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# CME BULLETIN

持續醫學進修專訊

香港醫學會
THE HONG KONG MEDICAL ASSOCIATION

## On Becoming A Competent Family Doctor

Dr LAM, Wing Wo

CME LIVE

# HKMA CME Bulletin
# 持續醫學進修專訊

# Contents



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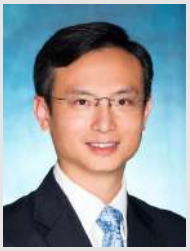
# EDITORIAL – October 2023 Issue



**Dr CHAN, Pierre**
*Chief Editor, Hong Kong Medical Association CME Bulletin*

The concept of primary care was first expounded in 1978. The World Health Organisation (WHO) held the first International Conference on Primary Health Services in Almaty. At the meeting, representatives of participating countries and organisations signed Almaty Declaration, stipulating that primary care services constitute the health system of an economic framework, promote overall socio-economic development, and are also the prerequisite for achieving the WHO goal of 'health for all'.

In current issue of HKMA CME Bulletin, Dr LAM, Wing Wo shares with us his experience "On Becoming A Competent Family Doctor", including challenges in primary health care in Hong Kong, Family Doctor and the Core Competences, Clinical Approaches and different Consultation Models, seven categories of Consultation Competences and the Process of Diagnosis and Management.

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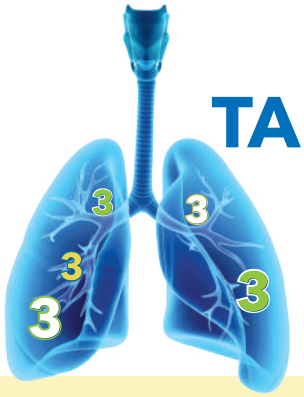

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NEW Pneumococcal Conjugate Vaccine since 2011[2]

Vaxneuvance® (PCV15) was SUPERIOR[a] to PCV13 for shared Serotype 3[1]

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## INFANTS

When compared to PCV13, Vaxneuvance® induced

**73%**

**increases IgG GMC against SEROTYPE 3,**

which was selected as one of the immunogenicity outcomes in phase 3 clinical trial[4,5]

(GMC ratio = 1.73, 95% CI 1.61, 1.87) p<0.001
Superiority criteria: lower bound of the 2-sided 95 % CI for the IgG GMC ratio (V114/PCV13) >1.2

## ADULTS

When compared to PCV13, Vaxneuvance® induced

**~60%**

**increases IgG GMC against SEROTYPE 3,**

which was selected as one of the immunogenicity outcomes in phase 3 clinical trial[1]

GMT Ratio: 1.60 (95% CI: 1.38-1.85)

Vaxneuvance® (PCV15) was noninferior[1a,4a] to PCV13 for all 13 shared serotype[1,4]

Vaxneuvance® (PCV15) was **SUPERIOR**[1a,4c] to PCV13 for **unique serotypes 22F** and **33F**[1,4]

[1a] in terms of OPA GMTs (according to a Phase 3 trial), [b] IPD: invasive pneumococcal disease, [4a] In terms of IgG response rates (proportion of participants meeting the serotype-specific IgG threshold value of ≥ 0.35µg/ml) at 30 days PD3 and IgG GMCs at 30 days PD4. (Non-inferiority criteria: for IgG response rates, the lower bound of the 2-sided 95 % CI for the between-group differences > -10 percentage points; for IgG GMCs, the lower bound of the 2-sided 95 % CI for the V114/PCV13 GMC ratios > 0.5), [4c] In terms of IgG response rates at 30 days PD3 and IgG GMCs at 30 days PD3 and 30 days PD4 (superiority criteria: for IgG response rates and IgG GMCs, the lower bound of the 2-sided 95 % CI for the between-group differences > 10 percentage points and > 2.0, respectively)

**Safety Result:** Adults: The majority of participants experienced at least 1 adverse event (67.9% after V114 and 58.2% after PCV13). The most frequently reported AEs (>5% of participants in either group) were the solicited events of injection-site pain, injection-site erythema, injection-site swelling, arthralgia, fatigue, headache, and myalgia.[1]
Children: The majority of participants experienced at least 1 adverse event (93.8% after V114 and 92.4% after PCV13). The overall proportions of participants with injection-site, systemic, vaccine-related, and serious AEs were generally comparable between treatment groups. The most common AEs were those solicited in the trial, with the 3 most frequently reported AEs being irritability, somnolence, and injection-site pain.[4]

