

香港醫訊



THE HONG KONG MEDICAL DIARY

OFFICIAL PUBLICATION FOR THE FEDERATION OF MEDICAL SOCIETIES OF HONG KONG

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- A New Subspecialty for Psychiatry?

Dr. Paul TC Lam

Medical Bulletin

- Drug-Induced Movement Disorders
- Management of Youth Substance Users in General Practice Settings
- Somatisation-Abnormal Illness Behaviour in Primary Care
- Treatment Resistance in Schizophrenia
- Early Detection and Intervention of Dementia
- Depression for General Practitioners

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Scientific Meetings

- Abstracts from the Hong Kong Society of Biological Psychiatry Conference,
18-20 October 2007

Lifestyle

- Bulgari Resort, Bali

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Dermatological Quiz

- Dermatological Quiz

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Treatment of Respiratory Failure

Speaker : Dr. Tsang Wah Tak, Kenneth (曾華德醫生) MD, FRCP

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Leukotriene Receptor Antagonist in Asthma Management: Past, Present & Future Roles

Speaker : Prof. David Price M.A., M.B. B.Ch, FRCGP, University of Aberdeen

Case Study in Psychiatry and Neurology: A Patient with Learning Difficulty

Speaker : Dr. Lam Tat Chung, Paul FRCP, FHKAM(Med), FHKAM(Psychiatry)

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A New Subspecialty for Psychiatry?

Dr. Paul TC Lam

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Editor



Dr. Paul TC Lam

Medicine has advanced very rapidly over the past 100 years. This is nowhere more evident than in the field of Psychiatry. During this time, we have passed from regarding psychiatric illness as a form of demonic possession, through measures used to segregate those afflicted, to the primitive treatment methods used in phrenology and mesmerism, and later to the psychoanalytic methods propounded by Sigmund Freud. Up to the 1950s, Psychiatry has moved very much away from mainstream medicine.

However, the pendulum has swung very much in the opposite direction in modern days. Psychiatric Units are now important parts of general hospital complexes. Patients are managed in the community rather than sent away to mental hospitals.

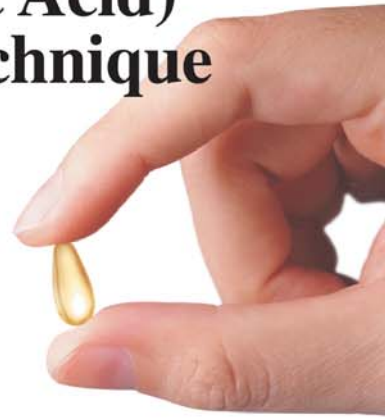
This has all been made possible by renewed understanding that psychiatric illness is a disease of the brain, and by the gradual unfolding of the pathological mechanisms that underlie such illnesses, and the consequent development of effective medications targeted at specific mechanisms. Today we are making advances in psychiatric illness in terms of the interplay of neurotransmitters and receptors, neurochemistry, genes, cell and molecular biology, and imaging techniques. We have also seen great advance in the efficacy and diversity of drugs available for use in psychiatry. Treatment of psychiatric patients nowadays has returned to a very similar model and approach as treatment of patients in other specialties in Medicine.

This convergence of psychiatry and medicine has taken a further twist. Nowadays we discover that there are a large number of patients with co-morbidities of both medical and psychiatric illnesses. The patient with schizophrenia is more prone to diabetes and the metabolic syndrome, and certain antipsychotic drugs promote hyperglycaemia and hyperlipidaemia. Patients with physical illnesses, e.g. ischaemic heart disease, may require treatment with psychotropic drugs which may induce cardiac arrhythmia or influence warfarin levels. Patients under treatment for viral eradication of hepatitis B and C often suffer from severe depressive symptoms that require psychiatric intervention. Similarly patients on chemotherapy for cancer may need psychotropic drug treatment. How do these different drugs interact in the body? And how does one disease process affect another? (Among middle-aged women, the presence of depression increases the adjusted risk of dying from heart disease by 50%). Does the doctor prescribing cardiac drugs have some knowledge about the psychotropic drugs prescribed by the psychiatrist and vice versa? It seems that there is both a deficiency of information in this area of medicine, and also a lack of doctors who are well-trained and experienced enough to handle such cases.

I therefore propose that there should perhaps be a new subspecialty of psychiatry, in addition to psychogeriatrics, child and adolescent psychiatry, forensic psychiatry, addiction etc, that specifically deals with this group of patients. For want of a better name, this subspecialty may be tentatively called "Somatic Psychiatry" or "Co-morbid Psychiatry". Physicians who work in this field should be trained in both psychiatry and general internal medicine, ideally with formal postgraduate qualifications in both specialties. This field is different from liaison psychiatry, in which the psychiatrist attends to patients, for example, in the surgical ward in close co-operation with the surgical team. In "Somatic Psychiatry", the doctor is expected to deal relatively independently with patients with co-morbid ischaemic heart disease and depression, or a diabetic patient with schizophrenia. I am sure there will not be any shortage of clinical material for research and management, and in fact this proposed new subspecialty will be in great demand in the days to come.

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2) Microcirculation-related diseases

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Improves immune function by suppressing PGA-E₂¹²

Inhibits angiogenic factor on endothelial cell motility¹³

Provides synergistic effect with other cancer treatment drugs.¹⁴

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Drug-Induced Movement Disorders

Dr. Kin-lun Tsang

MBBS(HK), MRCP(UK), FHKCP, FHKAM(Medicine)

Specialist in Neurology



Dr. Kin-lun Tsang

Significant proportion of drug-induced movement disorders is related to antipsychotic medications and neuroleptics are the commonest. Movement disorders induced by neuroleptics are divided into three time periods.¹ Early-onset type (within seven days of treatment) is known as neuroleptic-induced acute dystonia. Incidence is about 15-20% for typical neuroleptics and less than 5% for atypical medications. It is treated and can be prevented by benzotropine, trihexyphenidyl or diphenhydramine. Neuroleptic-induced parkinsonism and akathisia are of intermediate-onset (within first three months), with incidence of 30% and 20% respectively. Akathisia is a combination of sensation of inner restlessness and objective motor movements to satisfy the urge to move. Amantadine is approved to treat parkinsonian symptoms. Propranolol at a daily dose of 20mg to 100mg is effective in akathisia. Switching to atypical antipsychotics also helps. Neuroleptic-induced tardive dyskinesia (TD) is the chronic form and is related to total lifetime of treatment, with cumulative incidence of 5% per year. Locally, published data on prevalence of tardive syndromes would be dated back to 1992.² At that time, one study in a single mental hospital demonstrated that the prevalence rates were 9.3% for tardive dyskinesia, 0.4% for tardive dystonia, and 1.2% for respiratory dyskinesia. In 2003, the point prevalence of tardive dyskinesia in the same hospital was 6.7% and the main association factor was old age.³ The rates were much lower than Western studies but whether there is any genuine ethnic difference is unknown. The phenomenology of movement disorders associated with different medications is listed in Table 1.

In the past, tardive dyskinesia was used to describe the classical rhythmic oral-facial movements but is now renamed as tardive stereotypies. Tardive dyskinesia also includes tardive chorea, tardive dystonia, tardive akathisia, tardive tics, tardive myoclonus and tardive tremor. It is important to realise that up to 14% of non-medicated schizophrenia patients have involuntary movements. 1-8% of the elderly develop spontaneous oral facial dyskinesias, especially in the edentulous population.^{1,4} Thus psychiatric disease and age themselves are probably precipitating factors. The exact pathophysiology is unknown but striatal Dopamine (D2) receptor super-sensitivity has been the traditional explanation. Other mechanisms include destruction of GABA neurons in the striatum, production of excessive free radicals and oxidative stress. Some patients might be genetically more prone to develop TD, related to the D2 dopamine receptor gene (DRD2) allele and dopamine transporter gene (DAT1) polymorphism.

Table 1: Selected Agents Associated with Drug-induced Movement Disorders

Acute and Tardive Akathisia Antiemetics Droperidol Metoclopramide Prochlorperazine Promethazine Antiepileptics Carbamazepine Psychotropics Lithium Haloperidol Molindone Phenothiazines (e.g. chlorpromazine, fluphenazine, mesoridazine, perphenazine, thioridazine, trifluoperazine) Olanzapine (high dose) Pimozide Risperidone (high dose) Thioxanthenes (e.g. thiothexene)	Acute and Tardive Dystonia Antiemetics Droperidol Metoclopramide Prochlorperazine Promethazine Psychotropics Amoxapine Haloperidol Molindone Phenothiazines Olanzapine (high dose) Risperidone (high dose) Thioxanthenes
Active and Tardive Stereotypies Antiemetics Metoclopramide Prochlorperazine Antiepileptics Phenytoin Psychotropics Amoxapine Haloperidol Molindone Phenothiazines Olanzapine (high dose) Pimozide Risperidone (high dose) Thioxanthenes	Parkinsonism Antiemetics Droperidol Metoclopramide Prochlorperazine Promethazine Antiepileptics Valproate Cardiovascular Agents Alpha-methyl dopa Reserpine Psychotropics Amoxapine Haloperidol Molindone Phenothiazines Olanzapine (high dose) Risperidone (high dose) Thioxanthenes Vestibular Sedatives Cinnarizine Flunarizine Miscellaneous Pimozole Tetrabenazine

The oral-facial movements of tardive stereotypies are choreic in nature, in the form of lip-smacking and lip-pursing, tongue protrusion, and licking and chewing movements. Muscles of the upper face are much less commonly involved. The truncal and limb muscles may be affected, giving rise to respiratory dyskinesias, pelvic thrusting and chorea in the extremities. The movements tend to be repetitive in appearance and distribution, rather than random as in true chorea. They may not distress the patient, particularly if limited to the lingual and buccal muscles.

Conventionally there was no effective treatment and the most important aim was prevention. Prognosis was frequently poor as patients usually needed the offending agent to manage their underlying psychiatric or medical problem. Ceasing the neuroleptics at the early stage of tardive dyskinesia might help and newer antipsychotics are safer in this respect. Whereas the vast majority of other drug-induced movement disorders resolve rapidly after discontinuation of the medication, TD may take months to years to remit. Women may have a higher rate of more severe and persistent TD.



Some cases may appear to be permanent. Although the manifestations may emerge or worsen shortly after cessation of the drug (withdrawal dyskinesias), this effect is transient and there is no evidence that TD will progress without continued provocation.

If the patient is not disturbed by the dyskinesia, it is best not to treat but observe and hope for a spontaneous recovery. In those with pronounced disability, treatment is difficult.⁵ A minor tranquiliser such as the benzodiazepine clonazepam may provide mild symptomatic relief. In more severe or disabling cases, presynaptic dopamine blockade by reserpine or tetrabenazine may be used to control the dyskinesias after neuroleptic withdrawal. In recent small scale studies, piracetam and adenosine reuptake/transport inhibitors dipyridamole and nimodipine were shown to reduce the symptoms of tardive dyskinesia. Botulinum toxin injection is very effective for certain forms of focal movements. Bilateral deep brain stimulation of the internal part of globus pallidus could also reduce extrapyramidal symptoms by 50%.⁶

Drug-induced parkinsonism is most commonly caused by anti-dopaminergic agents, though some calcium antagonists can be the cause.⁷ As mentioned earlier, parkinsonism develops usually 2-10 weeks after initiation of treatment. Older patients tend to be more susceptible to this complication. Akinesia is the most common presenting symptom. Resting tremor, though usually less prominent, can be as vigorous as in Parkinson's disease. Drug-induced parkinsonism tends to dissipate gradually and spontaneously after several months despite continued neuroleptic treatment. If symptoms are disabling, consideration should first be given to substituting atypical antipsychotics. If antiparkinsonian medications are needed, the first choices are anticholinergics and amantadine. These drugs may be withdrawn regularly to reassess the need of continued therapy. If parkinsonism persists, concomitant Parkinson's disease should be kept in mind as it is a common condition after all.

Neuroleptic-induced akathisia can present as fidgety movements while seated, rocking in place while standing, pacing, or the inability to sit or stand still for an extended period of time as well as the overwhelming urge to move, which can cause severe distress and an increased risk of suicide for affected patients.⁸ First-line treatment of akathisia includes benzodiazepines or beta-blockers for patients who do not have symptoms of Parkinson's disease and anticholinergics for patients with Parkinson's symptoms. Despite a lowered incidence profile with newer anti-psychotics, akathisia and similar conditions continue to affect patients. Clinicians should ensure that an accurate diagnosis of akathisia is made and target symptoms are decreasing due to treatment, which does not negatively affect the mental health of the patient.

Movement disorders are also associated with other medications, such as antiemetics that block central dopamine receptors (i.e., droperidol, metoclopramide, and prochlorperazine), lithium, selective serotonin reuptake inhibitors (SSRIs), stimulants, and tricyclic antidepressants (TCAs). Tremor commonly occurs with lithium treatment and occasionally chorea. SSRIs can commonly cause tremor and, less commonly, dyskinesia,

dystonia, or parkinsonism. Stimulant drugs (e.g., amphetamine, and methylphenidate) have been known to produce a variety of movement disorders such as dyskinesias, dystonia, stereotypic behaviour, and tics. The most common movement disorders associated with TCAs are myoclonus and tremor. The antiepileptic drug valproate is commonly associated with tremor. For many years, chorea has been recognised as a complication of oestrogen- and progesterone-containing products. Psychotherapeutic combination products containing a neuroleptic, such as perphenazine/amitriptyline, should not be overlooked as causative agents.

