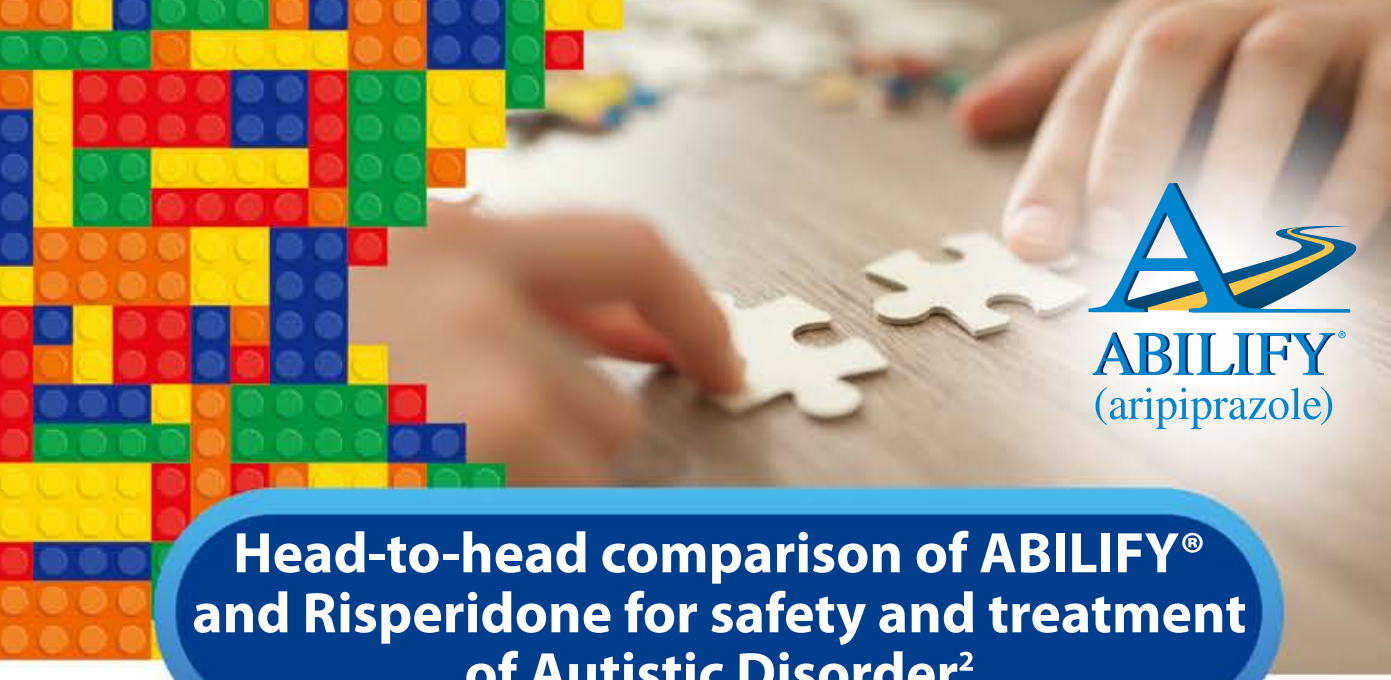


Mean change from baseline in ABC-J irritability score by week (LOCF; efficacy sample). Data are expressed as least squares mean (standard error). *P<0.05; **P<0.01 versus placebo

Low incidence rates with ABILIFY® in:[1]

- Prolactin elevation
- Weight gain
- Changes in triglycerides
- Changes in blood glucose

TDs = treatment differences ABC-J = Aberrant Behavior Checklist Japanese Version ABC = Aberrant Behavior Checklist
LOCF = last observation carried forward

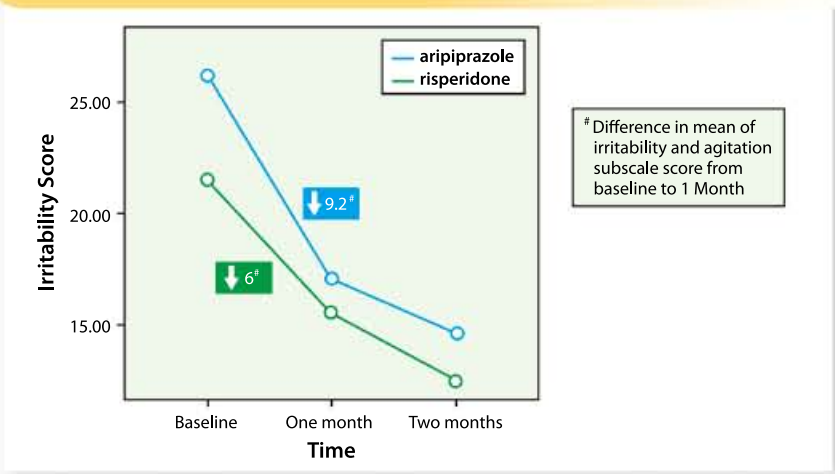


ABILIFY®
(aripiprazole)

Head-to-head comparison of ABILIFY® and Risperidone for safety and treatment of Autistic Disorder[2]

After first month, the decrease in the irritability and agitation subscale score in ABILIFY® group was greater than in Risperidone group

Comparison of irritability subscale score between the two groups during the trial



Study shown ABILIFY had also significantly decreased other ABC subscale scores, including inappropriate speech, hyperactivity and noncompliance, lethargy and social withdrawal, as well as stereotypic behavior.

ABILIFY® (aripiprazole) is indicated for the treatment of irritability associated with Autistic Disorder in pediatric patients aged 6-17 years.[3]

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For the product's safety, contraindications and side effect or toxic hazards, please refer to the package insert.
Detailed information is available upon request.

ABF 201705 (approved in Aug 2017)

Otsuka
Otsuka Pharmaceutical (H.K.) Ltd.

10/F, Phase I, China Taiping Tower, 8 Sunning Road,
Causeway Bay, Hong Kong.
Tel: (852) 2881 6299 Fax: (852) 2577 5206

Certificate Course for health care workers working with patients suffering from advanced life-limiting diseases including cancer and non-cancer diseases

- **Course No. C305**
- **CME/CNE Course**

Certificate Course on

Palliative Medicine for Health Care Workers 2017

Jointly organised by

The Federation of Medical Societies of Hong Kong

Hong Kong Society of Palliative Medicine

Objectives:

With an ageing population and an increasing number of patients suffering from advanced life-limiting diseases, palliative care is essential in improving their quality of life. This course aims to equip health care workers with the knowledge and skills of palliative care including control of pain and other distressing symptoms, effective communication, nutritional support, malignant wound management, palliative anti-cancer treatments and palliative care for non-cancer patients. Apart from theory, practical skills and tips will be discussed.

Date	Topics	Speakers
3 Oct	Pain Management in Palliative Care (I)	Dr. Raymond Kam-wing WOO *Associate Consultant* *Department of Medicine & Geriatrics Caritas Medical Centre*
	Pain Management in Palliative Care (II)	Dr. Yin POON *Resident Specialist* *Department of Medicine & Geriatrics Caritas Medical Centre*
10 Oct	Symptom Management in Palliative Care Other Than Pain	Dr. Alice Ka-wai MOK *Associate Consultant* *Hospice & Palliative Care Unit* *Shatin Hospital*
17 Oct	Communication in Palliative Care	Dr. Rico K.Y. LIU, *Associate Director* *Comprehensive Oncology Centre* *Hong Kong Sanatorium & Hospital*
24 Oct	Palliative Care for Non-cancer Patients	Dr. Jeffrey S.C. NG *Associate Consultant* *Department of Medicine* *Haven of Hope Hospital*
31 Oct	(a) Management of Malignant Wound	Dr. Theresa T.K. LAI *Nurse Consultant* *Palliative Medical Unit* *Grantham Hospital*
	(b) Nutrition in Palliative Care	Ms. Penny CHOI *Dietitian* *Tuen Mun Hospital*
7 Nov	Palliative Radiotherapy, Chemotherapy and Targeted Therapy	Dr. Wong Kam Hung *Consultant* *Department of Clinical Oncology* *Queen Elizabeth Hospital*

Date : 3, 10, 17, 24, 31 October, 2017 & 7 November, 2017 (Every Tuesday)
Time : 7:00 p.m. – 8:30 p.m.
Venue : Lecture Hall, 4/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong
Language Media : Cantonese (Supplemented with English)
Course Fee : HK$750 (6 sessions)
Certificate : Awarded to participants with a minimum attendance of 70%
Enquiry : The Secretariat of The Federation of Medical Societies of Hong Kong
Tel.: 2527 8898 Fax: 2865 0345 Email: info@fmshk.org

CME / CNE / CPD Accreditation in application
Application form can be downloaded from website: http://www.fmshk.org

Suicidality in Adolescents

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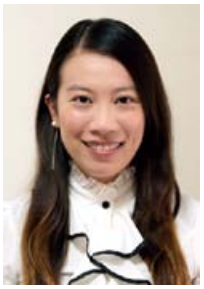

Dr Fong-chun CHAN Dr Maxine Ming-sum CHEUNG

Case Illustration

Angela was a 15 year-old grade 10 student at a local international school. She started studying there 3 years ago when her family moved to Hong Kong due to her parents' work. Angela's parents were from Germany and were both secondary school teachers. Since young, her parents took up different teaching contracts around the world, resulting in Angela having to change schools every 3 to 4 years. When she arrived in Hong Kong at the age of 12, she revealed difficulties adjusting to the new school environment. She was constantly bullied in her class and was unable to make any close friend. Academically, Angela struggled to get the good grades she previously got.

