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Emergency Medicine





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The Cover Shot



The Chosen Reflection

I had chosen a photo from my trip to Switzerland: the serene Kapellbrücke (Chapel Bridge), captured on a glorious day on 9th June 2023.

The image was more than just a snapshot; it held memories of a day bathed in soft sunlight. The sky was brilliant blue, and the scene was enriched by the delicate reflection of the Bridge shimmering on the water's surface. The reflection created a sense of duality, as if both the bridge and its reflection were engaging in a quiet conversation between reality and illusion. The tranquil moment reminded me of the beauty in resilience and hope. Each time I looked at this photo, I would be reminded of that tranquil moment.



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Strengthening the Chain of Survival - A Call to Action for the Hong Kong Medical Community

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Co-editors

The landscape of Emergency Medicine (EM) in Hong Kong has shifted from a model of rapid triage to one of high-precision stabilisation and specialisation. This issue of *the Hong Kong Medical Diary* highlights the clinical sophistication now inherent in the speciality, ranging from advanced bedside diagnostics to specialised sports medicine. However, it also highlights a critical public health challenge: the management of Out-of-Hospital Cardiac Arrest (OHCA).

THE RESUSITATION GAP: A SYSTEMIC CHALLENGE

Dr Sam Yang's analysis of resuscitation in Hong Kong highlights a critical vulnerability in our healthcare system. Despite our advanced infrastructure, our OHCA survival-to-discharge rate remains a sobering 2.3% - significantly lower than metropolitan peers such as Seattle or Seoul. The "pre-hospital phase" is the weakest link; the physiological window for survival often closes before an ambulance arrives. Low bystander CPR and AED usage, frequently rooted in a "fear of harming" necessitate urgent systemic reform.

Dr Sam Yang proposes three strategic pillars: enacting "Good Samaritan" legislation to provide legal immunity to lay rescuers, integrating mandatory CPR and AED training into the school curriculum, and establishing a territory-wide OHCA registry. As clinicians across all specialities, we must advocate for these changes. The survival of our patients in the community is the foundation upon which all subsequent hospital-based care is built.

ADVANCING BEDSIDE PRECISION

While Dr Yang addresses the system, other contributors demonstrate how EM is refining the "sharp end" of clinical practice. Dr Ralph Cheung discusses the transformative power of Point-of-Care Ultrasound (POCUS). No longer a novelty, POCUS has become the "visual stethoscope" of the modern emergency physician. By allowing for real-time visualisation of pathology - from undifferentiated shock to acute respiratory failure - POCUS enables "precision resuscitation", ensuring that the right intervention is delivered at the earliest possible moment.

Similarly, the diagnostic challenge of the "dizzy patient" is addressed by Dr Total Chan. By implementing the STANDING algorithm and the TiTrate approach in Emergency Medicine Wards (EMW), clinicians can now differentiate between benign peripheral vertigo and life-threatening posterior circulation strokes with greater sensitivity



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than early MRI. This move toward clinical diagnostic excellence reduces unnecessary neuroimaging and streamlines the patient's journey through the healthcare system.

ENHANCING PATIENT OUTCOMES AND SAFETY

The evolution of EM also encompasses improved pain management and geriatric care. Dr Man-ting Lau's article on the ultrasound-guided fascia iliaca block (FIB) for hip fractures illustrates a significant shift in practice. By providing adequate regional anaesthesia in the Emergency Department, we can significantly reduce the requirement for systemic opioids in the elderly. This intervention directly benefits our colleagues in Orthopaedics and Geriatrics by decreasing the incidence of post-operative delirium and respiratory complications.

Finally, the speciality's reach extends into the community through high-stakes medical coverage. Dr Clara Wu and Dr Ho-cheung Chu provide a fascinating look at the role of the Chief Medical Officer at the Hong Kong Jockey Club, and at the implementation of the latest SCAT6 concussion protocols. Their work underscores the necessity of having EM expertise on the sidelines to manage complex trauma and ensure athlete safety in a high-pressure environment.

CONCLUSION

The articles in this issue serve as a reminder that Emergency Medicine does not exist in a vacuum. The success of a resuscitation initiated in the street or a diagnosis made in the ED impacts the entire trajectory of patient care across all specialities.

We must particularly take Dr Yang's findings as a mandate for change. As members of the medical community, we have a responsibility to advocate for the legislative and educational reforms necessary to improve OHCA outcomes. By strengthening the pre-hospital link and continuing to embrace the clinical advancements detailed by our contributors, we can ensure that Hong Kong's emergency care remains truly world-class. We hope this issue inspires a renewed commitment to collaborative care and public health advocacy.

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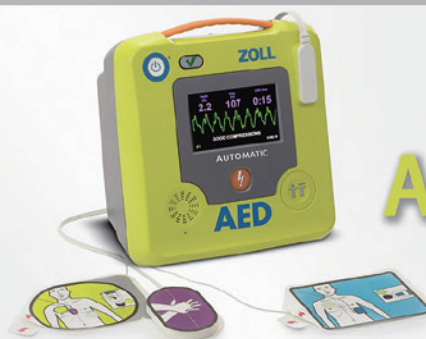
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Out-of-Hospital Cardiac Arrest in Hong Kong: Current Challenges and Future Strategies

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This article has been selected by the Editorial Board of the Hong Kong Medical Diary for participants in the CME programme of the Medical Council of Hong Kong (MCHK) to complete the following self-assessment questions in order to be awarded 1 CME credit under the programme upon returning the completed answer sheet to the Federation Secretariat on or before 31 March 2026.

INTRODUCTION

Out-of-hospital cardiac arrest (OHCA) represents a significant public health crisis globally, claiming millions of lives annually. In Hong Kong, this issue is particularly acute, with survival rates lagging far behind international benchmarks. OHCA occurs when the heart suddenly stops functioning outside a hospital setting, leading to rapid loss of consciousness and, without immediate intervention, death. The chain of survival - early recognition, prompt bystander cardiopulmonary resuscitation (CPR), rapid defibrillation, and advanced medical care - is critical to improving outcomes. However, in Hong Kong, systemic barriers hinder this chain, leading to dismal survival rates.

According to recent data, Hong Kong's OHCA survival rate stands at a mere 2.3 %, significantly below the global average of 8 - 12 %¹. This low rate is exacerbated by a bystander CPR initiation rate of only about 20 - 30 %, often due to inadequate training, fear of legal repercussions, and cultural hesitancy. The COVID-19 pandemic further compounded these challenges, with disruptions to the emergency response system and public reluctance to perform CPR due to infection fears³. This article explores the current challenges surrounding OHCA in Hong Kong, drawing on evidence from local studies and international guidelines, and proposes future strategies to enhance community preparedness, including mandatory CPR training in schools and the enactment of Good Samaritan laws.

CURRENT CHALLENGES IN MANAGING OHCA IN HONG KONG

Low Survival Rates and Bystander Intervention

Hong Kong's OHCA survival rate of 2.3% is alarmingly low, reflecting a combination of delayed emergency responses and insufficient public involvement. According to a registry-based study spanning 2017 to 2023, from pre- to post-COVID-19 pandemic, there was a rise in the OHCA rate and a worsening survival-to-admission rate, reflecting the overloading of the emergency medical system during this period (2024).

Globally, survival rates improved by 7 - 10 % for every minute earlier the CPR was started. Yet in Hong Kong, only 20.4 % of respondents in surveys express willingness to perform it, primarily due to a lack of training and confidence². The reluctance stems from multiple factors. A 2014 telephone survey revealed that less than half of Hong Kong residents were willing to initiate CPR, citing fears of infectious diseases, perceived incompetence in performing CPR, and concerns over medicolegal liability. Even among those trained, hesitation persists because of low re-certification rates and fading skills over time. Compression-only CPR, which eliminates the need for mouth-to-mouth ventilation, has been shown to yield comparable outcomes to traditional CPR for laypersons, potentially mitigating infection risks⁴. However, without widespread awareness and training, these benefits remain unrealised.

Absence of Good Samaritan Laws

A key deterrent to bystander intervention is the lack of legal protections for rescuers. Originating from the biblical parable emphasising altruistic help, Good Samaritan Laws encourage prompt assistance by alleviating fears of lawsuits. Hong Kong currently has no Good Samaritan law, which provides immunity from liability for individuals offering aid in emergencies, provided they act reasonably and without gross negligence. In contrast, countries like the U.S., Canada, Germany, Australia, China, India, and Japan have implemented such protections, varying in scope but unified in promoting community responsibility.

In Hong Kong, the absence of this law fosters a "bystander effect", where individuals avoid involvement due to potential legal risks. Studies indicate that even trained individuals hesitate, fearing accountability for unintended harm². Gross negligence - defined as a voluntary disregard for reasonable care - is not protected under the proposed frameworks, but ordinary negligence is, which could reassure rescuers. Without this, low CPR rates will persist, even with training availability, as bystander intervention remains suboptimal.



Inadequate CPR Training and Education

Public CPR training in Hong Kong is insufficient, with only a fraction of the population equipped with basic life support (BLS) skills. The "Heart-safe School Project" trains teachers, but it does not extend comprehensively to students, missing an opportunity to build a generation of responders. Overseas models, such as those in Denmark, Canada, and over 20 U.S. states, mandate school-based CPR training, leading to higher community preparedness⁶.

A 2018 survey of 110 Hong Kong secondary schools revealed that, while 69.1% of principals supported compulsory CPR training, implementation barriers included curriculum overload (34.1% of schools) and funding shortages (14.6 %)¹. Students, particularly those aged 10 - 12, are capable of effective chest compressions, and early education can instil lifelong skills⁶. However, without mandatory programmes, knowledge dissemination is limited, and family/community amplification - where trained students share skills - remains underutilised.

Lack of OHCA registry

The absence of a territory-wide OHCA registry hinders effective benchmarking, auditing, and surveillance, making it challenging to identify weak links in the chain of survival - such as bystander CPR rates, public access defibrillation, and prehospital response times - and to evaluate the impact of survival enhancement measures. While other countries and regions, including the U.S. (Cardiac Arrest Registry to Enhance Survival), Europe (European Registry of Cardiac Arrest), and Asia (Pan-Asian Resuscitation Outcomes Study)⁷, have established registries to monitor trends and improve outcomes, Hong Kong lacks this infrastructure, leading to fragmented data collection primarily from prehospital records without integration of in-hospital outcomes, perpetuating suboptimal OHCA management and community resilience.

Resource and Infrastructure Limitations

Hong Kong's dense urban environment poses logistical challenges for emergency medical services, with traffic congestion delaying response times. While automated external defibrillators (AEDs) are increasingly available in public spaces, their current distribution often falls short of the ideal 3-5-minute response time recommended by the American Heart Association for sudden cardiac arrest. This means that, in many cases, individuals in need of an AED may not have one readily accessible within the crucial timeframe that maximises survival. The International Liaison Committee on Resuscitation (ILCOR) 2023 statement emphasises AED education alongside CPR, as early defibrillation can drastically improve survival. Yet in Hong Kong, fear of liability and a lack of regular hands-on practice deter use.

FUTURE STRATEGIES TO ADDRESS OHCA CHALLENGES

Implementing Mandatory CPR Training in Schools

To combat low bystander CPR rates, Hong Kong should legislate mandatory CPR training in secondary schools, aligning with recommendations from the European Resuscitation Council (ERC) and the International Liaison Committee on Resuscitation (ILCOR). The ERC views school-based programmes as an "effective way to lower death rates from cardiac arrest", while ILCOR's 2023 review advocates starting education as early as age four for emergency recognition and age 10-12 for chest compressions⁶.

Key ILCOR strategies include:

- **Early Initiation:** Children can learn to call for help young and perform compressions by adolescence, retaining skills into adulthood.
- **Hands-on Practice:** At least two hours annually in small groups (3 - 5 students per instructor) ensures retention.
- **Technology Integration:** Virtual reality, apps, and videos enhance engagement, especially in resource-limited settings.
- **Teacher-Led Programmes:** Trained teachers are as effective as medical professionals.
- **AED Education:** Gradual integration of AED use to promote early defibrillation.