The newer atypical antipsychotics are more commonly prescribed nowadays, for their better side effect profile.⁹ Risperidone is a serotonin-dopamine antagonist. It has affinity for D2 and 5-HT2 receptor, with poor affinity for D1 receptor; and it also binds to adrenergic α_1 and histamine H1 receptor. Its anti-serotonergic effect decreases the risk of extrapyramidal side effects. The incidence of new-onset tardive dyskinesia was reported to be less than 1%. Cases of tardive dystonia, especially involving the neck region, have been reported. Clozapine has a higher affinity for D1 than D2 receptors, and it blocks D4, D3, serotonin, α_2 receptors. It requires frequent monitoring of blood counts due to the risk of agranulocytosis. There was evidence that clozapine improved tardive dystonia in several case reports and small series, but there were no double-blind controlled trials. Nonetheless, reduced extrapyramidal side effects (EPS) are not the same as no EPS, and most of the newer antipsychotics can still cause EPS in some patients. In general, the risk of causing EPS in increasing order is: clozapine, quetiapine, olanzapine and risperidone. The likelihood of developing EPS with a first-line second-generation anti-psychotics (or atypical anti-psychotics) depends not only on the specific agent, but also on the rapidity of dose escalation, the target dose, and the patient's intrinsic vulnerability to EPS. Even with the newer antipsychotics, clinicians should not be lulled into believing EPS cannot happen, but need to be able to recognise and manage both overt and subtle manifestations of EPS.

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Management of Youth Substance Users in General Practice Settings

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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 one CME credit under the programme upon returning the completed answer sheet to the Federation Secretariat on or before 29 February 2008.

Drug addiction...."it's like I've got a shotgun in my mouth, my finger's on the trigger and I like the taste of gun metal..."
Robert Downey, Jr.

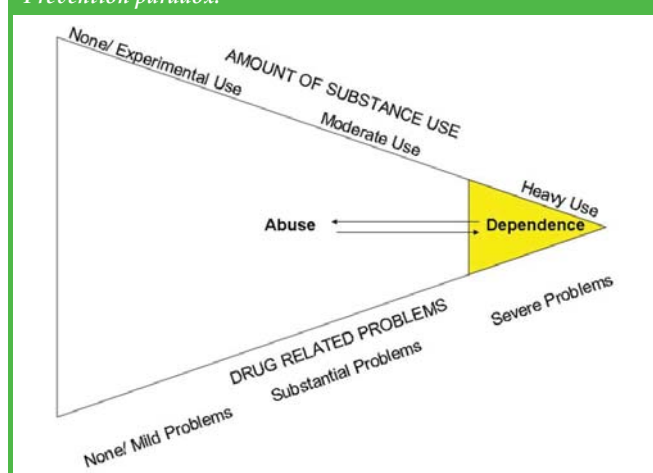
Introduction

Youth substance abuse is on the rise in Hong Kong. As of 2007, the drug trend is still going up. According to the Central Registry of Drug Abuse (CRDA), the proportion of reported young abusers under 21 was 20.1% in the first half of 2007, higher than that for the same period of 2006 (18.4%). Among the psychotropic substances, ketamine, triazolam/midazolam/zopiclone, ecstasy, cannabis and methylamphetamine (or commonly known as ice) were more commonly abused in recent years. From the treatment statistics in the Substance Abuse Assessment Unit at Kwai Chung Hospital between the year 2000 to 2005, the average "hidden" period between the onset of substance abuse and the time of presentation to treatment, there is an average time lag of 46 months. The Government of HKSAR has set up a task force, led by the Secretary for Justice, to spearhead the Government's efforts to tackle youth drug abuse. The Beat Drugs Fund has also reserved budgets to promote the participation of family physicians in combating youth illicit drug use. It is therefore timely to provide a guide to the assessment of substance abuse in general practice settings.

The need for early identification and early intervention in Hong Kong

Refer to Rose's **prevention paradox**^{1,2} as illustrated in the diagram, individuals at the right end of the continuum are those with intense drug use, heavy dependence and serious drug-related problems. Despite they are relatively few in number, they consume the main bulk of treatment resources including detoxification, treatment of physical and psychiatric complications. The converse of the paradox suggests that when early intervention can be delivered to the larger number of occasional and regular users before late complications develop, the total benefits to the drug use population will be much larger.

Prevention paradox:



The Role of Family Physicians in the Community Model of Substance Abuse Early Intervention

Conventional substance abuse treatments take place in settings with high threshold for intervention. Treatments are intensive, lengthy, multi-sessions and conducted by highly trained professionals. Such approach is relatively passive, waiting for clients to present for service after passed through various gatekeepers, and patients usually need to acceptance the label of an addict. Services are usually disruptive to clients, rendering them unable to fulfill family and social responsibilities.

In response to the rise of newer illicit substances affecting the younger generation of Hong Kong, there is a need to develop newer, community-based, low threshold and non-stigmatising services for earlier intervention. Family physicians are in a good position to provide time-limited, less intensive, problem-specific and low threshold substance abuse treatments, as they can help to attract early substance abusers into helping environments. General practice settings are more accessible with little stigma and less barriers to help-seeking of youth drug users. It must be emphasised that this new model of service delivery is not to compete with conventional services. It addresses a gap in service, and may serve as a gateway to conventional treatment agencies.



Practical guidelines to family physicians in assessing patients with substance related problems

SCREENING

Screening is a recommended good practice, enabling clinical practice to be more responsive and effective for people with co-occurring substance use disorders. CAGE is a well known screening instrument for the detection of alcohol. It has been modified to be used for screening of drug use. It could be administered easily in a busy clinic setting. Since the questions were originally developed for alcohol, the CAGE-AID³ may not apply to every illicit drug or drug user. As with the CAGE, one positive answer prompts further evaluation.

The CAGE Questions Adapted to Include Drugs (CAGE-AID)

1. Have you felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticising your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Another simple screening tool widely used for adolescents is known as CRAFFT. Evaluation research indicates that the CRAFFT⁴ screening instrument can be used to detect substance use disorders among adolescents. Two "yes" answers indicate a need for further assessment, while four "yes" answers are suggestive of dependence.

CRAFFT Screening instrument for adolescents

1. C - Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
2. R - Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
3. A - Do you ever use alcohol/drugs while you are by yourself, ALONE?
4. F - Do you ever FORGET things you did while using alcohol or drugs?
5. F - Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?
6. T - Have you gotten into TROUBLE while you were using alcohol or drugs?

Be alert to psychosocial warning signs:

Other than conducting screening, one should also develop a high level of suspicion for occult substance abuse cases. Markers of disturbed functioning may

include: (1) history of running away from home and truancy (2) evidence of stealing, property destruction and other offences (3) physical cruelty to others, bullying behaviour (4) initiation of fights and forcible sexual activity with others, and (5) other cognitive and psychological markers (e.g., low frustration tolerance, low self-esteem, irritability, poor modulation of or ability to handle anger).

SCREENING FOR SEVERITY:

The DAST-10 is a 10-item, self-report instrument that has been shortened from the 28-item Drug Abuse Screening Test⁵ (DAST), and should take less than 8 minutes to complete. The DAST-10 was designed to provide a brief instrument for assessment of severity and treatment evaluation. It can be used with adults and older youth.

Drug Abuse Screening Test (DAST-10)

These questions refer to the past 12 months

1. Have you used drugs other than those required for medical reasons? --- No / Yes
2. Do you abuse more than one drug at a time? --- No / Yes
3. Are you always able to stop using drugs when you want to? --- No / Yes
4. Have you had "blackouts" or "flashbacks" as a result of drug use? --- No / Yes
5. Do you ever feel bad or guilty about your drug use? --- No / Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs? --- No / Yes
7. Have you neglected your family because of your use of drugs? --- No / Yes
8. Have you engaged in illegal activities in order to obtain drugs? --- No / Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? --- No / Yes
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)

Scoring:

- | | |
|------|-----------------|
| 0 | No Problem |
| 1-2 | Low Level |
| 3-5 | Moderate Level |
| 6-8 | High Level |
| 9-10 | Very High Level |

TAKING A DRUG HISTORY

Before taking a drug history, one should keep updated on the common substances of abuse in Hong Kong. It is also important to know the street names so that one can communicate to clients in the same language. It may be helpful to keep a checklist on the desk, and go through it with clients to determine which drugs ever used by them.



Checklist of Drugs of Abuse and Their Street Names

Category	Drugs	Street Names
Narcotics 麻醉鎮痛劑	Codeine	高甸, 咳水
	Dipipanone	囉囉攀, 可待因
	Heroin:	紅色菲仕通
	No.3 heroin	海洛英, 白粉, 粉, 灰
	No. 4 heroin	三號粉, 砂仔
	Methadone	四號粉, 四哥, 四仔
	Physeptone	美沙酮, 老美
	Morphine	菲仕通, 帆船仔
	Opium	嗎啡針
	Opium	鴉片, 福壽膏
Psychedelics 迷幻劑	Cannabis 大麻	grass, pot, joint, marijuana, hashish, bush, weed
	1. Marijuana (dried leave)	1. 草
	2. Hashish (resin)	2. 大麻精
	3. Hash oil	3. 大麻油
	Lysergic acid diethylamide (LSD)	迷幻藥, 方糖, 郵票, Micropill, 黑芝麻
Stimulants 興奮劑	Phencyclidine (PCP)	天使塵, angle dust, hog, peace pill, horse tranquilizer
	Amphetamines	安非他命, 大力丸, speed, uppers, Bennies, black beauties, copilots, dexies, eye openers, lid poppers, pep pills, wake-ups, 冰
	1. Methylamphetamine	Fing頭, 狂喜,
	2. Methylene-dioxy-methyl-amphetamine (MDMA)	派對丸仔, E仔, EVE
		ecstasy, designer's drug
Depressants 鎮抑劑	Cocaine	可卡因, 可可精, C, coke, flake, snow, stardust
	Crack-cocaine	Crack, 霹靂, 可樂
	Barbiturates	巴比通
	Amylobarbitone (Amytal)	紫心丸, 藍魔鬼
	Quinalbarbitone (Secobarbital)	莉莉四十, 紅魔鬼
	Benzodiazepines:	
	Brotizolam (Lendormin)	屋仔, 二拾蚊, 13A
	Bromazepam (Lexotan)	寧神定
	Clonazepam	白天使
	Chlordiazepoxide (Librium)	綠豆仔, 利眠寧
	Diazepam (Valium)	羅氏二、五、十號
	Estazolam	舒樂安定
	Flunitrazepam (Rohypnol 1mg)	十字架(細十, 縮水)
	Flunitrazepam (Rohypnol 2mg)	十字架(大十)
	Midazolam (Dormicum)	羅氏藍精靈, 大藍
Others	Nimetazepam	五仔, 黃飛鴻
	Nitrazepam (Mogadon)	睡覺幫, 笑哈哈, 魔鬼黨
	Triazolam (Halcion)	藍瓜子, 藍精靈, 細藍
	Z drugs	
	Zolpidem	白瓜子, 憶夢返
	Zolpidem	啞吡咀, 思諾施
	Mandrax	忽得, 糖仔, MX,
	Ketamine	K仔
	Cough Mixture	MB, 咳水, B仔
	Gamma hydroxybutyrate (GHB)	迷姦水, X水, G水
	Dextromethorphan (Romila)	O仔
	Organic Solvents	天拿水, 打火機油, 飛機膠, 膠水, gas, glue

PSYCHOACTIVE DRUG HISTORY QUESTIONNAIRE

DRUG CATEGORY Note: First Use Card Sort With Client To Determine Which Drugs Ever Used	^a Ever Used 1 = No 2 = Yes	^b Total Years Used	Injection Drug Use 1 = No 2 = Yes NA = not applicable	Year Last Used 19 ____	^c Frequency of Use in Past 6 Months
^a If "EVER USED" is NO (1) for any given line, the remainder of the line should be left blank. ^b Code 87 = Infrequent Use (≤ 2 x/year) Code 88 = Brief Experimental Use (< 3 months lifetime use) ^c Frequency Codes: 0 = no use 3 = 2 to 3x/mo. 6 = 4 to 6x/wk. 1 = < 1x/mo. 4 = 1x/wk. 7 = daily 2 = 1x/mo. 5 = 2 to 3x/wk.					

RETROSPECTIVE ASSESSMENT OF DRUG USE

The Timeline Follow back (TLFB) is an interview technique that assists patients in recalling past drug use. Researches have shown that it has greater validity than do simple questions about usual quantity and frequency of drug use.^{7,8,9,10} TLBF includes a calendar to help people provide retrospective estimates of their daily drug use. Several memory aids were developed to help people recall.

2008	SUN	MON	TUES	WED	THURS	FRI	SAT
			1 New Year's Day	2	3	4	5
J	6	7	8	9	10	11	12
A	13	14	15	16	17	18	19
N	20	21 M.King Day	22	23	24	25	26
	27	28	29	30	31	1	2
F	3	4	5	6	7 Chinese NY	8 2 nd Day Ch.NY	9 3 rd Day Ch.NY
E	10	11	12	13	14 Valentine Day	15	16
B	17	18	19	20	21	22	23
	24	25	26	27	28	29	1
M	2	3	4	5	6	7	8
A	9	10	11	12	13	14	15
R	16	17	18	19	20	21 1 st Cool Tri Day	22
	23 Easter	24 Easter Monday	25	26	27	28	29
	30	31					

Memory Aids in using TLFB

Daily Calendar: Some people have found it useful to consult their personal appointment or date books as aids in completing the calendar. Use of aids is encouraged.

Key Dates: Use of holidays, birthdays, newsworthy events and other personal events that are meaningful to people can assist recall of alcohol.

Black and White Days: People are asked to recall lengthy periods of time when they completely abstained or used drugs in a very patterned manner (e.g., doing drugs every weekend).

Discrete Events and Anchor Points: Use of specific events such as hospitalisations, illnesses, employment, and treatment participation can be used to help people identify periods of extended alcohol use or abstinence.

