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THE HONG KONG MEDICAL DIARY

香 港 醫 訊

VOL.23 NO.10 October 2018

Integrative Chinese-Western Medicine in Hong Kong

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

Certificate Course for Healthcare Professionals

Course No. C323

CME/CNE Course

Certificate Course on Clinical Cytogenetics and Genetics 2018

Jointly organised by

The Federation of Medical Societies of Hong Kong

Hong Kong Society of Cytogenetics

Objectives:

To have more understanding on Clinical Cytogenetics and Genetics

Date	Topics	Speakers
12 Oct	Human Chromosomes and their identification	Dr. SIU Lai Ping , Lisa Scientific Officer, Queen Elizabeth Hospital
19 Oct	Genetic diseases, genetic ethics and genetic counselling	Dr. Lam Tak Sum, Stephen Cytogenetic Specialist, Hong Kong Sanatorium & Hospital
26 Oct	Cytogenetics in Prenatal Diagnosis	Mr. Chan Wing Kwong Consultant Clinical Geneticist, Hong Kong Sanatorium & Hospital
2 Nov	New Genetic Methods in IVF	Dr. Chan Tsun Leung, Chris Molecular Geneticist, Hong Kong Sanatorium & Hospital
9 Nov	Cytogenetics in Blood Cancers	Dr. WONG Wai Shan Haematology Consultant, Queen Elizabeth Hospital
16 Nov	Genetic tests and personalized medicine	Dr. MA Shiu Kwan, Edmond Haematology Consultant and Pathology Lab In-Charge Hong Kong Sanatorium & Hospital

Date : 12, 19, 26 October & 2, 9, 16 November 2018 (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 materials are in Chinese / 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 / CPD / CNE Accreditation in application
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Disclaimer

The Cover Shot

A Morning Walk on Yuanyang Rice Terraces

Humans look tiny in nature. We adapt to, utilise and at times reshape the environment. Only when we take a step back can we see the astonishing scenery assembled piece by piece.

Mr Chris CHAN

Council Member,
Hong Kong Association for Integration of Chinese-Western Medicine

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Editorial

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The phenomenon that patients seek help concurrently from both Chinese medicine (CM) practitioners and Western medicine (WM) doctors is a common practice in Hong Kong, and such practice has created precious opportunities for collaboration between the WM and CM systems. A group of pioneers in this collaborative work, including doctors, scientists and professors in WM and CM, led by Prof SP Chow, a well-respected WM doctor and medical educator, established the Hong Kong Association for Integration of Chinese-Western Medicine (HKAIM) in 2001. The Association has since been very active in the promotion of collaboration between WM and CM practitioners via various activities including but not limited to seminars, workshops, programmes and conferences.

Evidence-based collaboration between the two systems is the way of the future of healthcare delivery in Hong Kong. However, WM and CM are rather different healthcare delivery systems, varying greatly in terminology, medical theories, therapeutic principles and interventions, etc. Nonetheless, the two systems do harbour a shared mission for collaboration: the promotion of health and healing of illnesses, and to achieve this shared mission, the two systems can at times be seen as complementary, as CM has its own uniqueness in treatment and prevention, and can provide solutions to some diseases for which WM cannot at certain stages of the condition, regardless of whether scientific evidence can be documented. Our patients will stand to derive maximal benefit if WM and CM can work together rather than separately.

How the two systems can work side by side smoothly to solve the illnesses of the patients is a huge topic, not just at the individual patient level, but also at the level of the healthcare providers and at the governmental policy level. From a bottom-up approach, if a patient needs help from WM and CM concurrently, it is necessary to make sure that WM and CM can work hand in hand, without any barrier, to identify an effective and safe solution for the patient. From a top-down approach, the following building blocks need to be put in place, including: i) A training system that ensures mutual understanding between WM and CM, ii) A clinical governance system that provides a cordial collaborative environment for practitioners, and iii) A research system that provides the opportunities to evaluate the efficacy and safety, and investigates the scientific basis of synergistic effects if any.

There is urgency for working towards concrete collaboration between CM and WM. The year 2013 marked the HKSAR's initiative in building a CM hospital, which is now in the works, due for completion in 6-8 years. In the CM hospital, CM practitioners, WM doctors and allied health professionals will work together on patient care all under one roof. It would be a huge task, aside from working out the operative logistics, to ensure that these professionals can work happily, efficiently and safely together. Any initiatives that can help to cultivate a conducive environment for effective collaboration between WM and CM and allied health professionals are much welcome. The HKAIM has done, and will always be committed to do more to facilitate such collaboration, not just for the sake of the patients, but for the sake of a healthier society. The success of this exciting collaboration could well serve to showcase to the world a healthcare delivery model conjoining Chinese and Western medicine.

DUODART
(dutasteride/tamsulosin HCl) Capsules

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Dual Action
Dual PROtection

DUAL ACTION:

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DUAL PROTECTION:

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- BPH related surgery by **71%**

vs tamsulosin monotherapy[1]

*The **ONLY** fixed-dose combination in relieving BPH symptoms and reduce risk of AUR or BPH-related surgery*

BPH: Benign Prostatic Hyperlasia
AUR: Acute Urinary Retention

DUODART (Dutasteride-tamsulosin) abbreviated prescribing information[2]

Indications Treatment of moderate to severe symptoms of benign prostatic hyperplasia (BPH). Limitations of use: Dutasteride-containing products, including DUODART, are not approved for the prevention of prostate cancer. **Dosage and Administration** The recommended dose of DUODART (Dutasteride-tamsulosin) is one capsule (0.5 mg/ 0.4 mg) taken once daily. The capsules should be swallowed whole and not chewed or opened. Contact with the contents of the dutasteride capsule contained within the hard-shell capsule may result in irritation of the oropharyngeal mucosa. **Contraindications** Patients with known hypersensitivity to dutasteride, other 5 alphareductase inhibitors, tamsulosin (including tamsulosin- induced angio-edema), soya, peanut or any of the excipients; history of orthostatic hypotension; with severe hepatic impairment; women and children and adolescents. **Warnings and Precautions** *Cardiac Failure* In two 4-year clinical study, the incidence of cardiac failure (a composite term of reported events, primarily cardiac failure and congestive cardiac failure) was higher among subjects taking the combination of dutasteride and an alpha1- adrenoceptor antagonist, primarily tamsulosin, than it was among subjects not taking the combination. In these two trials, the incidence of cardiac failure was low (≤1%) and variable between the studies. *Effect on prostate-specific antigen (PSA) and prostate cancer detection* Digital rectal examination, as well as other evaluations for prostate cancer or other conditions which can cause the same symptoms as BPH, must be performed on patients with BPH prior to initiating therapy with DUODART and periodically thereafter. Serum prostate-specific antigen (PSA) concentration is an important component in the detection of prostate cancer. DUODART causes a decrease in mean serum PSA levels by approximately 50% after six months of treatment. Patients receiving Duodart should have a new PSA baseline established after 6 months of treatment with Duodart. It is recommended to monitor PSA values regularly thereafter. Any confirmed increase from lowest PSA level while on DUODART may signal the presence of prostate cancer (particularly high grade cancer) or noncompliance to therapy with DUODART and should be carefully evaluated, even if those values are still within the normal range for men not taking a 5α-reductase inhibitor. In the interpretation of a PSA value for a patient taking DUODART, previous PSA values while on dutasteride treatment should be sought for comparison. Total serum PSA levels return to baseline within 6 months of discontinuing treatment. The ratio of free to total PSA remains constant even under the influence of DUODART. If clinicians elect to use percent free PSA as an aid in the detection of prostate cancer in men undergoing DUODART therapy, no adjustment to its value appears necessary. *Prostate cancer and high grade tumours* Results of one clinical study (the REDUCE study) in men at increase risk of prostate cancer revealed a higher incidence of Gleason 8 – 10 prostate cancers in dutasteride treated men compared to placebo. The relationship between dutasteride and high grade prostate cancer is not clear. Men taking DUODART should be regularly evaluated for prostate cancer risk including PSA testing. *Renal impairment* The treatment of severely renally impaired patients should be approached with caution as these patients have not been studied. *Hypotension* Orthostatic: As with other alpha1-adrenoceptor antagonists, a reduction in blood pressure can occur during treatment with tamsulosin, as a result of which, rarely, syncope can occur. Patients beginning treatment with DUODART should be cautioned to sit or lie down at the first signs of orthostatic hypotension (dizziness, weakness) until the symptoms have resolved. Symptomatic: Caution is advised when alpha adrenergic blocking agents including tamsulosin are co-administered with PDE5 inhibitors. Alpha1-adrenoceptor antagonists and PDE5 inhibitors are both vasodilators that can lower blood pressure. Concomitant use of these two drug classes can potentially cause symptomatic hypotension. *Intraoperative Floppy Iris Syndrome* (IFIS, a variant of small pupil syndrome) has been observed during cataract surgery in some patients on or previously treated with tamsulosin. IFIS may increase the risk of eye complications during and after the operation. The initiation of therapy with DUODART in patients for whom cataract surgery is scheduled is therefore not recommended. During pre-operative assessment, cataract surgeons and ophthalmic teams should consider whether patients scheduled for cataract surgery are being or have been treated with DUODART in order to ensure that appropriate measures will be in place to manage the IFIS during surgery. Discontinuing tamsulosin 1 – 2 weeks prior to cataract surgery is anecdotally considered helpful, but the benefit and duration of stopping therapy prior to cataract surgery has not yet been established. *Leaking Capsule* Dutasteride is absorbed through the skin, therefore women and children and adolescents must avoid contact with leaking capsules. If contact is made with leaking capsules, the contact area should be washed immediately with soap and water. *Inhibitors of CYP3A4 and CYP2D6* Concomitant administration of tamsulosin hydrochloride with strong inhibitors of CYP3A4, or to a lesser extent, with strong inhibitors of CYP2D6 can increase tamsulosin exposure. Tamsulosin hydrochloride is therefore not recommended in patients taking a strong CYP3A4 inhibitor and should be used with caution in patients taking a moderate CYP3A4 inhibitor, a strong or moderate CYP2D6 inhibitor, a combination of both CYP3A4 and CYP2D6 inhibitors, or in patients known to be poor metabolisers of CYP2D6. *Hepatic Impairment* DUODART has not been studied in patients with liver disease Caution should be used in the administration of DUODART to patients with mild to moderate hepatic impairment. *Excipients* This medicinal product contains the colouring agent Sunset Yellow (E110), which may cause allergic reactions. *Breast neoplasia* Breast cancer has been reported in men taking dutasteride in clinical trials and during the post-marketing period. Prescribers should instruct their patients to promptly report any changes in their breast tissue such as lumps or nipple discharge. It is not clear if there is a causal relationship between the occurrence of male breast cancer and long term use of dutasteride. **Interactions** *Tamsulosin* Concomitant administration of tamsulosin hydrochloride with drugs which can reduce blood pressure, including anaesthetic agents, PDE5 inhibitors and other alpha1- adrenoceptor antagonists could lead to enhanced hypotensive effects. Dutasteride-tamsulosin should not be used in combination with other alpha1- adrenoceptor antagonists. Concomitant administration of tamsulosin hydrochloride and ketoconazole (a strong CYP3A4 inhibitor) resulted in an increase of the Cmax and AUC of tamsulosin hydrochloride by a factor of 2.2 and 2.8 respectively. Concomitant administration of tamsulosin hydrochloride and paroxetine (a strong CYP2D6 inhibitor) resulted in an increase of the Cmax and AUC of tamsulosin hydrochloride by a factor of 1.3 and 1.6 respectively. A similar increase in exposure is expected in CYP2D6 poor metabolisers as compared to extensive metabolisers when co-administered with a strong CYP3A4 inhibitor. The effects of co-administration of both CYP3A4 and CYP2D6 inhibitors with tamsulosin hydrochloride have not been evaluated clinically, however there is a potential for significant increase in tamsulosin exposure. Concomitant administration of tamsulosin hydrochloride (0.4 mg) and cimetidine (400 mg every six hours for six days) resulted in a decrease in the clearance (26%) and an increase in the AUC (44%) of tamsulosin hydrochloride. Caution should be used when dutasteride-tamsulosin is used in combination with cimetidine. A definitive drug-drug interaction study between tamsulosin hydrochloride and warfarin has not been conducted. Results from limited in vitro and in vivo studies are inconclusive. Diclofenac and warfarin, however, may increase the elimination rate of tamsulosin. Caution should be exercised with concomitant administration of warfarin and tamsulosin hydrochloride. **Fertility, pregnancy and lactation** DUODART is contraindicated for use by women. There have been no studies to investigate the effect of DUODART on pregnancy, lactation and fertility. As with all 5 alpha reductase inhibitors, when the patient's partner is or may potentially be pregnant it is recommended that the patient avoids exposure of his partner to semen by use of a condom. As with other 5 alpha reductase inhibitors, dutasteride inhibits the conversion of testosterone to dihydrotestosterone and may, if administered to a woman carrying a male foetus, inhibit the development of the external genitalia of the foetus. Dutasteride has been reported to affect semen characteristics (reduction in sperm count, semen volume, and sperm motility) in healthy men. The possibility of reduced male fertility cannot be excluded. Effects of tamsulosin hydrochloride on sperm counts or sperm function have not been evaluated. The effects of dutasteride 0.5 mg/day on semen characteristics were evaluated in healthy volunteers aged 18 to 52 (n=27 dutasteride, n=23 placebo) throughout 52 weeks of treatment and 24 weeks of post-treatment follow-up. At 52 weeks, the mean percent reduction from baseline in total sperm count, semen volume and sperm motility were 23%, 26% and 18%, respectively, in the dutasteride group when adjusted for changes from baseline in the placebo group. Sperm concentration and sperm morphology were unaffected. After 24 weeks of follow-up, the mean percent change in total sperm count in the dutasteride group remained 23% lower than baseline. While mean values for all parameters at all time points remained within the normal ranges and did not meet the predefined criteria for a clinically significant change (30%), two subjects in the dutasteride group had decreases in sperm count of greater than 90% from baseline at 52 weeks, with partial recovery at the 24 week follow-up. The possibility of reduced male fertility cannot be excluded. It is not known whether dutasteride or tamsulosin are excreted in human milk. **Adverse Reactions** *Clinical Trial Data* (Dutasteride and tamsulosin co-administration): Impotence, altered (decreased) libido, ejaculation disorders, breast disorders (includes breast tenderness and breast enlargement), dizziness and cardiac failure. (Dutasteride monotherapy): Impotence, altered (decreased) libido, ejaculation disorders, breast disorders (includes breast tenderness and breast enlargement), alopecia (primarily body hair loss), hypertrichosis. (Tamsulosin Monotherapy): Dizziness, abnormal ejaculation, palpitations, constipation, diarrhoea, vomiting, asthenia, rhinitis, rash, pruritis, urticaria, orthostatic hypotension, syncope, headache, nausea, angioedema, priapism, Stevens-Johnson syndrome. During postmarketing surveillance, reports of Intraoperative Floppy Iris Syndrome (IFIS), a variant of small pupil syndrome, during cataract surgery have been associated with alpha1- adrenoceptor antagonists, including tamsulosin. In addition atrial fibrillation, arrhythmia, tachycardia, dyspnoea, epistaxis, vision blurred, visual impairment, erythema multiforme, dermatitis exfoliative, ejaculation disorder, retrograde ejaculation, ejaculation failure and dry mouth have been reported in association with tamsulosin use. The frequency of events and the role of tamsulosin in their causation cannot be reliably determined.
Abbreviated PI based on HK092016(GDS11v3/MHRA20160901). Please refer to the full prescribing information before prescribing. Full prescribing information is available upon request.