Expanding the "Heart-safe School Project" to all students could amplify impact, with surveys showing over 90 % positive feedback from existing programmes¹. Recent high school graduates in Australia support similar mandates, reporting increased confidence⁸. In Hong Kong, integrating CPR into existing subjects like physical education would maximise curriculum disruption, addressing the 34.1 % of responses from schools that have concerns over curriculum overload¹.

Government funding for manikins, instructor training, and AEDs is essential. By creating a "generation of lifesavers" , this approach could boost community preparedness, as trained students share knowledge with families.

Enacting Good Samaritan Laws

Hong Kong must introduce a tailored Good Samaritan law to protect rescuers from liability for ordinary negligence, encouraging CPR initiation. Modelled after international examples, it should exempt well-intentioned bystanders while excluding gross negligence or willful misconduct. In the U.S., variations provide immunity in emergencies, with some states extending protections to physicians⁵. China's law similarly promotes prompt aid without fear.

Such legislation would address the medicolegal fear, potentially increasing willingness to perform CPR,



especially for OHCA in public areas. Combined with public awareness campaigns, it could foster a "culture of helping", align with global standards, and reduce hesitancy. Regular re-certification programmes, as suggested, would complement this by building confidence.

Establishment of local OHCA registry

Hong Kong should establish a sustainable territory-wide OHCA registry as a foundational step in an organised survival enhancement campaign, leveraging the existing digitisation of prehospital and in-hospital data to enable seamless integration and Utstein-style standardised reporting. This requires dedicated resources, governance through a management committee involving stakeholders such as the government, academia, and professional bodies, and personnel for maintenance and quality control. Such a registry would enable continuous surveillance, feedback for quality improvement, and assessment of interventions like mass CPR training and public defibrillator programmes, ultimately aiming to align Hong Kong's OHCA survival rates with international standards.

Enhancing Public Education and Infrastructure

Broader strategies include community-wide CPR campaigns, leveraging technology for virtual training to reach underserved populations. Public AED registries and apps could guide bystanders to devices, improving defibrillation rates. Apart from that, emphasising compression-only CPR for lay persons to alleviate infection fears is another option.

CONCLUSION

Hong Kong's OHCA crisis, marked by a 2.3 % survival rate and low bystander engagement, demands urgent reform. Challenges like absent Good Samaritan laws, inadequate training, and resource constraints perpetuate poor outcomes, but evidence-based strategies offer a path forward. Mandatory school CPR training, guided by ILCOR and ERC, can empower youth, while legal protections will embolden bystanders. By legislating these changes, allocating funds, and integrating technology, Hong Kong can transform its response to cardiac arrests, saving countless lives and aligning with international best practices. The time for action is now; a proactive approach will not only improve survival rates but also cultivate a compassionate, prepared society.

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MCHK CME Programme Self-assessment Questions

Please read the article entitled "Out-of-Hospital Cardiac Arrest in Hong Kong: Current Challenges and Future Strategies" by Dr Sam Siu-ming YANG and complete the following self-assessment questions. Participants in the MCHK CME Programme will be awarded CME credit under the Programme for returning completed answer sheets via fax (2865 0345) or answer link: <https://forms.gle/5qSNc2pSvdysm8df8> or by mail to the Federation Secretariat on or before 31 March 2026. Answers to questions will be provided in the next issue of The Hong Kong Medical Diary. (Address: Duke of Windsor Social Service Bldg., 4/Fl., 15 Hennessy Rd., Wan Chai. Enquiry: 2527 8898)

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

1. Hong Kong's OHCA survival rate is reported as 2.3 %, which is lower than the global average of 8 - 12%.
2. The COVID-19 pandemic had no significant impact on OHCA rates or survival-to-admission rates in Hong Kong.
3. Compression-only CPR has been shown to yield comparable outcomes to traditional CPR for laypersons, potentially reducing infection risks.
4. Hong Kong currently has a Good Samaritan law that provides immunity from liability for rescuers acting in emergencies.
5. A 2018 survey found that 69.1 % of Hong Kong secondary school principals supported compulsory CPR training.
6. Countries like the U.S., Canada, Germany, and China have implemented Good Samaritan laws to encourage bystander assistance.
7. ILCOR's 2023 statement recommends starting CPR education for children as young as age four for emergency recognition.
8. Hong Kong has a well-established territory-wide OHCA registry for monitoring trends and improving outcomes.
9. The absence of an OHCA registry in Hong Kong makes it difficult to integrate prehospital and in-hospital outcome data.
10. ILCOR strategies for school CPR training include at least two hours of annual hands-on practice in small groups.

ANSWER SHEET FOR MARCH 2026

Please return the completed answer sheet to the Federation Secretariat on or before 31 March 2026 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

Out-of-Hospital Cardiac Arrest in Hong Kong: Current Challenges and Future Strategies

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Answers to February 2026 Issue

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	 Inpatient hospitalizations	 Emergency department visits
HyperK-related	33.0% reduction[‡]	24.0% reduction[‡]
All-cause	23.3% reduction[‡]	24.1% reduction[‡]

LOKELMA™ was generally well-tolerated from the HARMONIZE trial²

- No hypoK events were reported as AEs with 5g and 10g of LOKELMA™
- No clinically significant changes in other electrolytes, vital signs, or arrhythmias occurred

*Up to 12 months based on the prespecified exploratory analysis of changes in RAASi dose during the maintenance phase of a phase III, open-label, single-arm, 12-month study.

[†]73.5% of participants in the ZORA study stabilized or up-titrated their RAASi dose with LOKELMA™. ZORA was a multi-country, observational cohort study comparing the likelihood of maintained RAASi therapy at 6 months following an episode of hyperK in patients with CKD and/or HF. Participants either received no K⁺ binder prescription, or had ≥ 120 days of LOKELMA™ treatment.

[‡]Long-term is defined as LOKELMA™ treatment of over 90 days.

[§]Risk reduction is compared with patients who had received LOKELMA™ treatment of ≤ 90 days.

[¶]Only the 5g and 10g doses of LOKELMA™ has been approved in Hong Kong. The 15g dose of LOKELMA™ is not available in Hong Kong.

Study design: HARMONIZE (ZS004) is a phase III, multicentre, multiphase, placebo-controlled study in 258 patients with hyperK. Open-label phase: LOKELMA™ 10g TID, administered for 48 hours, at which time patients (n=237) with normokalaemia (3.5–5.0 mmol/L) were randomised to LOKELMA™ or placebo; 5g, 10g or 15g QD for 28 days. Primary endpoint: mean serum K⁺ level with LOKELMA™ vs. placebo on days 8–29. Eligible patients then continued treatment with LOKELMA™ 10g QD. In a single-arm open-label extension study, patients from HARMONIZE with K⁺ 3.5–5.2 mmol/L received LOKELMA™ 5–10g QD for ≤ 337 days. In the CP, patients with K⁺ ≥ 5.5 mmol/L received LOKELMA™ 10g TID before entering the MP while patients with K⁺ 3.5–5.5 mmol/L immediately entered the MP phase and began LOKELMA™ 10g QD. Endpoints included achievement of mean serum ≤ 5.1 mmol/L (primary) or ≤ 5.5 mmol/L (secondary).²

Study design: The RECOGNIZE I is a retrospective noncomparative study using claims data from the HealthVerity warehouse, which included outpatients in the United States who had ≥ 6 months of continuous LOKELMA™ treatment. They continued to receive 6 months of LOKELMA™ for a total coverage of 12 months. The study aimed to describe healthcare resource utilization with long-term (>90 days' supply; n=748) LOKELMA™ and identify characteristics associated with long-term vs. short-term therapy.⁵

Abbreviations: AE: Adverse event; CKD: Chronic kidney disease; CP: Correction phase; HF: Heart failure; HyperK: Hyperkalaemia; HypoK: Hypokalaemia; K⁺: Potassium; MP: Maintenance phase; QD: Once daily; RAASi: Renin-angiotensin-aldosterone system inhibitors; TID: 3 times daily.

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Evaluation of Acute Dizziness in the Emergency Medicine Ward: A Novel Multi-faceted Approach

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INTRODUCTION

The first short-stay unit operated by the emergency department (ED) in Hong Kong was established in 2003¹. Since the formation of the Emergency Medicine Ward (EMW) Task Force by the Hospital Authority in 2006, EMW has been developed in most public hospitals with ED service². The model of care includes diagnostic evaluation, short-term treatment, psychosocial services and multi-disciplinary care.

Dizziness accounts for about 4 % of patients presenting to the ED in Hong Kong³. Many of these patients are admitted to EMW for monitoring, particularly if the symptom is persistent. However, the timely diagnosis of posterior circulation stroke remains one of the biggest challenges that emergency physicians face. It is common for doctors to rely on CT brain findings and the response to symptomatic treatments to make the diagnosis. In fact, it is not always straightforward to distinguish between peripheral and central causes of vertigo clinically, and CT brain has a very low sensitivity for stroke^{4,5,6}. This article focuses on how a multifaceted approach can be used to identify a cerebellar pathology or posterior circulation stroke in patients admitted to EMW for dizziness.

THE NEW CLASSIFICATION

Dizziness is traditionally categorised into "vertigo", "lightheadedness", "pre-syncope" or "disequilibrium". For decades, doctors have been taught to let the patient describe the symptom to determine the underlying aetiology. For example, a patient with vertigo would classically describe it as a spinning sensation. However, many patients are unable to give a reliable description to distinguish between vertigo and other types of dizziness^{7,8}. Over-reliance on the symptom description may lead to cognitive bias and contribute

to diagnostic errors. Recently, there was a paradigm shift in classifying dizziness into three categories: acute vestibular syndrome (AVS), spontaneous episodic vestibular syndrome (s-EVS), and triggered episodic vestibular syndrome (t-EVS), as shown in Table 1.

Emergency physicians should evaluate dizziness in four aspects:

- 1) TiTrATE approach and STANDING algorithm
- 2) Reasonable imaging investigations
- 3) Multi-disciplinary assessment
- 4) Risk stratification

THE TITRATE APPROACH AND STANDING ALGORITHM

Instead of basing the diagnosis on the patient's description, emergency physicians should adopt a more objective approach by considering other characteristics, such as onset and duration, provoking factors, and associated symptoms, and considering stroke as a possibility even if the patient's description is not typically vertiginous.

The new TiTrATE approach focuses on timing and trigger of dizziness, while the patient's description of the symptom has been de-emphasised. The TiTrATE acronym stands for timing, trigger and targeted examination¹⁰. Timing refers to the onset, duration and evolution of dizziness. Trigger refers to movements or situations that provoke dizziness in those with intermittent symptoms, such as arising from a lying position or rolling over in bed. It is noteworthy that 'trigger' means provocation of a new onset of the symptom rather than exacerbation. Head movements can exacerbate dizziness in both peripheral and central causes to some extent, so the physician should not assume that dizziness exacerbated by head movements is always peripheral¹¹. The underlying causes with

Table 1: Classification of dizziness (Modified from Edlow et al.⁹)

Syndrome	Description	Benign (peripheral) causes	Serious (central) causes
Acute Vestibular Syndrome (AVS)	Continuous dizziness lasting for days	Vestibular neuritis Acute labyrinthitis	Posterior circulation CVA
Spontaneous Episodic Vestibular Syndrome (s-EVS)	Episodic dizziness that is triggered and lasts for minutes to hours	Vestibular migraine Meniere's disease	Posterior circulation TIA
Triggered Episodic Vestibular Syndrome (t-EVS)	Episodic dizziness with an apparent trigger (changing head position or standing up) which is reproducible	Benign paroxysmal positional vertigo (BPPV) Orthostatic hypotension	Central positional vertigo (CPPV)



different timing and the presence or absence of trigger are as shown in Table 2.