Adults: Adults ≥ 50 Years old; CI: confidence interval; GMT: geometric mean titers; Infants: Healthy infants; IPD: invasive pneumococcal disease; OPA: opsonophagocytic activity; PCV13: 13-valent pneumococcal conjugate vaccine; PCV15: 15-valent pneumococcal conjugate vaccine

**Study design:** This was a phase 3, randomized, double-blind, active comparator- controlled study to evaluate the safety, tolerability, and immunogenicity of VAXNEUVANCE compared to PCV13 in healthy pneumococcal-vaccine naïve adults 50 years of age or older (Protocol V114-019). The study was conducted from June 2019 through March 2020 at 30 sites. The study enrolled 1,202 participants randomized in a 1:1 ratio to receive a single dose of Vaxneuvance (n=602) or PCV13 (n=600). Randomization was stratified by participant age at enrollment. The primary immunogenicity objectives were to compare Vaxneuvance to PCV13 for noninferiority of immune responses at 30 days postvaccination for shared serotypes (noninferiority met when lower bound of the 2 sided 95% CI of the OPA GMT ratio >0.5) and superiority of immune response at 30 days postvaccination for serotypes unique to Vaxneuvance (superiority met when lower bound of the 2-sided 95% CI of the OPA GMT ratio >2, and the lower bound of the 2-sided 95% CI of the difference between the proportions of participants with a ≥ 4-fold rise >0.1). The secondary immunogenicity objective was to assess superiority of immune response for serotype 3 at 30 days postvaccination (superiority met when lower bound of the 2-sided 95% CI of the OPA GMT ratio >1.2, and the lower bound of the 2-sided 95% CI of the difference between the proportions of participants with a ≥4-fold rise >0).[1]

This study was a phase 3, randomized, active comparator-controlled, double-blind study to evaluate the safety, tolerability, and immunogenicity of a 4-dose regimen of Vaxneuvance in healthy infants (protocol V114-029). It was conducted from June 2019 to May 2021. The study enrolled 1720 participants randomized in a 1:1 ratio to receive a 4-dose vaccination regimen of Vaxneuvance (n=858) or PCV13 (n=856). Primary immunogenicity objectives were to compare Vaxneuvance to PCV13 for non-inferiority for all serotypes using anti-PnPs serotype-specific IgG response rates (proportion of participants meeting the serotype-specific IgG threshold value of ≥0.35 Ig/ml) at 30 days PD3 and IgG geometric mean concentrations (GMCs) at 30 days PD3 and 30 days PD4. Serotypes 22F and 33F were compared to the lowest response rate or IgG GMC for any of the 13 shared serotypes among recipients of PCV13, excluding serotype 3. For IgG GMCs, the lower bound of the 2-sided 95% CI for the Vaxneuvance/ PCV13 GMC ratios needed to be >0.5 to meet non-inferiority criteria. Secondary objectives were to compare Vaxneuvance to PCV13 for superiority for IgG against serotypes 3, 22F, and 33F using anti-PnPs serotype-specific IgG response rates at 30 days PD3 and IgG GMCs at 30 days PD3 and 30 days PD4. For IgG response rates and IgG GMCs to serotypes 22F and 33F, the lower bound of the 2-sided 95% CI for the between-group differences needed to be >10 percentage points and >2.0, respectively, to meet superiority criteria. For shared serotype 3, superiority based on IgG response rates and IgG GMCs was demonstrated if the lower bound of the 2-sided 95% CI for the between-group was >0 percentage points and >1.2, respectively.[4]

**References:** 1. Platt HL *et al; Vaccine* 2022; 40(1):162-172. doi: 10.1016/j.vaccine.2021.08.049 2. Centre for Health Protection. Scientific Committee on Vaccine Preventable Diseases. Updated Recommendations on the Use of 13-valent Pneumococcal Conjugate Vaccine in Childhood Immunisation Programme; 2019. Adopted from: https://www.chp.gov.hk/files/pdf/updated_ recommendation_on_the_use_of_pcv3_in_hkcip_march2019_accessibility.pdf. Accessed on Nov 17, 2022. 3. Centre for Health Protection. Communicable Diseases Watch. *IPD* (2015-2021). 4. Lupinacci R *et al; Vaccine* 2023;41(5):1142-1152. doi: 10.1016/j. vaccine.2022.12.054. 5. Hong Kong Product Circular, Vaxneuvance, MSD.