Shortly after beginning school in Hong Kong, Angela expressed doubts about her sexuality, as she felt her hobbies – computer programming, software encoding, bike-riding and soccer – were typical of boys' hobbies rather than girls'. She then started wearing more boyish clothing. She also cut her hair short and tried to go to the gym to build up muscles. Around this time, she also found herself attracted to a girl classmate. Angela felt that she might be suffering from "gender identity disorder" – a term she learnt through the internet – and was somewhat preoccupied with becoming a transgender in the future. Yet when she was 14, Angela dated a boy who attended another international school. Angela then wondered if she was "bisexual".

Angela revealed 2 years ago, she met a group of teenagers on an internet forum, who also shared doubts about their sexuality. She began to chat with them frequently. However, this group also constantly engaged in self-harm behaviours. Since then, Angela started to develop habits of pinching herself, or punching the wall to ventilate frustration. She also began to cut her wrists with a razor blade.

1 year ago, following a stressful school period, Angela used a rope at home and tried to hang herself in her room. The rope broke and she fell. She did not sustain any significant injury consequently. She denied any detailed planning or any last act prior to her suicidal attempt. She was unsure whether she really wanted to die at the time, only that she felt very frustrated at that point.

6 months ago, her father blocked her access to the internet, to which Angela protested. Her mood notably worsened and her self-harm behaviours escalated in frequency. She lost appetite, had disturbed sleep with early morning wakening and she felt tired all the time. She reported more fleeting suicidal ideas of cutting herself to bleed to death. One day before her presentation to the emergency department, Angela used a razor blade to cut her right shoulder more than 10 times until it bled profusely – as she felt she did poorly on a school test that day. She revealed this to her school counsellor the next day, who encouraged her to attend the hospital.

On exploration of the developmental history, she was found to have poor eye contact since young. Socially she had difficulty to make friends. She also tended to be apathetic towards others' misfortune. She had particular interest in internet coding. She was noted to have rigidity in thinking since young, with the tendency to prefer "right or wrong" answers and some difficulties with taking on other people's perspectives.

Angela had a strong family history of psychiatric disorders, with her mother and maternal grandmother having suffered depression, while her maternal uncle suffered from bipolar disorder.

In view of the suicidal risk, Angela was arranged for admission to the child and adolescent psychiatric unit of the hospital. During her admission, her social skill was observed to be weak. She had difficulty in expressing her feelings. She also failed in theory of mind tasks. Her mood fluctuated easily and would throw temper at times. She was diagnosed to have a depressive episode with a background of autistic spectrum disorder. She received antidepressant treatment of Sertraline 50mg nocte. Angela was still noted to have significant irritability, with impulses to hit herself or punch the wall, at times when her desires were not gratified. This was particularly exacerbated when Angela was told she was not suffering from what she believed to be Gender Identity Disorder, and when she was denied requests to be socially accommodated as a "boy" at school or in hospital. Aripiprazole was added and titrated up to 5mg nocte. Her mood was gradually stabilised and suicidal ideations decreased. She subsequently attended small-group classes which discussed ways on mood regulation and stress-coping abilities. She received sessions with the clinical psychologist and discussed issues regarding her gender. After 3 months of admission, Angela appeared calmer and happier, without further suicidal ideations. She was less preoccupied with becoming transgender. She was granted trials of day-leave from the hospital to spend time with her family and re-attend school. Her school better understood her difficulties after communication made by the hospital social worker and Angela would be better supported upon return.

Certificate Course for Psychologists & Mental Health Professionals • Course No. 307 • CME/CNE Course

Certificate Course on

Psychologists and Mental Health Professionals as Expert Witnesses

Jointly organised by

The Federation of Medical Societies of Hong Kong

Hong Kong Clinical Psychologists Association

Objectives:

This course is designed for psychologists and mental health professionals who wish to prepare themselves fully when being asked to give expert evidence (knowledge) to court, whether written or verbal. It is meant to help participants to learn:

- When and how psychologists' and mental health professionals' opinions are being used in courts of law in Hong Kong;
- What to do when being asked to give expert evidence to court;
- The relevant laws and code of practice governing expert witness evidence;
- The usual requirements, elements and style of the expert "court report";
- How to prepare yourself to go to court to give expert evidence;
- Courtroom manners and court procedures relevant to the expert witness;
- How to present yourself as an expert witness;
- How to present your expert evidence (knowledge) in court;
- How to handle cross-examination and difficult situations during trial.

Date	Topics	Speakers
15 Sep	Essential legal knowledge. How psychological and mental health expert opinions are used in courts of law. Relevant laws and code of practice governing expert witness evidence. Selected court judgment quoting expert evidence.	The course will be conducted mainly by Dr. Ephraem P.W. TSUI, Lecturer, Department of Psychology, The University of Hong Kong; Registered Clinical Psychologist (HKPS) Special guest speaker: Professor Peter W.H. LEE, Director, Honorary Consultant, Clinical Health Psychology Centre, Hong Kong Sanatorium & Hospital
22 Sep	Types of expert court reports. Accepting or declining request for an expert report. Scheduling and fee-charging issues. Preparing a court report. Consent & collateral information. Requirements and elements of a court report. Submitting and amending a court report.	
29 Sep	Reviewing good and poor samples of court reports. Adjusting writing styles for court purposes. Ethical issues.	
6 Oct	Accepting or declining request to testify as an expert witness in court. Scheduling and fee-charging issues. Preparing to testify in court. Courtroom manners. Essentials of trial procedures. Skills of presenting one's expertise and expert evidence (knowledge). Psychological preparation.	
13 Oct	Role-playing exercises: Testifying as expert witness in court.	
20 Oct	Handling cross-examination and difficult situations during trial. Role playing exercises: Being cross-examined in court. Generalization of skills to different courts and statutory boards.	

Dates : 15, 22, 29 Sep and 6, 13, 20 Oct, 2017 (Every Friday)
Time : 7:00 pm – 8:30 pm
Venue : Lecture Hall, 4/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong
Language Media : Cantonese (Supplemented with English)
Course Fee : HK$750 (6 sessions)
Certificate : Awarded to participants with a minimum attendance of 70%
Enquiry : The Secretariat of The Federation of Medical Societies of Hong Kong
Tel: 2527 8898 Fax: 2865 0345 Email: info@fmshk.org

CME/CNE/CPD Accreditation in application
Application from can be downloaded from website : http://www.fmshk.org

Angela was eventually discharged after 4 months. She continues to take antidepressant medications and receive psychotherapy to further address the autistic cognitive aspects that predispose her to maladaptive coping behaviours.

Introduction

Adolescence is the transition period between childhood and adulthood. It is a period of physical and psychosocial maturation, during which an individual strengthens self-identity, deepens peer relationships, moves away from parental protection and seeks greater autonomy. Adolescence can be a challenging time for some. Those who struggle to deal with the demands taking place during this period may acquire maladaptive behaviours to cope with overwhelming frustrations. Suicidal behaviours represent an extreme and alarming form of maladaptive coping and may point towards underlying mental health and psychosocial issues.

Definition of suicidal behaviours

Suicidal behaviours include suicidal ideations, deliberate self-harm acts as well as the act of suicide. Suicidal ideation is defined as thoughts about an act of deliberate self-harm or suicide, including the wish to kill oneself, making plans of when, where and how to carry out the act, and having thoughts about the impact of one's self-harm or suicide on others (Rutter et al 2008). Deliberate self-harm is defined as any non-fatal, intentional act of self-injury or self-poisoning, irrespective of the motivation or the severity of the suicidal intent (Hawton et al 2012). Suicide includes deaths resulting directly from acts of deliberate self-harm (Rutter et al 2008). Suicidal behaviours may be regarded as a spectrum. Both suicidal ideations and deliberate self-harm have been associated with higher risks of eventual suicides (Posner et al 2007).