Table 2: Causes of dizziness with different timing and triggers (Modified from Himmel¹²)

Causes	Timing	Trigger	Central/peripheral
BPPV	< 1 min	Movement	Peripheral
CPPV	1 min or more	Movement	Central
Vestibular migraine	Mins to hours	Spontaneous	Central (benign)
Meniere's disease	Hours	Spontaneous	Peripheral
TIA (Posterior circulation)	Mins to hours	Spontaneous	Central
Labyrinthitis or vestibular neuritis	Days	Spontaneous	Peripheral
Posterior circulation stroke	Days	Spontaneous	Central

History taking for dizziness should also include associated symptoms such as headache, neck pain, tinnitus and hearing loss, risk factors for stroke, medications, as well as recent neck manipulation. It should be emphasised that the presence of auditory symptoms does not always imply a peripheral cause. For example, lateral pontine infarction can cause hearing loss and tinnitus. If causes other than vestibular syndromes are suspected, other associated symptoms such as chest pain, palpitations, fever, or recent blood loss should also be enquired about. The elements in history taking may include:

1. Type of dizziness (e.g. AVS: vomiting, gait disturbance)
2. Screening for stroke (e.g. unilateral weakness, double vision, speech disturbance)
3. Timing: onset and duration (e.g. BPPV lasts for < 1 min)
4. Trigger: provocation by position change (e.g. BPPV)
5. Associated symptoms: headache (e.g. intracranial haemorrhage), neck pain (e.g. vertebral artery dissection), hearing loss or tinnitus (e.g. acute labyrinthitis, Meniere's disease, stroke)
6. Risk factors: thromboembolic risk factors or neck manipulations
7. Medications (e.g. opioid analgesics, antidepressants, antipsychotics, ototoxic antibiotics)

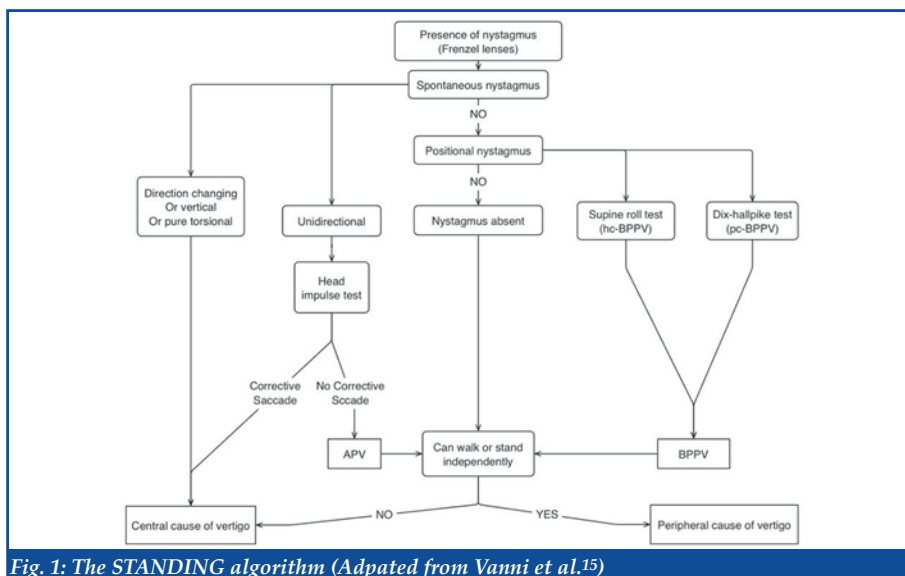
Physical examination for dizziness should begin with rapid screening of stroke by looking for focal motor and sensory deficits as well as the "Deadly Ds" including Diplopia, Dysarthria, Dysphagia, Dysphonia and Dysmetria. It should then be followed by cerebellar examination, which consists of multiple domains, including gaze and nystagmus, limb ataxia, and truncal ataxia. Findings that suggest a central or cerebellar lesion are as described below:

1. Gaze assessment
 - a) Impaired smooth pursuit (jerky when tracking a moving target)
 - b) Ocular dysmetria (overshooting when fixating on a target)

2. Nystagmus
 - a) Spontaneous vertical or purely torsional nystagmus (no horizontal component)
 - b) Gaze-evoked bidirectional nystagmus (unidirectional, more likely peripheral)
3. HINTS (only for AVS with nystagmus)
 - a) Head impulse test (HIT): no corrective saccade when the head is turned to the direction of fast beat nystagmus and then back to midline during visual fixation
 - b) Nystagmus (as described above)
 - c) Test of Skew: corrective vertical saccade when one eye is covered during visual fixation
4. Speech (scanning speech)
5. Coordination
 - a) Finger-to-nose test showing dysmetria (overshooting or undershooting)
 - b) Finger-to-nose test showing intention tremor
 - c) Dysdiadochokinesia
 - d) Heel-to-shin test showing clumsiness and jerkiness
6. Tone and reflexes
 - a) Hypotonia in the ipsilateral limb
 - b) Pendular reflex and rebound phenomenon
7. Truncal ataxia or gait assessment
 - a) Truncal ataxia (inability to sit up unsupported or fall when sitting up)
 - b) Broad-based stance or gait or swaying when standing, suggestive of ataxia (Romberg's sign absent, i.e. no difference whether eyes are open or closed)
8. Provocative test (e.g. Dix-Hallpike manoeuvre) results not suggestive of a peripheral aetiology

The HINTS exam is a useful tool when performed correctly. If all components are negative, the test is 100 % sensitive for ischemic stroke in patients with AVS. In comparison, MRI Brain with diffusion-weighted imaging (DWI) only has 88 % sensitivity¹³. However, emergency physicians should be aware of the pitfalls when using this exam, as it is only helpful for patients with continuous symptoms and must not be used for those with only episodic symptoms or those who don't have nystagmus. Studies have shown that the HINTS exam has limited diagnostic value in the ED setting, as it is often misused¹⁴. Moreover, the inability to interpret nystagmus correctly may affect the usefulness of the test, as nystagmus is often suppressed when the patient is asked to fixate their vision on an object. The detection of nystagmus can be improved by asking the patient to look at a blank sheet of paper or shining a pen torch to the patient's eye while covering the other eye when checking for nystagmus. Frenzel goggles can be an alternative, but they are usually not available in the ED or EMW setting.

The STANDING (SponTaneous, Nystagmus, Direction, head Impulse test, standiNG) algorithm was developed as a four-step, structured diagnostic tool that consisted of assessment of spontaneous nystagmus, positional nystagmus, HIT, and stance and gait assessment. This diagnostic algorithm, as shown in Fig. 1, demonstrated a high negative predictive value of 99 % for central vertigo in the ED in a multicenter study¹⁶. Therefore, it might be a helpful tool for the diagnosis of dizziness in the ED



(APV: acute peripheral vestibulopathy; hc-BPPV: horizontal canal BPPV; pc-BPPV: posterior canal BPPV)

or EMW. During ward rounds, the physician needs to check whether the patient can sit or stand unsupported. Gait should always be checked if there is no ataxia on sitting or standing. If the patient can't keep sitting up unsupported, a central lesion should be suspected.

REASONABLE AND APPROPRIATE IMAGING

It is quite common for a non-contrast CT of the brain to be performed in the ED to exclude a central cause^{17,18}. However, this investigation has only a very low diagnostic yield in acute dizziness, with finding of a causative brain lesion in only < 1 to 7 % of cases^{4,5,6}. Moreover, overuse of CT brain may prolong the length of stay in the ED and give the physician a false sense of reassurance that a central cause is unlikely.

In fact, the Society for Academic Emergency Medicine (SAEM) has published the GRACE-3 guidelines for reasonable and appropriate care of acute dizziness in the ED, which include evidence-based recommendations for imaging investigations¹⁹. There are recommendations for each type of vestibular syndrome:

1. Diagnosis of AVS
 - a) Do not routinely use non-contrast CT of the brain for patients with or without nystagmus
 - b) Do not use MRI or MRA as a first-line diagnostic test if a clinician trained in HINTS is available
 - c) Perform MRI or MRA if HINTS result is central or equivocal
2. Diagnosis of t-EVS
 - a) Do not routinely perform CT brain or CTA
 - b) Do not perform MRI or MRA for BPPV with a positive Dix-Hallpike test
3. Diagnosis of s-EVS
 - a) Do not use CT brain to distinguish between peripheral and central causes
 - b) If concerned about TIA, use CTA and MRA to diagnose extensive vessel pathology

Therefore, non-contrast CT brain should not be performed to distinguish between peripheral and central aetiologies; it should be reserved for cases with suspected stroke or cerebellar lesions that require further management. That said, for cases with negative CT brain being admitted to the EMW, if the patient subsequently develops signs of a posterior circulation stroke, CT brain should be repeated if MRI is not immediately available, to look for established infarcts or complications such as cerebellar oedema or hydrocephalus, while consulting the stroke team for reperfusion therapy or admitting the patient to the stroke unit.

MULTI-DISCIPLINARY ASSESSMENT

For patients admitted for acute dizziness, physiotherapists can be consulted for mobility assessment and walking exercise training. Their comprehensive assessments of stability and exercise tolerance often provide very useful information for the emergency physician during EMW ward rounds. For example, during mobility training, if the patient repeatedly leans on one side, shows body sway upon sitting or standing, or is unable to sit up for the assessment, it would be an alarming finding that requires further evaluation.

Patients with acute dizziness may also benefit from vestibular rehabilitation physiotherapy, both for therapeutic and diagnostic purposes. Physiotherapists often perform more in-depth vestibular function evaluations, including tests of saccadic eye movements, nystagmus, and the vestibulo-ocular reflex. They are also more professional in performing the manoeuvres used to diagnose or treat BPPV. The results of the physiotherapist's assessments and the response to their interventions may provide essential clues for the physician to make the correct diagnosis.



RISK STRATIFICATION

For some patients, especially those suffering from s-EVS, symptoms might have already subsided before ward rounds, and clinical examination is less reliable. It is essential to perform a risk assessment for every patient to avoid diagnostic errors. The TriAge+ score is a useful and applicable clinical prediction rule for assessing the risk of posterior circulation stroke and offers guidance on further radiological investigation, expert evaluation, discharge plan, and appropriate referrals.

The TriAge+ score comprises eight clinical parameters, as shown in Table 3. Patients can be categorised in low risk (0 - 4 points), intermediate risk (5 - 7 points), high risk (8 - 9 points), and very high risk (10 - 17 points). The original study reported a sensitivity of 96.6 % with a cutoff of five points. The score also outperformed the ABCD2 score in predicting stroke risk²⁰. The TriAge+ Score has been externally validated in a retrospective observational cohort study in the Prince of Wales Hospital of Hong Kong, which included 455 patients aged ≥ 18 presenting with dizziness to the ED. The local study showed high sensitivity of 96.4 % (95 % CI: 87.3 - 99.5) when a cutoff > 5 is used, and high specificity of 99.8 % (95 % CI: 98.6 - 100.0) when a cutoff > 10 is used²¹. For patients with a score > 10 , there is a high likelihood of stroke, so these patients must receive urgent neuroimaging studies or be transferred to the medical ward for further neurological assessment. For those with scores between 5 and 10, the patient may need to stay in EMW for more extended observation, followed by early neuroimaging on discharge or referral for early neurologist or stroke team assessment if TIA is suspected.

Table 3: The TriAge+ Score as a diagnostic model for stroke in dizziness. (Adapted from Kuroda et al.²⁰)

Initials	Variables	Points
Tri	No triggers	2
A	Atrial fibrillation	2
Ge	Gender (male)	1
B	Blood pressure $\geq 140/90$ mmHg	2
B	Brainstem or cerebellar dysfunction (Skew deviation, diplopia, oculomotor disturbance, unilateral facial sensation disturbance, dysphagia, hiccup, dysmetria or truncal ataxia)	1
C	Clinical features of stroke (focal weakness or speech impairment)	4
D	Dizziness (not vertigo)	3
H	No history of vertigo or dizziness or labyrinth or vestibular diseases	2

CONCLUSION

For patients with acute dizziness admitted to the EMW, emergency physicians should determine the type of vestibular syndrome the patient is experiencing. It is essential to adopt a structured framework in history taking and physical examination using the TiTrATE approach and STANDING algorithm, and avoid the cognitive error of excluding central aetiologies by performing a CT brain. The assessment done by physiotherapists may be useful to track the patient's progress and help the physician to make the diagnosis. Finally, risk assessment with the TriAge+ score can be a useful adjunct to guide further investigation or disposition.