Drug use Boundaries: When starting the interview, the interviewer can ask about the greatest and the least amounts consumed on any day in the reporting period. Reporting the greatest amount gives the person permission to admit to high levels of use.

Exaggeration Technique: If a person reports having used "a lot" on a day, but claims an inability to specify what "a lot" means, the interviewer can ask the person "Does 'a lot' mean doing 20 packs of Ketamine a day?" A typical response to this question might take the form of "certainly not 20, more like 10 packs."

ASSESSING A DETAILED DRUG HISTORY

Taking a detailed drug history is essential for establishing the baseline pattern of drug use, and for treatment planning. However, such task is usually performed poorly in busy clinic settings. A standardised sheet such as the Psychoactive Drug History Questionnaire⁶ is often useful. Each of the identified substance of abuse can be filled into the form one by one.



Assessing the readiness for change

Motivational interviewing¹¹ is a client-centred, directive method for facilitating change by helping people to explore and work through ambivalence. Motivation, as defined in the Motivational Theory, can be classified into reliable, predictable and well defined stages. The task of the therapist is to identify the stage the patient is in, and to apply stage-appropriate counselling approaches in order to obtain the best results. With training it can be adopted by family physicians into their clinical practices as an effective time-limited counselling approach. Those not responding to brief intervention can then be referred to specialists or agencies for more specialised treatments.

Stage	Features	Counselling Approach
Precontemplation	Not considering change	Acceptance, patience, acknowledging, helping attitude Explore previous experiences with drugs, and the effects in different aspects Introduce ambivalence: "Is there any way at all in which you would be better off if you quit drinking? Could it be something to think about?" Provide personal feedback of physical examination and lab. Investigation, letting the patient to make his own judgement. Be satisfied with minimal progress
Contemplation	Ambivalent about change	Explore the advantages and disadvantages of drug use, and of quitting. Try to decrease attractiveness of substance abuse. Identify barriers and remove them
Determination	Committed to change	Directness, clarity, specific advice Select potentially successful strategies based on the patient's personality, previous experiences, allowing the patient to make choice . Goal setting and structure a plan of action with the patient
Action	Involved in change	Provide detoxification if necessary Identify sources of support. External contingencies do help. Modify the plan to make it a realistic one Offering information about successful models
Maintenance	Behaviour change	Identifying relapse triggers by self-monitoring using diary Developing strategies to counter pressures to relapse Help increase patient's self-efficacy Providing encouragement and support even for minimal success
Relapse	Undesired behaviours	Reduce shame and guilt Help the patient to enter into another cycle of change quickly Review the failure and learn from the mistakes

Urine toxicology

Urine toxicology has an important role in confirming suspected cases, and to detect the nature and number of illicit substances involved. It is important to ensure that urine samples are valid by providing supervision, or checking the temperature, colour as well as the content of the urine. One should also bear in mind the detectability of drugs of abuse to avoid wasting of resources.

The detectability of common drugs

Drugs	Longest detection time after Last Use (Days)
Amphetamines	3
Barbiturates	
Short-acting	5
Long-acting	14
*Benzodiazepines	3
*Cannabis	14
Cocaine	3
Dextromethorphan	2
GHB	0.5
Ketamine	2
LSD	2
MDMA	3
Methadone	7
Methaqualone	14
Opiates	3
*PCP	14
Zolpidone	3

* Chronic use may lead to positive urine results for up to weeks.

Conclusion:

Family physicians have an important role to play in early identification, assessment and brief intervention of youth illicit drugs use. They should equip themselves with the required skills and knowledge, and incorporate them into their daily clinical practices.

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MCHK CME Programme Self-assessment Questions

Please read the article entitled "Management of Youth Substance Users in General Practice Settings " by Dr. Ben KL Cheung, and complete the following self-assessment questions. Participants in the MCHK CME Programme will be awarded 1 CME credit under the Programme for returning completed answer sheets via fax (2865 0345) or by mail to the Federation Secretariat on or before 29 February 2008. Answers to questions will be provided in the next issue of The Hong Kong Medical Diary.

Questions 1-10: Please choose the best answer:

1. Which of the following is not correctly matched?

- a). Cocaine--- Coke
- b). Dextromethorphan --- O仔
- c). Cocaine--- C仔
- d). GHB--- X水
- e). Heroin---四仔

2. Which of the following is not correctly matched?

- a). MDMA --- Fing頭
- b). Methylamphetamine --- 狂喜
- c). Zopiclone --- 白瓜子
- d). Crack cocaine --- 霹靂
- e). Dormicum --- 藍精靈

3. Which of the following is not correctly matched?

- a). Nemetazepam --- 縮水
- b). Rohypnol --- 十字架
- c). Cannabis --- 草
- d). Physeptone --- 帆船仔
- e). LSD --- 黑芝麻

4. Which of the following is not correctly matched?

- a). Librium --- 綠豆仔
- b). Hashish --- 大麻精
- c). Phencyclidine --- 天使塵
- d). Brotizolam --- 黃飛鴻
- e). Triazolam --- 藍瓜子

5. Which of the following may still be detected in urine 2 weeks from last use?

- a). Heroin
- b). Methadone
- c). Cannabis
- d). Ketamine
- e). MDMA

6. Which of the followings may still be detected in urine 5 days from last use?

- a). Cocaine
- b). MDMA
- c). Ketamine
- d). LSD
- e). Methadone

7. Which of the followings may not be detected in urine the following day from last use?

- a). Ketamine
- b). Heroin
- c). Zolpidone
- d). GHB
- e). MDMA



8. Motivational interviewing was developed by:

- a). Rose G
- b). Kwan E
- c). Skinner H
- d). Miller WR
- e). Wilcosky T

9. Prevention Paradox was described by:

- a). Rose G
- b). Kwan E
- c). Skinner H
- d). Miller WR
- e). Wilcosky T

10. DAST-10 was developed by:

- a). Rose G
- b). Kwan E
- c). Skinner H
- d). Miller WR
- e). Wilcosky T

ANSWER SHEET FOR FEBRUARY 2008

Please return the completed answer sheet to the Federation Secretariat on or before 29 February 2008 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

Management of Youth Substance Users in General Practice Settings

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1 2 3 4 5 6 7 8 9 10

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

HKID No.: _____ - _____ X X (x) Other Membership No. (please indicate): _____

Contact TelNo.: _____

Answers to January 2007 issue

Recent Advances in Percutaneous Coronary Intervention (PCI)

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



Somatisation-Abnormal Illness Behaviour in Primary Care

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Dr. Dicky WS Chung

Case History

A 35-year-old woman, a new immigrant from mainland China for two years, presented with year-long history of headache and chest pain to a GP clinic. She had sought help from various doctors for these problems. A lot of examinations and investigations were done but no abnormality was found. Her pain got no relief despite she had been given different kinds of medication. These symptoms and her fear of having a serious illness distressed her. She also felt sad and suffered from insomnia. However, she rather attributed her low mood to the disturbing pain, and so she denied any psychological explanation for her symptoms.

On further assessment, she revealed that her 50-year-old husband, previously a construction site worker, injured his back at work and hence has been unemployed for years. She was very disappointed on arriving Hong Kong to see the living environment different from what she had originally expected.

This case vignette illustrates a common phenomenon in primary care, i.e. a patient presenting with persistent distressing physical symptoms despite normal medical findings, however psychosocial difficulties being denied by the patient as one of the aetiological factors. It was found in the West that this sort of problems accounted for 20% of all new consultations in primary care. In primary care, up to 80% of consultations for non-specific physical symptoms, like dizziness, chest pain and fatigue, are medically unexplained¹.

The process leading to this kind of inappropriate illness behaviour is termed "somatisation". Somatising patients utilise a great amount of health care resources, for example, on unnecessary and repetitive investigations, drug dependence and "doctor shopping". Despite substantial medical attention given, they still report high level of disability and suffering.

There are studies showing Asian patients and patients from developing countries, when they are emotionally distressed, reporting more somatic symptoms than Caucasian patients. Cultural factors and stigmatisation of mental illness in a society greatly influence the prevalence of somatisation². Perhaps, some Chinese people might be less inclined to express their anxiety and depression with words or terminology in psychological manner. Or, they tend to experience emotions in a different way.

Terminology

"Somatisation" is also a term to describe patients' illness behaviour in which they have a tendency to experience and express physical symptoms for which they seek medical help, when they indeed have underlying psychological distress. This is not a diagnostic label. There are several similar disorders and terminology easily confusing non-psychiatric medical professionals. (Table)

Why do some patients tend to somatise? --- The relationship between psychological distress and somatisation

Some models are postulated. They are not mutually exclusive in explaining somatisation.

- Emotional distress prompts people to seek care for common somatic symptoms for which they would not seek medical advice in the absence of emotional distress.
- Some people, with the personality trait of amplifying perceptual style or as a result of abnormal neuropsychological information processing, have a lowered threshold for reporting physical symptoms.
- Physical symptoms may be an integral part of most psychiatric disorders. The somatising patient just focuses on these symptoms and attributes the psychological symptoms to the distress of having the physical symptoms. This is particularly common in patients suffering from panic disorder and masked depression.

Benefit of early intervention for somatisation --- GPs are particularly important in managing early somatisers

- Early detection will allow abnormal illness beliefs and attitudes to be modified more easily before becoming chronic and resistant.
- Psychiatric disorder can be managed earlier and hence better response to psychiatric treatment.
- The iatrogenic effects due to unnecessary investigations and inappropriate use of drugs, and "doctor shopping" can be avoided.
- Doctors' frustration and negative reactions towards somatising patients' inappropriate demands can be minimised, which is particularly important in the current medicolegal atmosphere.



Interview technique³

- Somatising patients may have difficulty in putting their feelings into words, and may fear disclosing their psychosocial problems related to their feelings so that they may subsequently be labeled as "mad". They dislike being told their symptoms are "all in their mind", "unreal", "imaginary" or "心理作用". If there were unsettled litigation issue with insurance, they would be afraid of being suspected of feigning illness. Therefore, to build up trust and to engage them in the therapeutic relationship are particularly important in treating this group of patients.
- No premature or empty reassurances. "Don't worry, there shouldn't be any problem" given too early and indiscriminately after a brief interview may irritate these doctor-shopping patients, who has lost confidence on doctors.
- No confrontation. Confrontation with the information that the somatic symptoms are psychological in origin is rarely helpful and generates an adversarial relationship.
- Pay more attention to a detailed history of somatic symptoms, i.e. the time course, whether more than one symptom present, a typical pain day, disability experienced. Such enquiry about somatic symptoms makes patients feel that their symptoms and the magnitude of distress are taken seriously.
- There is a need to be especially aware of verbal and non-verbal cues for psychosocial problems
- Empathic response to the account of symptoms. For example, as simple as a statement like "the pain must be very bad" may deepen the process of engagement and facilitate the exploration of mood state in the later stage.
- Don't give interpretative comment on the psychological cause of their somatic symptoms too early. It only becomes unconvincing, especially if it is given before a physical examination is done.

In the mental state examination, areas to be probed into:

- The patients' illness beliefs or myth, which may also be shared by other family members.
- The range and depth of their emotional response, sometimes they may appear detached, bland and affectless.
- The use of vocabulary to describe their somatic symptoms which is often limited, e.g. "just pain over here and it hurts very much"
- The level of denial of psychological factors influencing their perception of discomfort.
- Any hostility towards doctors
- Any grudges towards their employers if compensation in association with occupational accident is pending.

General principles of management

- Arrange for regular follow-up to legitimate their sick role and to convey a message of continuation of care for them
- Treat underlying mood or anxiety disorders
- Present a clear rationale for the proposed management plan
- Draw up a list of psychosocial problems with the patient

- Recognise and control negative reactions and counter-transference in doctor's side
- Minimise polypharmacy to prevent iatrogenic complications
- Aim at "coping" rather than "curing" the somatic discomfort

Specific approaches of management⁴

Reattribution approach

It aims at helping somatising patients to see their symptoms in a different way during the first few interviews in a primary care setting. It is suitable for somatisers who have some psychological understanding, are not overtly hostile, and whose symptoms are relatively mild or of a shorter duration (facultative somatisers)

After the interview (with the points mentioned above emphasized) and physical examination, it is time to broaden the agenda of the consultation. Summarising the physical findings is a good start. It is important to acknowledge the reality of the physical discomfort. For example, a statement like "clearly your discomfort is real and also distressing to you, but fortunately you are not suffering from serious illness" may set a platform for a later psychological explanation. A discussion of previously elicited psychosocial factors and the onset of their symptoms should then follow.

The task is to help the patient link his/her somatic symptoms with psychosocial stressful factors in his/her life. The strategy is a 3-stage explanation rather than a haste explanation of just linking stress with physical symptoms. Some examples are: "when people are anxious they secrete more adrenaline in their blood, and this makes their hearts beat faster"; "when people are depressed it alters their pain threshold, and makes the pain from your arthritic joints much worse"; "your internal organs are mainly under the influence of autonomic nervous system which is directed by your 'mood centers' in your brain". Practical demonstration is a good way to convince patients about muscular aches, which commonly occur in tense people. The patient is invited to hold heavy books with arm outstretched. They will quickly have to admit that tense muscles ache. The patient can also try hyperventilate briefly in front of doctor to feel the immediate dizziness and tingling sensation. But the doctor should immediately direct the patient to try deep slow breathing and relaxation technique to see the difference. Human body model can be used for vivid illustration. Other physiological mechanisms, like autonomic arousal, hyperventilation, physiological effect of inactivity, can also be used for explaining symptoms.