At month 48, the adjusted mean percentage change from baseline in total prostate volume was -27.3% for combination therapy, +4.6% (p<0.001) for tamsulosin, and -28.0% (p=0.42) for dutasteride.

References: 1. Roehrborn CG, *et al. Eur Urol* 2010;57(1):123–31 **2.** DUODART Hong Kong Full Prescribing Information 2016. Version number: HK092016(GDS11v3/MHRA20160901)

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HKRX/DUTT/0015/18 (05/2020)
Date of preparation: 12/06/2018

History of Integrative Medicine in Hong Kong

Dr Edwin Chau-leung YU

Honorary President, Hong Kong Association for Integration of Chinese-Western Medicine

Dr Edwin Chau-leung YU

INTRODUCTION

With Chinese medicine (CM) deeply rooted in Hong Kong's Chinese culture, empirical practice of CM has been the norm since the early days of Hong Kong. Western medicine (WM) had its humble beginnings in Hong Kong in the form of established services for colonial government staff; WM was subsequently extended to the Chinese population through missionary efforts. The scourge of the plague pestilence in 1894 gave WM an advantage whence enforced laws and regulations and the swing to scientific philosophy set a trend that snowballed WM dominance [1].

Since the late 19th century, Hong Kong residents have been seeking treatment from both CM and WM. CM was given an official status by the Basic Law in 1997. There came about the Chinese Medicine Ordinance in 1999 and the humble beginnings of Integrative Medicine.

THE FOUNDING AND MISSION OF THE HKAIM

In 1999, a group of doctors with CM training gathered to study how CM could become useful in the Hong Kong medical scene. With the guidance of academic advisers, these doctors held meetings on various logistical, legal and academic aspects. Around this time, the University of Hong Kong formed a liaison with the Chinese Association of Integrative Medicine (CAIM) in Beijing. In 2001, spearheaded by Professor SP Chow, the brainstorming group of Hong Kong doctors, scientists, and university professors in WM and CM joined hands and formed the Hong Kong Association for Integration of Chinese-Western Medicine (HKAIM). Since then, the HKAIM has led the development of Integrative Medicine (IM) in Hong Kong at four broad levels:

1. Socio-economic-political level,
2. Professional and bedside practice level,
3. Education and training level, and
4. Research and basic conceptual level.

The Association gained steady momentum under the leadership of its successive presidents, Shew-ping Chow, Wing-man Ko, Vivian Chi-woon Taam-Wong, Edwin Chau-leung Yu, Zhao-xiang Bian and Ka-hang Or. The HKAIM expanded to over 700 members inclusive of doctors, nurses, therapists, pharmacists, scientists and students. A good fraction of the members on the HKSAR Chinese Medicine Development Committee (CMDC) formed in 2013 were members of HKAIM. The Association has worked very hard to promote a dialogue between the practitioners in both fields. Indirectly, through its key members, the HKAIM has also impacted policies at the universities, the Hospital Authority (HA), the Department of Health (DH) and the Food & Health Bureau (FHB).

THE DEVELOPMENT OF INTEGRATIVE MEDICINE

Along with the HKAIM as the formal common platform for WM and CM came increasing cross-discipline interaction and development. The SARS epidemic in 2003 made an important milestone for such cross-discipline fertilization. While our city was baffled by a life-threatening infection which WM offered no definitive medical solution, news of good recovery from SARS traveled in from Mainland China. The HKAIM invited while HA engaged the CM professors with SARS experience in Guangzhou to travel to Hong Kong to share their expertise. Their presence in the local scene[2] enabled the setup of protocols incorporating CM as a research arm in the HA service, leading to the establishment of the post-SARS tripartite CM clinics run by the HA, universities and non-governmental organisations (NGO) as well as the establishment of Centres for Training and Research (CMCTR) working to provide evidence-based CM service and training for CM graduates, targeting to enhance healthcare delivery in the public sector.

The vision for the development of IM has evolved. To start with, the mainland developed a good environment for IM through support in clinical practice, training, scientific research and policy making. Awareness of different local and global policies and systems started our Hong Kong IM approach. It involves quality practice, mutual development and research projects from different disciplines. The system, recognised by mainland officials, is to bring the two streams of CM and WM together. The following describes some major IM activities.

EDUCATION: MAGNIFYING CM EXPERTISE AND WM UNDERSTANDING

A. From CM to WM

Degree programmes were set up at the Hong Kong Baptist University (HKBU) in 1998, and subsequently at the University of Hong Kong (HKU) and the Chinese University of Hong Kong (CUHK). Master degree courses were offered. M.Ph, Ph.D and post Doctorate positions are mostly for CM research.

The Chinese Medicine Council of Hong Kong has run a continuing medical education (CME) programme since 2004. The HKAIM, often in collaboration with HA, has been active in providing educational seminars in which WM specialists and CM experts together expound on how diseases can be best managed. CM associations and UGC-funded programmes delivering CM lectures at different universities, as well as various conferences and seminars, would nowadays also invite WM specialists as speakers. Since 2009, CM graduates are offered 3-year in-service training programme at the tripartite clinics[3]. Scholarships have also been set up to train potential leaders in CM specialties in renowned centres in Mainland China. A broader audience of CM & WM professionals, academics and managers have joined annual conferences of the International Conference on Modernised Chinese Medicine (ICMCM) since 2002, those of Consortium for Globalization of Chinese Medicine (CGCM) since 2003, and seminars on CM developments held by the Innovation and Technology Commission (ITC) since 2013.

B. From WM to CM

To increase mutual understanding, it is imperative that CM practitioners acquire more knowledge about WM practice. In Mainland China, IM started with WM doctors learning CM in the 1950s. In Hong Kong, the part-time CM degree courses organised by SPACE of HKU in the 1990s played a significant role in grooming certain WM doctors who had attended these courses as IM leaders. The HA organises CM certificate courses for WM doctors to promote CM-WM communication. In 2017, the HKAIM made a breakthrough in promoting clinical IM via interactive workshops in which a mixed WM-CM panel offered expert-led clinical and case-illustrative discussions while one third of the audience were WM practitioners.

Since 2003, the HKAIM, in collaboration with the HA, organise conferences involving both local and global academicians as speakers, covering a broad range of topics including cancer, infectious diseases, cerebrovascular and cardiovascular diseases, skin diseases, pain acumoxa, acupuncture, geriatrics, chronic diseases, Chinese Medicine Hospital operation, and IM. Since 2013, the HKAIM has run courses, with good response, as these courses enable the CM practitioners to learn directly from WM experts so that the CM practitioners could understand the whole spectrum of WM.

SERVICES

A. Service Provision

The HA, tasked with developing one CM Clinic in each district since 2000, built up tripartite collaboration involving the HA, the universities, and NGOs and formed the 18 CMCTRs. Clinical IM protocols were developed in Kwong Wah Hospital (KWH). CM services were all along provided only in clinics. The first primary care clinic with CM-WM joint consultation was started by HKBU in Queen Elizabeth Hospital in 2006.

Since 2007, HKBU has collaborated with the Hong Kong Anti-Cancer Society to provide integrative CM and WM service, including but not limited to stroke rehabilitation, pain syndrome, and late-stage cancer with 6 inpatient beds in the Nam Long Hospital, which was subsequently transformed as the Hong Kong Anti-Cancer Society Jockey Club Cancer Rehabilitation Centre. These two institutions started the Dr & Mrs Michael SK Mak Integrated Chemotherapy Centre for cancer patients in 2012.

Within a decade, there has been much IM development: geriatric services in Princess Margaret Hospital (PMH), FungYiu King Hospital, Shatin Hospital, and Haven of Hope Hospital; the Duchess of Kent Children's Hospital introduced neurological rehabilitation[3]. This movement later expanded to allow WM inpatients to request for referral for CM services with parallel or sequential CM/ WM consultation and intervention. More than 20 hospitals are now providing some degree of such service. Evidence-based medicine (EBM) is being held as the key principle that the Government steers the development of services integrating CM and WM.

IM for specific diseases include early treatment for mental health at the Tang Shiu Kin CMCTR collaborating with clinical psychologists from Queen Mary Hospital and CM practitioners trained at Kowloon Hospital. Acute low back pain was piloted at the Accident & Emergency Department in Pok Oi Hospital. In response to the growing demand for pain management in cancer patients, multiple initiatives have been undertaken. At the Prince of Wales Hospital Cancer Centre, acupuncture has been used for pain in advanced cancer. The Ha Kwai Chung CMCTR, along with the Cancer Centre of PMH, explored IM services to provide comprehensive services for cancer patients. Ngau Tau Kok Chinese Medicine Centre and the United Christian Hospital collaborated in trials of CM and WM for treating chronic pain with acupuncture and/or massage. Finally, for low back pain, stroke and cancer, IM service protocols were upgraded via the Integrated Chinese-Western Medicine ("ICWM") Pilot Programme by the HA in 2014.

The year 2013 marked the Government's initiation of the CM hospital. It will operate under the collaboration between CM and WM. In 2018, the Chinese Medicine Hospital Project Office was set up under FHB to plan and develop the CM Hospital for 400 beds.

B. Patient-driven IM service and referral systems

Studies in Hong Kong showed that, over the years, some 40% of chronically ill patients use both CM and WM at the same time. In this patient-driven clinical setting, CM practitioners not only use techniques from traditional CM theory and practice but also utilise modern CM research results. In the CM clinic of the HKU, for example, CM oncologists will take into account patients' WM data and will use CM and coordinate herbal actions according to the tumour types, stages, and stage of WM treatment.

For the government, CM has to be promoted on the basis of evidence-based Chinese medicine (EBCM). For frontline practitioners of both disciplines, mutual respect and acceptance arise from mutual trust built during interactions in a conducive system/environment. In 2014, the Hong Kong Institute of Integrative Medicine (HKIIM) embarked on IM clinics staffed by both CM and WM professionals; mutual referrals are facilitated by specialised nurses.

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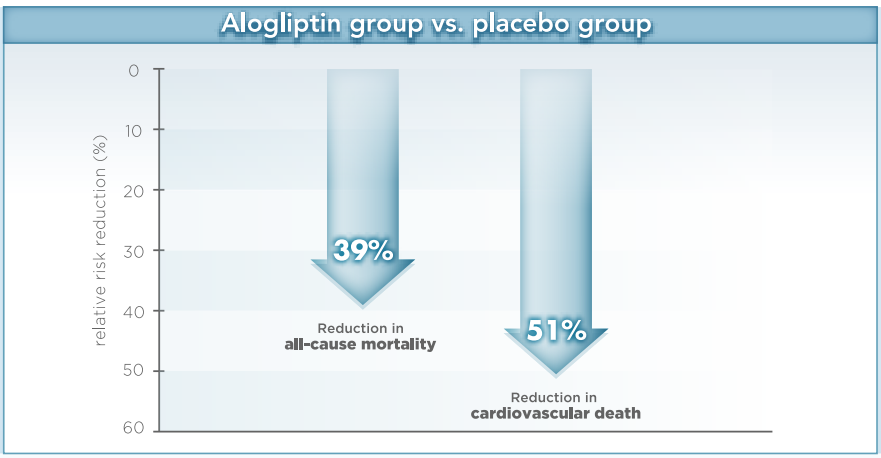

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*SU : sulfonylurea †ACS: acute coronary syndrome

^ EXAMINE Trial: EXamination of CArdiovascular OutcoMes with AlogliptIN versus standard-of-care in Patients with Type 2 Diabetes Mellitus and Acute Coronary Syndrome - Multi-centre, randomized, double-blind study including 5,380 patients. Patients randomly assigned to receive alogliptin (n=2,679) or placebo (n=2,701), in addition to standard-of-care treatment for type 2 diabetes. Median follow-up period was 18 months

Reference: 1. NHS Basildon and Brentwood, Thurrock Clinical Commissioning Group. Alogliptin Switch Guidance-Prescribing Quality Incentive Scheme 2016/17 2. Nesina HK package insert NES0314PILHK 3. White WB et al. Am J Med. 2018;131(7):813-819.e5.