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From Concept to Care: Enhancing Pain Management in Emergency Department with Fascia Iliaca Block

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INTRODUCTION

The fascia iliaca block is a regional anaesthetic technique that provides anaesthesia/analgesia to the hip and knee regions. It involves delivering a large volume of diluted local anaesthetic to the potential space between the iliacus muscle and the fascia that overlies it (fascia iliaca). Appropriate delivery of local anaesthetic will lead to fascial spread and anaesthesia of the femoral nerve, lateral femoral cutaneous nerve, and sometimes the obturator nerve^{1,2}.

The femoral nerve is the largest branch of the lumbar plexus. It innervates the anterior thigh muscles, skin of the anteromedial thigh, and sends articular branches to the hip and knee. Its terminal cutaneous branch, the saphenous nerve, innervates the skin and fascia on the anteromedial aspects of the knee, leg and foot. The lateral femoral cutaneous nerve innervates the skin of the anterolateral thigh.

By blocking the femoral nerve and the lateral cutaneous nerve in the fascia iliaca block, we can provide anaesthesia/analgesia to the hip and thigh, and down to the knee region.

Unlike the femoral nerve block, the needle is not directed to the femoral nerve, thus reducing the risks of nerve damage. So, the fascia iliaca block is considered a safe alternative to the femoral nerve block. It can be easily and safely performed by non-anaesthetists with adequate training, and it is considered a standard practice for pain control in geriatric proximal femoral fractures in many countries³. This article discusses the use of ultrasound-guided infrainguinal fascia iliaca block in the emergency department (ED).

INDICATIONS, CONTRAINDICATIONS AND COMPLICATIONS

In the ED, a fascia iliaca block can be used to provide preoperative analgesia for patients with proximal femoral fractures, including fractures of the femoral neck and intertrochanteric fractures.

Contraindications include patient refusal, known allergy to local anaesthetics, infection or inflammation over the intended injection site, previous femoral bypass surgery, known bleeding tendency, and patients on antiplatelets or anticoagulants (except aspirin)¹.

Complications include block failure, haematoma, and in rare cases, nerve damage and local anaesthetic systemic toxicity (LAST)¹.

LOCAL ANAESTHETIC SYSTEMIC

Local anaesthetic systemic toxicity (LAST) occurs when local anaesthetic is absorbed into the bloodstream, leading to life-threatening toxicity affecting the neurological and cardiovascular system. It can occur following inadvertent intravenous local anaesthetic injection, or systemic absorption after a large volume of local anaesthetic is injected into tissue.

Signs and symptoms of local anaesthetic systemic toxicity include:

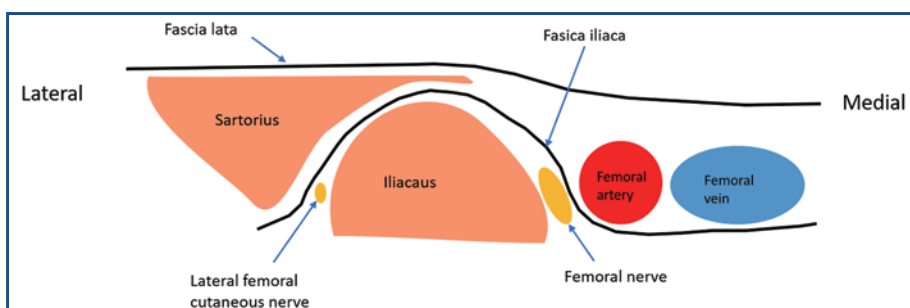


Fig. 1: Anatomy of the fascia iliaca block (Developed by author, with reference to teaching on ultrasound-guided fascia iliaca nerve block by nysora²)

a. Neurological effects

i. Early symptoms include

1. Metallic taste
2. Tinnitus
3. Disorientation
4. Dizziness
5. Visual disturbance
6. Perioral tingling/numbness
7. Light headedness

ii. Inhibition of all neurons eventually leads to seizures, coma, and respiratory arrest

b. Cardiovascular effects

- i. Bradycardia and heart block
- ii. Re-entrant arrhythmias, Ventricular Tachycardia and Fibrillation
- iii. Cardiac arrest
- iv. Prolonged PR interval and widening of QRS on ECG

To prevent LAST, the maximum safe dose of local anaesthetic must be calculated before any procedure. During the nerve block procedure, it is also recommended to confirm negative aspiration after needle reposition or after every 5 ml of local anaesthetic injection to ensure no intravascular injection.

The mainstay of management includes standard resuscitation with a focus on airway management and supportive care, and the specific antidote, intralipid. Intralipid, a 20 % lipid emulsion, should be administered for signs of LAST, with weight-based dosing (1.5 ml/kg bolus, followed by 0.25 ml/kg/min; maximum total dose 12 ml/kg)⁵.

As LAST is a rare but life-threatening event, guidelines and checklists for its management should be available to staff in every department where local anaesthetics are administered.

PROCEDURE TECHNIQUE

Three common techniques have been described, including the landmark technique, the ultrasound-guided suprainguinal approach, and the ultrasound-guided infrainguinal approach¹. Ultrasound-guided techniques are increasingly used nowadays. The more proximal suprainguinal approach theoretically provides better coverage of the lateral femoral cutaneous nerve and the obturator nerve; however, it carries the risk of perforating the peritoneal cavity. The ultrasound-guided infrainguinal approach is described here.

ULTRASOUND GUIDED INFRAINGUINAL APPROACH

With the patient in the supine position, a high-frequency linear ultrasound probe is placed transversely around the inguinal ligament. The relevant anatomy can be identified by first locating the femoral vessels, then scanning laterally to identify the sartorius muscle and the fascia iliaca. With the sartorius and the fascia iliaca in view, the nerve block needle is introduced in-plane from the lateral aspect. The needle tip should

be visualised at all times, and the femoral nerve and femoral vessels should be avoided.

As the needle pierces the fascia, a "pop" may be felt. After negative aspiration, 1 - 2 ml of local anaesthetic is injected to confirm the proper injection plane between the fascia and the iliopsoas muscle. If local anaesthetic spread is not visualised, the needle needs to be repositioned.

As it is a plane block, a relatively large volume of local anaesthetic (~30 - 40 ml) is required to ensure adequate spread. Safe dosage limits for local anaesthetics must be calculated in advance. In patients with body weight $\geq$ 50 kg, 40 ml of 0.25 % levobupivacaine can be used.

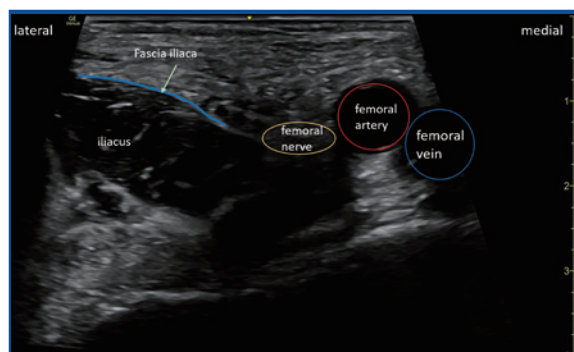


Fig. 2: Sonographic anatomy of the fascia iliaca block (Ultrasound image and annotation by author)

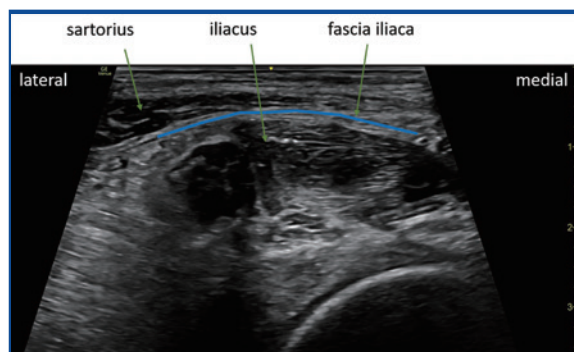


Fig. 3: Ultrasound image of the fascia iliaca. The femoral vessels are located medial to the image (Ultrasound image and annotation by author)

PATIENT MONITORING

Throughout the procedure, the patient should be monitored with a continuous ECG monitor and pulse oximetry, and blood pressure should be monitored regularly (e.g. every 10 minutes).

Regular vitals monitoring should be continued for at least 30 minutes after the procedure. The patient should be educated on the symptoms of local anaesthetic toxicity and instructed to report the symptoms.

RATIONALE

Fascia iliaca block for hip fractures is recommended as standard of care in many guidelines, including those



from the Royal College of Emergency Medicine and the Association of Anaesthetists of Great Britain and Ireland⁶. These guidelines also recommend that the fascia iliaca block can be performed by appropriately trained doctors in the ED.

It offers a viable alternative to non-steroidal anti-inflammatory drugs or opioids. Fascia iliaca block is especially beneficial to geriatric patients, as they are more susceptible to the adverse effects of non-steroid anti-inflammatory drugs or opioids. Performing the block in the ED is beneficial because admission blocks are common, and the pain during patient transfer from ED stretchers to hospital beds can be minimised.

A Cochrane review found that the fascia iliaca block for hip fractures in adults results in superior pain control compared with systemic analgesics⁷. Another meta-analysis also found that the fascia iliaca block performed pre-operatively for hip fractures reduces the need for additional opioid analgesia⁸. There is less evidence for the length of stay and mortality. However, a study showed that implementation of a fascia iliaca block protocol in the ED significantly reduced acute hospital length of stay and inpatient mortality in patients with hip fractures⁹.

IMPLEMENTATION OF FASCIA ILIACA BLOCK PROTOCOL IN EMERGENCY DEPARTMENT

As regional anaesthesia techniques are seldom practised in ED in Hong Kong, preparations must be made for safe and successful implementation. Here, the actions taken to implement the fascia iliaca block protocol in a local ED are outlined.

Protocols for the fascia iliaca block and the management of local anaesthetic systemic toxicity were developed based on current evidence and international guidelines. A procedure checklist was designed to see the process for patient assessment and selection, equipment preparation, and procedure monitoring, aiming to reduce the potential for errors.

Information leaflets in Chinese and English were prepared to facilitate staff communication with patients. Prescriptions for the local anaesthetic used in the nerve block and intralipid for LAST were entered into the electronic medical system, and the hospital pharmacy was notified.

We communicated with the ED nursing leadership to set up nerve block kits and local anaesthesia systemic toxicity (LAST) resuscitation kits. The nerve block kits include the nerve block needles, syringes, and dilution materials for the local anaesthetic. The LAST resuscitation kit the resuscitation flowchart, the intralipid resuscitation flowchart with the intralipid dose according to guidelines, and syringes and extension tubes for drawing up intralipid.

We also communicated with the department of anaesthesia and orthopaedics and traumatology, and the protocols were reviewed by their representatives.

Training was provided to medical and nursing staff in the ED, covering the fascia iliaca block and management of local anaesthetic systemic toxicity, along with information on the departmental protocol and relevant equipment.

In the beginning, the nerve block is performed by emergency physicians who have previous experience with regional anaesthesia. They are also responsible for training and supervising the other doctors in the department to conduct the blocks. Doctors can perform the block under the supervision of the trainers after didactic teaching. Doctors must be assessed by the trainers and attain sufficient competency before performing the block independently.

BROADER IMPLICATIONS AND FUTURE DIRECTION

Regional anaesthesia has significant potential for use in the emergency department, as emergency physicians often perform painful procedures and treat many acute painful injuries. Regional anaesthesia is increasingly performed by emergency physicians worldwide. For example, peripheral nerve blocks are performed to provide anaesthesia during painful procedures (e.g., closed reduction of fractures, incision and drainage), and the serratus anterior plane block is used for pain relief after rib fractures. Providing regional anaesthesia in the ED can improve patient outcomes and satisfaction, and increase overall perceptions of care quality and professionalism in emergency medicine.