Directive approach

When some patients are hostile or strongly deny the possibility of psychological factors, the case doctor needs to present himself as expert in controlling pain or helping people to cope with symptoms. This avoids discussing psychological issue related to aetiology. However, patients are encouraged to ventilate their feelings of anger and frustration about previous



treatment. They are treated as if they have a physical problem. A programme of activities is discussed to improve their "strength" or "functioning". The aim is for damage limitation. In the presence of obvious mood disorder, it would be appropriate to prescribe antidepressants. Antidepressants have been shown to have analgesic effect, which are independent of their antidepressant effect.

When to refer to psychiatrist?

- When the underlying psychiatric disorders are severe, with marked functional impairment, or the risk of suicide is high.
- When the somatisation is of long standing and resistant to change, long term psychotherapy (e.g. cognitive-behavioural or psychodynamic psychotherapy) is needed.
- It is important to prepare these patients well before referral because of their sensitivity towards their doctors and stigmatisation of mental illness as discussed above. It is sometimes more profitable to introduce psychiatrist as having expertise in "treating pain" or "rehabilitation".

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Table

Somatisation: A psychiatric terminology to describe a tendency in some patients who experience and express somatic distress and symptoms unaccounted for by pathological findings, and attribute them to physical illness, therefore seeking medical help for them. It is often assumed that somatisation becomes manifest in response to psychosocial stress brought about by life events that are personally stressful to the individual.

Somatoform disorder: ICD-10 mental disorder. The presence of physical symptoms that suggest but which are not fully explained by a general medical condition, the direct effects of drugs or another mental disorder. The symptoms have caused clinically significant distress, or impairment in social, occupational or other areas of functioning. In contrast to factitious disorders and malingering, these medically unexplained symptoms are not intentional.

Somatisation disorder: ICD-10 mental disorder. A rare and extreme subtype of somatoform disorder where the patient over many years seeks medical attention for many physical symptoms with no evidence of organ pathology. The diagnosis of the disorder requires the presence of 14 of 37 potential physical symptoms for women and 12 for men.

Hypochondriasis: morbid fears of having serious illness despite repeated negative findings. The gist is the preoccupation with these fears. The preoccupation must last at least six months, persist despite appropriate medical evaluation and reassurance and cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

Factitious disorder: The intentional production of false or grossly exaggerated symptoms for reasons that are not obvious (i.e. "unconsciously" in psychodynamic terms). It is presumed that there is a psychic need to assume the sick role and to receive care. Patients often present their history with flair or gross exaggeration, and receive multiple hospitalisations (Munchausen's syndrome). When there are external incentives or clear motives for this illness behaviour (e.g., financial gain), this is malingering but not factitious disorder.



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Treatment Resistance in Schizophrenia

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There is no general agreement about what is treatment resistance. For the present discussion it is taken as a patient diagnosed to be suffering from schizophrenia by an experienced psychiatrist after careful workout, who has failed to achieve significant symptom reduction or regain adequate social or occupational functioning after two different courses of first line antipsychotic treatment. The antipsychotic drugs must be given in adequate doses and each for at least 4-6 weeks. Treatment resistance occurs in about 20% of cases. If there is no improvement after measures are taken to deal with treatment resistance, the patient is considered treatment refractory. This is fortunately rare.

Factors that contribute to treatment resistance are (1) male sex. (2) early onset (3) prolonged duration of untreated psychosis (4) chronic patients (5) hebephrenic schizophrenia, a type of schizophrenia characterised by disorganisation of thoughts. (6) history of obstetric complications (7) history of prenatal and perinatal problems.

Probable neurobiological correlates are

(1) cortical atrophy and cerebellar atrophy.

This is confirmed by neuroimaging studies.^{1,2}

(2) low activities of MAO-A (Monoamine oxidase A) and

(3) low activities of COMT (Catechol-O-methyltransferase)³.

This is confirmed by genetic studies. Patients who respond poorly to antipsychotic drugs are six times more likely to have genotypes for low activities of MAO-A and COMT. It is postulated that these patients have a poor ability to metabolise dopamine.

The following guide may be used by clinicians to deal with treatment resistance.

Review the diagnosis. There are many conditions that can mimic schizophrenia. Is the syndrome one of delirium or dementia? Does the patient suffer from a symptomatic psychosis due to a general medical condition? This includes a long list of differential diagnoses such as nutritional deficiencies (nicotinamide or cyanocobalamin), endocrine disorders (Addison's disease, Cushing's syndrome, thyroid disorders), metabolic diseases (Wilson's disease, porphyrias), infectious diseases (syphilis), diseases of the brain (epilepsy or hydrocephalus), substances of abuse (cocaine, amphetamine) or toxic substances (arsenic, mercury). Some therapeutic agents may also be responsible (steroids, sibutramine, bromocriptine etc). A full investigation including blood test, brain scan and screening for drugs of abuse must be carried out.

Alternately, the patient may be suffering from a schizoaffective disorder. The mood symptoms must be specifically treated to get a better response of the schizophrenic symptoms. This will mean the concurrent use of antidepressants or mood stabilisers.

One would also need to consider the alternative diagnosis of affective psychosis, which requires a different treatment regime.

Examine the patient's adherence to treatment. Drug compliance is a problem for patients with chronic illnesses. About 40% of outpatients do not take their medications regularly. Poor compliance is associated with lack of insight, negative attitude to medication, younger patients, substance abuse, short duration of illness, cognitive dysfunction, poor motivation and lack of a trusting relationship with family members and the doctor. Troublesome side effects from the drugs administered, including extrapyramidal and anticholinergic side effects are also important factors.

For monitoring drug compliance, the doctor will need to use measures like counting of drugs not taken, checking regularity of follow up visits, report from relatives or serum drug level assessment. This problem can be dealt with by more intense supervision by the doctor or relatives, by education of the patient or by switching to a depot injection. In one review, the one year relapse rate for patients on depot antipsychotics was 27%, compared with 42% for patients on oral drugs.⁴

Determine the adequacy of treatment doses and duration. Each drug has an optimal dose. Patients must receive an optimal dose of the administered drug for 4-6 weeks. If a patient is going to respond, usually some improvement will be seen in the first 2 weeks, and a good effect will be seen in 4-6 weeks. 70% of the total improvement in one year is seen during this period. If there is no response during this period, the drug will probably be ineffective. It is a common problem with non-specialists handling such patients that an inadequate dose of drugs has been given.^{5,6,7}

Substances from lifestyle habits-tobacco and caffeine^{8,9,10,11}
The point prevalence of tobacco smoking is 71% in male schizophrenics and 44% among female schizophrenics. Polycyclic hydrocarbons in cigarettes induce hepatic cytochrome P450 enzymes that metabolise haloperidol, olanzapine and clozapine, resulting in lower serum levels. Smokers therefore require a 50% increase in doses of these medications.



Schizophrenics consume more caffeine from beverages than the average person.

In North America, the amount is 500 versus 200 mg per day. Caffeine acts on adenosine receptors in the central nervous system to enhance dopamine neurotransmission. There is some evidence that caffeine increases positive symptoms and hostility in schizophrenics. Patients may also purposely increase their caffeine intake to alleviate their negative symptoms. Therefore caffeine intake should be reduced or controlled in the treatment of schizophrenic patients.

Substances of Abuse. In North America 50% of schizophrenics are drug abusers.

Drugs like cocaine, cannabis and methamphetamine can induce and maintain schizophrenic symptoms, giving a picture of treatment resistance. Chronic excessive use of alcohol is also a problem. Drug abusers are less compliant to treatment regimes.¹²⁻¹⁴

Prescribed drugs Omeprazole, rifampicin, ritonavir, carbamazepine and phenytoin induce CYP1A2 activity and patients require a 50% higher dose of olanzapine and clozapine. Rifampicin, carbamazepine and phenytoin induce CYP3A. Quetiapine needs to be increased 5 fold, risperidone and aripiprazole 2 fold and ziprasidone by 50% when co-administered with these drugs. Oxcarbazepine, topiramate and St. John's Wort are also enzyme inducers.^{15,16}

Drugs like selective serotonin reuptake inhibitors inhibit cytochrome P450 enzymes.

When these drugs are withdrawn, there is increased activity of the enzymes with enhanced degradation of antipsychotic drugs. This may result in emergence of psychotic symptoms that have been under control.¹⁷

Genetic polymorphism. Certain population groups have a greater incidence of duplication in the CYP2D6 genes. This enzyme is important in the elimination of haloperidol, zuclopenthixol, risperidone, thioridazine and perphenazine. Patients with a double dose of the gene are rapid metabolisers of the drugs concerned. This occurs in 3% of white northern Europeans, 10% of white southern Europeans, 16% of Saudi Arabians and 29% of Ethiopians. Such patients are more prone to relapses and multiple hospitalisation. Hence blood level monitoring and genotyping may be necessary when dealing with this group of patients.¹⁸⁻²¹

Pharmacological Strategies in dealing with treatment resistance. If a patient has not responded to a first generation antipsychotic drug, a trial of another first generation drug would not be useful. A first line atypical drug should be started. About 50% of patients respond well. Should this fail, the option is to go on to another first line atypical drug, or to start clozapine. The choice to take will depend on the actual clinical situation and the patient's preference. For example, if weight gain is a problem with olanzapine, then risperidone may be used instead. If there is significant extrapyramidal symptoms, quetiapine may be an alternative. Patients may not wish to have clozapine due to the need to have frequent blood tests.

Clozapine is the gold standard for treatment of resistant schizophrenia. It is particularly useful in cases with persistent auditory hallucination, suicidal risk, tardive dyskinesia and hostility. An adequate serum level of more than 250 ng/ml must be ensured, especially in cases that do not seem to respond adequately. Monitoring for agranulocytosis, lipid disturbance, seizure and other side effects is required.^{22, 23}

Pharmacological augmentation Antipsychotic drugs are dopamine receptor blockers. Drugs that act on a different receptor system may be tried in augmentation therapy. Lamotrigine affects glutamate neurotransmission and had been used with some success in treatment of resistant schizophrenia. It may be used with first or second generation antipsychotic drugs. The control of positive symptoms is improved with the addition of Lamotrigine.^{24, 25}

Valproate acts on GABA receptors and indirectly modulates dopamine activity in the brain. The addition of valproate had been found to reduce agitation and hostility in schizophrenic patients.^{26, 27}

The omega-3 polyunsaturated fatty acid EPA is found to have some short term benefits in cases with residual symptoms. The dose is 2-3 gm daily.^{28, 29}

Non-pharmacological strategies. Counselling, psychological support, education, removal of psychological stress and social rehabilitation are always important measures in treating schizophrenic patients. This is more so in cases of resistant schizophrenia. A specific cognitive behaviour technique has been developed for use in schizophrenic patients with positive results.³⁰

Electroconvulsive therapy has been used in cases of resistant schizophrenia. Benefits are observed in some cases although systematic study of its application in resistant schizophrenia is lacking.³¹

Repetitive transcranial magnetic stimulation involves daily application of a magnetic field to the temporoparietal region for 10-14 days. Each session lasts 20 minutes. Patients do not require sedation or hospitalisation. It is found to reduce symptoms in patients with treatment resistant auditory hallucination. Further evaluation of this procedure is required.³²

Adapted from: H.A.Nasrallah and R.F.White

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HKABAC-000006



Early Detection and Intervention of Dementia

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Introduction

Dementia implies a decline in general cognitive function and interferes with many aspects of one's life. In a recent survey, it was estimated that more than 17% of the population aged over 70 in Hong Kong suffered from mild or very mild dementia.¹ Their prevalence increases with age. As the Hong Kong population is rapidly aging,² it is anticipated that the problems related to dementia are escalating rapidly. The impact of dementia on the daily living of patients and their carers can be paramount. There are numerous causes of dementia or cognitive impairment. Early detection and intervention of dementia can allow necessary investigations to be initiated. Reversible causes may be identified and treated earlier. Further significant deterioration may be prevented. Early diagnosis can also facilitate more proactive planning of the patients and their carers.

Clinical Diagnosis of Dementia

There is no single screening test for dementia. Clinical judgement is essential. ICD-10³ and DSM-IV⁴ are two sets of internationally accepted criteria. In ICD-10, dementia is described as a syndrome due to disease of the brain, usually of a chronic or progressive nature in which there is disturbance of multiple higher cortical function including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement. Consciousness is not clouded. The impairments of cognitive function are commonly accompanied, and occasionally preceded by deterioration in emotional controls, social behaviour or motivation. The DSM-IV definition has similar components, and emphasises on the necessity for a detrimental influence upon activities of daily living.

In Hong Kong, Alzheimer's disease (AD) and vascular dementia (VaD) are the two most common causes of dementia in the elderly population.⁵ In ICD-10, the criteria for AD can be summarised as: presence of a dementia; insidious onset with slow deterioration; absence of evidence that the cause may be due to another condition such as hypothyroidism; and absence of sudden onset or focal neurological signs. The key features of VaD are: a dementia resulting from vascular disease; uneven impairment of cognitive functions; abrupt onset or stepwise deterioration; focal neurological signs and symptoms; may coexist with AD. It should be noted that overlap of AD and VaD is

not uncommon. It has been shown that majority of people with AD have concomitant cerebrovascular pathology including a third who have cerebral infarction.⁶

Patients who present with Parkinson's disease may develop dementia. Dementia with Lewy Bodies (DLB) may also present with motor parkinsonism. For DLB, other typical features include fluctuating cognition with pronounced variations in attention and alertness and recurrent well formed visual hallucinations. DLB patients seem to be very sensitive to antipsychotic medications, which can considerably worsen parkinsonism symptoms and increase their risk of falls.