Epidemiology of adolescent suicides

Globally, suicides in those under 12 are rare. This is believed to be due to the lack of sufficient cognitive maturity to plan and acquire the means to execute a successful suicide (Goodman and Scott 2012). Once adolescence is reached, suicidal rates increase.

In the United States, suicide is the 2nd leading cause of death for the 15 to 24 years-old age group. The suicide rate of this age group in the US has been around 10.5 per 100,000 people (CDC 2016). In Hong Kong, suicide rates in the 15 to 24 age group are relatively lower than in Western countries, around 6.5 per 100,000 people (HKCSS 2017, Law et al 2013). Regardless of the figures, social and health care burdens of adolescent suicides remain high.

The general trend observed in adolescent suicidal behaviours is that suicidal ideas occur much more frequently than deliberate self-harm acts, which in turn, are more common than completed suicides (Evans et al 2005, Hawton et al 2012, Law et al 2013). One systematic review of suicidal phenomena in young people worldwide reported a lifetime prevalence of 29.9% for suicidal ideations, and 9.7% for suicidal attempts (Evans et al 2005). Another trend is that more adolescent females engage in deliberate self-harm acts, but rates of successful suicides occur much higher in males (Rutter et al 2008).

Methods of suicidal behaviours differ between countries. In the West, the most common self-harm method is cutting, while death from firearms and hanging contribute the greatest to completed suicides (CDC 2016). In Hong Kong, the most common self-harm method is by cutting (Law et al 2013), while over 50% of suicides have resulted from jumping from height. (HKCSS 2017).

Risk factors for adolescent suicides

What drives adolescents to suicidal behaviours is complex and multifactorial. Several significant risk factors have been identified and they appear to have a cumulative impact (Cheng and Myers 2011).

Personal Factors

1. *History of a psychiatric illness* is highly associated with suicidal behaviours (Evans et al 2004, Bridge et al 2006). Up to 80-90% of adolescent suicide victims and attempters in both clinical and community settings were found to have a mental disorder (Bridge et al 2006). The most common psychiatric conditions are mood, anxiety, conduct disorders and substance abuse. Studies have found up to 60% of adolescent suicide victims met diagnosis of depression at the time of death (Brent et al 2009). However, autopsy studies reveal a high proportion of suicidal victims had not made contact with psychiatric services prior to their death (Law et al 2016). These figures highlight the importance of assessing for underlying psychiatric comorbidities in any adolescent presenting with suicidal behaviours.

2. *Previous attempt of suicidal behaviours* is a strong predictor of recurrence. Up to 10% of those with self-harm were found to repeat within the next year (Rutter et al 2008). For those with a history of suicidal attempt, the greatest risk for a repeated attempt was within the first year.

3. *A family history of mental illness and/or suicidality* also poses a risk factor for adolescent suicide. There is growing evidence that there are genetic factors affecting the brain's serotonin system, which may contribute to a greater risk of depression and poorer impulse control.

4. *Certain personality traits and cognitive styles* have been associated with suicidal behaviours. These include traits of impulsivity, aggression and neuroticism (Bridge et al 2006). Cognitive styles associated with greater suicidality include dichotomous or all-or-nothing thinkers, and those who carry beliefs that things happen beyond their control (Rutter et al 2008).

5. *Adolescents with homosexual and bisexual orientation* have been found to have a two to six times increased risk of deliberate self-harm behaviours as compared with heterosexual adolescents (Gould et al 2003).

Certificate Course for Medical and Healthcare Professionals

• Course No. C304 • CME/CNE Course

Certificate Course on

Renal Medicine 2017

Jointly organised by

The Federation of Medical Societies of Hong Kong

Hong Kong Society of Nephrology

Objectives:

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

Date	Topics	Speakers
7 Sep	Common investigation tests for renal disease including approach to proteinuria and haematuria	Dr Sze-kit YUEN Associate Consultant Department of Medicine & Geriatrics Caritas Medical Centre
	Update and management of glomerular disease	Dr Tsz-ling HO Associate Consultant Department of Medicine Tsuen Kwan O Hospital
14 Sep	Update and management of acute kidney injury	Dr Chun-hay TAM Associate Consultant Department of Medicine & Geriatrics United Christian Hospital
	Nutritional Management in Kidney Diseases	Ms Cherry Pui-yee LAW Dietitian Hong Kong Dietitians Association
21 Sep	Update and management of hypertension	Dr Siu-man WONG Associate Consultant Department of Medicine Alice Ho Miu Ling Nethersole Hospital
	Drug prescribing in renal failure	Dr Kai-ching HAU Associate Consultant Department of Medicine & Geriatrics Tuen Mun Hospital
28 Sep	Kidney Involvement in Multi-System Disorders	Dr Desmond Yat-hin YAP Clinical Assistant Professor Department of Medicine, Queen Mary Hospital University of Hong Kong
	Update on diabetic nephropathy	Dr Terence Pok-siu YIP Consultant Department of Medicine Tung Wah Hospital
12 Oct	ABC of peritoneal dialysis therapy	Dr Joseph Ho-sing WONG Associate Consultant Department of Medicine Queen Elizabeth Hospital
	ABC of hemodialysis therapy	Dr Gensy Mei-wa TONG Private Neprologist
19 Oct	Update and management of chronic kidney disease	Dr Wing-fai PANG Associate Consultant Department of Medicine & Therapeutics Prince of Wales Hospital
	ABC of renal transplantation	Dr Ka-fai YIM Associate Consultant Department of Medicine & Geriatrics Princess Margaret Hospital

Dates : 7, 14, 21, 28 September 2017 & 12, 19 October, 2017 (Every Thursday, skip 5 October 2017)
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)
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They are also more likely than heterosexual adolescents to experience mental disorders including depression (Fergusson et al 1999). Homosexual and bisexual adolescents likely face greater struggles in finding social acceptance and consolidating self-identity.

Environmental Factors

1. *Certain characteristics in the family background are associated with increased rates of suicidality.* These include a history of parental separation or divorce, parental mental illness as well as childhood physical, emotional and/or sexual abuse (Rutter et al 2008). These factors may contribute to poor parent-child relationships, which often affect the building of healthy relationships later on.

2. *Recent, or proximity of life-stressors* have been found to be risk factors for completed and attempted suicides in adolescents (Posner et al 2007). These stressors include problems with authorities, academic difficulties, and relationship troubles, particularly involving the breakup of a romantic relationship (Posner et al 2007).

3. *Accessibility to lethal means of suicide* is a significant risk for completed suicide. Suicidal behaviours are often impulsive and less well planned in adolescents, but when coupled to an accessible, lethal means, the risk of death is high.

4. *Certain types of media-reporting of suicidal behaviours* have been identified as risks for increased suicidality in vulnerable adolescents (Rutter et al 2008). Media reports that tend to romanticise, or include fine details on specific methods of self-harm or suicide, may lead some adolescents to view suicidal behaviours as alternative ways to seek attention and acquire individuality.

5. There is growing concern about the effects of the internet and its social networking platforms. Previous research has found that interactions between adolescents with recurrent suicidal behaviours on chat forums may normalise and perpetuate these behaviours (Whitlock et al 2006). Further research is needed to determine the characteristics of those vulnerable to these influences, but there appears to be groups of adolescents susceptible to engaging in these behaviours either due to peer pressure, or as attempts to establish a form of self-identity.

Protective factors for adolescent suicides

Several factors have been found to protect adolescents from developing suicidal behaviours. These include personal factors such as good social skills, problem-solving skills, as well as cognitive styles that attribute an internal locus of control (Rutter et al 2008). Environmental factors include family cohesiveness, involvement in school, playing sports and religious affiliations.

Assessment of adolescent suicidality

The aims of assessment should include determining the psychopathology underlying the suicidal behaviour, the immediate risk posed and determine a suitable disposal plan if in the acute setting. Identification of the predisposing, precipitating and perpetuating factors and the adolescent's personal strengths and weaknesses are important for subsequent management.

Given that suicidality is highly associated with psychiatric illnesses, it is important to determine whether any psychiatric comorbidity, particularly depression, is present. Assessment of the immediate risk posed by the patient should include thorough enquiries about their suicidal attempts. Adolescent perceptions of suicidal lethality may be under- or over-estimated, and this needs to considered in conjunction with their level of impulsivity.

When conducting the interview, questions should be posed at a developmentally appropriate manner (Cheng and Myers 2011). The patient should be interviewed separately and then together with the parents where possible.