It is hoped that the introduction of toward incorporating more regional anaesthetic techniques into ED practice. Training for more advanced skills can promote a culture of continuous learning and professional development, and emergency physicians and trainees can feel a sense of achievement.

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1. Ibarra F Jr, Holzmann S, Shah S, et al. Utility of nicardipine in the management of hypertensive crises in adults with reduced ejection fractions. *Am J Emerg Med*. 2024;75:79-82.
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Clinical Pearls and Pitfalls of Emergency Ultrasound (POCUS) in the Resuscitation Rooms

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INTRODUCTION

Emergency ultrasound, particularly point-of-care ultrasound (POCUS), has become an essential extension of clinical examination across multiple domains of acute care. In the resuscitation bay, where time is critical, we rely on ultrasound to expedite real-time diagnoses, guide interventions, and improve patient outcomes.

Advantages of POCUS include bedside availability, repeatability, and the ability to integrate findings with ongoing resuscitation efforts. Key applications include:¹⁻³

1. eFAST (extended Focused Assessment of Sonography of Trauma) in trauma assessment.
2. Assessment of acute abdomen.
3. Lung assessment.
4. Shock: Protocols like RUSH (Rapid Ultrasound in Shock) and FEEL (Focused Echocardiographic Evaluation in Life Support).
5. Cardiac Arrest: identify causes.
6. Procedural Guidance: improves the success of vascular access, pericardiocentesis, and thoracostomy.

Although POCUS is readily available at the bedside and provides rapid diagnostic insights, improper use or misinterpretation can delay care or cause confusion. This article shares practical pearls and common pitfalls drawn from frontline experience, aiming to refine its safe and effective application.

1. eFAST IN TRAUMA: QUICK BUT NOT ALWAYS EASY

eFAST has become a staple in blunt and penetrating trauma evaluation.

Roles⁴

- Detect free fluid in the abdomen, chest, or pericardium.
- Detect pneumothorax, haemothorax.

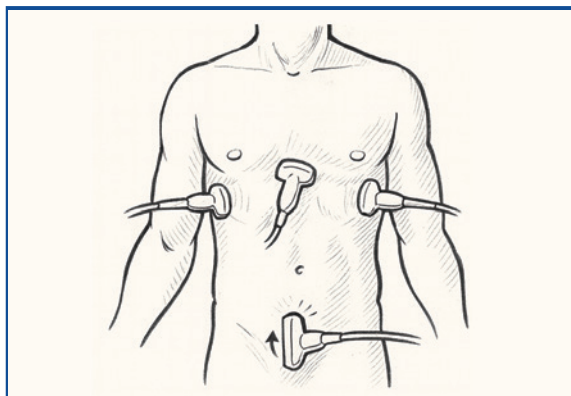


Fig. 1: Probe placements: 1. RUQ (right upper quadrant) view (hepatorenal + right lung base); 2. LUQ (left upper quadrant) view (splenorenal + left lung base); 3. Suprapubic views; 4. Cardiac (subxiphoid); 5. Optional additional lung views (left and right anterior chest) (Created using AI-based image generation software, verified and adapted by the author)

Pearls

- Use a curvilinear (more often) or phased-array probe.
- Prioritise RUQ view (Morison's pouch) - high yield.
- Use rib shadowing to your advantage to align the probe.

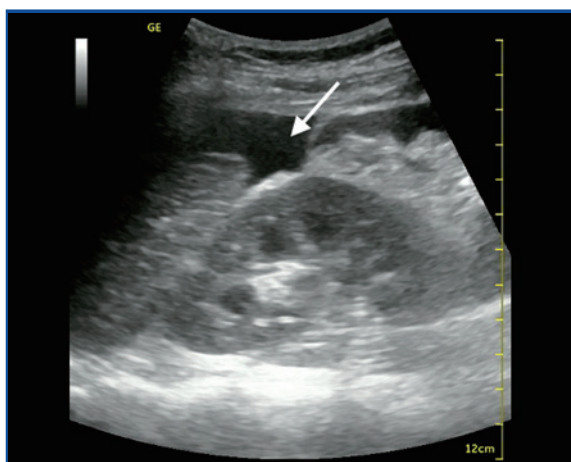


Fig. 2: Presence of intra-peritoneal free fluid at Morrison pouch (arrow). (Clinical photo from the author)

Pitfalls

- Fluid can be missed if the probe angulation is off-axis or a small amount of fluid.
- Subcutaneous emphysema impairs acoustic windows.
- Not sensitive in detecting retroperitoneal haemorrhage and hollow viscus injury.

2. ACUTE ABDOMEN: CHOLECYSTITIS AND BEYOND

Roles

- Hepatobiliary ultrasound: detection of cholecystitis/gallstones, biliary obstruction, space-occupying lesion in the liver.
- Renal and bladder ultrasound: detection of hydronephrosis, stones.
- Aorta: detection of abdominal aortic aneurysm (AAA), aortic dissection.

Pearls¹

- Gallstones (echogenic foci with posterior acoustic shadowing).
- Gallbladder wall thickening > 3 mm is abnormal.
- Have a low threshold to image the aorta in the elderly with flank pain to detect aortic emergencies.
- An AAA is defined as an abdominal aortic diameter > 3 cm, measured from **outer wall to outer wall**.

Pitfalls

- Difficult to pick up the retroperitoneal rupture of AAA.
- Bowel gas and obesity impair visualisation: can try an alternative view.
- Renal sinus fatty tissue may appear hypoechoic and may be misread as fluid.

3. LUNG ULTRASOUND: BEYOND THE CHEST X-RAY

Roles⁵

- Detect pneumothorax, pulmonary oedema, and pleural effusion.

Pearls

- Pneumothorax: lung sliding excludes pneumothorax in the area directly underneath the probe. Signs of pneumothorax are absent lung sliding, and the presence of A-lines (horizontal reverberation artefact from pleura).

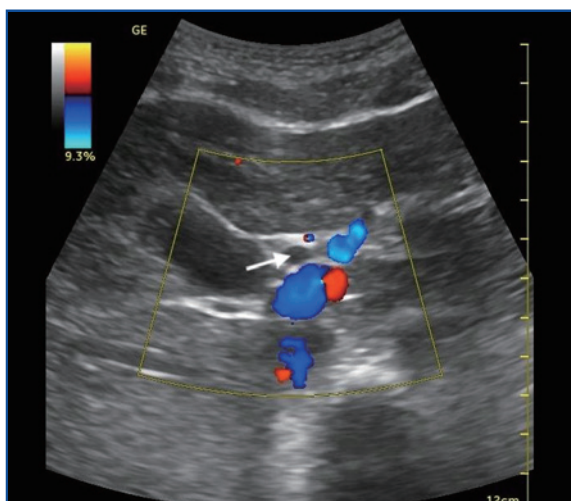


Fig. 3: Normal common bile duct (CBD) in cross section (arrow), appearing as a hypoechoic round structure resembling the "right ear" of the "Mickey Mouse sign". It is not dilated.

Colour flow demonstrates the portal vein (the most posterior structure, resembling the "head" of the "Mickey Mouse sign") and the hepatic artery (resembling the "left ear" of the "Mickey Mouse sign") in cross section. (Clinical photo from the author)

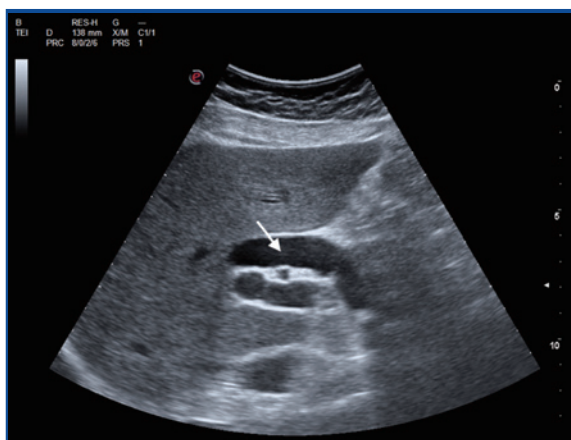


Fig. 4: The CBD in long axis (arrow) is dilated (diameter > 1 cm) in another patient. He had cholangitis. (Clinical photo from the author)

- Pulmonary oedema: three or more B-lines (which are vertical reverberation artefacts from pleura) per intercostal space are considered diagnostic for interstitial syndrome, most commonly pulmonary oedema.
- Pleural Effusion: anechoic space between the lung and diaphragm.

Pitfalls

- Atelectasis, pleural adhesions, or severe pneumonia can cause absent lung sliding.
- B-lines can occur in fibrosis or pneumonia - not just pulmonary oedema.

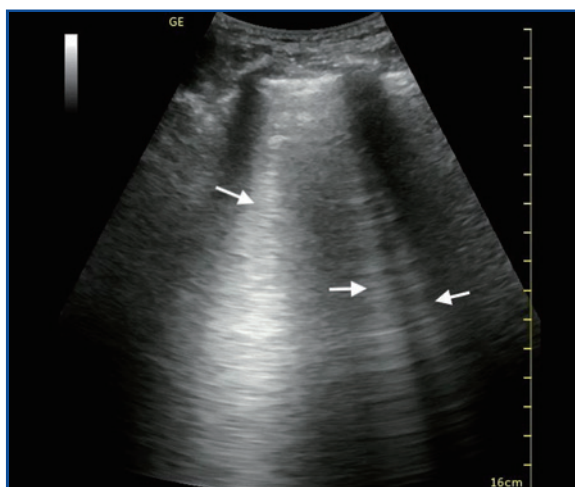


Fig. 5: Multiple (> 3) B-lines (arrows) in an intercostal space. This patient had pulmonary oedema. (Clinical photo from the author)

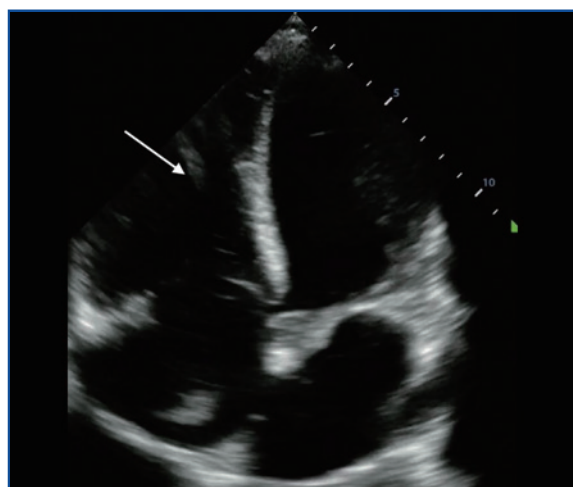


Fig. 6: Enlarged right ventricle (arrow) in a patient with pulmonary embolism, in apical 4-chamber view. (Clinical photo from the author)

4. RUSH PROTOCOL: DECODE UNDIFFERENTIATED SHOCK

The Rapid Ultrasound in Shock (RUSH) exam helps delineate the cause of shock: hypovolemic, cardiogenic, obstructive, or distributive.⁶

Components

The RUSH exam encompasses scanning of the following components:

- **H:** Heart (cardiac assessment)
- **I:** IVC (inferior vena cava)
- **M:** Morrison's pouch (FAST exam)
- **A:** Aorta
- **P:** Pneumothorax

Pearls

- In (transthoracic) cardiac ultrasound, look for pericardial effusion, RV (right ventricular) strain (pulmonary embolism), poor LV (left ventricular) contractility.
- Focus on qualitative assessment when time is critical.
- IVC collapsibility provides clues to volume status and fluid responsiveness.

Pitfalls

- Pericardial fat pads or pleural effusion can mimic pericardial effusion.
- IVC interpretation is different in ventilated patients.

5. CARDIAC ARREST: POCUS – FRIEND OR FOE?

POCUS during CPR (cardiopulmonary resuscitation) aids in identifying reversible causes like cardiac tamponade, massive pulmonary embolism, or tension pneumothorax.⁷

Pearls

- Use subxiphoid, or parasternal long-axis views.
- Perform POCUS during minimise CPR interruptions.
- Look for organised cardiac motion to guide further ACLS steps.