HK/ALO/2018-00008

EVERY PIECE COUNTS

RESEARCH

Interest of WM workers in CM started early since the 1970's. Acupuncture for heroin addicts pioneered original research. That for induction of labour in post term pregnancies was studied. Development of mouse models for CM patterns in spinal condition, and herbal medicine for prevention of amputation in diabetic gangrene were other pioneering examples.

A. Seeking Good Evidence-based CM

There are some pillars to build up evidence-based medicine in IM. For one, evidence of CM effectiveness for diseases needs to be demonstrated. For the major disease burdens, the HA commissions systematic reviews of RCTs and new RCTs, resulting in many publications in English peer-reviewed journals. Since 2009, research training courses have been offered to CMPs in CMCTRs to enhance their basic knowledge.

Besides, clinical research activities need to be promoted. HKBU started clinical research on irritable bowel syndrome, functional constipation, rheumatoid arthritis, and Parkinson's disease. CUHK conducts research on diabetes, hepatitis, lung cancer, asthma, rheumatism, carpal tunnel syndrome, gallstone, multiple sclerosis, and functional gastrointestinal diseases. HKU combining principles and methods of traditional and modern medicine, works on the prevention and treatment of cardiovascular and cerebrovascular diseases, neuropsychiatric diseases, chronic pain, and malignant tumours as well as acupuncture and its effectiveness and mechanisms. Other universities in Hong Kong also establish their CM institutes. Work is also done for modernising CM. HKUST with years of neuroscience research worked up >100 herbs for neurodegenerative diseases, Parkinson's disease and depression. After 2010, HA has established a mechanism to commission and review Chinese medicine (CM) research projects. Topics include CM-WM interactions, obesity, traumatic brain injury and insomnia, dysphagia after swallowing, etc.

B. Promoting Evidence-based Practice of CM

Another pillar is at the practice level. The CM Research Practical Training programme was launched to enhance CM Practitioners' competency and CMCTRs' capacity for evidence-based practice. Since 2017, CUHK's Integrative Medicine Clinical Evidence Portal[4] offers to practitioners a search engine for evidenced-based CM usage and practice, as Asia's first CM clinical evidence on-line portal, gathering studies from around the world. Placing CM with WM on the same electronic platform for HA data coding in the Clinical Management Information System (CMIS) using the system from the mainland, it has impacts by contributing significantly in the development of the new electronic version of the 2019 International Classification of Diseases (ICD 11) after being put forward to WHO in 2011.

Details are necessary for safer CM-WM collaboration. A CM Toxicology Laboratory was built in PMH to support or refute diagnosis of herbal toxicity. The HA eKG intranet was enriched with a 'herb-drug interaction database' arising from commissioned scientific reviews. Government in 2011 formed the Committee on Research and Development of Chinese Medicine. ITC seminars in conjunction with HA and DH discussed CM-WM collaboration, exchanging EBM experiences and researches on CM and WM complementarity.

C. Opening Wider Perspectives for CM Research

The year 2014 was a special year for IM advancement. HKIIM of CUHK, the ICWM Pilot Programme for HA in-patients, and the CM hospital were started. The Endowed Professor in IM in HKU was established earlier.

Government has reserved a piece of land at Tseung Kwan O for the CM hospital with facilities to support teaching, clinical practice and scientific research of the SCMs under the three Universities.

HKIIM developed a comprehensive platform with research and development, clinical service and teaching. Collaboration between different disciplines and scholars from different areas under models of safe and effective IM treatment is expected to achieve breakthrough results. On common chronic conditions with unmet needs in treatment, including functional gastrointestinal disorder, neurodegenerative disease and palliative medicine, IM clinical trials were initiated. The Analytic and Clinical Cooperative Laboratory for Integrative Medicine (ACCLAIM) is a joint platform for scientists and clinicians in sharing information technology, data analysis, and clinical research for the advancement of evidence-based IM. It has a focus on downstream applied clinical research, with translational deliverables and big-data applications in clinical trials, building on an established international collaboration network.

The ICWM Pilot Programme cumulates experience on ICWM in-patient care for realizing a model/ framework at the system level. With protocols for treating defined target patient groups basing on the best available evidence, and with treatment objectives of CM and WM streams defined and complementing each other for patient care, treatment outcomes can be monitored for overall evaluation. A clinical framework was developed to guide disease selection, service scope, clinical management and managing clinical risks. An operation framework functions to guide patient flow, organisation of care processes and development of infrastructure systems. Three disease areas including stroke care, low back pain care and cancer palliative care were chosen, being joined by three and later seven public hospitals. The Phase III launched in 2018 additionally includes shoulder and neck pain care. The experiences learnt would be of value for the further development of ICWM in Hong Kong.

D. Supported with Funders

The Innovational and Technology Fund of ITC, the Health and Medical Research Fund (HMRF), and the Research Grants Council (RGC) provide good funding sources. Researches range from studies on attitudes and behaviours towards the use of Traditional CM, integrated approach to treatment using CM and WM for diseases, understanding the mechanism and application of herbs in diseases, and better designs to study the efficacy of CM and IM, and better rehabilitative and palliative management. Another direction is to develop new useful CM products, and finding active ingredients from herbs. Funders would emphasise the purpose of such researches, the basic and clinical research contributions, and the impact to combine the research

outputs into practice. The better defined the local needs together with success to advance into international domains will draw better support.

FUTURE: APPLYING IM FOR COMMUNITY USE

While much has been done in public hospitals, it is in the community, where CM can play an advantageous role for chronic diseases, and side by side CM-WM practice can bring people better health. Facilitative details are needed for WM-CM coordination and communication. Since 2015, HKAIM started an Integrative Joint Organisational Platform (IJOP), with the objective to build a conducive environment for CM-WM collaborative practice[5]. It focuses on using quantitative and qualitative inter-professional approaches as the basis for exchanging experience and ideas to compose good details for collaboration while creating opportunities and avenues of CM-WM collaboration in the community.

HKAIM public education went into the media with RTHK in 2004, with alternating WM and CM experts in programmes on clinical problems. It was restarted as a long series of weekly programmes after 2013, presenting evidenced knowledge of herbal formulae and CM/IM practices to the public, as these capture the interests of WM doctors. An Internet platform eKG for public information, education and research was built by HA in 2011 and revised in 2015.

In Hong Kong, integrating CM and WM is to have the two streams collaborating, by jointly determining the diagnosis and observing clinical management of patients. The purpose is to combine the advantages of the two medical disciplines, strengthen the results of clinical curative effects, and minimise the side effects in the course of medical treatment. Then effective applications may make possible the formulation of a plan that is most suitable for the patient to accelerate recovery.

ACKNOWLEDGEMENT

We thank with much appreciation for the help and contributions in writing from Vivian Taam-Wong, Wai-lun Cheung, Justin Wu, Yi-bin Feng, Zhao-xiang Bian and Shew-ping Chow who provided stimulating informative guides on developments in HA and the Universities.

The author apologies for limitations in embrasure of modernisation of CM and herb-pharmacy, of nursing and paramedical developments, the herbal industry, and other research and funding institutions.

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When West Meets East: A Brief Explanation of Chinese Medicine to Western Medical Doctors

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Dr Kevin Ka-hang OR

AN EFFECTIVE ALTERNATIVE, OTHERWISE WHY BOTHER?

In this age of information explosion, doctors are busy in keeping up with the rapid medical advances in their respective fields. An often-asked question by Western medical doctors is where the evidences are to demonstrate the clinical effectiveness of Chinese medicine (CM). In other words, if CM does not work, why bother? My short answer to this question for the busy clinician is that it depends on one's area of interest. Although this is beyond the scope of this introductory article, it suffices to say that, in some areas, CM is already an effective alternative to Western medicine.

With regard to evidence base, recently there has been an update on the guidelines on how to conduct clinical trials in CM[1]. This is a standard evidence-based set of guidelines adapted to the characteristics of CM. The adaptation is well justified because of the way CM is practised and, in certain basic ways, disease understanding in CM is very different from Western medicine.

Here we shall describe how Chinese herbal medicine is being practised, and in particular how it can be understood in nowadays language in connection with Western medicine.

A STEP-BY-STEP DESCRIPTION OF HOW CHINESE HERBAL MEDICINE IS BEING PRACTISED

Each treatment modality often defines the type of Chinese medical practice; modalities commonly include herbal medicine, acupuncture and moxibustion, Tuina (therapeutic massage); and bone setting. Here we describe a typical clinic consultation in herbal setting since herbal diagnosis and treatment epitomises the principle and practice of CM.

When the patient presents to the CM practitioner at a herbal clinic, he or she will be assessed clinically through the Four Diagnostics [四診], which includes, in no particular order, inspection, smell and taste, history taking; and palpation [望聞問切]. Analogous to the systematic review in Western medical history taking, CM practitioners always ask every patient about his/her appetite, sleep, urination and defaecation.

In physical examination, examination of the pulse and tongue is much more elaborate than in Western medicine; and these physical signs have dominating diagnostic values. Yet, similar to the many subtle physical signs in Western medicine, pulse and tongue examination can be mastered only after prolonged training. On the other hand, much of the physical examination in Western medicine including many of the subtle physical signs like jugular venous pulsation is not well taught in CM.

Usually after some years of postgraduate clinical training, CM practitioners become proficient in clinical data collection via the Four Diagnostics. They identify the pattern of the Four Diagnostics items; then infer the underlying aetio-pathological mechanism [病因病機] in CM terms.

Based on the identified pattern of the Four Diagnostics items and the inferred aetio-pathological mechanism, a CM practitioner summarises the diagnostic information in compact terminology, known as disease pattern or Zheng [證候/證]. Based on Zheng, the practitioner determines the treatment strategy and method [治法], followed by formula and herbal prescription [方藥].

Depending on the disease activity, the patient usually returns for follow up after several days of herbal treatment. Both Zheng and treatment are highly individualised, and treatment is often without well-defined endpoints. This is in sharp contrast to the often-discrete treatment outcomes of Western medical practice.

A FEW EXPLANATORY NOTES

Given how herbal CM is being practised, a few points of contrast with Western medicine are essential to our understanding of CM from a Western medical perspective. For a more detailed exposition, the reader is referred to two excellent articles written by Dr Edwin Chau-leung Yu[2,3].

A. Uniquely structured disease understanding

CM contrasts with Western medicine rather interestingly in its understanding of health and disease. Unlike Western medicine, CM does not focus on the disease, or its distinction from health by discrete diagnostic criteria. Instead, it emphasises the health-disease continuum as the result of the interaction among many opposing restorative and destructive processes.

Health-related processes both inside the living body and outside in the surrounding environment are taken into consideration. Disease occurs when the harmony of the interaction among processes is imbalanced to the extent that symptoms and signs become observable clinically.

Such basic health-disease understanding leads to a unique kind of medical thinking. There is a constant quest for clinical clues of opposing patho-physiological processes. The Chinese medical treatment goal is often aimed at restoring equilibrium of bodily function.

The most basic representation of the complex interaction of Chinese medical patho-physiological processes is to abstract the health status as a dynamic equilibrium between Yin and Yang. These are the two universal metaphysical elements that are opposing, yet inseparably interdependent with, each other. It is also important to realise that due to their intrinsic nature, Yin and Yang are not interchangeable. This is to a certain extent similar to the negative and the positive charges in the physical world where there is a tendency towards electro-neutrality in dynamic equilibrium.

Hence, instead of the relatively static operative such as disease in Western medicine, CM focuses more on the ever-changing interaction of multiple patho-physiological processes. These processes can often be common across different diseases.

Whilst the understanding of Western medical patho-physiological processes is based mostly on clinical observation and on various branches of science, Chinese medical patho-physiological processes are represented as a mixture of clinical observation and its inferential correlates that are derivatives of Yin-Yang [證候]. It is labelled as disease pattern or Zheng [證].

The Chinese medical understanding of health-disease follows the conceptual structure derived from Yin-Yang, which has been vindicated and refined through centuries of the empirically observed clinical symptoms and signs. The derivation procedure follows the principle and practice of CM. For instance, Yin-Yang can be derived into the pathological location [病位] of deep-superficial [裡表], and the pathological nature [病性] of cold-hot [寒熱] and deficiency-excess [虛實] respectively. These four pairs together are known as the Eight Classes or Categories of Diagnoses [八綱辨證] in CM diagnostics.

There are six to eight commonly used diagnostic approaches in Chinese medical practice. For example, Yin and Yang can be quantised further respectively into three Yin's and three Yang's to form the Six Meridian Diagnostics [六經辨證]. Zang-Fu or Organ-based Diagnostics [臟腑辨證] is a common diagnostic approach that bases primarily on the pathological location [病位] of the disease. A detailed exposition of the CM theoretical framework is beyond the scope of this short introductory article. One can readily refer to any one of the many CM diagnostics [中醫診斷學] textbooks for details.