Confidentiality may become an issue with adolescents. No promises to full confidentiality should be made. The patient should be made aware that some information will be shared with parents or other providers if it is necessary to ensure his or others' safety.

Management of adolescent suicidal behaviours

Management can be considered in the acute, short and longer-term time frames. The general goal at each phase is to minimise significant risk factors and promote protective factors.

Acute management includes risk assessment, attending to any injury and determining whether an emergency department referral or hospitalisation is necessary. If hospitalisation is not arranged, further engagement with medical and social service providers is essential for both the adolescent and family.

Once in a safe setting, treatment for any underlying psychiatric illness should be commenced. Pharmacotherapy should be considered for illnesses that have established medication treatment, such as in depression. Psychotherapy such as cognitive-behavioural therapy can also be helpful in treating mood disorders, and may be useful in the short and longer-terms to address cognitive distortions that may be risks for increased suicidality. In the longer term, interventions to build up protective factors – such as enhancing problem-solving skills, mood-regulation and impulse-control, may be beneficial for adolescents identified with weaknesses in these areas. Family therapy may also be helpful for those whose family dynamics contribute to their psychopathology.

A multidisciplinary contribution is essential in the treatment plan. Successful engagement with both the adolescent and the family is likely to provide better long-term outcomes.

Conclusion

Adolescent suicidality represents a spectrum of behaviours including suicidal ideations, deliberate self-harm acts and suicides. Suicidal ideations are the most common, followed by deliberate self-harm, then suicide deaths. Suicidality is frequently associated with recurrent suicidal behaviours, and the majority of those demonstrating suicidal behaviours may have an underlying psychiatric illness. It is crucial that any presentation of suicidal behaviours is taken seriously and the amenable risk factors identified and treated promptly.

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Functional Foods for Heart Health - An Update

Dates : 23 Sept 2017 (Sat)
Time : 3:00pm to 4:30pm
Venue : Lecture Hall, The Federation of Medical Societies of Hong Kong, 4/F Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai

Speaker : Ms Sylvia LAM
Senior Dietitian (APD, Australia), Pro-Cardio Heart Diseases and Stroke Prevention Center

Moderator : Dr. Ludwig TSOI
Council Member of FMSHK

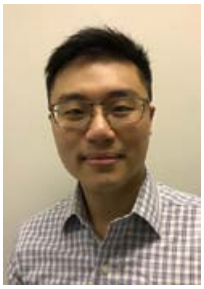
Rundown : 3:00pm Registration and light refreshment
3:30pm Lecture

Registration: Interested parties please complete the application form and fax to 2865 0345 or email to eva.tsang@fmshk.org on or before 18 Sept, 2017 (Mon)
Enquiry: FMSHK Secretariat
Tel: 2527 8898 Fax: 2865 0345 Email: eva.tsang@fmshk.org
Accreditations: CNE/CPD has been applied and pending confirmation

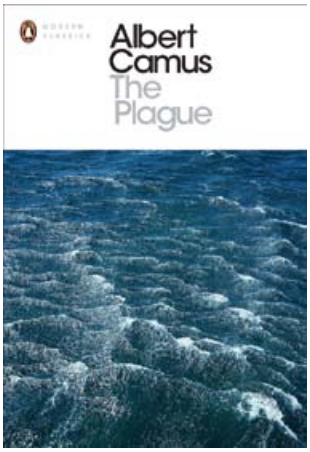
The Plague - A Book Review

Dr Wilfred Shone-horn WONG

MBChB
Resident
Department of Psychiatry, Queen Mary Hospital



Dr Wilfred Shone-horn WONG



The Plague

Author: Albert Camus

Published July 2001 by
Penguin Modern Classics
(first published 1947)

The Plague (La Peste) was published five years after The Stranger (L'étranger) and The Myth of Sisyphus (Le Mythe de Sisyphe) in post-war 1947. Camus was attempting something more ambitious than the Stranger, the work that had made his name. Camus, the resistance hero and celebrity existentialist, together with his contemporary Jean Paul Sartre, led France and perhaps the wider European continent in philosophical meditation after the horrors of the War. The Holocaust, the genocide, the ravaging of nations and the employment of atomic weapons shocked mankind. People were asking questions about how such evil could have been present in humanity and they were not getting the answers that they were hoping for. The gradual decline of the Church brought about a growing population who were either atheistic or agnostic who had trouble accepting the traditional dichotomy of good and evil. In Europe, there were the evil ones - the Nazis who ordered and arranged the minute details of the Holocaust. Then, there were the good ones - the Resistance that helped Allied troops or Jews escape persecution. But then there were those who walked the line between such labels. There were Resistance fighters who ratted out the Jewish population because they blamed them for the War. Then there were the French collaborators who believed that working with the Nazis could bring about a better outcome for France. It is all too easy to be moral when the times are good and when the sun is shining; it is quite different when death and starvation is a daily prospect.

The Plague is set in Oran, a coastal town in Algeria in 1947. The town is ordinary, nothing different from any other French prefectures. The town was infested by plague, a disease that first killed off the rats and then quickly moved on to cause widespread contagion amongst the people of Oran. The town was closed down soon after and people were not allowed to enter or leave. The story follows Dr Rieux and a few of his friends and their fight against the plague. As the number of people who succumbed to illness grew every day, the numerical figure had started to become meaningless or even absurd (the philosophical use of the term). The accumulation of such deaths was nothing more than a sped-up microcosm of humanity and the inevitability of a march towards death. The actions of our heroes, in their attempts to prevent less victims from falling to the plague, was done in blindness to whether the plague will ultimately take the whole town and in light of the fact that everyone will ultimately meet their ends.

The different characters behaved and reacted differently in the presence of the Plague. Dr Rieux advocated for early implementation of sanitary measures and was the first to call the Plague by its name. His actions, though valiant and noble, seemed to have no particular effect on the plague. The number of victims kept rising and his ability to save a single person was drowned out by thousands more who perished. He did not believe himself to be a heroic person, having given up the opportunity to leave town in order to fight, but that he was simply fulfilling the meaning in life as he was taught to do - to heal and give health even against an inevitable mortality. Raymond Rambert, a Parisian journalist, was inadvertently trapped in Oran when he was there for an unrelated assignment. In the early parts of the book, he pleaded with Dr Rieux and the authorities for him to be allowed to return to his wife in Paris as this was not a fight that involved him. For months, he had planned an escape from the town. On the night of the escape, he had elected to stay in Oran and assist Dr Rieux in the fight against the plague. He chose to forgo individual happiness for the allegiance to a higher moral cause. Father Paneloux preached to his congregation that the plague was a sign of a punishment from God and that they must repent their ways in order to gain salvation. Whilst fighting the plague, he witnessed the deaths of innocent children who were not guilty of any sin. Wrecked, he ultimately interpreted the plague as a sign that suffering was of absolute good and urged his congregation to embrace the suffering.

To understand Camus is to understand the Absurd. Like those who did not agree with Father Paneloux despite fighting against the plague alongside him, Camus rejected divinity. However, this leaves mankind in a situation where nothing ever matters since a brief life of enjoyment or suffering is simply a prelude to an eternity

of nothingness. That leaves mankind with only a few available options. Do we return to the idea of divinity as the only logical option, as the great Danish philosopher Søren Kierkegaard has proposed? Or do we accept nihilism as Friedrich Nietzsche did?

Albert Camus chose courage and responsibility. His idea of the absurd is undoubtedly positive and full of optimism. Against meaninglessness, mankind must create his own meaning amongst an indifferent universe. This is seen in courage and responsibility, in love and camaraderie, and in art and poetry. One must rebel against the absurd by rejecting suicide or false hope and centres himself amongst humanity. One must fight by creating a better future for others, however ephemeral it might be. Man is responsible for mankind and thus carries the weight of humanity on his/her shoulders.

"Sometimes at midnight, in the great silence of the sleep bound town, the doctor turned on his radio before going to bed for the few hours' sleep he allowed himself. And from the ends of the earth, across thousands of miles of land and sea, kindly, well-meaning speakers tried to voice their fellow-feeling, and indeed did so, but at the same time proved the utter incapacity of every man truly to share in the suffering that he cannot see. "Oran! Oran!" In vain the call rang over oceans, in vain Rieux listened hopefully; always the tide of eloquence began to flow, bringing home still more the unbridgeable gulf that lays between Grand and the speaker. "Oran, we're with you!" they called emotionally. But not, the doctor told himself, to love or to die together-- and that's the only way..." - The Plague.