Pitfalls

- Excessive scanning delays chest compressions.
- Pericardial fluid may be small – interpret in clinical context.

6. PROCEDURE GUIDANCE: DO IT WITH VISION?

Ultrasound guidance improves the safety and success of central line placement⁷, nerve blocks, and pericardiocentesis.

Pearls

- Confirm the needle tip before injecting into nerve blocks.
- For pericardiocentesis, the subxiphoid view helps guide angle and depth.
- Out-of-plane techniques can be considered for quick vascular access, though maintaining visualisation of the needle tip is essential for safety.

Pitfalls

- Shadowing from ribs or probe position may hide vessels.
- Over-reliance on landmark knowledge without proper understanding of distorted anatomy can be hazardous.

THE HONG KONG PERSPECTIVE

The HKCEM Ultrasound Subcommittee has been instrumental in restructuring the POCUS EM Certification framework since 2022². Many departments now implement structured protocols for eFAST, RUSH, and procedural guidance. Nurses and paramedics are also being trained in select applications, such as bladder scanning and FAST.

BEYOND THE CORE: EXPANDING POCUS APPLICATIONS

Additional applications, including airway, advanced cardiac, and musculoskeletal ultrasound, are recognised utilities.^{3,9} Future developments in POCUS are:^{2,9}

- **AI-assisted POCUS:** Helping beginners obtain and interpret images.
- **TEE (transoesophageal echocardiography) in ED:** Emerging use during resuscitation, especially cardiac arrest.
- **Cloud-integrated archiving:** For quality assurance and education.

CONCLUSION

Emergency ultrasound, when used thoughtfully, is an unparalleled tool that brings the unseen into view. With growing accessibility, education, and collaboration, Hong Kong's doctors are well-positioned to lead in POCUS excellence for resuscitation care.

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Overarching Mission: Preparedness and Response Planning for Horse Racing Emergencies

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Dr Ho-cheung CHU

INTRODUCTION

Horse racing was introduced to Hong Kong by the British in the 1840s and has since become a subject of great interest. It is so ingrained in local culture that, in the 80's, it became a symbol of a smooth transfer of sovereignty when China's late paramount leader Deng Xiaoping assured the people of Hong Kong that 'the horse racing will continue, the dancing will stay'. Racing, being a high-risk sport associated with speed and physical exertion, presents a higher risk of severe injuries such as fractures and concussions. Since 2018, a four-member Chief Medical Officer Team (CMO Team) has been commissioned to ensure the health, safety and welfare of jockeys competing in a risk-controlled racing environment.

ROLE OF THE CMO TEAM

Members of the CMO Team specialise in Emergency Medicine and have been conferred Fellowship of the Faculty of Sports and Exercise Medicine (FFSEM). They are experienced in life-saving medical intervention and prehospital care for elite athletes.

The CMO Team plays a pivotal and multifaceted role in ensuring the health, safety, and well-being of the racing community, particularly jockeys. Working in collaboration with various medical support and auxiliary teams, including healthcare professionals from the Hospital Authority and St. John Ambulance, the CMO Team provides on-site emergency first response and prehospital care for barrier trials, race meetings, and international races, adopting a multidisciplinary approach. Medical protocols and operating guidelines would undergo regular review, covering responsibilities spanning the management of concussion, rehabilitation of injuries after falls, examination for fitness to ride, and physical and mental health assessment.

CAPACITY BUILDING FOR FIRST RESPONDERS

Quarterly exercises and combined drills have been organised to develop and strengthen the competencies of medical response partners and other core members. This, in turn, helps the whole team be geared up to facilitate access to medical care of the highest quality on racedays, as per the emergency and response

plans carefully set out, and to ensure a safe racing environment. Compliance of standard protocols, skills and competencies on emergency management and effectiveness of team communication would be assessed for professional capacity building.

Prehospital care plays a critical role in improving patient outcomes, particularly in cases of time-sensitive emergencies. The CMO Team is committed to upgrading the prehospital care and support services available at horse racing events and to preparing the medical team to manage riders who may suffer a fall or be injured in any way on racedays, before they reach hospital or during emergency transfer. Since 2023, the members have been actively engaged in the structured training course "Certificate Course on Prehospital Medical Support for Horse Racing" run by the Hong Kong College of Emergency Medicine (HKCEM), which has been accredited by the International Federation for Emergency Medicine (IFEM). The certificate course aims to foster understanding of the medical aspects and safety measures specific to horse racing, to enrich the knowledge and skills of managing injuries on race tracks, and to strengthen the team communication.

CONCUSSION PROTOCOL UPDATES

The CMO Team has, over the years, been assuming an advisory role, recommending and advocating refinements to rules, engaging stakeholders on integrity matters, and reviewing compliance with medical protocols to ensure they remain fit-for-purpose, on par with the prevailing racing industry best practice at a global level.

One single jockey injury incident is far too many, even though the fall rate remains low in Hong Kong. The concussion safety and protocol for jockeys, as well as the associated medical care management, have been reviewed, with major changes made to further reinforce concussion baseline and post-fall assessment. The FDA-cleared tool, "Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT)", has also been introduced to support trained healthcare providers in making sound return to activity decisions with an overseas neuropsychologist engaged. Objective data about a jockey's cognitive function before and after concussion assesses the severity and tracks the recovery progress of the jockey. The Sport Concussion

Assessment Tool 6th Edition (SCAT6) and ImPACT are being performed for all jockeys before the start of each season and are complementary to each other. The concussion safety and protocol for jockeys, as well as the associated medical care management has been reviewed with major changes made to further reinforce concussion baseline and post-fall assessment.

RACING CONTINUES AMIDST GLOBAL HEALTH CRISIS

The continuation of racing in a safe and secure environment is paramount. The CMO Team provides comprehensive support for the city's racing events and world-class competitions during the COVID-19 pandemic, when our daily lives were disrupted. Despite all the logistical challenges encountered by the medical support team and emergency response partners, no single race meeting was cancelled due to the pandemic in Hong Kong.

The CMO Team devised specific protocols and health promotion information, with briefing sessions conducted. Stringent anti-pandemic measures were implemented, including a robust PCR testing regime for all licensed jockeys and staff, with test results reported and uploaded to an electronic portal in a timely manner. Temporary vaccination centres were set up at racecourses to boost vaccine uptake. Fit tests of N95 respirators were also arranged for the racing medical team, in addition to supplying adequate personal protective equipment.

For international races, a strict racing bubble for overseas participants was established, based on a closed-loop management framework with multiple layers of protection, as per the requirements decided by the HKSAR Government for quarantine exemptions. The racing bubble was intended to ensure that overseas participants, under continuous medical surveillance by the CMO Team, would have no contact with the general public. These layers included compulsory vaccination for both overseas participants and all locals associated with the racing bubble - movements restricted to point-to-point transport between the airport, the quarantine hotel and racecourses. The CMO Team took charge of the on-site infection control measures and quarantine, ensured strict adherence to the COVID-19-related measures, provided continuous medical surveillance, reviewed test reports, provided necessary professional advice to the overseas participants, and communicated with various consular missions about the jockey management plan to ensure their seamless arrival for participation in races.

Through the determination of everyone involved, the racing continued without causing any public health risks during the pandemic. This showcases Hong Kong's strong spirit, which helps us overcome challenges.

RESEARCH ON FALLS AND INJURIES IN RACING EVENTS

With continual efforts to maintain a registry that records all jockey falls and injuries characteristics over the years, the CMO Team will participate in epidemiological

research to study the incidence, causes, and outcomes of falls and injuries, utilising retrospective data collected from racing events, medical records, and injury reports. The research objectives are to determine the incidence and prevalence of jockey fall injuries in Hong Kong professional flat racing for a designated period, including detailed analysis of specific injury types and locations; to identify demographic, environmental, and behavioural factors associated with jockey fall injuries; to analyse the circumstances surrounding the injuries, including race conditions, track surfaces and jockey experience; to compare trends of jockey fall injury incident rates over the years and across different months within each year to identify any seasonal patterns; and to provide an updated comprehensive analysis of falls and injury incidents in professional flat horse racing in Hong Kong over the specified period to support targeted injury prevention and medical care strategies.

CONCLUSION

People from all walks of life gather at racecourses, enjoying a carnival-like atmosphere. The CMO Team members are united and passionate about the overarching mission to plan and execute effective emergency preparedness and response plans that serve the best interests of all individuals involved. They maintain momentum in upholding professional competency and ethical practice and remain abreast of emerging trends and industry best practices to ensure a safe racing environment.



Raising the Bar in Sports

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Dr Chi-wai CHAU

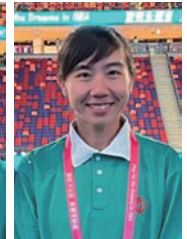
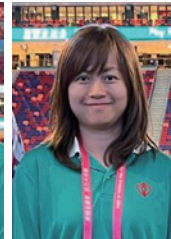
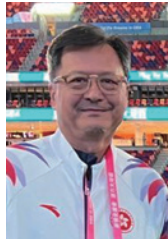
MBBS (HK), MRCS (Edin), FHKCEM, FHKAM (Emergency Medicine)
Past Vice-chairman of Sports Medicine Subcommittee, Hong Kong College of Emergency Medicine
Specialist in Emergency Medicine

Dr Wendy CHENG

MBBS (HKU), MRCS (Edin), FHKCEM, FHKAM (Emergency Medicine), Dip Med. (CUHK), DFM (Monash)
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Vice-chairman of Sports Medicine Subcommittee,
Hong Kong College of Emergency Medicine
Specialist in Emergency Medicine
Sports Medicine Subcommittee,
Hong Kong College of Emergency Medicine



Dr Wing-cheung WU

Dr Chi-wai CHAU

Dr Wendy CHENG

Dr Kit-ying SO



Fig. 1: Dr Wing-cheung WU, Dr Wendy Cheng, Dr Kit-ying So, Dr Chi-wai Chau (from left to right), photo taken during the medical support session at the 15th National Games of the People's Republic of China The Hong Kong Jockey Club Trophy Rugby Sevens Competition in 2025 at Kai Tak Stadium (Personal collection from the authors)

SPORTS MEDICINE SUBCOMMITTEE DEVELOPMENT IN EMERGENCY MEDICINE

The evolution and current standing of the Sports Medicine Subcommittee of the Hong Kong College of Emergency Medicine (HKCEM) is a narrative deeply intertwined with the broader rise of sports culture within Hong Kong. This growth, fueled by increased Government and commercial support alongside a surge in public interest in both spectator and participation sports, has led to an ever-expanding calendar of major sporting events. In the early years, medical coverage for such events was sporadic and often provided by doctors from diverse backgrounds, primarily for major public spectacles such as horse racing. However, it became increasingly apparent that sports events presented not just injuries but a spectrum of potential medical emergencies, positioning emergency physicians - with their broad-based training in managing acute medical and surgical crises - as the ideal specialists to deliver

comprehensive on-site care. This recognition was further bolstered as many emergency medicine colleagues began pursuing postgraduate qualifications in sports medicine, cultivating a dedicated interest in this field. A pivotal moment in this journey was the identification of the need for robust medical support for the Oxfam Trailwalker, a gruelling 100-km trek across Hong Kong's most rugged terrain. Beginning in 1996, the Accident and Emergency Department of Queen Elizabeth Hospital took on this responsibility, a commitment that expanded to the entire Kowloon Central Cluster by 2004. This initiative vividly illustrates the scaling up of efforts; what began with a modest team of fewer than 40 voluntary medical personnel in 1996 has, through the dedication of countless volunteers, grown into a massive operation involving over 250 doctors and nurses. Parallel to this, the Hospital Authority's formal invitation in 2,000 to provide medical support for horse racing at the Happy Valley and Shatin racecourses signified another significant institutional commitment. Beyond these organised efforts, numerous physicians have independently provided ad hoc medical services for a diverse array of events, sometimes through voluntary agencies like the Auxiliary Medical Service, covering everything from the Standard Chartered Marathon and International Badminton Championships to Muay-Thai Tournaments and exhibitions by Olympic diving champions.