B. Fluidity of Chinese medical diagnosis-and-treatment

Western medicine has undergone rapid changes and advances in the past forty years. During this period of development, it has adopted an evidence-based approach. This is a systematic and objective approach to collect and analyse empirical data so as to advance knowledge with unbiased diagnostic and treatment recommendation for clinical practice.

Prima facie to this data-driven approach is the requirement of definable and discrete data. This approach suits Western medicine well since its clinical interest is usually about disease, and disease is an entity that is relatively static and definable in comparison to the dynamic patho-physiological interaction and its instantaneous representation of Zheng in CM.

Furthermore, data readout from Western medical diagnostics is sufficiently discrete since it is often the result of application of newly gained knowledge from other branches of science, in contradistinction to the non-data driven, long-established conceptual structure in Yin-Yang derivative in Zheng [證]. Interestingly, one traditional branch of CM has been about the discrete Yin-Yang calculation of Zheng based on Yijing [易經].

The hallmark of Yijing is about the ever-changing nature of the cosmos. Its mathematics reflects the instantaneous nature of Chinese medical diagnosis, and the fluidity of its closely coupled treatment [辨證論治] over time[4].

C. Clinical outcome and adverse reaction understood differently

Treatment outcome is expressed as Zheng that is altered either qualitatively or quantitatively after receiving treatment. Traditionally, there is a relative lack in disease-specific outcome in CM. Adverse reaction resulting from treatment is regarded as a variant of Zheng or complication [變證]. Hence, diagnostic assessment and treatment outcomes in Chinese medical practice are often a spiralling loop of Zheng's with less distinct endpoints in comparison to Western medicine.

CLOSING REMARKS

In less than 40 years, evidence-based medicine has swept through Western medicine with its emphasis on objectivity and reproducibility in research undertaking. The resultant explosion of information and knowledge has transformed the education and teaching of Western medicine from one-on-one mentor-apprenticeship to problem solving and learning over the Internet.

Yet rising healthcare demands still outstrips such rapid Western medical development. Given proper understanding and appropriate context, CM can be an effective healthcare partner to Western medicine. It can offer exciting alternative and/or complementary approach to tackle the many pressing healthcare problems that we face.

How big a role in healthcare that CM can play depends on the development of objective evidence. Obviously, no one scientific method fits all disciplines. Given CM's unique characteristics, evidence-based research in CM cannot simply copy the disease approach from Western medicine. As well said in the recently published guidelines[1], evidence-based approach can be adopted in CM research without compromising the principle and practice of CM.

Traditional CM is a mixture of life science and philosophical medicine founded on Yin-Yang from which its conceptual framework is derived[4]. Amidst this conceptual transformation of Yin-Yang, clinical

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symptoms and signs remain the empirical evidence of Zheng. Hence, an essential aspect in the development of evidence-based Chinese medical practice is to advance our understanding of the vital relationship between the clinical findings and the conceptual (Yin-Yang) derivatives in diagnosis and treatment.

Practice changing development is challenging especially when such change may raise frontline practitioners' suspicion and doubt, similar to what the Western practitioners might have experienced in the early days of the development in evidence-based Western medicine. Due empathy and understanding of the sentiments of frontline practitioners, as well as due respect and support, should be given. We are now at the early phase of development in evidence-based CM. Building on the experience from Western medicine development, it is likely that we will need no more than 40 years before CM can fulfil its full potential as part of the mainstream service in modern healthcare delivery.

ACKNOWLEDGEMENT

The title of this article is inspired by the bestseller written by my friend, Dr Derrick Kit-sing Au, "When Chinese Medicine Meets Western Medicine – History and Ideas", Joint Publishing (H.K.), 2004.

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Radiology Quiz

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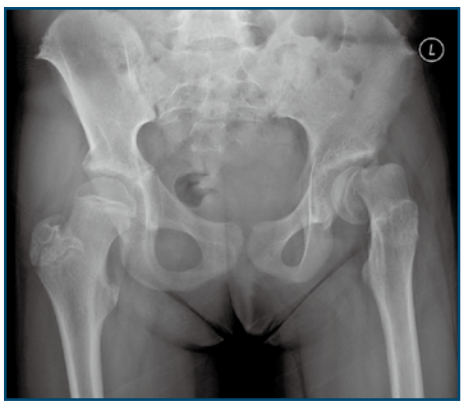

Questions

1. Please look at the X-ray of the pelvis of a 14 year old girl presenting with a limping gait.
   What are your findings?
2. What is your diagnosis?
3. What type of injury is this?
4. What is the percentage of this condition occurring bilaterally?
5. What further investigation would you suggest?
6. What are the sequelae of this condition if left untreated?

(See P.32 for answers)

Evidence of Acupuncture for Pain Management

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INTRODUCTION

Acupuncture is an archaic healing art which has been used in China and other East Asian countries for thousands of years. In history books, this traditional therapy was well documented as part of Chinese culture dating back to over 2,000 years ago[1]. After centuries of development, it is now used in more than 183 countries, according to the *'WHO traditional medicine strategy: 2014-2023'*[2]. In clinical practice, acupuncture is used to alleviate various ailments. A large majority of those are pain conditions. Pain is a prevalent condition that carries negative impact on both the physical and psychological well-being of a person. According to the WHO, the prevalence of chronic pain in primary care reaches 22%, approximately[3]. In the U.S., prevalence of pain in the general population rises to 65%, which leads to a more devastating public health event, the opioid crisis. Therefore, non-addictive therapeutics for pain management is urgently needed[4-7]. In Hong Kong, pain condition also represents great challenges to our public health system. Studies estimated that only 35.7% of patients with pain conditions in Hong Kong received helpful or adequate pain management interventions[8]. Recently, acupuncture analgesia has been validated by extensive clinical evidence, which promotes the spread of acupuncture globally. This paper provides an overview of the scientific evidence of acupuncture analgesia.

WHAT IS CLINICAL EVIDENCE AND WHY IS IT IMPORTANT?

In the 1990s, evidence-based medicine (EBM) emerged as a promising field of medical research. It is defined as *'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients'*[9]. Such visions fitted in the rising demands of the public for credible evidence in clinical decision making[10]. EBM values the quality of evidence and has built up a hierarchical evaluator pyramid to classify the level of evidence[11]. Systematic reviews, meta-analysis, and randomised controlled trials are ranked at the top of the evidence hierarchy, as they are the most reliable source of clinical evidence[12]. Randomised controlled trials as the golden standard of medicine are used to assess the clinical effectiveness of medical interventions. By utilising this system, modern medicine has developed a large body of evidence in recent years, which is used as a powerful tool by clinicians, patients and policymakers in clinical decisions making. Clinical decisions no longer merely rely on physicians' personal experience[13]. Therefore, the importance of clinical evidence is highlighted in delivering validated medical service to patients. EBM also facilitates the integration of acupuncture into the framework of mainstream medicine through generating a large body of evidence. It contributes to the recognition of acupuncture therapy and provides a language for traditional medicine to communicate with Western medicine.

THE GROWING BODY OF EVIDENCE OF ACUPUNCTURE ANALGESIA

A trend of clinical studies in acupuncture started in the 1990s. In 1997, the National Institute of Health (NIH) held a landmark consensus conference on acupuncture[14]. It formally endorsed acupuncture for its use in postoperative and many other pain conditions. It claimed that acupuncture is with promising evidence for treating arthritis, menstrual pain, headache, low back pain, etc. Since then, evidence-based research paradigm became a major scheme in acupuncture research. Many randomised controlled trials were strictly conducted and reliable clinical evidence of acupuncture was generated.

Randomised Controlled Trials (RCT)

Berman and *Lao* et al conducted a double-blind RCT to assess the effect of acupuncture for knee osteoarthritis[15]. 570 eligible patients with osteoarthritis of the knee were recruited, and then randomly divided into three groups, acupuncture, sham control and education groups. After baseline, patients were treated by acupuncture twice per week for 8 weeks, and then tapered down to once a week, every other week, and once a month for up to 26 weeks. Patients in the sham control group received sham acupuncture treatment and those in the education group received no treatment but 6 sessions of health education. After treatment completion, a standard instrument, Western Ontarian McMaster Osteoarthritis Index (WOMAC), was used at 8 and 26 weeks to assess the changes in pain intensity and joint function. The results showed that patients in the acupuncture group experienced greater improvement in WOMAC function scores (MD (mean difference): -2.9, P = 0.01) than the sham control group at 8 weeks but not in pain scores. At 26 weeks, patients in the acupuncture group experienced greater improvement in function scores (MD: -2.5, P = 0.01) and pain scores (MD: -8.7, P = 0.003). Even compared with intra-articular injection of hyaluronic acid, the clinical effect observed is still significant (intra-articular injection versus placebo: MD for WOMAC pain: 0.6, P = 0.35; MD for WOMAC function: 0.2, P = 0.91)[16].

Clinical studies have also been carried out to assess the analgesic effect of acupuncture for acute pain. Shin et al. compared motion style acupuncture (MSA) with

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conventional diclofenac injections in treating acute low back pain (aLBP)[17]. In MSA treatment, patients were required to passively or actively move their body during needle retention. The outcomes included improvement of pain intensity measured by a 10-point VAS, and change in functional disability measured by the Oswestry Disability Index (ODI) at 30 minutes and at 2, 4, and 24 weeks after treatment. It showed that 30 min after treatment the acupuncture group had more pain relief (MD: 3.12, P<0.0001) and more functional improvement (MD: 32.95%; P<0.0001) than conventional diclofenac injection. The effect lasted to 4 weeks after treatment.

MacPherson et al (2015) conducted a pragmatic trial to assess the effect of acupuncture plus usual care versus Alexander techniques plus usual care versus usual care alone in treating chronic neck pain[18]. They used the Northwick Park Questionnaire to measure the improvement in neck pain and its associated disability and showed that at 12 months both acupuncture and Alexander techniques significantly ameliorated neck pain and improved its associated disability as compared with usual care. Moreover, both acupuncture and Alexander techniques exerted long-term therapeutic effects. This study showed that in clinical settings both therapies could be introduced to patients to alleviate chronic neck pain. Similar research protocols used by other teams also found acupuncture was effective in 'real-world' settings for the treatment of chronic low back pain[19], chronic shoulder pain[20], chronic headache[21], menopausal symptoms[22], etc.

Systematic Reviews and Meta-analysis

In order to generate more powered evidence, the *Acupuncture Trialists Collaboration* conducted an individual patient data (IPD) meta-analysis to evaluate the effect of acupuncture for patients with chronic pain[23]. The IPD meta-analysis of 29 RCTs with 17,992 patients demonstrated that patients receiving acupuncture experienced less pain in back/neck pain, osteoarthritis or headache, as compared with the sham control. The effect size of acupuncture in treating neck and back pain is 0.37 SDs over the sham control; and 0.26 SDs for osteoarthritis and 0.15 and 0.62 SDs for treating chronic headache and shoulder pain, respectively. When compared to no-acupuncture treatments, the effect size of acupuncture was even larger.

Evidence Map

Previous trials also compose an evidence map of acupuncture analgesia. WHO in 2003 summarised the strength of existing evidence on acupuncture and acknowledged that acupuncture is effective for managing 28 conditions[24]. According to the 2014 '*Evidence Map of Acupuncture*' by the Department of Veteran Affairs, there is strong evidence showing the effect of acupuncture in treating pain conditions, such as headache, chronic pain and migraine[25]. It also has potential effects on dysmenorrhoea, labour pain, cancer pain, as well as many non-painful conditions. However, the report also pointed out that clear evidence is still needed to determine whether or not acupuncture is useful for rheumatoid arthritis, shoulder pain, adverse effects of cancer, and irritable bowel syndrome. For carpal tunnel syndrome and cocaine addiction, current evidence does not support acupuncture. Nevertheless, 'No evidence of effect' does not mean 'evidence of no effect'. More rigorously and innovatively designed clinical trials are needed to determine the effect of acupuncture.

CONCLUSION

EBM has ushered in the era of clinical research on acupuncture, and the research findings have made considerable impact on the clinical application of acupuncture. Over 42% of U.S. hospitals provide outpatient and/or inpatient acupuncture service nowadays[26]. At least 24 clinical practice guidelines issued by Western medicine organisations have recommended acupuncture as an adjunct to conventional therapies for managing various conditions (https://www.guideline.gov/).

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- 生產過程規範標準，產品更穩定
- 參與國家標準、國際標準的研究制定

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Clinical Efficacy and Therapeutic Mechanisms of Chinese Medicine for Neuroprotection and Neurogenesis in the Management of Stroke

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INTRODUCTION

Among various medical conditions, stroke constitutes the second commonest cause of death, and a leading cause of adult disability worldwide[1,2]. Ischaemic stroke accounts for about 85% of all strokes[3]. The rapid degeneration of brain structure following functional neuronal loss secondary to ischaemic injury induces several neurological dysfunctions, inducing limb paralysis, loss of speech, loss of vision, disturbance in balance or coordination, and coma, etc. Recombinant tissue-plasminogen activator (rt-PA) is the only FDA-approved drug for ischaemic stroke but such treatment is limited by a rather restrictive therapeutic window of at most 4.5 hours after onset of an ischaemic stroke. Although early thrombolytic therapy using rt-PA could decrease morbidity and mortality, most of the patients with ischemic stroke do not present themselves early enough to catch this golden therapeutic window. Delayed rt-PA treatment brings increased risk of haemorrhagic transformation[4-5]. It has been shown that patients who received t-PA treatment beyond the 4.5 hours stood a 10-fold increase in the risk of haemorrhagic transformation (HT), which was associated with increased morbidity and mortality[6-7]. Current available therapies for post-stroke rehabilitation are seldom successful for improving recovery of neurological deficits.