Particular attention should be paid that medical problems could affect cognitive function. Clarfield has reviewed 32 studies involving 2889 subjects and the commonest causes of "reversible or partially reversible dementia" are: drugs, depression, metabolic causes, thyroid disease, vitamin B12 deficiency, calcium disturbance, liver disease, normal pressure hydrocephalus, subdural haematoma, neoplasm.⁷ Some of these causes may be more amenable to treatment before dementia is established. People presenting with Mild Cognitive Impairment (MCI) should receive similar degree of medical assessment as those who present with dementia.

Mild Cognitive Impairment (MCI)

MCI refers to the clinical state in which a subject is cognitively impaired, usually in the memory domain, which is greater than that expected for an individual's age and education level but not demented.⁸ Typically, subjects are aware of their deficit but corroboration by an informant is usually useful. Being distinct from dementia, MCI does not interfere notably with activities of daily life.

MCI with memory complaints, which is classified as the amnesic subtypes of MCI, has been consistently shown to have a high risk of progression to dementia, particularly of AD. In a 3-year multi-centre randomised clinical trial, the rate of progression from amnesic MCI to AD was found to be 16% per year.⁹ While memory is the domain usually being affected, other cognitive domains, including language, attention/executive function, and visuospatial skills, may also be affected and should be evaluated.

The term MCI has been widely used in research studies.



However, it is controversial whether it should be used in clinical practice as a medical diagnosis. MCI seems to be an umbrella term including heterogeneous pre-dementia conditions. It is possible that persons with MCI may revert back to normal. On the other hand, it was argued that "patients with a mild cognitive impairment should be recognised and monitored for a cognitive and functional decline due to their increased risk for subsequent dementia."¹⁰

Clinical Assessment

The clinical assessment of suspected cognitive impairment in either MCI or dementia is similar. The history is the cornerstone of any assessment. Some patients may not have awareness of cognitive deficits or the high quality of information is limited by the cognitive impairment. The history should be verified by a reliable informant and supplementary information from other sources. The onset of AD is typically gradual and there is progressive decline. The onset of cognitive impairment in VaD can be sudden. A short history with fluctuation in consciousness level might suggest delirium, either as a primary cause or superimposed on a dementia.

The clinician should perform a mental state examination. The presence of features such as depression, hallucinations, delusions, paranoid ideations or misidentification phenomena should be assessed. For basic cognitive testing, the Cantonese version of Mini-Mental State Examination (MMSE) has been widely used in local clinical settings.^{11,12} It is useful in assessing and monitoring the change in general cognitive performance for local elderly persons. It is noteworthy that the performance in MMSE is shaped by education. Since many older people are illiterate, it is better to combine the MMSE score with reports from family members about cognitive and functional capacity for the assessment.

The general neurological examination should be done. Abnormalities such as parkinsonism, focal neurological deficits or deficits in other parts of the nervous system should be looked for. It is possible that patients with dementia will have concurrent medical illnesses. The symptoms may be masked. These medical illnesses may worsen the cognitive impairment and cause changes in behaviour. Possible illnesses include acute infections, electrolyte imbalance, metabolic imbalance and side effects of medications. The neurological examination should be complemented by a general medical examination and other investigations.

Various laboratory and radiological tests are useful in evaluating a patient who has cognitive impairment, which are outlined in Table 1. In selected cases testing for HIV should be considered. A urine culture may be important in some cases. These investigations may reveal potentially treatable causes of cognitive impairment. Impaired renal function or liver function tests may affect treatment decisions. Vascular risk factors, such as hypertension, diabetes, abnormal lipid profile, as revealed by the investigation need additional medical attention. The computed tomography or

resonance imaging of the brain can be used to look for structural lesions, such as stroke, neoplasm or subdural haematoma.

Patients with dementia may present with different kinds of risks. There are risks of harm to one's self or to others. These risks may be related to the presence of other psychiatric features, such as hallucination, delusion and depression. The patients may get lost in unsafe areas. Poor self care and judgement may cause risks to one's physical health and well being. Systematic evaluation of risks or risk assessment is valuable.

Management

There is no single recipe in management. The management plan depends on the results of the assessment and should address the needs of the patients. Some general approach may be still useful. After full assessment of the patient, it would be helpful to construct a problems list. These problems should be prioritized because it is unlikely that all problems can be tackled at once. It is also helpful to involve both the patient and his/her carer in the management plan. In complicated cases or cases with high risk, specialist care or input from a multidisciplinary team is necessary.

The causes of MCI or dementia are numerous. If a treatable cause is identified, it should be managed accordingly. However, it may not be possible at the initial assessment to determine whether delirium, depression or other treatable conditions is a primary diagnosis or a co-morbid condition. In either case, appropriate treatment should be initiated and the patient should be reassessed.

The risk of dementia has been shown to increase with vascular risk factors, in particular hypertension.¹³⁻¹⁷ Other important risk factors include diabetes mellitus,¹⁸ raised homocysteine,¹⁹ and smoking.²⁰ The vascular risk factors may increase the risk of both VaD and AD. Primary and secondary prevention of stroke appear to be useful in the prevention of dementia.²¹ Aspirin therapy can help to prevent further ischaemic damage in VaD. Treatment of hypertension, hyperlipidaemia, adequate control of diabetes and cessation of smoking are also useful.

Donepezil, rivastigmine, galantamine are the commonly used drugs in the symptomatic treatment of mild AD. They are cholinesterase inhibitors. Little evidence recommends one over the other. They appear to be effective in the treatment of AD over 6-12 months, improving their cognition, activities in daily living and global functioning. However, they do not appear to have a significant impact on the underlying pathological process of AD. As for the amnesic MCI, these drugs may have transient effects. A large trial showed that no significant differences in the probability of progression from amnesic MCI to AD in patients allocated vitamin E or donepezil, compared with placebo, during the 3 years of treatment.⁹ However, there was significant difference recorded favouring the donepezil group on various measures during the first 12 months of the study including delay of diagnosis of AD. Cholinesterase inhibitors have



been suggested to be used in managing other features of dementia. In DLB, the visual hallucinations are associated with greater deficits in cortical acetylcholine²² and may respond to cholinesterase inhibitors.²³

Caring for a person with a chronic mental condition is very stressful. The stress may be psychological, physical, financial or social. In the community, the burden of caring the patients often falls on one's spouse, who are themselves often elderly and frail. Education, support groups and provision of information alone may not be efficacious in reducing carer stress. Other psychosocial interventions, such as respite care, day care centres, home help services, residential care, financial support, individual counselling, family therapy, should be considered.

Conclusion

Dementia is an important clinical problem and should be intervened at an early stage. Early identification of dementia can facilitate detailed assessment, control of risk factors and initiation of treatment. Clinical assessment should include evaluation of cognitive functioning, risk assessment, and investigations of possible treatable causes. Proper involvement of patient and carer in the management plan can be important.

Table 1. Useful investigations for dementia or cognitive impairment

Blood investigations:

Complete blood count
Liver function test
Electrolytes, urea, creatinine, calcium
Thyroid function studies
Syphilis serology
Vitamin B12 level
Folate level
Blood glucose
Blood lipid profile

Electrocardiogram

Chest X-Ray

Non-contrast computed tomography or magnetic resonance imaging of brain

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Depression for General Practitioners

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Dr. Ka-hin Lau

Mental health nowadays is not just the work of psychiatrists or psychologists. Many people with depression are reluctant to see mental health professionals. Sometimes they attend their general practitioners but hide their depressive symptoms behind the commonly presented somatic complaints.

Depression is common and has many severity levels. The severe one is called Major Depression. There are more than 50% of the core features shown in the 9 key criteria for major depression. These nine features include:

1. Depressed mood
2. Lack of interest or pleasure in all, or almost, all activities
3. Insomnia or hypersomnia
4. Feelings of worthlessness or excessive guilt
5. Psychomotor agitation or retardation
6. Poor appetite or weight loss
7. Poor concentration
8. Fatigue or loss of energy
9. Suicidal idea or attempt

The features have regular strong appearance for at least 2 weeks and disturb the social and occupational life of the patient.

Minor depression has slightly less than 50% of the core features.

Long term lower level of depression is also very common. Dysthymic disorder is characterised by chronic depression, but with less severity than a major depression. The essential symptom for dysthymic disorder is an almost daily depressed mood for at least two years, but without the necessary criteria for a major depression. Low energy, sleep or appetite disturbances and low self-esteem are usually part of the clinical picture as well. The diagnostic criteria are as follows: On the majority of days for 2 years or more, the patient reports depressed mood or appears depressed to others for most of the day.

When depressed, the patient has 2 or more of:

1. Appetite decreased or increased
2. Sleep decreased or increased
3. Fatigue or low energy
4. Poor self-image
5. Reduced concentration or indecisiveness
6. Feels hopeless

During this 2 year period, the above symptoms are never absent longer than 2 consecutive months

ICD 10 diagnosis for dysthymia is even looser. It requires 4 out of 12 symptoms:

1. Energy decrease
2. Insomnia
3. Self confidence decrease
4. Difficulty in concentrating
5. Frequent Tearfulness
6. Loss of interest
7. Feeling of hopelessness
8. Inability to cope with the routine responsibilities of everyday life
9. Pessimism about the future or brooding over the past
10. Social withdrawal
11. Reduced talkativeness
12. Depressed mood

The Elderly are prone to dysthymia. In addition, elderly patients often show the below features. :

1. Persistently depressed mood
2. Anhedonia: loss of ability to enjoy usual pleasures
3. Loss of interest in usual activities
4. Decreased concentration, leading to short term memory impairment: "Depressive Pseudodementia"
5. Feelings of worthlessness and suicidal thoughts or actions
6. Psychomotor changes, agitation and irritability commoner than retardation
7. Psychotic symptoms, which are mood-congruent, including delusions and hallucinations
8. Somatic complaints: "masked depression"
9. Burden to family and society
10. Increased morbidity and mortality
11. Risk of suicide or physical harm to others

Depression can be presented with pure depressive symptoms but mixed emotional problems are common too. With stressful living common in Hong Kong as in many cosmopolitan cities, anxiety mixed with depression is common. Depression mixed with anxiety can be well controlled by treatment from general practitioners.

Depression can alternate with mania and can be more tricky in dealing with, requiring care in not shifting the depression pharmacologically into mania. The following is a comparison of the unipolar and bipolar depression.

Features	Unipolar Depression	Bipolar Depression
Age of onset	30-40	20
Gender	Mostly women	Equal
Genetics	High risk if parents and siblings are diagnosed	High risk for both types of depression
Motor activity when depressed	Agitated	Lethargic
Sleep	Less	More



Depression can affect children to the elderly. It is of grave concern as it can be closely linked with killing of one self, a type of premature death that is preventable and treatable.

Depression is a major burden in Hong Kong and over 1000 suicidal deaths are recorded every year for over a decade. The Elderly with depression have a higher suicidal rate than younger people.

How common is depression ?

Depression prevalence can be one in ten persons. It is of social concern because of the high frequency in the community. It is more common in females than males. It is a social problem aspect as well as a personal problem aspect. The sick person might not have done anything wrong to cause the illness.

While psychiatrists frequently dealt with major depression and in-patient treatment, it is just the tip of the depression iceberg. Depressive reaction to lost events are very common. Depression can also worsen the presentation and prognosis of physical illnesses.

Aetiology of depression:

The aetiology of depression is linked with stress and losses. Genetic contribution is also important and depression can run in the family. In depression, the brain serotonin and noradrenalin metabolism are frequently disturbed. The neuroendocrine changes are dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis.

With antidepressant drug treatment aiming at the correction of neurotransmitter disturbance, we hope to improve the emotional and behavioural functioning of our clients. The depressed elderly are more prone to develop dementia later in the course. There are structural changes with enlarged ventricles for some depressed patients.

Assess depression in relation to physical illnesses and suicidal risk?

Watch out for some physical illnesses closely linked with depression. These include:

- Endocrine/metabolic
 - Hypo/hyperthyroidism
 - Pernicious anaemia
 - Cushing's syndrome
- Organic brain diseases
 - Cerebrovascular disease
 - Parkinson's disease
 - Tumours
 - Alzheimer's disease
- Chronic infections
 - Brucellosis
 - Neurosyphilis
 - AIDS
- Occult carcinoma
 - Pancreas
 - Lung

- Some drug treatment can cause secondary depression:
 - Centrally acting antihypertensive drugs, e.g. methyl dopa
 - Steroids
 - Analgesics
 - Anti-parkinsonism drugs
 - Psychotropic drugs
 - Miscellaneous, e.g. sulphonamides

It is important to assess the risk of suicide of a patient. We can use the "SAD PERSONS" to help us:

Assessment	Patients with the following factors having higher risk of suicide
S Sex	Male
A Age	Younger than 19 or the elderly
D Depression	Depressive disorder
P Previous suicidal attempt	History of suicidal attempt
E Ethanol or drug abuse	Substance abuse
R Rational thinking impaired	Irrational thinking or psychotic
S Social support	Lack of social support
O Organised plan	Well-organised suicidal plan
N No spouse	Widowed
S Sickness	Physical illness, esp., chronic, severe or debilitating

To effectively prevent suicide, we should avoid leaving the depressed patient into a helpless and hopeless position. Seriously suicidal patients need to be watched over until the risk subsides.

The steps in the treatment of depression involve taking a history and doing a mental state examination. A basic physical examination should be performed such as blood pressure, pulse and ECG. Modern antidepressants have better side effects and cardiac safety profiles than the first generation tricyclic agents which are now rarely prescribed.

How to treat depressed patients?

Different people might require different drugs. The aim of pharmacotherapy for depression is to start low, go slow, reach there and stay there especially for elderly patients. Many modern medications are simple and often without need for titration. Patience is required as therapeutic effects might take 2 to 4 weeks to appear. Suitable nocturnal sedation is required for some patients especially those on Selective Serotonin Reuptake Inhibitors (SSRI).