"Lights across the Fields of Hvolsvöllur"
Photo by Dr Wilfred Wong – Hvolsvöllur, Iceland, 2015.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					★ Joint Surgical Symposium – Bleeding after Whipple Operation 1	2
★ HKMA Badminton Tournament 2017 3	4	★ HKMA Tai Po Community Network - Common Sports Injury of Lower Limbs ★ FMSHK Officers' Meeting ★ HKMA Council Meeting 5	★ HKMA Golf Tournament 2017 ★ HKMA Shatin Doctors Network - PCSK9 Inhibitor – Which Patients will it Benefit Most? 6	★ HA-United Christian Hospital, HK College of Family Physicians & HKMA-KLN East Community Network - Certificate Course for GPs 2017 - Update on Chronic Cough Management in Children 7	8	★ Hong Kong Medical Association & HKFMS Foundation Care for Advanced Diseases Consortium - Care for Advanced Diseases: Joint CME Seminar with HKMA ★ Refresher Course for Health Care Providers 2017/2018 9
10	11	★ HKMA Kowloon West Community Network - Ws of Sarcopenia ★ HKMA Yau Tsim Mong Community Network - The Right ULT to the Right Patients 12	★ 19th Beijing/Hong Kong Medical Exchange ★ Hong Kong Neurosurgical Society Monthly Academic Meeting –Parkinson's Disease ★ HKMA Shatin Doctors Network - Midlife Intervention for Better Brain and Muscle Health ★ HKMA Central, Western & Southern Community Network - Bridging the Gap in Pneumonia Management 13	★ HKMA Hong Kong East Community Network - Asthma: When, Whom and Why to Treat? ★ HKMA Kowloon East Community Network - Assessment and Management of Older Adults' Cognitive Impairment in Primary Care Setting ★ HKMA New Territories West Community Network - Three Non-Drug Pillars in Dementia Management ★ HKMA-HKS&H CME Programme 2017-2018 –"Update in Medical Practice" 14	★ HKMA Kowloon City Community Network - Pectus Excavatum (Funnel Chest): What is it and How do we Manage? 15	16
★ HKMA Badminton Tournament 2017 17	18	★ HKMA Tai Po Community Network - Topic 1: The Application and Advantages of Protein Chip in Allergen Detection Topic 2: Food Avoidance in Childhood Eczema 19	★ MPS Workshop - Mastering Your Risk 20	★ HA-United Christian Hospital, HK College of Family Physicians & HKMA-KLN East Community Network - Certificate Course for GPs 2017 - Update on Management of Irritable Bowel Syndrome ★ FMSHK Executive Committee Meeting 21	★ HKMA Central, Western & Southern Community Network - Computer/Mobile Phone Related Orthopaedic Problems ★ HKMA Shatin Doctors Network DH-Primary Care Office - Assessment and Management of Older Adults' Cognitive Impairment in Primary Care Setting 22	★ HKSSM Annual Scientific Meeting 2017 23
★ HKMA Tennis Tournament 2017 24	25	★ HKMA Kowloon West Community Network - Menopausal Health 2017 26	27	★ HKMA Hong Kong East Community Network & DH-Primary Care Office - How to Help Children Eat Well - Transition to Eating Family Meal ★ HKMA Kowloon East Community Network - Translating Scientific Advancement to Real Life Benefits: RV & MMRV Vaccination ★ HKMA New Territories West Community Network - Management on Insomnia – Update and New Approaches ★ MPS Workshop - Mastering Difficult Interactions with Patients 28	★ HKMA Yau Tsim Mong Community Network - LUTS Management: A New Step after 30 Years 29	30

Date / Time	Function	Enquiry / Remarks
1 FRI 8:00-9:00 AM	**Joint Surgical Symposium – Bleeding after Whipple Operation** Organizers: Department of Surgery, The University of Hong Kong & Hong Kong Sanatorium & Hospital; Chairman: Professor CHAN See-Ching; Speakers: Professor FAN Sheung-Tat, Dr. DAI Wing-Chiu; Venue: Hong Kong Sanatorium & Hospital	Department of Surgery, Hong Kong Sanatorium & Hospital Tel: 2835 8698 Fax: 2892 7511 1 CME Point (Active)
3 SUN 1:00 PM	**HKMA Badminton Tournament 2017** Organiser: The Hong Kong Medical Association; Chairman: Dr. CHAN Hau Ngai, Kingsley / Dr. IP Wing Yuk; Venue: MacLehose Medical Rehabilitation Centre (MMRC), 7 Sha Wan Drive, Pokfulam, HK	Miss Ada SIU / Miss Denise KWOK Tel: 2527 8285
5 TUE 1:45 PM	**HKMA Tai Po Community Network - Common Sports Injury of Lower Limbs** Organiser: HKMA Tai Po Community Network; Chairman: Dr. CHOW Chun Kwan, John; Speaker: Dr. WONG Tsz Cheung; Venue: Chiuchow Garden Restaurant (潮江春), Shop 001-003, 1/F, Uptown Plaza, No.9 Nam Wan Road, Tai Po, NT	Ms. Tracy CHEUNG Tel: 8226 9564 1 CME Point
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
9:00 PM	**HKMA Council Meeting** Organiser: The Hong Kong Medical Association; Chairman: Dr. CHOI Kin; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, HK	Ms. Christine WONG Tel: 2527 8285
6 WED 11:30 AM	**HKMA Golf Tournament 2017** Organiser: The Hong Kong Medical Association; Chairman: Dr. CHAN Hau Ngai, Kingsley / Dr. IP Wing Yuk; Venue: Hong Kong Golf Club, Fanling, NT	Miss Ada SIU / Miss Denise KWOK Tel: 2527 8285 CME Point
1:00 PM	**HKMA Shatin Doctors Network - PCSK9 Inhibitor – Which Patients will it Benefit Most?** Organiser: HKMA Shatin Doctors Network; Chairman: Dr. MAK Wing Kin; Speaker: Dr. MIU Kin Man, Raymond; Venue: Jasmine Room, Level 2, Royal Park Hotel, 8 Pak Hok Ting Street, Shatin, NT	Ms. Candice TONG Tel: 2527 8285 1 CME Point
7 THU 1:00 PM	**HA-United Christian Hospital, HK College of Family Physicians &** **HKMA-KLN East Community Network - Certificate Course for GPs 2017 - Update on Chronic Cough Management in Children** Organiser: HA-United Christian Hospital & HK College of Family Physicians & KMA-KLN East Community Network; Speaker: Dr. CHIU Wa Keung; Venue: Multi-media Conference Room, 2/F, Block S, United Christian Hospital	Ms. Polly TAI Tel: 3513 3430 1 CME Point
9 SAT 12:30 PM	**Hong Kong Medical Association & HKFMS Foundation Care for Advanced Diseases Consortium - Care for Advanced Diseases: Joint CME Seminar with HKMA** **1. Palliative care for advanced diseases: from principles to practice** **2. Update on oncological palliation for advanced cancers** Organiser: Hong Kong Medical Association & HKFMS Foundation Care for Advanced Diseases Consortium; Speaker: Dr. LAW Chun Key, Stephen & Dr. LO See Kit, Raymond; Venue: 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong	HKMA CME Dept. Tel: 2527 8452 2 CME Point
2:15 PM	**Refresher Course for Health Care Providers 2017/2018** Organiser: Hong Kong Medical Association; HK College of Family Physicians; HA-Our Lady of Maryknoll Hospital; Speaker: Dr. Peter LO & Dr. Victor CHAN; Venue: Training Room II, 1/F, OPD Block, Our Lady of Maryknoll Hospital, 118 Shatin Pass Road, Wong Tai Sin, Kln	Ms. Clara TSANG Tel: 2354 2440 2 CME Point
12 TUE 1:00 PM	**HKMA Kowloon West Community Network - Ws of Sarcopenia** Organiser: HKMA Kowloon West Community Network; Chairman: Dr. CHAN Ching Pong; Speaker: Dr. WONG Wai Hong, Bruce; Venue: Crystal Room IV-V, 3/F., Panda Hotel, 3 Tsuen Wah Street, Tsuen Wan, NT	Mr. Ziv WONG Tel: 2527 8285 1 CME Point
1:00 PM	**HKMA Yau Tsim Mong Community Network - The Right ULT to the Right Patients** Organiser: HKMA Yau Tsim Mong Community Network; Chairman: Dr. HO Kit Man, Carmen; Speaker: Dr. SUNG Chi Keung; Venue: Crystal Ballroom, 2/F, The Cityview Hong Kong, 23 Waterloo Road, Kln	Ms. Candice TONG Tel: 2527 8285 1 CME Point
13 WED	**19th Beijing/Hong Kong Medical Exchange** Organiser: The Hong Kong Medical Association & Chinese Medical Association; Chairman: Dr. HO Chung Ping, MH, JP; Speaker: Various; Venue: International Convention Centre, InterContinental Wuhan, Wuhan	Miss Ellie FU Tel: 2527 8285
7:30 AM	**Hong Kong Neurosurgical Society Monthly Academic Meeting –Parkinson's Disease** Organiser: Hong Kong Neurosurgical Society; Chairman: Dr LEE Wing Yan, Michael; Speaker: Dr KO Man Wai, Natalie; Venue: Seminar Room, G/F, Block A, Queen Elizabeth Hospital	1.5 points College of Surgeons of Hong Kong Dr. LEE Wing Yan, Michael Tel: 2595 6456 Fax. No.: 2965 4061
1:00 PM	**HKMA Shatin Doctors Network - Midlife Intervention for Better Brain and Muscle Health** Organiser: HKMA Shatin Doctors Network; Chairman: Dr. MAK Wing Kin; Speaker: Dr. DAI Lok Kwan, David, JP; Venue: Jasmine Room, Level 2, Royal Park Hotel, 8 Pak Hok Ting Street, Shatin, NT	Ms. Connie NG Tel: 2806 4287 1 CME Point
1:00 PM	**HKMA Central, Western & Southern Community Network - Bridging the Gap in Pneumonia Management** Organiser: HKMA Central, Western & Southern Community Network; Chairman: Dr. TSANG Kin Lun; Speaker: Dr. KWOK Kai Him, Henry; Venue: HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road, Central, HK	Mr. Ziv WONG Tel: 2527 8285 1 CME Point
14 THU 1:00 PM	**HKMA Hong Kong East Community Network - Asthma: When, Whom and Why to Treat?** Organiser: HKMA Hong Kong East Community Network; Chairman: Dr. LAM See Yui, Joseph; Speaker: Dr. KWONG Kwok Chu; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, HK	Ms. Candice TONG Tel: 2527 8285 1 CME Point
1:00 PM	**HKMA Kowloon East Community Network - Assessment and Management of Older Adults' Cognitive Impairment in Primary Care Setting** Organiser: HKMA Kowloon East Community Network; Chairman: Dr. TING Ka Chu; Speaker: Dr. LUK Kam Hung; Venue: Lei Garden Restaurant (利苑酒家), Shop no. L5-8, apm, Kwun Tong, No. 418 Kwun Tong Road, Kowloon	Mr. Ziv WONG Tel: 2527 8285 1 CME Point
1:00 PM	**HKMA New Territories West Community Network - Three Non-Drug Pillars in Dementia Management** Organiser: HKMA New Territories West Community Network; Chairman: Dr. CHAN Lam Fung, Lambert; Speaker: Dr. CHAN Chun Chung, Ray; Venue: Pak Loh Chiu Chow Restaurant (百樂潮州酒樓), Shop A316, 3/F, Yoho Mall II, 8 Long Yat Road, Yuen Long, NT	Mr. Ziv WONG Tel: 2527 8285 1 CME Point
1:00 PM	**HKMA-HKS&H CME Programme 2017-2018 –"Update in Medical Practice"** Organiser: The Hong Kong Medical Association & Hong Kong Sanatorium & Hospital; Speaker: Dr. CHAI, Joyce; Venue: HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road, Central, HK	HKMA CME Dept. Tel: 2527 8452 1 CME Point