Neural stem/progenitor cell (NSC)/progenitor cell (NSC) transplantation becomes an attractive strategy for brain repair but many unsolved problems preclude the clinical application of NSC transplantation in the near future[8-9]. Endogenous adult neurogenesis brings new hopes for regeneration therapy. Adult neurogenesis mainly occurs in the subgranular zone (SGZ) in the dentate gyrus (DG) of the hippocampus and subventricular zone (SVZ) adjacent to the lateral ventricle[10,11]. Enhanced neurogenesis can be found in ischaemic brains of neonatal mice, adult rats and aged humans *in vivo*[12-16]. However, spontaneous neurogenesis has failed to help regain neurological functions in ischaemic stroke patients. Development of novel therapeutic strategies is timely important for stroke management.

TRADITIONAL CHINESE MEDICINE IN POST-STROKE MANAGEMENT

Stroke is defined as "*Wind Stroke*"in Traditional Chinese Medicine (TCM). "Wind Stroke" is characterised by sudden collapse and unconsciousness, deviation of the tongue and mouth, hemiplegia, slurred speech, or only deviation of the tongue and mouth and hemiplegia without collapse. With over thousand years' practice, many medicinal herbs and TCM formulas have been gathered up for stroke. Those TCM formulas are specifically designed for respective clinical patterns based on syndromic differentiation. For examples, *Tianma Gouteng Decoction* and *Zhengang Xifen Decoction* are commonly used to prevent stroke attack for patients suffering from primary hypertension and transient ischaemic attack (TIA). *Angong Niuhuang Wan* and *Lingjiao Guoteng Decoction* are used in acute stroke patients. *Jieyu Dan* and *Buyang Huanwu Decoction* are effective TCM formulas for regaining neurological functions from stroke sequela. Those formulas are composed based on the principles of "*King-Minister-Assistant-Guider*"[君臣佐使] for restoring the Balance of *Yin-Yang* [陰陽], *Qi-Blood* [氣血] and *Zang-fu* [臟腑] functions.

CURRENT PROGRESS IN CLINICAL EVALUATION OF TCM FORMULAS IN POST-STROKE MANAGEMENT

Although acute stroke patients are commonly treated with Western conventional medicine, TCM formulas play their unique roles in improving the outcome of stroke, first as adjunctive therapy during the acute phase of stroke and then serving to promote neurological functional recovery during the chronic phase. In recent years, much effort has been made to verify the clinical efficacy of TCM formulas and to understand the underlying mechanisms as well as the molecular targets which facilitate neuroprotection and neurogenesis. TCM formulas include thousands of chemical ingredients with their action on body network regulations toward multiple cellular signalling pathways. The development of comprehensive and advanced analytic approaches brings novel insights into understanding the therapeutic principles of TCM formulas. Among the TCM formulas, *Angong Niuhuang Pill* [安宮牛黃丸] and *Buyang Huanwu Decoction* [補陽還五湯] are two representative TCM for neuroprotection and neurogenesis respectively. *Angong Niuhuang Pill* is specifically used for the acute phase of stroke for "Weaken-up Strategy" whereas *Buyang Huanwu Decoction* is for recovery of neurological functions in post-stroke management. Herein, we briefly introduce those classic TCM formulas and current progress for evaluating their clinical efficacy and elucidating scientific basis for stroke treatment.

A. Angong Niuhuang Pill

Angong Niuhuang Pill (AGNH Pill) was first described by Dr Jutong Wu in the Qing Dynasty. AGNH Pill is consistant of *Artificial Musk, Broneolum Syntheticum, Curcumae Radix, Fructus Gardeniae, Calculus Bovis, Radix Curcumae, Cornu bubali, Radix scutellariae, Margarita, Cinnabar, Realgar, and Rhizoma coptidis*, etc. The formula is suitable for the clinical pattern characterised by fever, stupor, coma, hemorrhage, etc. The formula could serve as first aid for diseases with cognitive impairment, high fever and seizures, etc. such as acute ischemic stroke, acute hemorrhagic stroke, viral encephalitis, and traumatic brain injury[17]. Notably, AGNH Pill contains several metal elements, namely realgar and cinnabar, which are 90% of As4S4 and 96 % of HgS respectively. With arsenic and mercurial elements, AGNH Pill is forbidden in the Northern American or European markets because of potential safety concerns. Realgar and cinnabar-containing traditional medicines could have potential renal toxicity[18]. However, the sulfide forms of arsenic and mercuric materials might be less toxic than other forms[19–20]. To address the safety concerns, we conducted a systematic literature review of the adverse drug reactions (ADRs) and adverse events (AEs)[21]. We searched 6 databases for articles published between 1974 and 2015. We found that the ADRs/AEs were mainly attributed to the improper use of AGNH Pill, such as overdosing in children or being used with incompatible drugs. AGNH Pill is considered to carry relatively low risk of ADRs/AEs when used at regular doses for 1 week or less[21]. Our unpublished data indicate that short-term administration of AGNH Pill at regular doses provide neuroprotective effects against cerebral ischaemia-reperfusion injury without liver and renal toxicity. Other studies revealed that AGNH Pill improved neurological outcomes[22-23]. AGNH Pill promoted the recovery of consciousness[24] and reduced body temperature in the stroke patients with fever[24]. One should be cautioned that most of the published clinical trials on AGNH Pill are of poor quality. Well-designed randomised clinical trials (RCTs) are much needed to assess the efficacy and safety of this concoction. Animal studies have shown that AGNH Pill decreased infarct volume and brain oedema, improved neurological outcomes, and decreased the mortality rates in various ischemic stroke models[25-27]. AGNH Pill treatment also decreased blood-brain barrier damage, brain oedema, and inflammation, and improved neurological outcomes in animal models of intracerebral hemorrhage[28-30]. The underlying therapeutic mechanisms could be related to anti-apoptosis[26], antioxidant[27] and anti-neuroinflammation, etc.[31].

B. Buyang Huanwu Decoction

Buyang Huanwu Decoction (BYHWD) was first described by Dr Qingren Wang in the Qing Dynasty. BHD consists of *Astragalus membranaceus, Angelica sinensis, Paeonia lactiflora, Ligusticum chuanxiong, Carthamus tinctorius, Prunus persica and Lumbricus* at the ratio of 120:4.5:3:3:3:3:3. *A. membranaceus* accounts for about 85% of the composition of BHDWD, and functions as the 'King' component. *A. sinensis , P. lactiflora , L. chuanxiong , C. tinctorius* and *P. persica* are 'Minister' and 'Assistant' components whereas *Lumbricus* serves as a 'Guider' component. Many clinical trials revealed the neuroprotective effects of BYHWD on ischemic brain injury and neurological deficits[32,33]. We previously searched 6 databases and conducted a meta-analysis to evaluate the efficacy and safety of BYHWD for acute ischemic stroke. The study identified 19 RCTs with 1,580 individuals for evaluating efficacy and safety of BYHWD for acute ischemic stroke. Meta-analysis showed that BYHWD could improve neurological deficits and should be safe for acute ischaemic stroke patients. Similarly, well designed RCTs are called for to further confirm its efficacy[34]. Our studies revealed that BYHWD promoted the proliferation of NSCs and neurons in vivo and in vitro under ischemic/hypoxic conditions[35]. BYHWD ameliorated post-stroke depression via promoting neurotrophic pathway-mediated neuroprotection and neurogenesis[36]. BYHWD improved synaptic plasticity for neurorehabilitation in cerebral ischaemic rats[37]. BYHWD increased the BrdU positive neural progenitor cells in rat hippocampus and SVZ after ischemic stroke[38-39]. BYHWD up-regulated 93 genes but down-regulated 284 genes in a cerebral ischemic mouse model. Of the 93 genes, 6 are related to neurogenesis, 9 to nervous system development, 14 to anti-inflammation, 15 to anti-apoptosis, 11 to anti-angiogenesis and 7 to anti-coagulation[40]. Those results suggest that BYHWD provides neurogenesis-promoting effects via multiple network regulations in post-stroke management. The chemical constituents in BYHWD include C-glycosyl quinochalcones, flavonoid O-glycosides, isoflavones, monoterpene, glycosides, saponins, organic acids and amino acids[41]. The absorbed components and metabolites in rat urine were identified after oral administration of BYHWD. A total of 50 compounds were found in rat urine samples within 20 min, including 12 parent compounds and 38 metabolites[41]. Interestingly, 17 characteristic compounds were found in the drug-containing urine sample. These 17 compounds include 11 isoflavanoids, 2 pterocarpanoids and 4 isoflavonoids[41]. A recent study further explored 15 absorbable chemical constituents of BYHWD and found that those compounds played respective roles in anti-inflammation and neuroprotection. BYHWD exerts its neuroprotective effects by modulating multiple targets with its multiple components[42]. Taken together, those studies provide scientific evidence for better understanding of the molecular targets and of active compounds which have contributed to the neurogenic effects of BYHWD for brain repair and neurological functional recovery in post-stroke management.

In summary, Chinese herbal medicine has been used at the bedside for treating stroke for centuries. Recently, US and Chinese scientists have jointly established a library with 202 authenticated medicinal plant and fungal species and about 10,000 standard fractions from these materials, offering great and unique sources for drug discovery. With the development of advanced technologies in proteomics, metabonomics and bioinformatics, we are at the gate to open the magical world in which network regulation of multiple signalling pathways will create opportunities for improving our stroke management.

ACKNOWLEDGEMENTS

The work was supported by grants from RGC GRF (No. 17102915; No. 17118717), HMRF No. 13142901 and ITF UICP (No. UIM/289). Hong Kong SAR, China

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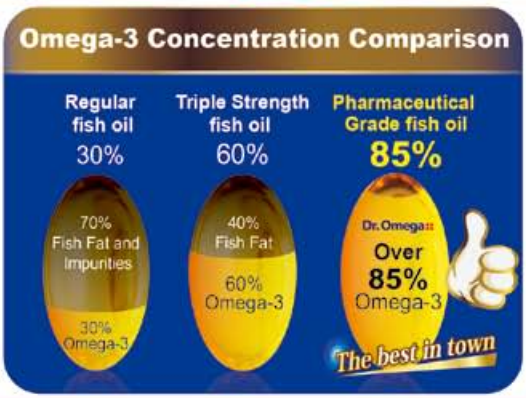

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Herb Safety in Integrative Medicine

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This article has been selected by the Editorial Board of the Hong Kong Medical Diary for participants in the CME programme of the Medical Council of Hong Kong (MCHK) to complete the following self-assessment questions in order to be awarded 1 CME credit under the programme upon returning the completed answer sheet to the Federation Secretariat on or before 31 October 2018.

INTRODUCTION

Medical practice integrating Chinese and Western medicine has been systematically tried in selected sites in the Hospital Authority (HA) known as the Integrated Chinese-Western Medicine (ICWM) pilot project since 2014. Patients with pre-defined illnesses are cared for by both Chinese medicine (CM) practitioners and Western medicine (WM) doctors using an integrative approach. These patients are treated according to management protocols established by expert groups. Herb and drug safety issue is one area of major concern particularly when they are administered in complicated medical in-patient settings where high risk drugs like anti-platelets, anti-coagulants, cardiovascular drugs and strong analgesics require close titration. There are up to 10,000 known CM herbs while the Hospital Authority Chinese Medicine service provides 649 types of commonly used CM herbs. Most of the commonly used herbs have not been associated with significant toxicity in humans. Many of them like ginseng or licorice root are also used as food ingredients, and hence there is a large overlapping zone between CM herb and food.

Although WM doctors rarely approve of the co-use of herbs with drugs, studies have repeatedly shown that a large proportion of patients were taking both drugs and herbs without informing their doctors, not to mention the consumption of Chinese herbs in food[1,2]. On the other hand, CM practitioners frequently treat patients with chronic diseases such as diabetes who are on regular medication without being well informed of the potential drug toxicities and the possible harm from herb-drug interaction. The WM doctors might over-estimate while the CM practitioners might under-estimate the risk of drug-herb interaction in their practice. This big difference in risk perception was a major hurdle in the start-up of the ICWM project. An objective approach was needed to better assess such risk in a scientific manner and hence to manage it in a logical way. An expert group composed of experts from both sides was formed to assess, quantify and draw up guidelines to mitigate the clinical risk associated with herb-drug co-use. Three areas of major concern were (1) quality assurance of Chinese herbal medicine (CHM), (2) intrinsic toxicity of CHM, (3) Unwanted effect from the interaction of CHM and Western medicine (WM).

QUALITY OF CHM

CHM as natural products are at risk of quality fluctuation which can be the result of intrinsic factors and extrinsic factors. Intrinsic factors include species identification, time and place that the herb was cultivated and variation among sub-species. Extrinsic factors include contamination, substitution, adulteration, processing and storage. Modern CM pharmacology practice has incorporated strategies to assure herb quality. CHM used in the ICWM project was procured through a standardised process to ensure quality. Only CHM from licensed manufacturers with Good Manufacturing Practice certification were considered. Safety testing reports on microbes, toxic metals, pesticides and residual sulphur dioxide concentration are required for all CHM batches. For selected CHM with high quality risk, extra and more frequent target testing was required. These included toxic aconite alkaloid content in *Aconite* rootstocks (川烏, 附子), aristolochic acid in *Asarum* root (細辛), aflatoxin and organochlorines in selected CHM.