Psychosocial counselling and support are helpful additions to drug treatment which puts the patient in a better performing platform for interaction with others.

Irrational beliefs like the ones listed below can be challenged if the patient is ready for that and in the communication mode:

1. It is of the utmost importance that an individual is loved or approved of by almost every other important person in his or her social world.
2. I must be competent and successful in just about everything I do if I am to consider myself worthwhile.
3. Some people are evil and wicked and should be severely punished for their behaviour.
4. It is dire devastating and catastrophic when things are not how I want them to be.



5. People have little or no control over their lot in life and happiness is caused externally.
6. One should be concerned about and keep dwelling on the possibility of something frightening and dangerous happening.
7. It is hard to face up to certain problems and responsibilities and much easier to avoid them instead.
8. I should depend on other people and need to rely on someone who is stronger.
9. My past history is the most important thing in determining my present behaviour. Just because something in the past had a devastating effect. It will always have the same effect.
10. It is my responsibility to be very upset about the problems of other people.

Electroconvulsive therapy (ECT) is effective but decreasingly performed with success of modern drug treatment for depression. An anaesthetist is involved for general anaesthesia although the procedure is safe with no long term side effects. ECT can help up to 80 % of depressed patients returning to health.

Apart from drug treatment and psychotherapy, patients should be helped to feel at ease and have undertaking which help to promote self esteem and community living and adaptation

Active problem solving would relieve the patients some difficulties and maintain the task solving ability of the patient.

Effective monitoring of the mood through the visual analogue scale or Geriatric Depression Scale (GDS) is helpful. GDS is a 15-question assessment scale with 7 as the cut off point for depression.

Last but not least, learn what is important for mental health and prevention of depression.

Protective factors for depression include:

- Medical/Physical
 - Optimising physical health
 - Correcting physical deficits e.g. hearing loss
 - Good nutrition
- Coping behaviour
 - Adaptive, integrated personality
 - Capacity for confiding relationships
 - Active coping style
- Social supports
 - Adequate social network
 - Tangible social support
 - Positive perceptions of support
 - Confiding relationships
 - Religious/spiritual beliefs

Diploma in Child Health Examination (DCH) 2008

The Hong Kong College of Paediatricians (HKCPaed) and the Royal College of Paediatrics and Child Health (RCPCH) will hold a Joint Diploma in Child Health Examination in Hong Kong in 2008 awarding DCH (HK) and DCH (International) to successful candidates.

The Examination is divided into two parts, Written (MRCPCH Pt IA) and Clinical. The MRCPCH Part 1A Examination is held three times a year in Hong Kong. The next MRCPCH Part 1A Examination will be held on **Tuesday, 13 May 2008**. The examination fee is **HK\$4,080** for Part IA. Candidates who wish to enter the examination must hold a recognized medical qualification.

Application: Candidates who wish to sit the examination in Hong Kong **MUST** apply through the Hong Kong College of Paediatricians (HKCPaed). For application details, please visit the HKCPaed website at www.paediatrician.org.hk/entcnews.htm or call the College Secretariat at 28718871.

Deadline for Application: Monday, 18 February 2008

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New Clinical Examination for DCH from March 2006

A new format of the DCH clinical examination has been adopted since March 2006. Details of the new format and other relevant information can be viewed on the RCPCH website at: www.rcpch.ac.uk



Abstracts from the Hong Kong Society of Biological Psychiatry Conference, 18-20 October 2007

Hippocampal Pathology in Schizophrenia: Disturbed Synaptogenesis, Neurogenesis or What Else?

Volume reduction of the hippocampus is quite prevalent in schizophrenia and can be found in the different stages of the illness. Metaanalyses demonstrate a bilateral 6% volume reduction in chronic schizophrenia. Although this volume decrease is accompanied by clinically relevant deficits in episodic memory, the underlying mechanism still are unclear. In a recent study examining the hippocampus volume in families uni- and multiply affected with schizophrenia a bilateral decrease was shown in family members suffering from schizophrenia and to a lesser extent in their first degree relatives. Interestingly the biggest effect was due to the at-risk-haplotype of Neuregulin-1, while obstetric complications formed an additional independent risk factor.

Using stereology we have examined which cellular compartment is involved in the volume reduction revealed in the hippocampus of schizophrenics. Preliminary results on 10 patients with schizophrenia and 10 control subjects post mortem we could see a significant decrease of the macroneurons in the subiculum and an overall reduction of the volume of the macroneurons in all subsegments of the hippocampus. Interestingly a circumscribed reduction of the number of oligodendocytes was revealed while sparing astrocytes and interneurons. The findings could indicate a disturbance of micro- and macroconnectivity in the hippocampus of schizophrenia.

Finally I would like to mention the study where we examined the influence of exercise on psychopathology, cognition and brain structure in schizophrenia. We found a marked volume increase of the hippocampus bilaterally in controls as well as schizophrenia patients performing defined exercise over three months. In comparison to that, patients with schizophrenia performing a control condition over the same period of time showed a significant worsening of the psychopathology, no improvement of cognition and no increase of the hippocampal volumes.

In summary there is increasing evidence that disturbed synaptic and possibly mechanisms of neurogenesis underlie the pathophysiology seen in the limbic system in schizophrenia.

Acknowledgement, The Hong Kong Society of Biological Psychiatry.

Antipsychotics: Which Neurotransmitters to Tackle?

Coincidental clinical observations with drugs that could alleviate or elicit symptoms of schizophrenia, have led to hypotheses on possible involvement of defective signaling of three different neurotransmitter systems in schizophrenia: dopamine, 5-hydroxytryptamine (5HT) and glutamate.

The first generation of antipsychotic drugs was discovered and developed based on the dopamine hypothesis. Research with these drugs showed that blockade of dopamine-D2 receptors could alleviate positive symptoms of schizophrenia. However, dopamine D2 receptor blockade also underlies potential side effects such as extrapyramidal symptoms and prolactin elevation. The discovery of 5HT2 receptors, later classified as 5HT2A receptors, and the study of the pharmacological and clinical properties of drugs that blocked these receptors, led to the second generation of so-called atypical antipsychotics; a right balance in blockade of 5HT2A and D2 receptors appeared to alleviate positive and negative symptoms of schizophrenia. However, atypical antipsychotics have broad pharmaceutical profiles and interact with various different neurotransmitter receptors, which more often leads to side effects rather than contributing a therapeutic benefit.

The observation that phencyclidine (also referred to as PCP), a glutamate-N-Methyl-D-Aspartate (NMDA) receptor blocker, can elicit positive and negative symptoms of schizophrenia, underlies the glutamate hypothesis and possible defective NMDA receptor signaling in schizophrenia.

Today several receptor subtypes for each of the above neurotransmitter have been identified and ample knowledge has been acquired about the signaling and regulation of the various receptors.

Five dopamine receptors, thirteen 5HT, three major classes of ionotropic glutamate receptors and eight metabotropic glutamate receptors are known.

Several of these receptors are being investigated as possible targets for drugs that can treat symptoms of schizophrenia, including positive, negative and cognitive symptoms. Various ways of modulating receptor signaling are being studied with compounds that act as antagonist, inverse agonist, full or partial agonist, positive or negative allosteric modulator at the



receptors or with compounds that inhibit intra-cellular enzymes involved in second messenger formation or breakdown. The lecture will address nowadays research along these lines.

Acknowledgement, The Hong Kong Society of Biological Psychiatry.

New Approaches to the Development of Antidepressants

It is generally assumed that all effective antidepressants enhance monoaminergic function in some way. Despite this belief, the mode of action of antidepressants remains an enigma. The disparity between the acute effects of antidepressants and the delay in their therapeutic action has long been recognised. The observation that the adaptive changes in post synaptic monoaminergic receptors approximately coincides with the onset of their therapeutic action has led to a change in emphasis from the pre-synaptic to the post-synaptic intracellular changes. This has resulted in the molecular hypothesis of antidepressant action that postulates that adverse environmental conditions, acting on genetic vulnerability, cause maladaptive changes in neuronal networks. Effective antidepressant treatment normalises the functioning of these networks, possibly by increasing neurotrophic factor synthesis and enhancing neurogenesis.

This new hypothesis, linking depression to malfunctioning neural networks, has stimulated novel approaches to antidepressant development. For example, the S100 beta peptide is known to be important in neurogenesis. It is linked to the 5HT 1B receptor via the p11 peptide. The p11 peptide has been shown to be reduced in post mortem brains from depressed patients; chronic antidepressant treatments, and ECT, increase the synthesis of this peptide and reverses depressive-like behaviour in rodent models of depression. This could provide a starting point for the development of new classes of antidepressants. A disruption of the circadian rhythm is a characteristic feature of depression. This has stimulated the development of agomelatin, a melatonin-1 receptor agonist and a 5HT_{2C} antagonist. While the effects on the circadian rhythm may be of importance, it would

appear that the reduction in the 5HT_{2C} receptor function may be the main explanation for its antidepressant action. There are several non-monoaminergic approaches that are receiving attention. Several tachykinin receptor antagonists have been developed. These drugs would appear to indirectly enhance serotonergic function. A more novel approach involves antagonists of the NMDA glutamate receptors. These drugs have been shown to have antidepressant activity in experimental models of depression, possibly by blocking the neurodegenerative changes in the hippocampus caused by environmental stress. The novel sigma receptor antagonist, igmesine, that exhibits antidepressant activity, may block these neurodegenerative changes by blocking the action of glycine on the NMDA receptor complex. Other amino acid receptor targets include antagonists of the G-protein coupled GABA-B receptors.

The HPA axis has become an important target for antidepressant action due to the key role that stress plays in the pathology of depression. Some success has been obtained in the development of glucocorticoid type 2 receptor antagonists such as mifepristone. In addition, centrally acting anti-inflammatory drugs such as celecoxib have been shown to enhance antidepressant response in depressed patients who fail to show an optimal response to a conventional antidepressant. As there is now substantial evidence to show that low grade inflammatory drugs play an important role in the pathology of depression, it is postulated that centrally acting anti-inflammatory drugs may have antidepressant properties in their own right.

Other more molecular approaches that could lead to novel antidepressant targets include drugs that act on mitogen activated protein kinase (MAP-kinase). This enzyme stimulates the synthesis of brain derived neurotrophic factor, a key neurotrophic factor involved in the repair of damaged neurons.

Whether any of these approaches will result in new and more effective antidepressants only the future will tell!

Acknowledgement, The Hong Kong Society of Biological Psychiatry.

恭喜發財
新年進步



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





Bulgari Resort, Bali

Ms. Annie Lam



Ms. Annie Lam

Villa 65 is just a hop away!

A direct airlight of about four and a half hours will deport a toiled mortal of a concrete jungle like Hong Kong to this heavenly paradise on earth. Came out of the stuffy, noisy airport of Bali, I was met by a uniformed hotel receptionist holding the usual white paper card bearing my name. Polite and smiling, he took my luggage, albeit only 2 small pieces, and led me to a brand new S350 Mercedes Benz. The half-hour drive following was enjoyable, with introductions and explanations of the latest developments of this popular tourist city. The car then veered into a private driveway to stop at a temple-like structure. One then went through security checks like putting undercar reflectors, and sniffing by the police dogs, which could be quite scary the moment when the guard opened the car door.

Situated near the cliff-top of the Pura Luhur Uluwatu Temple and the village of Pecatu on the southern tip of the island, and positioned 150 metres above the seashore, the resort property offers views across the Indian Ocean. The reception hall is constructed like a worship temple. Entrance steps are made of granite. All guests were offered with glasses of cool fruity drinks adorned with white orchids.



Designed by architects Antonio & Partners, this 59-villa resort reflects a contemporary interpretation of traditional Balinese design intertwined with the distinctive Bulgari Italian style. The resort opened in October 2006, so it was barely 5 months old when Paul and I visited in February 2007. The entire resort was furnished using hand-cut volcanic stones, rich exotic wood and refined fabrics. Natural lava, pallimanan stones and numerous other types of stones and

hardwoods, the origins of which unknown to me, were used to decorate the gardens, interior walls, outdoor showers and swimming pools. The guests commute by golf-cars among these 59 villas, the restaurants, the spa and the main reception area. You do not have to wait for more than 2 minutes to get the golf car. Our villa is No. 65. The resort has skipped some unlucky numbers and started at No. 10.



The villa doors, in traditional Balinese style, are double-folded and open to a small pebbled courtyard leading to a large open but covered pavilion lounge furnished with wooden dining table and chairs, sideboards and sofas. It continues to open out to a roofless terrace with views of the ocean, equipped with 2 deck-chairs, a small plunge pool---for dipping your dainty little feet---and some green shrubs. The first impression instantly delivered a sense of serenity, brightness and openness to the residents.

The bedroom is divided into two parts, one of the bedroom proper, and the other the shower/bath part. The bedroom proper, with floor-to-ceiling windows, benefits from views across the terrace and the ocean. The bed linens and the mattress are among the most comfortable ones I have experienced. Separate wardrobe closets for ladies and gentlemen are behind the bed separated by a wall, with lots of storage space and drawers enough for a family of four. The floors are made of long mahogany hardwood. I was told that the B & O Audio/Video equipment was the first one ever used by any hotel/resort in Bali.

The bathroom, including the shower area and toilet, boasts a net area of about 800 sq. feet, large enough to be a good-sized apartment in Hong Kong. It features



again floor-to-ceiling windows, and is enclosed by a private courtyard garden. The bath-tub is made of some unknown precious volcanic stone and is situated right at the centre of the room. There are lots of space to move around. In fact, too much. I found it a bit tiring having to go from the dressing table at one corner to fetch a piece of towel on the towel-rack at the other, and then back. It was enough morning exercise for me. The amenities provided are of course of Bulgari, of "au thé vert" flavour (green tea).