Date / Time	Function	Enquiry / Remarks
15 FRI 1:00 PM	**HKMA Kowloon City Community Network - Pectus Excavatum (Funnel Chest): What is it and How do we Manage?** Organiser: HKMA Kowloon City Community Network; Chairman: Dr. CHIN Chu Wah; Speaker: Dr. LO Cheuk Kin; Venue: President's Room, Spotlight Recreation Club, 4/F., Screen World, Site 8, Whampoa Garden, Hunghom, Kln	Ms. Candice TONG Tel: 2527 8285 1 CME Point
17 SUN 1:00 PM	**HKMA Badminton Tournament 2017** Organiser: The Hong Kong Medical Association; Chairman: Dr. CHAN Hau Ngai, Kingsley / Dr. IP Wing Yuk; Venue: MacLehose Medical Rehabilitation Centre (MMRC), 7 Sha Wan Drive, Pokfulam, HK	Miss Ada SIU / Miss Denise KWOK Tel: 2527 8285
19 TUE 1:45 PM	**HKMA Tai Po Community Network - Topic 1: The Application and Advantages of Protein Chip in Allergen Detection** **Topic 2: Food Avoidance in Childhood Eczema** Organiser: HKMA Tai Po Community Network; Chairman: Dr. CHOW Chun Kwan, John; Speaker: Mr. CHEN Kang Hsin & Prof. HON Kam Lun, Ellis; Venue: Chiuchow Garden Restaurant (潮江春), Shop 001-003, 1/F, Uptown Plaza, No.9 Nam Wan Road, Tai Po, NT	Mr. Freeman WONG Tel: 5282 1316 1 CME Point
20 WED 6:30 PM	**MPS Workshop - Mastering Your Risk** Organiser: The Hong Kong Medical Association & Medical Protection Society; Speaker: Dr. LEE Wai Hung, Danny; Venue: HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road, Central, HK	HKMA CME Dept. Tel: 2527 8452 2.5 CME Point
21 THU 1:00 PM	**HA-United Christian Hospital, HK College of Family Physicians & HKMA-KLN East Community Network - Certificate Course for GPs 2017 - Update on Management of Irritable Bowel Syndrome** Organiser: HA-United Christian Hospital & HK College of Family Physicians & HKMA-KLN East Community Network; Speaker: Dr. KUNG Kam Ngai; Venue: Multi-media Conference Room, 2/F, Block S, United Christian Hospital	Ms. Polly TAI Tel: 3513 3430 1 CME Point
8:00 PM	**FMSHK Executive Committee Meeting** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Council Chamber, 4/F, Duke of Windor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Nancy CHAN Tel: 2527 8898
22 FRI 1:00 PM	**HKMA Central, Western & Southern Community Network - Computer/Mobile Phone Related Orthopaedic Problems** Organiser: HKMA Central, Western & Southern Community Network; Chairman: Dr. YIK Ping Yin; Speaker: Dr. YUEN Chi Pan; Venue: HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road, Central, HK	Mr. Ziv WONG Tel: 2527 8285 1 CME Point
1:00 PM	**HKMA Shatin Doctors Network** **DH-Primary Care Office - Assessment and Management of Older Adults' Cognitive Impairment in Primary Care Setting** Organiser: HKMA Shatin Doctors Network & DH-Primary Care Office; Chairman: Dr. MAK Wing Kin; Speaker: Dr. LEUNG Man Fuk, Edward; Venue: Jasmine Room, Level 2, Royal Park Hotel, 8 Pak Hok Ting Street, Shatin, Hong Kong	Ms. Candice TONG Tel: 2527 8285 1 CME Point

Federation News

Public talk on Cervical Cancer

On 24 June 2017, a public talk on Cervical Cancer was held in the Federation's Lecture Hall. Despite heavy rain, 41 participants came. Cervical cancer has become the eighth commonest cancer among Hong Kong women. It is mainly caused by Human Papillomavirus (HPV). Most of these cases are curable if detected at an early stage. The Federation was privileged to have Dr CHAN Kai Ming, Specialist in Infectious Disease, to explain the types of HPV infections and their prevention in men and women. Another speaker, Dr. SIU Shing Shun Nelson, Specialist in Obstetrics & Gynaecology, and also Vice-president of the Hong Kong Society for Colposcopy and Cervical Pathology, shared with the audience the treatment options for patients with cervical cancer in different stages. Numerous questions from the audience and lively discussion during the Q&A session brought the interactive seminar to a successful conclusion.