**Vaxneuvance Selected Safety Information: Indications:** • Vaxneuvance is indicated for active immunisation for the prevention of invasive disease, pneumonia and acute otitis media caused by *Streptococcus pneumoniae* in infants, children and adolescents from 6 weeks to less than 18 years of age • Vaxneuvance is indicated for active immunisation for the prevention of invasive disease and pneumonia caused by *Streptococcus pneumoniae* in individuals 18 years of age and older. • The use of Vaxneuvance should be in accordance with official recommendations. **Contraindications:** Hypersensitivity to the active substances, to any of the excipients, or to any diphtheria toxoid-containing vaccine. **Precautions:** • In order to improve the traceability of biological medicinal products, the name and the batch number of the administered product should be clearly recorded. • Vaxneuvance must not be administered intravascularly. • As with all injectable vaccines, appropriate medical treatment and supervision should always be readily available in case of a rare anaphylactic event following the administration of the vaccine. Vaccination should be postponed in individuals suffering from acute severe febrile illness or acute infection. The presence of a minor infection and/or low-grade fever should not delay vaccination. • As with other intramuscular injections, the vaccine should be given with caution to individuals receiving anticoagulant therapy, or to those with thrombocytopenia or any coagulation disorder such as haemophilia. Bleeding or bruising may occur following an intramuscular administration in these individuals. • The potential risk of apnoea and the need for respiratory monitoring for 48-72 hours should be considered when administering the primary immunisation series to very premature infants (born ≤ 28 weeks of gestation) and particularly for those with a previous history of respiratory immaturity. As the benefit of vaccination is high in this group of infants, vaccination generally should not be withheld or delayed. • Immunocompromised individuals, whether due to the use of immuno-suppressive therapy, a genetic defect, HIV infection, or other causes, may have reduced antibody response to active immunisation. • Safety and immunogenicity data for Vaxneuvance are available for individuals living with HIV infection. Safety and immunogenicity data for Vaxneuvance are not available for individuals in other specific immunocompromised groups (e.g., haematopoietic stem cell transplant) and vaccination should be considered on an individual basis. • As with any vaccine, vaccination with Vaxneuvance may not protect all vaccine recipients. Vaxneuvance will only protect against *Streptococcus pneumoniae* serotypes included in the vaccine. • This medicinal product contains less than 1 mmol sodium (23 milligrams) per dose, i.e. essentially 'sodium-free'. **Adverse events:** The most frequently reported adverse reactions following vaccination with Vaxneuvance were solicited. The most frequent adverse reactions were pyrexia, injection-site pain, fatigue, myalgia, headache, injection-site swelling, injection-site erythema and arthralgia. The majority of solicited adverse reactions were mild (based on intensity or size) and of short duration (≤ 3 days); severe reactions (defined as being extremely distressed or unable to do usual activities or size > 7.6 cm) occurred in ≤4.5% of children and adolescents; severe reactions (defined as an event that prevents normal daily activity or size > 10 cm) occurred in ≤1.5% of adults across the clinical program. • Older adults reported fewer adverse reactions than younger adults. • For detailed side effects, please consult the full prescribing information.
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# ON BECOMING A COMPETENT FAMILY DOCTOR

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## Introduction

"Primary healthcare (PHC) is the first point of contact for individuals and families in a continuous healthcare process in the living and working community, which entails the provision of accessible, comprehensive, continuing, coordinated and person-centred care. A well-established and overarching PHC system routinely manages, maintains, and enhances the health of the population at the community level, forms the foundation and portal of the pyramid of healthcare services, and serves as a gateway to specialized secondary and tertiary healthcare in hospital and institution settings. It is recognized as the most essential component in a well-functioning healthcare system." (Primary Healthcare Blueprint)[1] PHC consists of a broad range of services including health promotion, prevention of acute and chronic diseases, health risk assessment and disease identification, treatment and care for acute and chronic diseases, self-management support, rehabilitative, supportive, and palliative care for disability or end-stage diseases.[2]