Fig. 2: Medical Support at the Oxfam Trailwalker 2022 (Personal collection from the authors)

The formalisation of these dispersed interests and efforts culminated in the Spring of 2005 with the establishment of the Sports Medicine Interest Group under the HKCEM's Scientific Affairs Committee. Founded by a cadre of doctors who were both clinically interested in sports medicine and keen sporting individuals themselves, the Group's mission was twofold: to foster academic growth through regular gatherings where experts shared insights on topics like 'Risk Assessment before Exercise' and 'High Altitude Illnesses', and to provide pro bono medical coverage at sports events. This proactive approach quickly garnered respect within the sporting community, leading to prestigious invitations to support events like the Davis Cup Tennis Tournament, equestrian events, and, most notably, the world-renowned Hong Kong Rugby Sevens in 2004. This participation was a clear demonstration of the growing need for, and recognition of their specialised expertise. The scope of sports medicine itself was understood by the group in its modern, comprehensive form - not merely as the treatment of sports injuries, but as the broader field of Sports and Exercise Medicine (SEM), encompassing a broad spectrum of sciences aimed at promoting health, fitness, and safety among all participants. The rising popularity of sports in Hong Kong, driven by health trends and local athlete celebrities, created fertile ground for this expanded vision, with events like the Hong Kong Marathon and the Rugby Sevens evolving into government-endorsed "M" Mark major events.

The group's trajectory of professionalisation continued in 2007 when it was elevated to an official subcommittee under the HKCEM, a move that significantly raised its institutional profile. After the subcommittee formation, it was immediately followed by the Inaugural Symposium on Emergency Medicine and Sports, featuring Dr Karim Khan, a global authority in the field, as the keynote speaker. This development was also strategically timely, enabling Hong Kong to contribute to the 2008 Beijing Olympics by co-organising an 'Emergency Care at Equestrian Events' course to prepare personnel for the Olympic Equestrian competitions held in Hong Kong.

OUR WORK

A critical pillar of the Subcommittee's work has been its unwavering focus on practical, hands-on training. Recognising that international sports organisations increasingly require physicians with specific sports medicine qualifications to lead medical teams, the Subcommittee has actively worked to bridge the gap between academic knowledge and pitch-side skills. In 2009, the Subcommittee organised a 'Sports Event Medical Coverage' course for the East Asian Games and, most significantly, launched the Pitch Side Immediate Trauma Care (PSITCC) course in Hong Kong. Originally developed in the U.K. for rugby, this course was adapted and broadened to cover a diverse range of sports injuries in the Hong Kong context. Under the guidance of experts like Dr Andy Smith and in collaboration with the Hong Kong China Rugby (HKCR), previously Hong Kong Rugby Union, the course - renamed 'Immediate Care in Sports' in 2011 - has become an annual cornerstone of training, co-organised by HKCEM and HKCR, and is essential for nurturing a stable of personnel equipped with the vital skills to respond effectively in dynamic and

often unpredictable sports event and general event environments.



Fig. 3: "Prehospital Sports Event Medical Course" organised by the Subcommittee in 2023 (Personal collection from the authors)

This dedication to practical application is embodied in the Voluntary Sports Medicine Group, the operational arm of the Subcommittee. Over the past decade, this group has provided medical cover for an incredibly wide and diverse range of sports, including show-jumping, rugby, endurance events, cycling, swimming, tennis, badminton, Sumo wrestling and Judo. This extensive experience has not only provided invaluable hands-on opportunities for medical personnel but has also allowed for the accumulation of highly specialised knowledge in managing injuries unique to each discipline. The Subcommittee's contributions were formally recognised in 2015 when it was nominated by the Hong Kong Badminton Association to receive the M-Mark Event Certificate of Appreciation from the Hong Kong SAR Government's Sports Commission, a testament to its integral role in the success of major sporting events.



Fig. 4: Medical support for Victoria Harbour Race (Cross Harbour Swim) (Personal collection from the authors)



Fig. 5: Medical support at 2021 UCI Track Cycling Nations Cup during the COVID-19 pandemic (Personal collection from the authors)



LOOKING AHEAD

Looking ahead, the future of the Sports Medicine Subcommittee is exceptionally bright and full of purpose. The recent successes of Hong Kong athletes on the international stage have spurred the Government to further promote sports within the community, support elite athletes, and solidify Hong Kong's status as a hub for major international sports events. Riding this wave of momentum, the Subcommittee aims to expand its scope and reach through deeper collaboration with other medical specialties and sports associations, diversifying the skills and knowledge of its personnel. It remains committed to raising the standard of sports medicine through intensified training and development programmes, with the ultimate goal of nurturing the next generation of specialists and working towards formal accreditation as a subspecialty qualification.

As Hong Kong continues to host world-class events and its athletes achieve new heights, the Sports Medicine Subcommittee of the HKCEM is poised to play an increasingly integral and pivotal role in safeguarding athlete health and welfare, and propelling the field of sports medicine forward in the city.

Dermatology Quiz



Dermatology Quiz

Dr Lai-yin CHONG

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



Dr Lai-yin CHONG



Fig.1: Lesions on the left lower leg

This 20-year-old man presented with an acute onset of painful and itchy skin rash on his left lower legs for one day. On examination, there were erythematous lesions with a bizarre and figurate configuration (Fig.1).

Questions

1. Before asking further history, what is your spot diagnosis at first glance?
2. What will be the first question you ask?
3. What are the possible severe consequences?
4. How do you manage this condition?

(See P. 32 for answers)



Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	★ HKMA CME Portal (Online) The HKMA-KWC CME Online Lecture Series on Common Medical Conditions for GP in 2026 Topic: Thyrotoxicosis and Primary Hyperparathyroidism 2	★ In-person / HKMA CME Portal (Online) The HKMA-HKSH CME Programme 2026 Topic: Alzheimer Disease Care Giver Education 3	★ In-person / HKMA CME Portal (Online) The HKMA CME Hybrid Lecture Topic: From LDL-C to CV Outcomes: Integrating PCSK9 Inhibitors into Lipid Management 4	★ In-person / HKMA CME Portal (Online) The HKMA CME Hybrid Lecture Series on Obesity Liver Disease and Fatty Liver Disease and Primary Care Topic: Evidence-Based Practices 5	★ In-person The HKMA CME Lecture in Physical Attendance Mode Topic: Intensive Lipid Management for Atherosclerotic Cardiovascular Disease (ASCVD) Patients – How and When? 6	7
8	9	★ In-person / HKMA CME Portal (Online) The HKMA CME Hybrid Lecture Topic: Vitiligo Management: Not Just Waiting for Godot? 10	★ The Hong Kong Neurosurgical Society Monthly Academic Meeting - To be confirmed ★ In-person The HKMA CME Lecture in Physical Attendance Mode Topic: The Architecture of Strength: Mastering the Synergy of Bone Growth and Joint Longevity 11	★ HKMA CME Portal (Online) The HKMA CME Online Lecture Topic: From Gut to Glow: Understanding the Gut Microbiome's Role in Skin and Gut Health ★ FMSHK Executive Committee Meeting 12	★ HKMA CME Portal (Online) The HKMA CME Online Lecture Topic: Onychomycosis in Primary Care: Diagnosis, Treatment and Optimising Outcomes with Topical Therapy 13	14
15	★ HKMA CME Portal (Online) The HKMA Adult Immunisation Campaign 2025 CME Online Lecture Topic: The Next Chapter of COVID Prevention: Understanding Hong Kong's Disease Burden and the New LP.8.1 Vaccine 16	17	★ In-person The HKMA CME Lecture in Physical Attendance Mode Topic: Impact of Influenza and the Need for Better Protection against Influenza ★ Certificate Course on Urological Disorders 2026 (Video Lectures) 18	19	★ HKMA CME Portal (Online) The HKMA Adult Immunisation Campaign 2025 CME Online Lecture Topic: Postherpetic Neuralgia: A Persistent Pain Beyond Herpes Zoster 20	21
22	23	★ In-person / HKMA CME Portal (Online) The HKMA CME Hybrid Lecture Series on Obesity Agonists in Primary Care: Outcomes Beyond Weight Loss 24	★ Certificate Course on Urological Disorders 2026 (Video Lectures) 25	★ HKMA CME Portal (Online) The HKMA CME Online Lecture Topic: The Gut-Brain Connection: Microbiome Modulation as a Novel Approach to Adult Depression and Anxiety 26	★ HKMA CME Portal (Online) The HKMA CME Online Lecture Topic: Lower Urinary Tract Symptoms (LUTS) Management in Primary Care Setting 27	28
29	★ HKMA CME Portal (Online) The HKMA CME Online Lecture Topic: Managing MASLD associated Diabetes (MAD) - Practical strategies in Primary Care 30	31				



Date / Time	Function	Enquiry / Remarks
2 MON 2:00 PM	HKMA CME Portal (Online) HKMA-KWC CME Online Lecture Series on Common Medical Conditions for GP in 2026 Topic: Thyrotoxicosis and Primary Hyperparathyroidism Organisers: The Hong Kong Medical Association and Kowloon West Cluster of HA Speaker: Dr Vicki Ho-kee TAM	HKMA CME Dept. Tel: 2527 8452 1 CME Point
3 TUE 2:00 PM	In-person / HKMA CME Portal (Online) HKMA-HKSH CME Programme 2026 Topic: Alzheimer Disease Care Giver Education Organisers: The Hong Kong Medical Association and Hong Kong Sanatorium & Hospital Speaker: Dr Ping-wing NG Venue: The HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	HKMA CME Dept. Tel: 2527 8452 1 CME Point
4 WED 2:00 PM	In-person / HKMA CME Portal (Online) The HKMA CME Hybrid Lecture Topic: From LDL-C to CV Outcomes: Integrating PCSK9 Inhibitors into Lipid Management Organiser: The Hong Kong Medical Association Speaker: Dr Chak-kwan LAU Venue: Shanghai Room, 8/F, Cordis Hong Kong, 555 Shanghai Street, Mong Kok, Kowloon	HKMA CME Dept. Tel: 2527 8452 1 CME Point
5 THU 2:00 PM	In-person / HKMA CME Portal (Online) The HKMA CME Hybrid Lecture Series on Obesity Topic: Metabolic Fatty Liver Disease and Obesity: Evidence-Based Primary Care Practices Organiser: The Hong Kong Medical Association Speaker: Dr Long-yan LAM Venue: Forum Room I, Basement 2, Regal Hongkong Hotel, 88 Yee Wo Street, Causeway Bay	HKMA CME Dept. Tel: 2527 8452 1 CME Point
6 FRI 2:00 PM	In-person The HKMA CME Lecture in Physical Attendance Mode Topic: Intensive Lipid Management for Atherosclerotic Cardiovascular Disease (ASCVD) Patients – How and When? Organiser: The Hong Kong Medical Association Speaker: Dr Chak-kwan LAU Venue: Crystal Ballroom A&B, 2/F, The Cityview, 23 Waterloo Road, Kowloon	HKMA CME Dept. Tel: 2527 8452 1 CME Point
10 TUE 2:00 PM	In-person / HKMA CME Portal (Online) The HKMA CME Hybrid Lecture Topic: Vitiligo Management: Not just Waiting for Godot? Organiser: The Hong Kong Medical Association Speaker: Dr King-man HO Venue: HKMA Central Clubhouse, 2/F, Chinese Club Building, 21-22 Connaught Road Central, Central	HKMA CME Dept. Tel: 2527 8452 1 CME Point
11 WED 7:30 AM	The Hong Kong Neurosurgical Society Monthly Academic Meeting - To be confirmed Organiser: Hong Kong Neurosurgical Society Speaker(s): Dr Desiree Ka-ka WONG Chairman: Dr Tak-lap POON Venue: Seminar Room, G/F, Block A, Queen Elizabeth Hospital; or via Zoom meeting	CME Accreditation College: 1.5 points College of Surgeons of Hong Kong Dr Jason CHOW Tel: 2595 6456 Fax. No.: 2965 4061
11 WED 2:00 PM	In-person The HKMA CME Lecture in Physical Attendance Mode Topic: The Architecture of Strength: Mastering the Synergy of Bone Growth and Joint Longevity Organiser: The Hong Kong Medical Association Speaker: Dr Kin-cheung MAK Venue: Maggie Room, 2/F, Eaton HK Hotel, 380 Nathan Road, Kowloon	HKMA CME Dept. Tel: 2527 8452 1 CME Point
12 THU 2:00 PM	HKMA CME Portal (Online) The HKMA CME Online Lecture Topic: From Gut to Glow: Understanding the Gut Microbiome's Role in Skin and Gut Health Organiser: The Hong Kong Medical Association Speaker: Dr Kenny KUNG	HKMA CME Dept. Tel: 2527 8452 1 CME Point
12 THU 7:30 PM	FMSHK Executive Committee Meeting Organiser: The Federation of Medical Societies of Hong Kong Venue: Council Chamber, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms Nancy CHAN Tel: 2527 8898
13 FRI 2:00 PM	HKMA CME Portal (Online) The HKMA CME Online Lecture Topic: Onychomycosis in Primary Care: Diagnosis, Treatment and Optimising Outcomes with Topical Therapy Organiser: The Hong Kong Medical Association Speaker: Dr Wai-fuk WU	HKMA CME Dept. Tel: 2527 8452 1 CME Point
16 MON 2:00 PM	HKMA CME Portal (Online) The HKMA Adult Immunisation Campaign 2025 CME Online Lecture Topic: The Next Chapter of COVID Prevention: Understanding Hong Kong's Disease Burden and the New LP.8.1 Vaccine Organiser: The Hong Kong Medical Association Speaker: Dr Kin-wing CHOI	HKMA CME Dept. Tel: 2527 8452 1 CME Point
18 WED 2:00 PM	In-person The HKMA CME Lecture in Physical Attendance Mode Topic: Impact of Influenza and the Need for Better Protection against Influenza Organiser: The Hong Kong Medical Association Speaker: Dr Raymond TSO Venue: Diamond 8, 2/F, The Royal Garden Kowloon East, 3 Tong Tak Street, Tseung Kwan O, Hong Kong	HKMA CME Dept. Tel: 2527 8452 1 CME Point