Date / Time	Function	Enquiry / Remarks
23 SAT	**HKSSM Annual Scientific Meeting 2017** Organiser: Hong Kong Society of Sleep Medicine; Speaker: Prof Atul Malhotra (UC San Diego), Dr To Kin Wang, Dr Ho Lai In, Jeni, Dr Samson Fong, Mr Clover Ho; Venue: The Park Lan Hotel	Ms Joan Ha T: 2821 3513
24 SUN 8:00 PM	**HKMA Tennis Tournament 2017** Organiser: The Hong Kong Medical Association; Chairman: Dr. CHAN Hau Ngai, Kingsley / Dr. IP Wing Yuk; Venue: Kowloon Tong Club, 113A Waterloo Rd, Kln	Miss Ada SIU / Miss Denise KWOK Tel: 2527 8285
26 TUE 1:00 PM	**HKMA Kowloon West Community Network - Menopausal Health 2017** Organiser: HKMA Kowloon West Community Network; Chairman: Dr. TONG Kai Sing; Speaker: Dr. CHAN Leung Kwok; Venue: Crystal Room IV-V, 3/F., Panda Hotel, 3 Tsuen Wah Street, Tsuen Wan, NT	Mr. Ziv WONG Tel: 2527 8285 1 CME Point
28 THU 1:00 PM	**HKMA Hong Kong East Community Network & DH-Primary Care Office - How to Help Children Eat Well - Transition to Eating Family Meal** Organiser: HKMA Hong Kong East Community Network & DH-Primary Care Office; Chairman: Dr. LEUNG Kwan Kui, Terence; Speaker: Dr. Vinci MA; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, HK	Ms. Candice TONG Tel: 2527 8285 1 CME Point
1:00 PM	**HKMA Kowloon East Community Network - Translating Scientific Advancement to Real Life Benefits: RV & MMRV Vaccination** Organiser: HKMA Kowloon East Community Network; Chairman: Dr. SHIU Ka Lok, Ivan; Speaker: Dr. LEE Cheuk Hon; Venue: V Cuisine, 6/F., Holiday Inn Express Hong Kong Kowloon East, 3 Tong Tak Street, Tseung Kwan O	Mr. Ziv WONG Tel: 2527 8285 1 CME Point
1:00 PM	**HKMA New Territories West Community Network - Management on Insomnia – Update and New Approaches** Organiser: HKMA New Territories West Community Network; Chairman: Dr. CHEUNG Kwok Wai, Alvin; Speaker: Dr. CHEUNG Ching Ping, Dennis; Venue: Atrium Function Rooms, Lobby Floor, Hong Kong Gold Coast Hotel, 1 Castle Peak Road, Gold Coast, NT	Mr. Ziv WONG 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. CHENG Ngai Shing, Justin; Venue: The Cityview, Kowloon	HKMA CME Dept. Tel: 2527 8452 2.5 CME Point
29 FRI 1:00 PM	**HKMA Yau Tsim Mong Community Network - LUTS Management: A New Step after 30 Years** Organiser: HKMA Yau Tsim Mong Community Network; Chairman: Dr. LEUNG Wai Fung, Anders; Speaker: Dr. CHUNG Yeung, Vera; Venue: Crystal Ballroom, 2/F, The Cityview Hong Kong, 23 Waterloo Road, Kln	Ms. Candice TONG Tel: 2527 8285 1 CME Point

Upcoming Meeting

18-19 Nov 2017	**The 7th Joint Scientific Meeting of The Royal College of Radiologists & Hong Kong College of Radiologists and 25th Annual Scientific Meeting of Hong Kong College of Radiologists** Venue: Hong Kong Academy of Medicine Jockey Club Building, 99 Wong Chuk Hang Road, Aberdeen, HKSAR, China	HKCR Secretariat Tel: 2871 8788 Registration Secretariat Te: 8106 9878

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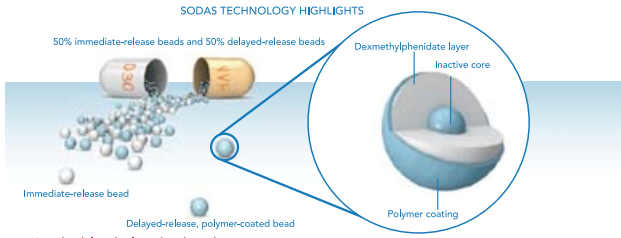

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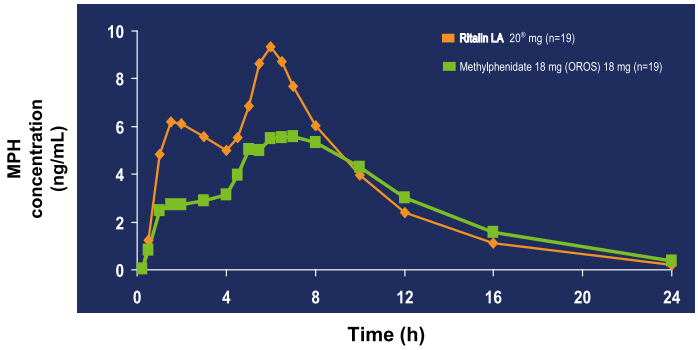
Ritalin LA® demonstrated rapid initial and subsequent absorption phases and reached substantially higher peak plasma concentrations[4]



PK Release Profile of SODAS™ and OROS® Delivery Systems Produce Expected Results [4]

References:

1. *Lopez F et al. Pediatr Drugs* 2003;5(8):545-555. 2. SODAS™ is a trademark of Elan Corporation, plc. 3. Lyseng-Williamson KA, Keating GM. *Drugs* 2002:62 (15): 2251-2259. 4. Markowitz JS, *et al. Clin Pharmacokinet*. 2003;42:393-401. 5. Local prescribing information of **Ritalin LA**.