In addition to the quality assurance procedures done externally by suppliers, the HA also conducted a series of internal quality assurance procedures before putting the CHM on shelf. Every herb batch was assessed by an in-house CM pharmacologist with input from external expert advisers. Repeated laboratory testing was carried out on the high-risk species to double ensure safety before dispensing.

The quality assurance process did not stop at the central level but was followed through by the frontline CM pharmacologists and dispensers in every HA CM tripartite clinic. They were trained to spot irregularities in herbs and were empowered to stop dispensing and to report suspected quality problems through an herb quality complaint system.

INTRINSIC TOXICITY AND HERB-DRUG INTERACTION

Adverse effects from herbs did not stop after ensuring good herb quality. More and more studies have shown the pharmacological activity of CHM. Pharmacological activity could translate into toxicity when an herb was improperly used or being used on patients with increased susceptibility. Another source of adverse effects was herb-drug interactions. There exist several databases developed in the English-speaking world that supposedly provide guidance for the co-use of drugs and herbs. However their recommendations have largely based on precautionary principles against herb

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Study design: 1. In a randomized, double-blind, controlled trial, patients with baseline HbA_{1c} 7.5-12% were randomized to receive either dapagliflozin 10 mg with metformin XR, dapagliflozin 10 mg alone or metformin XR alone for 24 weeks. The primary efficacy endpoint was the HbA_{1c} change from baseline at week 24. Change in total weight was one of the key secondary endpoints, and blood pressure changes were measured as safety assessment. 2. The present study was an extension of an earlier randomized, double-blind, phase III study of dapagliflozin (n=406) vs glipizide (n=408) to 208 weeks (4 years). Patients continued to receive their assigned medication.

Patients continued to receive their randomly assigned medication, either dapagliflozin (2.5, 5 or 10mg) or glipizide (5, 10 or 20mg), combined with open-label metformin (1500–2500mg/day), as well as lifestyle advice. The aim is to assess the long-term efficacy and tolerability of dapagliflozin versus glipizide as add-on to metformin in patients with inadequately controlled type 2 diabetes.

BP=blood pressure. HbA_{1c}=glycated hemoglobin. SBP=systolic blood pressure.

References: 1. Henry RR, et al. Int J Clin Pract. 2012;66(5):446-56. 2. S. Del Prato, et al. Long-term glycaemic response and tolerability of dapagliflozin versus a sulphonylurea as add-on therapy to metformin in patients with type 2 diabetes: 4-year data.

Presentation: dapagliflozin propanediol monohydrate film-coated tablet. **Indication and Usage:** Improve glycaemic control in adults aged 18 years and older with type 2 diabetes mellitus, as monotherapy when diet and exercise alone do not provide adequate glycaemic control in patients for whom use of metformin is considered inappropriate due to intolerance; or in combination with other glucose-lowering medicinal products including insulin, when these, together with diet and exercise, do not provide adequate glycaemic control. **Dosage and Administration:** 5 mg or 10 mg. To be taken orally once daily at any time of day with or without food. Tablets are to be swallowed whole. **Contraindications:** Hypersensitivity to the active substance or to any of its excipients. **Warnings and Precautions:** Should not be used in type 1 diabetes mellitus; treatment of diabetic ketoacidosis; hereditary problems of galactose interolerance, the Lapp lactase deficiency, or glucose-galactose malabsorption; and while breast-feeding. Not recommended in moderate to severe renal impairment; concomitant treatment with pioglitazone or loop diuretics; volume depletion; and in elderly (≥ 75 years) when initiating dapagliflozin. Discontinue if renal function falls below CrCl < 60 ml/min or eGFR < 60 ml/min/1.73 m^2; in suspected or diagnosed diabetic ketoacidosis; and when preganancy is detected. Temporarily interrupt when volume depleted, ; treated for pyelonephritis or urosepsis; and hospitalised for major surgical procedures or acute serious medical illnesses. Caution in concomittant anti-hypertensive therapy with a history of hypotension; elderly; and already elevated haematocrit. Limited or no data in hepatic impairment; cardiac failure; pregnancy; paediatric population; and when used with DPP4 inhibitors or GLP1 analogues. **Adverse Reactions:** Very common: Hypoglycaemia when used with SU or insulin. Common: Vulvovaginitis, balanitis and related genital infections, urinary tract infection, dizziness, rash, back pain, dysuria, polyuria, dyslipidaemia, decreased creatinine renal clearance, and increased haematocrit. Uncommon: Fungal infection, volume depletion, thirst, constipation, dry mouth, nocturia, renal impairment, vulvovaginal and genital pruritus, increased blood creatinine and blood urea, and decreased weight. Rare: Diabetic ketoacidosis. **Drug interaction:** Coadministration with rifampicin may reduce dapagliflozin systemic exposure; coadministration with mefenamic acid may increase dapagliflozin systemic exposure. **Local prescribing information is available upon request. API.HK.FOR.0617**

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use while high-level scientific evidence was lacking. To tackle the problem, a pragmatic approach was adopted in order to develop herb safety guidelines that were more balanced on scientific evidence, and being practical, agreeable to expert opinions from both CM and WM sides and applicable to the closely monitored ICWM clinical environment. The possible occurrence of adverse reactions from herb-drug co-use was managed as a form of clinical risk.

The first risk-mitigating strategy was to limit the number of herbs that could be used in the project that would be expanded progressively by phases. The second was to assess the risks associated with each individual herb to be used. A multi-disciplinary expert herb safety panel comprising of a clinical pharmacologist, a toxicologist, a pharmacist, clinical leaders of the projects in CM and WM fields, CM experts, and CM pharmacologists was formed. An extensive search in the English and Chinese literature for reported adverse events of the allowed list of herbs was performed. Toxicity reports from in-vitro and in-vivo studies supplemented the clinical reports. The panel developed the initial risk assessment algorithm that evaluated each herb based on the likelihood of adverse reactions and the overall strength of scientific evidence behind. The actual assessment was performed by organ-system sub-panels that respective medical sub-specialists were invited to join, as in the case of having a group of hepatologists on the liver toxicity sub-panel. The sub-panels critically appraised the toxicity evidence of each herb and the herb-drug pair according to severity, quality of evidence, applicability and relevance to the ICWM practice.

The list of herbs was categorised into 4 groups according to the risk level of each herb in causing adverse effects. Consensus-forming meetings were held to form guidelines for the safe use of each at-risk herb. Findings of the expert panel were summarised below.

INTRINSIC TOXICITY

Among 323 herbs, no reported clinical toxicity could be found in 258 of them while 3, 11 and 51 herbs were judged to have high, moderate and low risk of toxicity respectively when they were used under recommended dose ranges and indications specified in the project. The 3 high-risk herbs were Zhishi 枳實 (*Aurantii Fructus Immaturus*), Heshouwu 何首烏(*Polygoni Multiflori Radix*) and stir-baked Cang'erzi 炒蒼耳子 (*Xanthii Fructus preparata*). It was judged that a normal dose of Zhishi might contain enough quantity of synephrine to worsen hypertension and tachycardia. There were also rare reports of prolonged QT intervals associated with Zhishi intake. The expert panel recommended against its use in patients with uncontrolled hypertension or tachyarrhythmia, or with an existing long QTc interval. Among patients receiving Zhishi, additional blood pressure, pulse and electrocardiogram monitoring were also recommended. Heshouwu associated liver injuries were repeatedly reported in Mainland China. The occurrence appeared epidemiologically compatible with an idiosyncratic drug reaction. Although anthraquinones have been proposed as the toxic ingredient, concrete proof and toxic mechanism had yet to be worked out. The panel decided to recommend against its use in patients with liver disease. Cang'erzi contained carboxyatractyloside, which was a well-known mitochondrial toxin while stir-baking could largely destroy the toxin. Its use was associated with multi-organ toxicities. Its use was recommended against in patients with cardiovascular, liver or kidney diseases.

HERB-DRUG INTERACTION

Two, 19 and 5 herbs were judged to have high, moderate and low herb-drug interactions respectively. The 2 high-risk herb-drug pairs were cyclosporine with Huanglian 黃連 (*Coptidis Rhizoma*) or Huangbai 黃柏 (*Phellodendri Chinensis Cortex*). Human immunosuppressant-sparing studies in Mainland China had shown significant blood cyclosporine level increase by adding on either herb. The panel recommended avoiding the 2 herbs in patients receiving cyclosporine and if the herb-drug combination was deemed necessary, therapeutic drug monitoring of cyclosporine was needed. Other herb-drug interactions of moderate risk included interaction with anti-coagulants, anti-human immunodeficiency virus drugs, anti- diabetic drugs, sex hormone and calcium channel blockers.

ADVERSE DRUG EVENT DETECTION

Reporting of any suspected adverse drug events (ADE) by ICWM frontlines provide important data for the expert panel. Herb-drug pharmaco-vigilance by WM doctors and CM practitioners should be encouraged and facilitated for the good of ICWM advancement. Apart from obvious acute ADE, there are other less easily recognisable ADEs that might appear after longer periods of treatment. One example was the risk increase for another natural disease such as stroke or myocardial infarction. Only large scale case-control or pharmacoepidemiological studies can unmask this type of ADEs[3].

CONCLUSION

The ICWM projects have been running for more than 3 years. No major herb toxicity or herb-drug interaction has been reported at the time of writing this article. The guidelines appeared to be practical and acceptable to both CM and WM practitioners involved. This scientifically-based, CM and WM expert consensus approach may be a good starting point to develop future guidance for integrative medicine practice.

DISCUSSION

Herb-drug co-use is a common practice by patients, though its efficacy and safety has not been well studied. Clinical guidelines on the integrative use of more than 300 herbs have been developed through expert consensus in the ICWM pilot project within the Hospital Authority, where internal validation is ongoing to assure its performance. One limitation of the guidelines is their intended use in a closely controlled clinical environment making it not directly applicable to the everyday general practice. ICWM theoretical potential to out-perform either CM or WM alone. Better understanding of the interplay among herbs, drugs, disease states and patient groups could only come after a larger amount of ICWM practice and good scientific research. Its advancement should be balanced against patient safety and be guided by scientific evidence. More pharmacological and toxicological research should be done on Chinese herbs, particularly on their long term use and interaction with commonly used drugs. Adverse Herb/Drug Events

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Disease in Otorhinolaryngology, Head & Neck Surgery (ENT)

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Hong Kong Society of Otorhinolaryngology, Head & Neck Surgery

Date	Topics	Speakers
24 Oct	Diagnosis and surgical management of common facial lesions	Dr. FUNG Tai Hang, Thomas Consultant Department of Ear, Nose & Throat Pamela Youde Nethersole Eastern Hospital
31 Oct	Management of obstructive sleep apnea syndrome - a surgeon's perspective	Dr. CHAN Kin Ming Specialist in Otorhinolaryngology Private Practice
7 Nov	Endoscopic management of sinonasal diseases	Dr. LEE Chi Wai Specialist in Otorhinolaryngology Private Practice
14 Nov	Liquid Biopsy – its role in NPC screening	Dr. LAM Wai Kei Clinical lecturer Department of otorhinolaryngology, head and neck surgery The Chinese University of Hong Kong
21 Nov	How to approach a vertigo patient	Dr. WONG Ka Fai Associate Consultant Department of Ear, Nose & Throat Queen Mary Hospital
28 Nov	Minimal invasive surgery in head and neck disease	Dr. CHUNG Chun Kit, Joseph Associate Consultant Department of Ear, Nose & Throat Queen Mary Hospital

Date : 24, 31 October 2018 & 7, 14, 21, 28 November, 2018 (Every Wednesday)
Time : 7:00 pm – 8:30 pm
Venue : Lecture Hall, 4/F., Duke of Windsor Social Service Building,15 Hennessy Road, Wanchai, Hong Kong
Language Media : Cantonese (Supplemented with English)
Course Fee : HK$750 (6 sessions)
Certificate : Awarded to participants with a minimum attendance of 70%
Enquiry : The Secretariat of The Federation of Medical Societies of Hong Kong
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should be monitored and reported in all CM or ICWM clinical trials. The recognition, recording, reporting and study of CM ADEs should be encouraged. Collection points of ADE information in the healthcare system should be established and the data be made available to researchers. Pharmaco-epidemiology or other big-data approach might be the appropriate tool in future research on ICWM safety.

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3. Ray WA. Population-based studies of adverse drug effects. N Engl J Med 2003;349(17):1592-4.