PHC services may be provided by different healthcare providers as a team, including western medicine doctors, dentists, chinese medicine practitioners, nurses, chiropractors, physiotherapists, occupational therapists, clinical psychologists, dietitians, pharmacists, optometrists, speech therapists, podiatrists, etc.[2] Family doctors are considered as the major PHC service provider who play a pivotal role in providing comprehensive, continuous, whole-person care to the citizens, from prevention to treatment of diseases, in collaboration with other healthcare professionals under the concept of multi-disciplinary care.[1,3] In Hong Kong, for various historical factors and individual reasons, we have a heterogeneous group of PHC western medicine doctors – family doctor (as equivalent of general practitioner and family physician), family medicine specialist, internalist, paediatrician. geriatrician, and specialist of other disciplines. Despite the differences and varieties, I hope every doctor who is willing to serve for PHC can be professionally accountable and will continue life-long learning so as to practice as a competent family doctor. This article elaborates on some core elements of family medicine and consultations in PHC settings.

## Challenges in PHC in Hong Kong

With the recommendations set out in the Primary Healthcare Blueprint and the establishment of District Health Centres (DHCs) in all districts in Hong Kong, we look forward to joining hands with every citizens to develop a sustainable and effective community-based PHC system, and to materialize the concept "Family Doctor for All" so as to cope with the various challenges ahead and to improve the overall health and the quality of life of the public. Diagram 1 summarizes the health challenges we are facing in PHC locally. On practitioner level, we may help to contribute by fulfilling our roles and trying our best in every clinical encounter.

**Diagram 1: Challenges in Primary Healthcare (PHC) in Hong Kong**


## Family Doctor and the Core Competences

Family doctor can be defined as a doctor whom a person would first consult and for all types of health problems.[4] Under the umbrella of the World Organization of Family Doctors (WONCA), WONCA EUROPE (The European Society of General Practice/Family Medicine) issued a consensus statement to define the discipline of general practice/family medicine, the professional tasks of a family doctor, and the core competencies required of family doctors.[5] Six categories of core competences are identified and they are illustrated and explained in Diagram 2 – The WONCA Tree and Table 1.

| The Core Competencies of Family Doctor | The corresponding characteristics of the discipline of general practice/family medicine are that it: |
|---|---|
| 1. Primary care management | a) is normally the ***point of first*** medical contact within the health care system, providing open, easy, and unlimited access to its users, dealing with all health problems regardless of the age, sex, class, race, religion, or any other characteristic of the person concerned.<br>b) makes efficient use of health care resources through ***coordinating care***, working with other professionals in the primary care setting, and by managing the interface with other specialties taking an advocacy role for the patient when needed. |
| 2. Person-centred care | c) develops a ***person-centred approach***; demonstrates an understanding of patients' experiences of illness (ideas, feelings, and expectations) and of the full impact of their illness experience on their lives.<br>d) promotes ***patient empowerment*** through educational opportunities during longitudinal care, respecting their autonomy and facilitating them to "take charge" of their own health care and make decisions in their best interests.<br>e) has a unique consultation process, which establishes a ***relationship*** over time, through effective communication between doctor and patient involving empathy, sensitivity, curiosity, self-awareness, and respect for patient autonomy.<br>f) is responsible for the provision of ***longitudinal continuity of care*** as determined by the needs of the patients through the whole of their life. |
| 3. Specific problem-solving skills | g) has a ***specific decision-making process*** determined by the prevalence and incidence of illness in the community, which can be quite different from that found in hospital settings.<br>h) manages simultaneously ***all health problems*** (acute and chronic) of individual patients, not limited to the presenting illness; the simultaneous response to several demands renders necessary a ***hierarchical management*** of the problems which takes account of both the patient's and the doctor's priorities. |
| 4. Comprehensive approach | i) manages illness which presents in an ***undifferentiated*** way at an early stage in its development, which may require urgent interventions, but based on limited information and less certain predictive value of clinical examination and tests; ***risk assessment and management under uncertainty*** is the key and having excluded an immediately serious outcome, the decision may well be to await further developments and review later – "use time as a diagnostic tool".<br>j) promotes ***preventive care***, health and well-being, or palliation by appropriate and effective interventions. |
| 5. Community orientation | k) has a specific professional responsibility for the health of the ***community***, helps to maintain rational and effective use of the healthcare system, able to adapt to people's changing needs, changing circumstances, and ***mobilize appropriate resources*** to address patient's needs; taking responsibility for continuously monitoring, maintaining and if necessary, improving clinical aspects, services and organization, patient safety, and patient satisfaction of the care they provide. |
| 6. Holistic modelling | l) deals with health problems in their ***physical, psychological, social, cultural, and existential dimensions***, utilizing the knowledge and trust engendered by repeated contacts. |