Date / Time	Function	Enquiry / Remarks
18 WED 7:00 PM	Certificate Course on Urological Disorders 2026 (Video Lectures) Organisers: The Federation of Medical Societies of Hong Kong, Hong Kong Society of Practising Urologists & The Hong Kong Society of Endourology Speakers: Dr Wai-kit MA & Dr Raymond KAN	Ms ToTo CHAN Tel: 2821 3512
20 FRI 2:00 PM	HKMA CME Portal (Online) The HKMA Adult Immunisation Campaign 2025 CME Online Lecture Topic: Postherpetic Neuralgia: A Persistent Pain Beyond Herpes Zoster Organiser: The Hong Kong Medical Association Speaker: Dr Man-shun LAW	HKMA CME Dept. Tel: 2527 8452 1 CME Point
24 TUE 8:00 PM	In-person / HKMA CME Portal (Online) The HKMA CME Hybrid Lecture Series on Obesity Topic: GLP-1 Receptor Agonists in Primary Care: Outcomes Beyond Weight Loss Organiser: The Hong Kong Medical Association Speaker: Speaker who is specialist in Endocrinology, Diabetes & Metabolism Venue: Salon I-III, Lobby Level, Hyatt Regency Hong Kong, 18 Hanoi Road, Tsim Sha Tsui, Hong Kong	HKMA CME Dept. Tel: 2527 8452 1 CME Point
25 WED 7:00 PM	Certificate Course on Urological Disorders 2026 (Video Lectures) Organisers: The Federation of Medical Societies of Hong Kong, Hong Kong Society of Practising Urologists & The Hong Kong Society of Endourology Speakers: Dr Joseph LI & Dr Alexander FAN	Ms ToTo CHAN Tel: 2821 3512
26 THU 2:00 PM	HKMA CME Portal (Online) The HKMA CME Online Lecture Topic: The Gut-Brain Connection: Microbiome Modulation as a Novel Approach to Adult Depression and Anxiety Organiser: The Hong Kong Medical Association Speaker: Dr Dennis Ching-ping CHEUNG	HKMA CME Dept. Tel: 2527 8452 1 CME Point
27 FRI 2:00 PM	HKMA CME Portal (Online) The HKMA CME Online Lecture Topic: Lower Urinary Tract Symptoms (LUTS) Management in Primary Care Setting Organiser: The Hong Kong Medical Association Speaker: Dr Alan Kwan-kit LO	HKMA CME Dept. Tel: 2527 8452 1 CME Point
30 MON 2:00 PM	HKMA CME Portal (Online) The HKMA CME Online Lecture Topic: Managing MASLD associated Diabetes (MAD) - Practical strategies in Primary Care Organiser: The Hong Kong Medical Association Speaker: Dr Enoch WU	HKMA CME Dept. Tel: 2527 8452 1 CME Point

Certificate Course for General Practitioners, Nurses and Health Care Providers

Course No. C432 CME/CNE Course

Certificate Course on

Urological Disorders 2026
(Video Lectures)

Jointly organised by



The Federation of Medical Societies of Hong Kong



Hong Kong Society of Practising Urologists



The Hong Kong Society of Endourology

Date	Topics	Speakers
18 Mar 2026	Latest Treatment Landscape in Kidney Mass and Upper Urinary Tract Cancer	Dr. Ma Wai Kit Specialist in Urology
	Personalised Prostate Health Assessment and Treatment in Elderly	Dr. Raymond Kan Specialist in Urology
25 Mar 2026	Recent Advances in the Management of Urinary Tract Stones	Dr. Joseph Li Specialist in Urology
	Current Approaches to Managing Benign Prostatic Hyperplasia	Dr. Alexander Fan Specialist in Urology
1 April 2026	Lower Urinary Tract Symptoms Made Easy	Dr. Clarence Leung Specialist in Urology
	Approach to Patients with Male Infertility	Dr. James Tsu Specialist in Urology
8 April 2026	Reconstructive Surgery in Urology	Dr. Thomas Wong Specialist in Urology
	From Haematuria to Surgery: Walkthrough of Early Bladder Cancer Management	Dr. Wilson Lam Specialist in Urology
15 April 2026	Common Penile Disorders – No Longer a Hard Problem !	Dr. Wayne Lam Specialist in Urology
	Advances in the Management of Muscle Invasive Bladder Cancer	Dr. Brian Ho Specialist in Urology
22 April 2026	Latest Developments in the Management of Prostate Cancer	Dr. Ng Chi Man Specialist in Urology
	Management of Stress Urinary Incontinence in Female Patients	Dr. Wilson Chan Specialist in Urology

Dates : 18, 25 March and 1, 8, 15, 22 April 2026 (WED)

Duration of Session : 1.5 hours (6 sessions)

Time : 7:00 pm – 8:30 pm

Course Feature : Video lectures (with Q&A platform for participants to post the questions)

Language Media : Cantonese (Supplemented with English)

Quiz for Doctors : DOCTORS are required to complete a quiz after the completion of each lecture

Course Fee : HK\$1,200

FMSHK Certificate : Awarded to participants with a minimum attendance of 70% (per Lecture and 4 out of 6 Lectures)

Deadline : 11 March 2026

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

Tel.: 2821 3512 Fax : 2865 0345 Email : toto.chan@fmshk.org

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Answers to Dermatology Quiz

Answers:

1. Jellyfish stings with these typical whip-like streaks.
2. Any history of swimming, diving, or walking along the beaches.

This young gentleman had a history of swimming in sea while he had these skin lesions. Jellyfish sting typically presented with immediate and intense burning pain or itchiness at area of contact within minutes to hours. The inflamed lesions appear as lines simulate whip marks, sometimes with wheals and small blisters. These streaks represent the area of contact with the jellyfish's tentacles.

3. Most jellyfish stings are mild and will recover over a few days or weeks. However, in severe reactions, emergency medical care is needed. Systemic symptoms include shortness of breath, nausea and vomiting, hyperhidrosis, chest or abdominal pain, muscle cramps, etc. In rare situations, the condition can be life-threatening, such as those stung by Box jellyfish, Portuguese man-of-war, Lion's mane, and Sea nettle.
4. The immediate actions include getting out of the water to get away from the jellyfish and prevent further stings, washing the tentacles and venom off with seawater (Don't use freshwater). The affected area should not be rubbed with a towel or applied with a pressure immobilisation bandage, as these may cause more venom to be injected.

Symptomatic measures like calamine lotion, steroid cream, simple analgesic, anti-inflammatory agents and anti-histamines can be given. Topical antiseptics or oral antibiotics are given if necessary. In severe cases, antivenom may be needed.

Dr Lai-yin CHONG

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Specialist in Dermatology & Venereology

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Certificate Course on

Clinical Ophthalmology 2026 - Contemporary Practice and Emerging Trends (Video Lectures)

Jointly organised by



The Federation of Medical
Societies of Hong Kong



The Hong Kong
Ophthalmological
Society

Objectives:

This course aims to provide an updated overview of contemporary ophthalmic practice, enhance recognition and assessment of common and urgent eye conditions, introduce emerging clinical trends and technologies, and support safe, patient-centred eye care through practical, clinically relevant learning.

Date	Topics	Speakers
9 April 2026	Modern Cataract Care - Beyond Lens Opacity	Dr. Tommy Chan Honorary Clinical Associate Professor Department of Ophthalmology (HKU); Honorary Clinical Associate Professor Department of Ophthalmology and Visual Sciences (CUHK)
16 April 2026	Seeing Clearly in 2026 - Refractive Errors and Vision Correction Today	Dr. Julia Chan FCOphthHK FHKAM (Ophthalmology) FRCOphth
23 April 2026	Glaucoma Care in Real Life - From Detection to Long-Term Management	Dr. Nancy Yuen Specialist in Ophthalmology Honorary Clinical Associate Professor (HKU) Honorary Clinical Associate Professor (CUHK)
30 April 2026	When the Eye Is an Emergency - Red Flags, Trauma, and Urgent Care	Dr. Poemen Chan Associate Professor Department of Ophthalmology and Visual Sciences (CUHK)
7 May 2026	Macula and Retina in Focus - Common Diseases and Current Treatments	Dr. Jason Chan Specialist in Ophthalmology Temporary Part-time Associate Consultant (HKEH) Clinical Assistant Professor (Honorary) (CUHK) FCOphthHK FHKAM (Ophthalmology)
14 May 2026	Seeing Inside the Eye - Ophthalmic Imaging and Its Clinical Impact	Dr. Sunny Au Honorary Clinical Assistant Professor Department of Ophthalmology LKS Faculty of Medicine (HKU)
	Periocular and Orbital Diseases - Clinical Recognition and Updates	Dr. Tracy Kwok FCOphthHK FHKAM (Ophthalmology)

Date : 9, 16, 23, 30 April and 7, 14 May 2026 (THUR)

Duration of Session : 1.5 hours (6 sessions)

Time : 7:00 pm – 8:30 pm (or within 4 days from each Lecture Date)

Course Feature : Video lectures (with Q&A platform for participants to post the questions)

Language Media : Cantonese (Supplemented with English)

Quiz for Doctors : DOCTORS are required to complete a quiz after the completion of each lecture

Course Fee : HK\$1,200

Certificate : Awarded to participants with a minimum attendance of 70% (per Lecture and 4 out of 6 Lectures)

Deadline : 30 March 2026

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

Tel: 2821 3512 Fax: 2865 0345 Email : toto.chan@fmsk.org





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

FEDERATION SPORTS DAY 2026

15 March 2026 (SUN)

1:30 – 8:30 PM (Tentative)

Ying Wa College

FORM YOUR TEAM NOW!

Registration Enquiries:

Ms. Aries YEUNG

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Email: aries.yeung@fmshk.org