MCHK CME Programme Self-assessment Questions

Please read the article entitled "Herb safety in Integrative Medicine" by Dr Man-li TSE and complete the following self-assessment questions. Participants in the MCHK CME Programme will be awarded CME credit under the Programme for returning completed answer sheets via fax (2865 0345) or by mail to the Federation Secretariat on or before 31 October 2018 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. **Patients usually inform doctors of their use of herbal medicine.**
2. **Herb quality assurance is a major safety concern in integrative medicine.**
3. **Herb quality can be affected by intrinsic and extrinsic factors.**
4. **Drug adulteration is routinely tested on herb samples procured by Hospital Authority.**
5. **All Chinese herbs are free of intrinsic toxicity.**
6. **Individual susceptibility is a causative factor for some herb-induced adverse reactions.**
7. **Large amount of high level scientific data on integrative medicine safety already exist.**
8. **Zhishi 枳實 may worsen hypertension.**
9. **Anti-coagulant and anti-HIV agents are at risk of herb-drug interactions.**
10. **Randomised controlled trial is the preferred methodology to prove the long term safety of integrative medicine.**

ANSWER SHEET FOR OCTOBER 2018

Please return the completed answer sheet to the Federation Secretariat on or before 31 October 2018 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

Herb safety in Integrative Medicine

Dr Man-li TSE

Consultant in charge, Hong Kong Poison Information Centre, Hospital Authority
Vice-President, Hong Kong Association for Integration of Chinese-Western Medicine

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

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

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Answers to September 2018 Issue

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

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Healthcare Preventive Approaches in Chinese Medicine

Dr Linda LD ZHONG

Research Assistant Professor, Clinical Division, School of Chinese Medicine, Hong Kong Baptist University

Dr Bacon FL NG

Honorary Associate Professor, The Open University of Hong Kong

Dr Linda LD ZHONG Dr Bacon FL NG

INTRODUCTION

Hong Kong, like many developed economies, faces the challenges posed by changes in health-risk profile arising from an ageing population, stressful life, unhealthy diet and social maladies. Preventive actions addressing common behavioral risk factors can improve the community's health profile and also lower the disease incidence rate. The concept of preventive medicine (治未病) in Traditional Chinese Medicine (TCM) could be traced back to 2,000 years ago. It emphasises prevention before disease occurring and prevention of disease progression (未病先防，既病防變). In TCM, for those who have no definite disease, a syndrome could be identified even in the process of developing. The stages of progressing to an unhealthy condition are very critical in early identification and prevention of disease progression. TCM has always emphasised the importance of individuality and variability of Body *Constitution* (體質). *Body Constitution* serves as the treatment reference and reflection on the sub-health status in an individual[1]. Modern researches indicated that the imbalance of body constitution was associated with the medical service utilisation rate and certain types of disease like diabetes[2]. Therefore, how to change the Body Constitution into a balanced pattern in reversing the sub-health and preventing acquisition of diseases become the goals of the TCM preventive care strategy.

Integrated internal and external TCM approaches could be provided to attain their body equilibrium and sustain health. Some common TCM healthcare strategies include Chinese Medicine herbal therapy, acupuncture, *Tuina* (推拿) and *scrapping* (刮痧), diet therapy, tea therapy, and health qigong.

MAIN PREVENTIVE APPROACHES IN TRADITIONAL CHINESE MEDICINE

Chinese herbal therapy is the most widely used TCM treatment modality, including plant, animal and mineral substances. CM practitioners often use several substances in Chinese medicinal formulations to create a balanced, synergistic effect that reflects the holistic nature of the diagnosis.

Acupuncture (針刺) is the stimulation of specific acupuncture points of the body using thin needles. For traditional treatment modality, it is usually combined with the treatment of moxibustion (艾灸) [burning of moxa] and cupping (拔罐) [local suction on skin]. According to the TCM theory, stimulating specific acupoints / target area of skin can correct imbalances in the flow of Qi through meridians, thus mitigating cold and dampness in the body.

Tuina (推拿) and scrapping (刮痧) are the traditional forms of Chinese manipulative therapy. The former includes the use of hand techniques (e.g. brush, knead, roll/press, and rub) to massage the soft tissues (muscles and tendons) of the body, and manipulation techniques to realign the musculoskeletal and ligamentous relationships (bone-setting). The latter involves rubbing an instrument (e.g. scrapping plate, stone, coin, or spoon) across the lubricated (oiled or wet) skin to promote healing. It is used to treat common cold, influenza, muscle pain and stiffness, and other disorders.

Health qigong practice is one of the therapeutic exercises with roots in Chinese Medicine and Philosophy. It harmonises breathing, body and our mind through co-ordinated movements. From the angle of modern behavioural medicine, qigong exercises are highly beneficial both physiologically and psychologically.

TRADITIONAL CHINESE MEDICINE DIET AND TEA

In TCM, diet can be a therapy given to people who are suffering from illness to regain balance or those who want to stay healthy. Foods have their natures; like herbs, they can be classified as warming or cooling. Therefore, some of the foods are appropriate to an individual, while some are not. The diet therapy serves a variety of purposes, including strengthening the Zang Heart and Lungs, reinforcing the Zang Spleen and the Qi, and quelling the dampness. The promotion of diet awareness related to low-fat, whole foods, plant-based, more fruit and vegetable are emphasised in both TCM and WM. A recent study showed that diet control in lifestyle modification is one of the important components contributing to increase telomerase activity and maintenance capacity in human immune-system cells in combating the ageing process[3].

Tea is believed to have been discovered by Sheng-Nong (神農氏), the pharmacology originator, who discovered tea as a detoxification substance during the experimenting process. Tea, as one of the favourite choices to people around the world, possesses both physiological and psychological effects. Tea polyphenols are known to be effective antioxidants to enhance serum total antioxidant and offer anti-inflammatory effects by suppressing the serum malondialdehyde and C-reactive protein[4] as well as down-regulation of fatty acid synthases and promoting energy consumption to prevent obesity[5]. The psychological, social and relaxation effects during tea sharing are also deeply appreciated by people around the world.

FUTURE DEVELOPMENT

In recent years, more emerging evidences are discovered to explain the mechanisms of the above TCM health prevention strategies. Future studies using an integrative approach of the West-and-East health prevention and preservation are worth exploring.

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4. Neyestani TR, Shariatzade N, Kalayi A, Gharavi A. Regular Daily Intake of Black Tea Improves Oxidative Stress Biomarkers and Decreases Serum C-Reactive Protein Levels in Type 2 Diabetic Patients. Ann Nutr Metab. 2010;57:40–9.
5. Lin JK, Lin-Shiau SY. Mechanisms of hypolipidemic and anti-obesity effects of tea and tea polyphenols. Mol Nutr Food Res. 2006;50(2):211–7.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	* HKMA-HKS&H CME Programme 2018 -2019 * FMSHK Officers' Meeting * HKMA Council Meeting 2	* FMSHK Certificate Course on Renal Medicine 2018 3	* HKMA Hong Kong East Community Network - How to Personalize the Treatment Approach for Patients with Diabetes? * HKMA-Kowloon East Community Network - Novel treatments of CV & DM management - From Primary to Secondary Prevention * FMSHK Certificate Course on Respiratory Medicine 2018 4	5	* Refresher Course for Health Care Providers 2018/2019 - Sports Medicine 6
* FMSHK Annual Scientific Meeting 2018 7	8	* HKMA Yau Tsim Mong Community Network - Optimizing Treatments in Long-Term Osteoporosis Management * MPS Workshop - Building Resilience and Avoiding Burnout 9	* The Hong Kong Neurosurgical Society Monthly Academic Meeting –Optical Coherence Tomography in Neurosurgery * HKMA Central, Western & Southern Community Network - Certificate Course on Psychiatry (Session 3) - Diagnosis and Management of Attention Deficit Hyperactivity Disorder (ADHD) in Children * FMSHK Certificate Course on Renal Medicine 2018 10	* HKMA New Territories West Community Network - Updates on BPH Management and Local Practice Sharing * MPS Workshop - Mastering Difficult Interactions with Patients * FMSHK Certificate Course on Respiratory Medicine 2018 11	* HKMA Kowloon City Community Network - A Clinical Update in Lipid Management: PCSK9 Inhibitors * FMSHK Certificate Course on Clinical Cytogenetics and Genetics 2018 12	13
* HKMA Swimming Gala 2018 14	* FMSHK Certificate Course in Cardiology 2018 15	16	17	* HKMA Hong Kong East Community Network - Updates on Advanced LDL-lowering Treatment * HKMA Kowloon East Community Network - The "Rights" and "Wrong" of Atopic Dermatitis * FMSHK Executive Committee Meeting 18	* HKMA Shatin Doctors Network - Degenerative Osteoarthritis in the General Population * FMSHK Certificate Course on Clinical Cytogenetics and Genetics 2018 19	* 20th Beijing / Hong Kong Medical Exchange - Update on Important Infectious Dieases 20
* 20th Beijing / Hong Kong Medical Exchange - Update on Important Infectious Dieases 21	* FMSHK Certificate Course in Cardiology 2018 22	* HKMA Kowloon West Community Network - Management of Sarcopenia * MPS Workshop - Mastering Shared Decision Making 23	* HKMA Central, Western & Southern Community Network - Updates on Pneumonia and Empyema * FMSHK Certificate Course on Disease in Otorhinolaryngology, Head & Neck Surgery (ENT) 24	* HKMA New Territories West Community Network - The New Era of Antihistamines in Treatment of Urticaria * FMSHK Council Meeting 25	* HKMA Yau Tsim Mong Community Network - PCSK9 Inhibitor Use in Primary Care * FMSHK Certificate Course on Clinical Cytogenetics and Genetics 2018 26	27
28	* FMSHK Certificate Course in Cardiology 2018 29	30	* FMSHK Certificate Course on Disease in Otorhinolaryngology, Head & Neck Surgery (ENT) 31			

Date / Time	Function	Enquiry / Remarks
2 TUE 1:00 PM	**HKMA-HKS&H CME Programme 2018 -2019** Organiser: Hong Kong Medical Association & Hong Kong Sanatorium & Hospital; Speaker: Dr. CHOW Chi Ping, Alex; Venue: HKMA Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, HK	HKMA CME Dept. Tel: 2527 8285 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. HO Chung Ping, MH, JP; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, HK	Ms. Christine WONG Tel: 2527 8285
3 WED 7:00PM	**FMSHK Certificate Course on Renal Medicine 2018** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wan Chai, Hong Kong	The Secretariat of FMSHK Tel: 2527 8898 Fax: 2865 0345
4 THU 1:00 PM	**HKMA Hong Kong East Community Network - How to Personalize the Treatment Approach for Patients with Diabetes?** Organiser: HKMA Hong Kong East Community Network; Chairman: Dr. LAM See Yui, Joseph; Speaker: Dr. TING Zhao Wei, Rose; 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 - Novel treatments of CV & DM management - From Primary to Secondary Prevention** Organiser: HKMA-Kowloon East Community Network; Chairman: Dr. AU Ka Kui, Gary; Speaker: Dr. MIU Kin Man, Raymond; Venue: Lei Garden Restaurant, Shop No. L5-8, apm, Kwun Tong, No. 418 Kwun Tong Road, Kowloon	Ms. Antonia LEE Tel: 2527 8285 1 CME Point
7:00 PM	**FMSHK Certificate Course on Respiratory Medicine 2018** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wan Chai, Hong Kong	The Secretariat of FMSHK Tel: 2527 8898 Fax: 2865 0345
6 SAT 2:15 PM	**Refresher Course for Health Care Providers 2018/2019 - Sports Medicine** Organiser: Hong Kong Medical Association; HK College of Family Physicians; HA-Our Lady of Maryknoll Hospital; Speaker: Dr. Vincent YU; Venue: Training Room II, 1/F, OPD Block, Our Lady of Maryknoll Hospital, 118 Shatin Pass Road, Wong Tai Sin, Kowloon	Ms. Clara Tsang Tel: 2354 2440 2 CME Point
7 SUN 9:30AM	**FMSHK Annual Scientific Meeting 2018** Organizer: The Federation of Medical Societies of Hong Kong Venue: Ballroom, 3/F, Sheraton Hong Kong Hotel & Towers	The Secretariat of FMSHK Tel: 2527 8898 Fax: 2865 0345
9 TUE 1:00 PM	**HKMA Yau Tsim Mong Community Network - Optimizing Treatments in Long-Term Osteoporosis Management** Organiser: HKMA Yau Tsim Mong Community Network; Chairman: Dr. HO Lap Yin; Speaker: Dr. WU , Enoch; Venue: Crystal Ballroom, 2/F, The Cityview Hong Kong, 23 Waterloo Road, Kowloon	Ms. Candice TONG Tel: 2527 8285 1 CME Point
6:30 PM	**MPS Workshop - Building Resilience and Avoiding Burnout** Organiser: The Hong Kong Medical Association & Medical Protection Society; Speaker: Dr. FUNG Shu Yan, Anthony; Venue: HKMA Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, HK	HKMA CME Dept. Tel: 2527 8285 3 CME Point
10 WED 7:30AM	**The Hong Kong Neurosurgical Society Monthly Academic Meeting –Optical Coherence Tomography in Neurosurgery** Organizer: Hong Kong Neurosurgical Society; Speaker(s): Dr HUNG Sze Lok Remy; Chairman: Dr Larry WONG; Venue: Seminar Room, G/F, Block A, Queen Elizabeth Hospital	Dr. WONG Sui To Tel: 2595 6456 Fax. No.: 2965 4061 1.5 points College of Surgeons of Hong Kong
1:00 PM	**HKMA Central, Western & Southern Community Network - Certificate Course on Psychiatry (Session 3) - Diagnosis and Management of Attention Deficit Hyperactivity Disorder (ADHD) in Children** Organiser: HKMA Central, Western & Southern Community Network; Chairman: Dr. TSANG Chun Au; Speaker: Dr. MAK Kai Lok, Gregory; Venue: HKMA Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, HK	Ms. Antonia LEE Tel: 2527 8285 1 CME Point
7:00PM	**FMSHK Certificate Course on Renal Medicine 2018** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wan Chai, Hong Kong	The Secretariat of FMSHK Tel: 2527 8898 Fax: 2865 0345
11 THU 1:00 PM	**HKMA New Territories West Community Network - Updates on BPH Management and Local Practice Sharing** Organiser: HKMA New Territories West Community Network; Chairman: Dr. CHAN Lam Fung; Speaker: Dr. CHAN Shu Yin, Eddie; Venue: Pak Loh Chiu Chow Restaurant, Shop A316, 3/F, Yoho Mall II, Yuen Long	Ms. Antonia LEE 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: HKMA Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, HK	HKMA CME Dept. Tel: 2527 8285 3 CME Point
7:00PM	**FMSHK Certificate Course on Respiratory Medicine 2018** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wan Chai, Hong Kong	The Secretariat of FMSHK Tel: 2527 8898 Fax: 2865 0345
12 FRI 1:00 PM	**HKMA Kowloon City Community Network - A Clinical Update in Lipid Management: PCSK9 Inhibitors** Organiser: HKMA Kowloon City Community Network; Chairman: Dr. CHIN Chu Wah; Speaker: Dr. TAM Kin Ming; Venue: President's Room, Spotlight Recreation Club, 4/F., Screen World, Site 8, Whampoa Garden, Hunghom, Kowloon	Ms. Candice TONG Tel: 2527 8285 1 CME Point