Table 1: The Core Competences of Family Doctor in relation to the characteristics of the discipline of general practice/family medicine[5] (with elaborations)

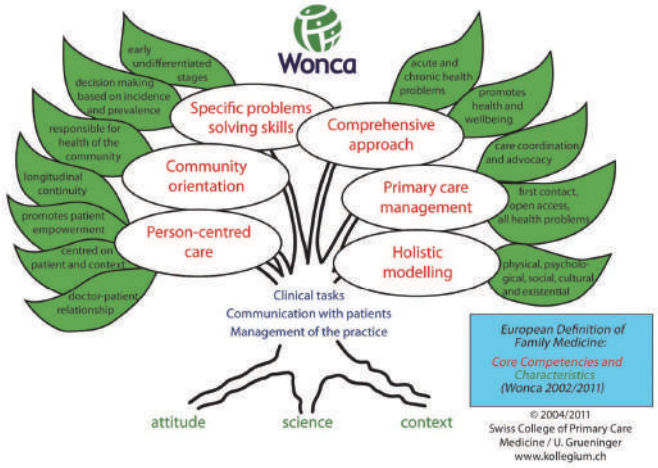


Diagram 2: The WONCA TREE (2011) – Produced by the Swiss College of Primary Care[5]

For family doctors to apply these core competences effectively, three additional features should be considered: a. ***Contextual:*** Understanding the context of doctors themselves, their families, and the environment in which they work, including their working conditions, community, culture, financial and regulatory frameworks; b. ***Attitudinal:*** based on the doctor's professional capabilities, values and ethics; c. ***Scientific:*** adopting a critical and research-based approach to practice and maintaining this through continuing learning and quality improvement.[5]

## Clinical Approaches in PHC

To meet the different challenges in PHC, I advocate a triple clinical approach: ***evidence-based, patient-centred*** (refer to the Pendleton Model discussed later) and ***family-oriented*** (refer to my two articles published in HKMA CME Bulletin[6,7]). ***Evidence based medicine (EBM)*** is the conscientious, explicit, judicious and reasonable use of modern, best evidence in making decisions about the care of individual patients.[8] EBM systemically integrates clinical expertise/experience and patient values (unique preferences, concerns, and expectations) with the best available research information.[9] Group for Evidence Based Medicine Resource from McMaster University identified the approach in 5 steps (Table 2) for applying EBM to clinical practice.[9]

| Steps to Apply EBM | |
|---|---|
| 1. Problem definition -formulate a relevant and answerable clinical question | • A good clinical question should have four essential components structured in the PICO format (Patient or problem, Intervention, Comparison, Outcome).<br>• Distinct topics: intervention, aetiology and risk factors, frequency and rate, diagnosis, prognosis, and prediction. |
| 2. Search for wanted sources of information | • 6 levels of evidence: graded the levels of evidence or data according to their relative strength.<br>• Literature-search skills, setting search criteria.<br>• E.g., PubMed, Cochrane Library, UpToDate, websites, journals, etc. |
| 3. Critical evaluation of the information | • A process that involves careful reading and analysis of methodology, contents, and conclusions.<br>• What is it? Is it true/valid? Is it important/relevant? |
| 4. Application of information of the patient | • Are the participants in the study similar enough to my patient?<br>• What alternatives are available?<br>• Are the outcomes appropriate to the patient?<br>• Does the treatment conflict with the patient's values and expectations?<br>• Weigh the potential harm from the benefit of applying the evidence. |
| 5. Efficacy evaluation of this application on a patient | • Assess whether the evidence which is applied to the patient caused good changes and to the extent that it is confirmed by research.<br>• If the data differ significantly, it would be necessary to investigate why those patients did not respond to the changes introduced in the expected way and what should change. |

Table 2: 5 Steps to apply Evidence-based Approach in Daily Practice[9,10] (with elaborations)

## Consultation Models

With the clinical competencies and consultation approaches in mind, let's discuss the various aspects of consultations. In many countries such as in UK, family doctors are being trained through repeated practices of completing high quality consultations within 10 minutes, with demonstration of tasks such as establishing rapport, noting opening gambits, hidden cues, the golden 60 seconds at the start of the consultation of not interrupting, eliciting ideas, concerns, expectations, summarizing, handing over, checking understanding, safety-netting, patient involvement in decisions and choices, and other tasks.[11] Over the years, various consultation models have been developed to serve as a potential structure for clinical training and practices. The best way to use consultation models is to read them all, see which you like and take the best out of each to develop your own model.[12] For years, I have been adopting the Stott and Davis Model in my daily practice, with incorporation of the patient-centred elements of the Pendleton Model.