"Ding-dong, ding-dong"..... I have to rush from the dressing area to open the heavy double-door of the villa, across the slippery hardwood floor, turning small corners and stepping down to the small pebbled courtyard---mind you, it's no small feat for a Hong Kong tai-tai living in this 3500 sq. ft. house who would definitely have the maid to answer the door----just to be met with the butler in charge of my villa, beaming with a friendly smile, bearing a dish filled with my favourite sweet snacks, "Klepon", a green glutinous triangle-shaped sweets with brown sugar juice inside. Specially made for Villa 65! I have 12 of them at one time, 2 times a day. No ladies eat that many, so not so many made in stock.

The private beach is long, pristine, and very, very quiet. Because the resort is situated on a 150-meter plateau, it has to be reached by a small glass cyber-like inclined elevator descending from the cliff to the beach. There is a small, yet simple, private Beach Club. The resort's landscape is featured by walls in butik stone, a white coral stone, obtained from the promontory. To the visitor, the view is very much like one of a medieval fortress, closed with its walls and unexpectedly tucked away in the tropical vegetation of the private gardens.

There are 2 restaurants and one bar. "Sangkar" offers fusion Indonesian cuisine, and "Il Ristorante" Italian cuisine. "The Bar" is near the infinity swimming pool. I was a bit disappointed with Sangkar, its menu being limited, and the standard of cooking just ordinary. I did not have better luck with "Il Ristorante". Because of the altitude, water pressure was not enough on the night we were there. Some parts of the connecting water pipes were broken. The restaurant did not have enough water and I had to wait for quite a long while before even getting to place orders. Too many guests were placing orders at the same time. It went without saying that on that afternoon as well, there was no water supply in the villa.

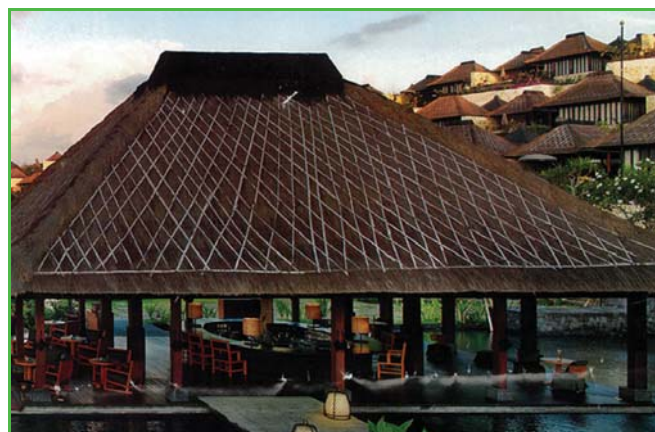


To do spa is the soul of going to a resort nowadays. I am not much of a fan but not to be out-fashioned, I duly made my appointment, chose the desired massage, and headed to the spa pavilion. Compared with the other 5 or 6-star hotels, I would rate it as average. There was not much worth mentioning, except that after the spa, you were led to a covered terrace facing a small oblong pool, looking onwards to the ubiquitous Indian Ocean. Lazing half shaded, half in the sun, I slowly sipped some herbal tea, tasted some Vietnamese dim-sums, and that completed my spa ritual.

As to the swimming pool, again it is standard of any 5-star resorts. Infinity pool, with five to six cabanas on the side, facing the Indian Ocean of course. Nice and quiet for spending an afternoon or two to finish your favourite readings.

I should remind all potential guests to bring your own high-powered torches if you contemplate to go to this resort. I have made complaints to the management that the lightings were so dim that anybody would have fallen upon the many stoney staircases, pebbled walks and dark grasslands. So, all ye hold tight!

Staying in a Bulgari hotel/resort underlines the spirit and prestige of Bulgari all over the world. This designer resort takes artistic pride in having the opportunity to better serve their clientele with a lifestyle experience that associates with the quality of the brand which it has established over the years. It wants to combine impeccable service, exclusive location and contemporary style into one. Of course it has to be pricey---at around HK\$9,600 per night. Once in a while, it is nice to be extravagant.





Dermatological Quiz

Dr. Ka-ho Lau

MBBS(HK), FRCP(Glasg), FHKCP, FHKAM(Med)
Yaumatei Dermatology Clinic, Social Hygiene Service



Dr. Ka-ho Lau



Fig 2a: Lesions in the eyelid, face and the neck



Fig 2b: Close up view of lesions in the neck

This 18-year-old man who had longstanding history of itchy skin problem since early childhood suddenly developed this painful rash on his face, neck and upper trunk for two days. Associated with the rash, he felt generally unwell and feverish. He consulted his family physician and was given topical steroid cream with no improvement.

Questions:

1. What is your diagnosis?
2. How can you confirm your clinical diagnosis quickly by a simple bedside testing?
3. How will you manage this patient?

(See P. 34 for answers)



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The Chinese University of Hong Kong

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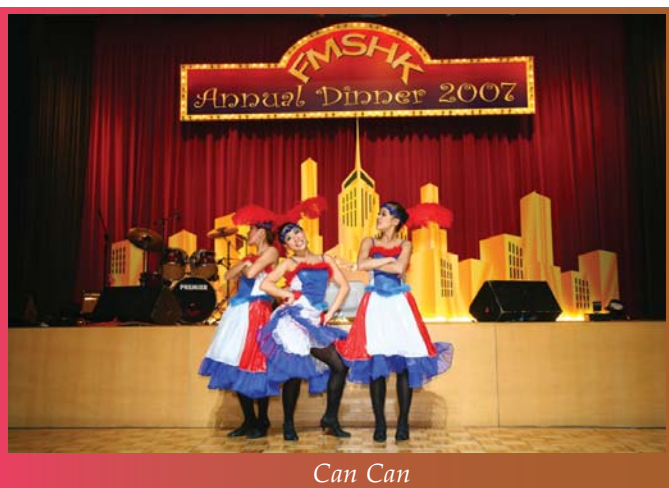
The Federation Annual Dinner 2007 - New Year's Eve on Broadway

The Federation Annual Dinner 2007 was held on 31 December 2007 at the Hong Kong Academy of Medicine Jockey Club Building. The night was filled with lively entertainment of Broadway songs, grand dancing performance, live-band singing and social dance. Special musical notes on "Memory", "Sound of Music", "The Prayer" and etc brought more than 260 participants to various Broadway shows and led them to the count-down for Year 2008. The Annual Dinner marked a wonderful start of the New Year, especially for more than 60 lucky guests who won great prizes, such as golf sets, luxury watches and gold coins in the raffle and lucky draws.

Please visit our homepage www.fmshk.org to recall the atmosphere of the night.



Chorus Line



Can Can



From left to right: Dr. Mok Chun-on, Ms. Tina Yap, Dr. Philip Lee, Dr. Raymond Lo, Dr. Susanna Lo, Dr. Chan Chok-wan, Dr. Dawson Fong (President, FMShK), Prof. Grace Tang, Dr. Luk Kwok-fai, Dr. the Hon. Joseph Lee, Mr. Nelson Lam, Mr. Benjamin Lee, Dr. Chan Chi-kuen, Dr. Man Chi-wai, Dr. Chan Sai-kwing (Ball Chairman)



Society News

News from Member Societies:

Hong Kong College of Radiologists

Updated office-bearers for the year 2007-2008 are as follows: President: Dr. Lilian LEONG, Secretary: Prof. Jonathan S.T. SHAM, Treasurer: Dr. Cheuk-man TONG

Hong Kong Physiotherapy Association Ltd

Updated office-bearers for the year 2007-2008 are as follows: President: Ms. LAU Mo Yee, Polly; Honorary Secretary: Ms. LEUNG Ka Po, Andrea; Honorary Treasurer: Mr. CHAN Chi Ming, Andy

The College of Dental Surgeons of Hong Kong

Updated office-bearers for the year 2007-2008 are as follows: President: Dr. LING Yu Kong, John; Honorary Secretary: Dr. CHAN Sai Kwing; Hon Treasurer: Dr. TSANG Chee Ching, Alfred



The College of Nursing, Hong Kong

The College of Nursing, Hong Kong (the College), began as the Hong Kong Nurses Association in 1964, is an organization of nurses committed to professional excellence in nursing for the benefit of health of the community. The College has become a member of the International Council of Nurses (ICN) since 1965. Our membership of ICN permits us to send delegates to the International Council through which we contribute to the international affairs of the profession. Besides, the College is working closely with our neighbouring areas to promote professional exchange. Locally, the College has made efforts to provide continual education for registered and enrolled nurses over the years by offering refresher courses, management and clinical courses, seminars, conferences, study days and workshops. To extend the educational dimension, we also publish the Hong Kong Nursing Journal.



Council members & College members participated in the ICN Conference at Yokohama, Japan on May 28 - 2 June 2007.

As an associate member of FMSHK, we look forward to working together for the health of Hong Kong community.

Hong Kong Society for Infectious Diseases



Dr. Lai Jak-yiu

The Hong Kong Society for Infectious Diseases was founded in December 1995 with the objectives to promote the advancement of the study of infectious diseases, and to keep the health-care profession and public well informed of the latest developments in the battle against infectious agents.

The Society has established her role in promoting the study of infectious diseases through organising scientific and educational programmes for the medical profession. These include annual scientific meetings, annual anti-infective forums, half-yearly seminars on infectious disease and certificate courses on infectious disease. The Society also collaborated with the Department of Health and newspaper media on public education programmes and produced public education booklets on travel health and infectious diseases.

The Society also disseminates knowledge of infectious diseases to medical professionals and the public through the website www.hksid.org. Apart from on-line publication of the Society Bulletin, our website can also link to Department of Health Hong Kong, World Health Organisation, Centers for Disease Control and Prevention of USA, Johns Hopkins Infectious Diseases, Johns Hopkins AIDS Service and many other useful sites for wider sources of information on infectious diseases.

Our Twelfth Annual Scientific Meeting will be held on 15 March 2008. Do visit our website at www.hksid.org for more details on our publications and activities.

Dr. Lai Jak-yiu
President

The Hong Kong Society for Infectious Diseases



The Hong Kong College of Family Physicians - Annual Scientific Meeting "Family Physicians and Our Community"

On behalf of the Annual Scientific Meeting Organising Committee, I am delighted to inform you that our College's Annual Scientific Meeting (ASM) 2008 will be held from 24 May 2008 to 25 May 2008. The venue of the meeting will be at the Hong Kong Academy of Medicine Jockey Club Building.

Since our establishment in 1977, our college has greatly influenced the growth and practice of many doctors working in the community. In order to further strengthen our field, ongoing improvements in teaching, training and research are essential. Without doubt the upcoming ASM 2008 will provide opportunities for family medicine and other specialty doctors, plus health care professional colleagues to share and learn new ideas, thus further promoting health in our community.

We now cordially invite you to submit abstracts for paper presentations and posters at ASM 2008. Instructions for abstract submission, registration form and the tentative programme are available at our College's website (<http://www.hkcfp.org.hk>). Full papers submitted before the deadline will automatically be competing for the 'Best research', the 'Best trainee submission' and the 'Best innovation' awards. I look forward to meeting you at ASM 2008 and the fellowship conferment ceremony.

Dr. Winnie W. Y. Chan
Chairlady
ASM Organising Committee



Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1	2 ★ Refresher Course for Health Care Providers 2007/2008 (VI) - Dermatological Emergencies
3 ★ HKMA Structured CME Programme at Queen Elizabeth Hospital Year 07/08 (XI) - Dermatology	4 ★ When Should We Take an Infected Kidney Out?	5 ★ FMSHK Officers' Meeting	6	7	8	9
10	11	12 ★ HKMA Newsletter Editorial Meeting	13 ★ Hong Kong Neurosurgical Society Monthly Academic Meeting - Special Lecture: Update on Intervention for Cerebrovascular Diseases	14 ★ HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2008 (II) ★ Kidney Disease Management Course 2008 (IV) ★ HKMA Council Meeting	15	16
17	18	19	20	21 ★ Kidney Disease Management Course 2008 (V) ★ FMSHK Executive Committee Meeting & Council Meeting	22	23
24 ★ HKMA Structured CME Programme at Kwong Wah Hospital Year 07/08 (XI) - Orthopaedics & Traumatology	15	26	27	28 ★ Kidney Disease Management Course 2008 (VI)	29	