Date / Time	Function	Enquiry / Remarks
12 FRI 7:00PM	**FMSHK Certificate Course on Clinical Cytogenetics and Genetics 2018** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wan Chai, Hong Kong	The Secretariat of FMSHK Tel: 2527 8898 Fax: 2865 0345
14 SUN 12:00 PM	**HKMA Swimming Gala 2018** Organiser: The Hong Kong Medical Association; Chairman: Dr. CHAN Hau Ngai, Kingsley, Dr. IP Wing Yuk, Dr. YEUNG Hip Wo, Victor; Venue: Hong Kong Polytechnic University	Miss Sinn TANG Tel: 2527 8285
15 MON 7:00 PM	**FMSHK Certificate Course in Cardiology 2018** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wan Chai, Hong Kong	The Secretariat of FMSHK Tel: 2527 8898 Fax: 2865 0345
18 THU 1:00 PM	**HKMA Hong Kong East Community Network - Updates on Advanced LDL-lowering Treatment** Organiser: HKMA Hong Kong East Community Network; Chairman: Dr. KONG Wing Ming, Henry; Speaker: Dr. CHAN Leung Kwai, Jason; 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 - The "Rights" and "Wrong" of Atopic Dermatitis** Organiser: HKMA Kowloon East Community Network; Chairman: Dr. CHU Wen Jing, Jennifer; Speaker: Dr. David LUK Chi Kang; Venue: V Cuisine, 6/F., Holiday Inn Express Hong Kong Kowloon East, 3 Tong Tak Street, Tseung Kwan O	Ms. Antonia LEE Tel: 2527 8285 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
19 FRI 1:00 PM	**HKMA Shatin Doctors Network - Degenerative Osteoarthritis in the General Population** Organiser: HKMA Shatin Doctors Network; Chairman: Dr. MAK Wing Kin; Speaker: Dr. YEUNG Sze Tsun, Eric; Venue: Diamond Room, 2/F, Royal Park Hotel, 8 Pak Hok Ting Street, Shatin	Ms. Candice TONG Tel: 2527 8285 1 CME Point
7:00 PM	**FMSHK Certificate Course on Clinical Cytogenetics and Genetics 2018** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wan Chai, Hong Kong	The Secretariat of FMSHK Tel: 2527 8898 Fax: 2865 0345
20 SAT 1:45 PM	**20th Beijing / Hong Kong Medical Exchange - Update on Important Infectious Dieases** Organiser: The Hong Kong Medical Association & Chinese Medical Association; Chairman: Dr. LEUNG Chi Chiu, Prof. HO Pak Leung; Venue: Crystal Ballroom, B1, Holiday Inn Golden Miles, Tsim Sha Tsui	Miss Sandy WONG Tel: 2527 8285 3 CME Point
21 SUN 9:15 AM	**20th Beijing / Hong Kong Medical Exchange - Update on Important Infectious Dieases** Organiser: The Hong Kong Medical Association & Chinese Medical Association; Chairman: Dr. LEUNG Chi Chiu, Prof. HO Pak Leung; Venue: Crystal Ballroom, B1, Holiday Inn Golden Miles, Tsim Sha Tsui	Miss Sandy WONG Tel: 2527 8285 5 CME Point
22 MON 7:00 PM	**FMSHK Certificate Course in Cardiology 2018** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wan Chai, Hong Kong	The Secretariat of FMSHK Tel: 2527 8898 Fax: 2865 0345
23 TUE 1:00 PM	**HKMA Kowloon West Community Network - Management of Sarcopenia** Organiser: HKMA Kowloon West Community Network; Chairman: Dr. MOK Kwan Yeung, Matthew; Speaker: Dr. YIP Wai Man; Venue: Fulum Palace, Shop C, G/F, 85 Broadway Street, Mei Foo Sun Chuen	Ms. Antonia LEE Tel: 2527 8285 1 CME Point
6:30 PM	**MPS Workshop - Mastering Shared Decision Making** Organiser: The Hong Kong Medical Association & Medical Protection Society; Speaker: Dr. FUNG Shu Yan, Anthony; Venue: HKMA Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, HK	HKMA CME Dept. Tel: 2527 8285 3 CME Point
24 WED 1:00 PM	**HKMA Central, Western & Southern Community Network - Updates on Pneumonia and Empyema** Organiser: HKMA Central, Western & Southern Community Network; Chairman: Dr. LAU, Kevin Chung Hang; Speaker: Dr. WONG King Ying; Venue: HKMA Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, HK	Ms. Antonia LEE Tel: 2527 8285 1 CME Point
7:00 PM	**FMSHK Certificate Course on Disease in Otorhinolaryngology, Head & Neck Surgery (ENT)** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wan Chai, Hong Kong	The Secretariat of FMSHK Tel: 2527 8898 Fax: 2865 0345
25 THU 1:00 PM	**HKMA New Territories West Community Network - The New Era of Antihistamines in Treatment of Urticaria** Organiser: HKMA New Territories West Community Network; Chairman: Dr. TSANG Yat Fai; Speaker: Dr. LAM Yuk Keung; Venue: Atrium Function Room Rooms, Lobby Floor, Hong Kong Gold Coast Hotel, 1 Castle Peak Road, Gold Coast, Hong Kong	Ms. Antonia LEE Tel: 2527 8285 1 CME Point
8:00 PM	**FMSHK Council Meeting** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Council Chamber, 4/F, Duke of Windor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Nancy CHAN Tel: 2527 8898
26 FRI 1:00 PM	**HKMA Yau Tsim Mong Community Network - PCSK9 Inhibitor Use in Primary Care** Organiser: HKMA Yau Tsim Mong Community Network; Chairman: Dr. LEE Wai Lun; Speaker: Dr. Norman CHAN; Venue: Diamond Room, 5/F, The Cityview Hong Kong, 23 Waterloo Road, Kowloon	Ms. Candice TONG Tel: 2527 8285 1 CME Point

Date / Time	Function	Enquiry / Remarks
26 *FRI* 7:00PM	**FMSHK Certificate Course on Clinical Cytogenetics and Genetics 2018** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wan Chai, Hong Kong	The Secretariat of FMSHK Tel: 2527 8898 Fax: 2865 0345
29 *MON* 7:00PM	**FMSHK Certificate Course in Cardiology 2018** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wan Chai, Hong Kong	The Secretariat of FMSHK Tel: 2527 8898 Fax: 2865 0345
31 *WED* 7:00PM	**FMSHK Certificate Course on Disease in Otorhinolaryngology, Head & Neck Surgery (ENT)** Organiser: The Federation of Medical Societies of Hong Kong; Venue: Lecture Hall, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wan Chai, Hong Kong	The Secretariat of FMSHK Tel: 2527 8898 Fax: 2865 0345

Upcoming Event

18 Nov 2018 9:00 AM	**Endocrinology, Diabetes & Metabolism Hong Kong (EDMHK) Inauguration Conference** Organizer: KK Leung Diabetes Centre, Osteoporosis Centre of Queen Mary Hospital, the University of Hong Kong Venue: Hong Kong Convention and Exhibition Centre	EDMHK 2018 Conference Secretariat c/o International Conference Consultants Ltd. Tel: (852) 2559 9973 Email: edmhk2018@icc.com.hk

Answers to Radiology Quiz

Answer:

1.
   - Widening of left proximal femoral epiphysis.
   - Disrupted left Shenton's line.
   - Line along lateral edge of left superior femoral neck on anteroposterior view (line of Klein) does not intersect epiphysis (Trethowan sign).
   - Lateral displacement of the metaphysis so that it does not overlap the posterior lip of acetabulum as normal (loss of triangular sign of Capener).

2. Left slipped capital femoral epiphysis (SCFE).

3. SCFE is a relatively common condition affecting the growth plate of the proximal femur in adolescents. It is a type I Salter-Harris growth plate injury. The age of presentation is somewhat dependent on gender with boys presenting later (10-17 years) than girls (8-15 years). It is rare to occur less than 9 years of age.

4. It is bilateral in ~20% of cases.

5. MRI of the pelvis for both hips to look for bilateral involvement and complications such as avascular necrosis.

6. Degenerative arthritis; varus deformity; avascular necrosis; leg length discrepancy.

Dr Michelle CHEUNG
Department of Radiology, Queen Mary Hospital

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Annual Scientific Meeting 2018

Medical Advances in Community Health

Date: 7 Oct 2018 (Sunday) Time: 9:30am - 5:00pm
Venue: Ballroom, 3/F, Sheraton Hong Kong Hotel & Towers, 20 Nathan Road, Tsim Sha Tsui, Kowloon

Opening Ceremony

Session I - Community Health
Chairpersons: Dr. Jane CHAN & Dr. Ludwig TSOI

- 二孩政策对医疗系统带来的转变
  顾向应教授
  主任医师、中华医学会计划生育分会主任委员
- **Ethical Issues in Community Healthcare**
  Dr. Derrick Kit-sing AU
  Director of the CUHK Centre for Bioethics, Medical Faculty, the Chinese University of Hong Kong

Session II - Hepatology & Cardiology
Chairpersons: Dr. Mario CHAK & Prof. Bernard CHEUNG

- **Hepatitis C in 2018**
  Prof. Ching-lung LAI
  Chair Professor, Department of Medicine, The University of Hong Kong, Queen Mary Hospital
- **Fighting Cardiovascular Disease from Framingham Heart Study to PCSK9 Inhibitors**
  Prof. David Chung-wah SIU
  Clinical Professor, Department of Medicine, The University of Hong Kong

Lunch Symposium - Brain Health
Chairperson: Dr. Samuel FUNG

- **Etiology Based Management of Epilepsy: How Genetics & Surgical Treatment Make a Difference?**
  Dr. Mario Wai-kwong CHAK
  President, The Federation of Medical Societies of Hong Kong

Session III - Mental Health & Oncology
Chairpersons: Dr. Yin-kwok NG & Dr. Desmond NGUYEN

- **Depression: Recent Advances**
  Prof. Siu-wa TANG
  Professor of Psychiatry, University of California, Irvine, USA
- **Colorectal Screening – Where Are We Heading?**
  Dr. William Chia-shing MENG
  Specialist in General Surgery

Session IVa - Respiratory Health
Chairpersons: Dr. Alson CHAN & Dr. Tony TO

- **One Airway Diseases Management: Allergic Rhinitis & Asthma**
  Dr. Henry P.H. PAU
  Specialist in Ear, Nose and Throat
- **Electronic Cigarette and New Tobacco Products To Ban or To Let Free?**
  Dr. Tai-hing LAM
  Chair Professor of Community Medicine and Sir Robert Kotewall Professor in Public Health, School of Public Health, The University of Hong Kong

Session IVb - Metabolic Disease
Chairpersons: Dr. Kai-ming CHAN & Dr. Victor YEUNG

- **Current Landscape of Obesity in Hong Kong**
  Dr. Michele Mae-ann YUEN
  President, Hong Kong Obesity Society (Medical Chapter)
- **Advances in Diabetic Nephropathy**
  Dr. Samuel Ka-shun FUNG
  Chief of Nephrology & Consultant Physician, Department of Medicine & Geriatrics, Princess Margaret Hospital

Session Va - Dermatology & Allergy
Chairpersons: Dr. Edwin YU & Ms. Tina YAP

- **Eczema Management - Anything New?**
  Dr. Kingsley Hau-ngai CHAN
  Specialist in Dermatology & Venereology
- **Diagnosis and Management of Allergic Diseases: A Practical Update**
  Dr. Alson Wai-ming CHAN
  Specialist in Paediatric Immunology & Infectious Diseases, Allergy Centre, Hong Kong Sanatorium & Hospital

Session Vb - Infection & Urology
Chairpersons: Dr. Thomas SO & Dr. Kwai-ming SIU

- **Management of Benign Prostatic Hyperplasia (BPH) in the Modern Era**
  Dr. Victor Hip-wo YEUNG
  Specialist in Urology
- **Update in the Use of Antibiotics**
  Dr. Kai-ming CHAN
  Specialist in Infectious Diseases

Registration Fee

HK$100 Members of Member Societies of FMSHK
HK$400 Non-members

Registration

Application form can be downloaded from website http://www.fmshk.org
CME / CNE Accreditation is pending
Enquiry: 2527 8898

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