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Important note: Before prescribing, consult full prescribing information.
Presentation: ♦Immediate-release (**Ritalin®**) tablets containing 10 mg methylphenidate hydrochloride. ♦ ♦Modified-release capsules (**Ritalin® LA**) containing 10 mg, 20 mg, methylphenidate hydrochloride.
Indications: Attention-deficit/hyperactivity disorder (ADHD) in children aged 6 years and older; narcolepsy (**Ritalin** tablets only)
Dosage: ♦ Daily dosage should not exceed 60 mg. ♦For children, start with 5 mg once or twice daily and increase in increments of 5 to 10 mg weekly. ♦For **Ritalin LA**, starting dose is 20 mg. Patients may begin treatment with **Ritalin LA** 10 mg if necessary. **Ritalin LA** dosage may be adjusted at weekly intervals in 10 mg increments. ♦For adults treated for narcolepsy, the usual daily dose is 20 to 30 mg. ♦**Ritalin LA** is for once daily administration.
Contraindications: ♦ anxiety and tension states, agitation, a family history or diagnosis of Tourette's syndrome, glaucoma, hyperthyroidism, pre-existing cardiovascular disorders including uncontrolled hypertension, angina pectoris, arterial occlusive disease especially coronary arteries; heart failure, haemodynamically significant congenital heart disease, cardiomyopathies, myocardial infarction, cardiac arrhythmia and channelopathies (disorders caused by the dysfunction of ion channels), treatment with monoamine oxidase inhibitors, and also within a minimum of 14 days following discontinuation of a monoamine oxidase inhibitor (hypertensive crises may result), phaeochromocytoma, known drug dependence or alcohol abuse; severe depression, anorexia nervosa, psychotic symptoms or suicidal tendency, since **Ritalin** might worsen these conditions; known hypersensitivity to methylphenidate or to any component of the formulation.
Warnings/Precautions: ♦Generally should not be used in patients with structural cardiac abnormalities or other serious cardiac disorders that may increase the risk of sudden death. ♦Pre-existing cardiovascular disorders, a family history of sudden death and ventricular arrhythmia should be assessed before initiating treatment. ♦Caution in patients with pre-existing hypertension. Blood pressure should be monitored during treatment. ♦Patients who develop symptoms suggestive of cardiac disease should undergo prompt cardiac evaluation. Misuse may be associated with sudden death and other serious cardiovascular adverse events. ♦Patients with pre-existing cerebrovascular abnormalities should not be treated. ♦Patients with additional risk factors (history of cardiovascular disease, concomitant medications that elevate blood pressure) should be assessed regularly for neurological/psychiatric signs and symptoms. ♦Pre-existing psychiatric disorders and a family history of psychiatric disorders should be assessed before initiating treatment. ♦Should not be initiated in patients with acute psychosis, acute mania or acute suicidality. ♦In case of emergent psychiatric symptoms (e.g. hallucinations or mania, aggressive behaviour and suicidal tendency) or exacerbation of pre-existing psychiatric symptoms, **Ritalin** should not be given to patients unless the benefit outweighs the potential risk. ♦Family history should be assessed and clinical evaluation for tics or Tourette's syndrome in children should precede ADHD treatment. ♦Patients should be regularly monitored for the emergence or worsening of tics during initiating treatment. ♦Growth should be monitored during treatment as clinically necessary, treatment interruption may be considered. ♦Caution in patients with epilepsy. ♦Chronic abuse can lead to marked tolerance and psychological dependence. ♦Caution in emotionally unstable patients. ♦Careful supervision during withdrawal. ♦Blood count monitoring during long-term treatment. Consider appropriate medical intervention in the event of hematological disorders. ♦Not recommended for children under 6 years of age. ♦Refrain from driving and using machinery if dizziness, drowsiness, blurred vision, hallucination or other CNS side effects occur. ♦Not recommended during pregnancy unless benefits outweigh risks. ♦Avoid breast-feeding during treatment with **Ritalin.** Prolonged and painful erections, sometimes requiring surgical intervention, have been reported with methylphenidate products in both pediatric and adult patients. Priapism was not reported with drug initiation but developed after some time on the drug, often subsequent to an increase in dose. Priapism has also appeared during a period of drug withdrawal (drug holidays or discontinuation). Patients who develop abnormally sustained or frequent and painful erections should seek immediate medical attention.
Interactions: ♦**Concomitant use contraindicated:** MAO inhibitors (currently or within the preceding 2 weeks). ♦Caution when used concomitantly with drugs that elevate blood pressure, coumarin anticoagulants, anticonvulsants, centrally acting alpha-2 agonists (e.g. clonidine), direct and indirect dopaminergic drugs (e.g. tricyclic antidepressants, DOPA, antipsychotics), phenylbutazone. ♦**Alcohol:** patients should abstain from alcohol during treatment. ♦**Ritalin** should not be taken on the day of a planned surgery due to risk of sudden blood pressure increase during surgery. ♦May induce false positive laboratory tests for amphetamines.
Adverse reactions: Very common: nasopharyngitis, decreased appetite, nervousness, insomnia, nausea, dry mouth. **Common:** anxiety, restlessness, sleep disorder, agitation, tremor, dyskinesia, headache, drowsiness, dizziness, dyskinesia, tachycardia, palpitation, arrhythmias, changes in blood pressure and heart rate (usually an increase), cough, abdominal pain, vomiting, dyspepsia, toothache, rash, pruritus, urticaria, fever, scalp hair loss, hyperhidrosis, arthralgia. **Rare:** difficulties in visual accommodation, blurred vision, angina pectoris, moderately reduced weight gain and slight growth retardation during prolonged use in children, weight decreased, feeling jittery. **Very rare:** leucopenia, thrombocytopenia, anemia, hypersensitivity reactions, including angioedema and anaphylaxis, hyperactivity, psychosis (sometimes with visual and tactile hallucinations), transient depressed mood, convulsions, choreoathetoid movements, tics or exacerbation of existing tics and Tourette's syndrome, cerebrovascular disorders including vasculitis, cerebral hemorrhages and cerebrovascular accidents, neuroleptic malignant syndrome, abnormal liver function, thrombocytopenic purpura, exfoliative dermatitis, erythema multiforme, muscle cramps. **Reported with other methylphenidate-containing products:** pancytopenia, auricular swelling, irritability, aggression, affect lability, abnormal behavior or thinking, anger, suicidal ideation or attempt (including completed suicide), mood altered, mood swings, hypervigilance, mania, disorientation, libido disorder, apathy, repetitive behaviors, over-focusing, confusional state, dependence, cases of abuse and dependence have been described, more often with immediate release formulations, reversible ischaemic neurological deficit, migraine, mydriasis, visual disturbance, cardiac arrest, myocardial infarction, peripheral coldness, Raynaud's phenomenon, pharyngolaryngeal pain, dyspnea, diarrhea, constipation, angioneurotic edema, erythema, fixed drug eruption, myalgia, muscle twitching, hematuria, gynaecomastia, chest pain, fatigue, sudden cardiac death, cardiac murmur.
Packing: Ritalin: Tab 10 mg x 200's per box, **Ritalin LA**: Cap 10mg and 20 mg x 30's per bottle.

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NP4-HK1505334033

Answers to Dermatological Quiz

Answer:

1. Based on the clinico-pathological correlation, the diagnosis of periorbital xanthogranuloma has been made.

2. The other differential diagnoses include juvenile xanthogranuloma, necrobiotic xanthogranuloma, xanthoma, Langerhans cell histiocytosis, Rosai-Dorfman disease and granuloma annulare.

   Periorbital xanthogranuloma has only rarely been reported in ophthalmological literatures. It has been postulated that xanthogranuloma may be a disease spectrum with juvenile xanthogranuloma at one end and necrobiotic xanthogranuloma at the other, while the periorbital xanthogranuloma is just lying in-between. This hypothesis has been supported by the fact that some cases eventually develop necrobiotic xanthogranuloma with paraproteinaemia after many years.

3. Though based on anecdotal reports, periorbital xanthogranuloma has a potential risk of associated haematological abnormalities, while necrobiotic xanthogranuloma is almost invariably associated with paraproteinaemia. It is therefore important to follow-up these patients as the condition may run an indolent and slowly progressive course. Due to the rarity of this condition, no established treatment is available. Treatment is mostly targeted to the associated haematological abnormalities that cause morbidity and mortality.

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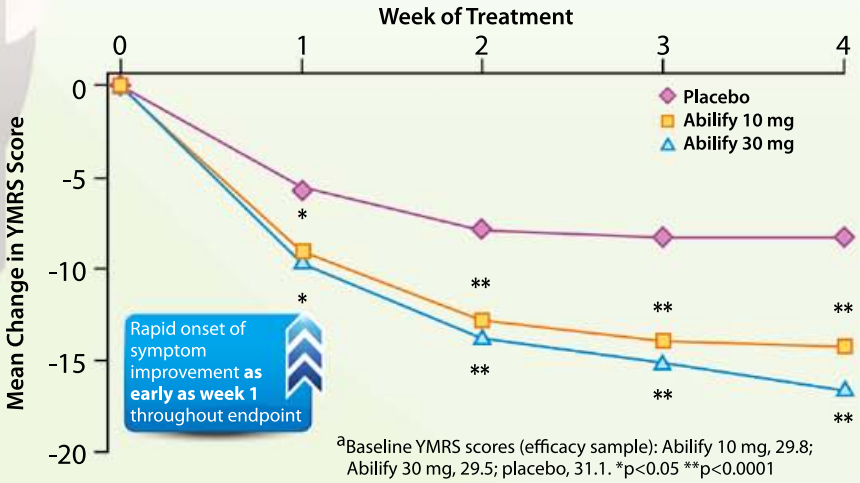
MBBS(HK), FRCP(Lond, Edin, Glasg), FHKCP, FHKAM(Med)
Specialist in Dermatology & Venereology

Effective and rapid onset of action for treatment of adolescents with Bipolar I Disorder

In a randomized, double-blind, placebo-controlled study[1]

ABILIFY® shown significantly greater mean change on the YMRS total score as compared with placebo from baseline to endpoint[1]

Mean change from baseline in YMRS total score (LOCF) weeks 1 through 4 for Abilify 10 mg, Abilify 30 mg and placebo (efficacy sample)[a]



[a]Baseline YMRS scores (efficacy sample): Abilify 10 mg, 29.8; Abilify 30 mg, 29.5; placebo, 31.1. *p<0.05 **p<0.0001

ABILIFY® (aripiprazole) is indicated for the acute and maintenance treatment of manic and mixed episodes associated with Bipolar I Disorder for patients aged 10 -17 years, both as monotherapy and as an adjunct to lithium or valproate.[2]

YMRS = Young Mania Rating Scale LOCF = last observation carried forward

ABF 201702 (approved in Aug 2017)

References:

1. Findling RL, *et al. J Clin Psychiatry.* 2009 Oct;70(10):1441-1451 **2.** Abilify Package Insert

For the product's safety, contraindications and side effect or toxic hazards, please refer to the package insert. Detailed information is available upon request.

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ABILIFY® (aripiprazole)

Start early and keep steady with ABILIFY® on functioning for adolescents with first episode schizophrenia

- **Early treatment** may help preserve executive function and prevent further degradation[1]
- **Exhibited most symptomatic improvement as early as week 2** with nearly 50% decrease in PANSS and more likely to achieve remission at week 6[2]

ABILIFY® (aripiprazole) is indicated for the treatment of Schizophrenia in adolescents aged 13-17 years.[3]

Recommended 1st line treatment for young patients with first episode schizophrenia[1]

PANSS = Positive and Negative Syndrome Scale

References:
1. Yeh CB, *et al. Nord J Psychiatry.* 2014 Apr;68(3):219-224 **2.** Correll CU, *et al. J Am Acad Child Adolesc Psychiatry.* 2013 Jul;52(7):689-698.e3 **3.** Abilify Package Insert

For the product's safety, contraindications and side effect or toxic hazards, please refer to the package insert. Detailed information is available upon request.

ABF 201704 (approved in Aug 2017)

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