Date / Time	Function	Enquiry / Remarks
2 SAT 2:30 pm	Refresher Course for Health Care Providers 2007/2008 (VI) - Dermatological Emergencies Organised by: The Hong Kong Medical Association & Our Lady of Maryknoll Hospital Speaker: Dr. M.C. WONG # Training Room II, 1/F., OPD Block, Our Lady of Maryknoll Hospital, 118 Shatin Pass Road, Wong Tai Sin, Kowloon, Hong Kong	Ms. Clara TSANG Tel: 2354 2440 2 CME Points
3 SUN 2:00 pm	HKMA Structured CME Programme at Queen Elizabeth Hospital Year 07/08 (XI) - Dermatology Organised by: The Hong Kong Medical Association & Queen Elizabeth Hospital Speaker: Dr. T.S. CHEUNG # Lecture Theatre, G/F., Block M, Queen Elizabeth Hospital, Kowloon	Miss Viviane LAM Tel: 2527 8452 (Registration Fee is required) 3 CME Points
4 MON 7:30 pm - 8:30 pm	When Should We Take an Infected Kidney Out? Organised by: Hong Kong Urological Association Chairman: Dr. LAM Kin Man Speaker: Dr. YU Cheong # Seminar Room, G/F, Block A, Queen Elizabeth Hospital, Kowloon	Dr. CHAN Kwok Keung Sammy / Ms. Siddy MA Tel: 2958 6006 Fax: 2958 6076 1 CME Point
5 TUE 8:00 pm - 10:00 pm	FMSHK Officers' Meeting Organised by: The Federation of Medical Societies of Hong Kong # Gallop, 2/F., Hong Kong Jockey Club Club House, Shan Kwong Road, Happy Valley, Hong Kong	Secretariat Tel: 2527 8898 Fax: 2865 0345
12 TUE 8:00 pm	HKMA Newsletter Editorial Meeting Organised by: The Hong Kong Medical Association Chairman: Dr. H.H. TSE # HKMA Head Office, 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Tammy TAM Tel: 2527 8941
13 WED 7:30 am	Hong Kong Neurosurgical Society Monthly Academic Meeting - Special Lecture: Update on Endovascular Intervention for Cerebrovascular Diseases Organised by: Hong Kong Neurosurgical Society Speaker: Dr. Simon YU & Dr. John KWOK # Seminar Room, G/F., Block A, Queen Elizabeth Hospital, Kowloon	Dr. Y.C. PO Tel: 2990 3788 Fax: 2990 3789 2 CME Points
14 THU 2:00 pm 2:00 pm 8:00 pm	HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital Year 2008 (II) Organised by: The Hong Kong Medical Association & Hong Kong Sanatorium & Hospital Speaker: Dr. W.T. SIU # HKMA Dr. Li Shu Pui Professional Education Centre, 2/F., Chinese Club Building, 21-22 Connaught Road Central, Hong Kong Kidney Disease Management Course 2008 (IV) Organised by: The Hong Kong Medical Association Speaker: Dr. C.P. HO & Dr. K.M. WONG # Lecture Theatre, G/F., Block M, Queen Elizabeth Hospital, Kowloon HKMA Council Meeting Organised by: The Hong Kong Medical Association Chairman: Dr. K CHOI # HKMA Head Office, 5/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Miss Viviane LAM Tel: 2527 8452 (Registration Fee is required) 1 CME Point Miss Gloria CHEUNG Tel: 2527 8941 (Registration Fee is required) 1.5 CME Points Ms. Christine WONG Tel: 2527 8285
21 THU 2:00 pm 7:00 pm - 10:00 pm	Kidney Disease Management Course 2008 (V) Organised by: The Hong Kong Medical Association Speaker: Dr. K.W. HO & Dr. Y.P. SIU # Lecture Theatre, G/F., Block M, Queen Elizabeth Hospital, Kowloon FMSHK Executive Committee Meeting & Council Meeting Organised by: The Federation of Medical Societies of Hong Kong # Council Chambers, 4/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Miss Gloria CHEUNG Tel: 2527 8941 (Registration Fee is required) 1.5 CME Points Secretariat Tel: 2527 8898 Fax: 2865 0345
24 SUN 2:00 pm	HKMA Structured CME Programme at Kwong Wah Hospital Year 07/08 (XI) - Orthopaedics & Traumatology Organised by: The Hong Kong Medical Association & Kwong Wah Hospital Speaker: Dr. K.K. WONG & Dr.W.K. HUI # Lecture Theatre, G/F., Block M, Queen Elizabeth Hospital, Kowloon	Miss Viviane LAM Tel: 2527 8452 (Registration Fee is required) 3 CME Points
28 THU 2:00 pm	Kidney Disease Management Course 2008 (VI) Organised by: The Hong Kong Medical Association Speaker: Dr. W.C. CHEUNG & Dr. C.P. HO # Lecture Theatre, G/F., Block M, Queen Elizabeth Hospital, Kowloon	Miss Gloria CHEUNG Tel: 2527 8941 (Registration Fee is required) 1.5 CME Points

Calendar of Events



Meetings

11-12/7/2008	Hong Kong Surgical Forum, Summer 2008 Organised by: Department of Surgery, Li Ka Shing Faculty of Medicine, University of Hong Kong Medical Centre; Queen Mary Hospital & Hong Kong Chapter of the American College of Surgeons # Underground Lecture Theatre, New Clinical Building, Queen Mary Hospital, Pokfulam, Hong Kong Enquiry: Forum Secretary Tel: 2855 4885 Fax: 2819 3416 Email: hksf@hkucc.hku.hk Website: http://www.hku.hk/surgery
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Courses

14,15,16/3/2008	Advanced Trauma Life Support (ATLS) Provider Course Organised by: Skills Development Centre, Department of Surgery, Li Ka Shing Faculty of Medicine, The University of Hong Kong & the American College of Surgeons, Hong Kong Chapter # Skills Development Centre, Department of Surgery, Li Ka Shing Faculty of Medicine, University of Hong Kong Medical Center, Queen Mary Hospital, Pokfulam, Hong Kong Enquiry: Program Manager Tel: (852) 2855 4885 / 2855 4886 Fax: (852) 2819 3416 E-mail: qmhsdc@hkucc.hku.hk Web site: http://www.hku.hk/surgery
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Courses

28/3/2008 5:30pm-8:30pm, 1-3/4/2008 6:30pm-9:30pm, 6/5/2008 6:30pm-7:30pm	Course on Nosocomial Infection and Control Measures in Hospital Organised by: Stanley Ho Centre for Emerging Infectious Diseases, School of Public Health, The Chinese University of Hong Kong # Prince of Wales Hospital, Shatin, N.T Tel: 2252 8812 Fax: 2635 4977 Email: ceid@med.cuhk.edu.hk Website: http://ceid.med.cuhk.edu.hk
8,15,22,29/4/2008, 13,20,27/5/2008, 3/6/2008 6:30pm-9:30pm 10/6/2008 6:30pm-8:30pm	Course on Common Viral Infections Organised by: Stanley Ho Centre of Emerging Infectious Diseases, School of Public Health and Department of Microbiology, The Chinese University of Hong Kong # Prince of Wales Hospital, Shatin Tel: 2252 8812 Fax: 2635 4977 Email: ceid@med.cuhk.edu.hk Website: http://ceid.med.cuhk.edu.hk
4/2008-6/2008	Course on Application of Geographic Information System (GIS) In Public Health Organised by: Stanley Ho Centre for Emerging Infectious Diseases, School of Public Health, The Chinese University of Hong Kong # Prince of Wales Hospital and CUHK Campus, Shatin, N.T Tel: 2252 8812 Fax: 2635 4977 Email: ceid@med.cuhk.edu.hk Website: http://ceid.med.cuhk.edu.hk
2,9,16,23,30/5/2008 6,13,20,27/6/2008 6:30pm to 9:30pm	Certificate Course in Ward Management - Module III: "Managing risk at workplace" (Code No. TC-WM-0107III) Organised by: College of Nursing, Hong Kong Enquiry: Secretariat Tel: 2572 9255 Fax: 2838 6280

Answer to Dermatological Quiz

Answer :

1. The correct diagnosis is eczema herpeticum. There are multiple widespread disseminated vesicles and erosions, many of which are scabbed, in a background of eczematous skin at the patient's face, periorbital area and neck. Together with the associated systemic upset and a history of longstanding itchy skin rash since childhood compatible with atopic eczema, the correct diagnosis of eczema herpeticum can be made clinically. Eczema herpeticum is a generalised cutaneous infection with herpes simplex virus (HSV) in individuals with predisposing skin diseases such as atopic eczema. It is accompanied by severe toxic symptoms and, if severe, may be fatal. The yellow crusted eroded area in the right side of the neck is due to superimposed staphylococcal infection. Differential diagnoses include widespread bullous impetigo, disseminated varicella zoster, bacterial folliculitis and contact dermatitis.
2. The clinical diagnosis can be confirmed with a Tzanck smear. Tzanck smear is a simple, quick yet reliable bedside method of confirming a herpetic infection. Smears from the base of the lesion stained with Giemsa, Wright or toluidine blue stain demonstrate multinucleated giant cells which are diagnostic of HSV infection. The positivity of the Tzanck smear is 67%, 55%, and 16.7% in vesicular, pustular or crusted lesions respectively. Viral culture, although takes longer time, generally has a higher yield of positive HSV. Electron microscopy, if available, may reveal herpesvirus-type particles.
3. Acyclovir (Zovirax) 200mg 5 times a day for 5 days, valacyclovir (Valtrex) 1000mg BD for 7 days, or famciclovir (Famvir) 250mg TDS for 7 days are the drugs of choice for eczema herpeticum. For severe episode, intravenous acyclovir 5mg/kg Q8H for 5 to 7 days can be given. Secondary impetiginisation with staphylococcal infection should also be treated with oral antibiotics such as cloxacillin.

Dr. Ka-ho Lau

MBBS(HK), FRCP(Glasg), FHKCP, FHKAM(Med)

CALL FOR SUBMISSION OF ARTICLES FOR PUBLICATION IN THE HONG KONG MEDICAL DIARY

The Editorial Board of the Hong Kong Medical Diary invites you to send in your interesting articles for publication in the Hong Kong Medical Diary (500 -1,500 words per article). Abstracts from recent local or international meetings/symposia are also welcome. You can send in your manuscript by facsimile at 2865 0345, through mail or via email at sue.cheng@fmshk.org. The Editorial Board of the Hong Kong Medical Diary will give you a prompt reply.



The Federation of Medical Societies of Hong Kong

Members' Benefits

Please be advised that the FMSHK Affinity Credit Card Programme with Fubon Bank (Hong Kong) Limited is terminating on 31 March 2008.

Before the Programme End Date, Fubon Bank will re-issue other Fubon credit card to existing FMSHK Visa Credit Card Cardholders in substitution of their FMSHK Visa Credit Cards, including both Principal Cards and Supplementary Cards.

Please contact our Secretariat at 2527 8898 or info@fmshk.org if you wish to obtain more information on the transition details.

We are pleased to announce a new benefit for our members. The Federation, in cooperation with Kingsway Concept Limited, will offer a discount on petrol and diesel purchases of HK\$0.9/litre from **Caltex, Shell, Esso and Sinopec** to members and their families of all Ordinary and Associate member societies under the Federation. Please contact our Secretariat at 2527 8898 and info@fmshk.org or Kingsway Concept Limited at 2541 1828 and kingswayconcept@yahoo.com for further details and terms for this offer.



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INSTRUCTIONS TO AUTHORS

ISSN 1812 - 1691

The Hong Kong Medical Diary is published monthly by the Federation of Medical Societies of Hong Kong (comprising of 71 ordinary, 51 associate and 1 student member.) The Federation of Medical Societies of Hong Kong was first established in 1965 and the Hong Kong medical Diary was first published in 1971. The HKMD has a circulation of 10,000 distributed to member societies, doctors, dentists, some nurses and allied health professionals. The HKMD is also available online to over 2,000 doctors / dentists at www.fmshk.org.

EDITORIAL POLICY

To improve the healthcare of our patients through the development and education of our members and the advancement of our specialty fields.

MANUSCRIPT GUIDELINES

Papers submitted for publication are subject to review and editing by the Editorial Board and should follow the following guidelines:

1. Typed on one side of numbered A4 size papers in double line spacing with 3cm margins, and preferably submitted in the form of word file (*send to info@fmshk.org*).
2. List of full names (both English and if Chinese applicable) of authors, giving a maximum of two qualifications and current appointment of each.
3. The principal author should give his or her address for correspondence. A passport size photo of the principal author(s) (*maximum of two photos*) can be supplied for publication.
4. Spelling should conform to the Oxford Dictionary. Abbreviation should be written in full when first used.
5. Both generic names and proprietary names of drugs may be used.
6. Tables and illustrations should be on separate sheets and clearly labelled.
7. Photographs should be labelled on the reverse. The Editorial Board reserves the right to print photos in black and white only. Colour illustrations or photos should be submitted in a CD-ROM.
8. References should conform to the Vancouver style and should be numbered in correct order in the text. Journal titles should be abbreviated to index medicus style.
(e.g. 1. Ahuja A, Ying M. *Sonography of neck Lymphnodes*. Clin Radiol 2003;58:359-366,
2. Van Hasselt CA, Leung S. F. *Clinical Picture*. In: Van Hasselt CA, (Gibb A. (eds) *Nasopharyngeal Carcinoma*. 2nd ed. Hong Kong The Chinese University Press; 1999:105-110).
9. Requests for reprints for a fee will be considered.
10. Correspondence should be addressed to the Editor, The Hong Kong Medical Diary, 4/F Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong. All manuscripts for publication on first of the month should reach the Editor before the 15th of the previous month.

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CATEGORIES OF ARTICLES

Medical Bulletin

Original research papers, recent advances, educational updates, review papers, discussion papers on medical topics relevant to medical practice are welcome. Articles should be between 800 and 2,400 words (one to three pages). References are encouraged but not required.

Drug Review

Articles on clinical approach to the safe use of a particular drug or groups of drugs are welcome. These articles should be from 800 to 1,600 words. (one to two pages).

Special Feature

Interviews with presidents of member societies and prominent members of the medical and health profession; publication of keynote addresses and presentations.

Clinical Quiz

Case studies in question and answer format in dermatology, radiology, medicine and surgery will be considered for publication. These articles should be under 500 words (one page).

Abstracts

Selected summaries and proceedings of local, regional and overseas medical meetings will be published.

Lifestyle

Interesting articles on hobbies, sports, travel, dining, movies, investments and careers are welcome. These articles should be kept under 1,600 words (two pages).

Society News

Brief reports on news of member societies, the HKFMS Foundation Limited and the Federation of Medical Societies of Hong Kong will be printed as a service to members.

Medical Diary of the month

Medical events of the month will be printed as a service to members (all should be submitted before the 10th of the previous month).

Calendar of Events

Future events including medical meetings, conferences and courses up to 24 months ahead will be printed as a service to members.



The Federation of Medical Societies of Hong Kong

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