### A. Stott and Davis Model

Stott and Davis Model is a four-point framework which has been found to be helpful for family doctors who try to achieve greater breath and to fully realize the practical potential in any consultations.[13] One of the beauties of the model is its simplicity, and it also allows some flexibility in consultation style.[14] Many family doctors found it easily memorized, clear, and highly applicable. Table 3 lists the four tasks of the model, and they are arranged in the order of the usual process of consultation.

| 4 Tasks of Consultation | |
|---|---|
| 1. Management of Presenting problems | • The primary task of every consultation.<br>• May be connected with the continuing problems (check and review relevant information such as eHealth record).<br>• Triple diagnosis (BioPsychoSocial).<br>• Address the "hidden agenda," by responding to the verbal or non-verbal cues of patients.<br>• As a good practice to embark on the other tasks as far as time permits. |
| 2. Management of Continuing Problems | • Consider reviewing any coexisting conditions at each consultation, related, or not related to the presenting problems.<br>• Time spent on this task will result in better compliance and reduce complications from chronic diseases.<br>• Help the person holistically, rather than disease labels. |
| 3. Opportunistic Health Promotion | • Every consultation presents an opportunity for preventive care (4 levels, to be elaborated in the session on Patient Management).<br>• May be linked to the presenting problems, using the "teachable moments.[15]<br>• Use evidence-based references, such as: "Life Course Preventive Care, Health Bureau"[16]<br>• May apply the strategies for behavioural changes, E.g., the Transtheoretical Model (Stages of Change), Motivational interviewing.<br>• Make use of the available resources in the local community, E.g., DHCs.<br>• Involve family when necessary. |
| 4. Modification of Help Seeking Behaviour | • Assumption: Every doctor-patient encounter plants the seeds of future patterns of illness behaviour which will affect the over-use and under-use of medical services.<br>• May also involve the different strategies for behavioural changes. |

Table 3: Stott and Davis Model[13] (with elaborations)

For family doctors, each consultation is one episode in a continuing relationship.[17] This model widens the scope and highlights the potentials of different consultations in PHC settings. It is important to appreciate that it may not be appropriate or possible to attempt all the potential tasks of the consultation on every occasion.[18] For time constraints, you may prioritize and focus on the most immediate problems during the consultation and arrange another appointment to deal with the rest. Yet, for patients with established doctor-patient relationship, it is usually possible to address all or the first three tasks within a 10-minute consultation.

## B. Pendleton Model

Pendleton model outlines seven tasks in a patient-centred consultation (Table 4). It emphasizes the importance of eliciting the RICE of the patient- reason(s) for consultation, ideas, concerns, and expectations. To understand the patient's agenda, you may ask specifically about each component, especially if you are stuck not knowing what to make of the patient's symptoms:[19]

- Idea: Ask "What do you think is the cause of your problem?"
- Concern: Ask "What is it about this problem that worries you most?"
- Expectations: Ask "What do you think I should do about your problem today?"
- Effects of the Problem: Ask "How is this problem affecting your life at the moment?"

Hidden agendas are quite common in PHC and often emerge late in consultation.[20] It was shown that patient's unmet concerns can be substantially reduced by asking "Do you have some other concerns you would like to discuss today?"[21]

| 7 Patient-centred Consultation Tasks | |
|---|---|
| **1. To define the reason(s) for consultation and to assess the presenting problem and the patient** | • The reason(s) for consultation.<br>• The history, nature, and etiology of the problem.<br>• The patient's ideas, concerns, expectations; the meaning/effects of the problems on the person ***(Patient's Agenda)***.<br>• Ticket of entry vs hidden agenda. |
| **2. To consider other problems** | • Continuing problems.<br>• Risk factors.<br>• Preventive care. |
| **3. To choose "with the patient" the appropriate action for each problem** | • ***Explanation and negotiations.***<br>• Patients differ in their wish to be involved in decision making, acknowledge and adjust accordingly.<br>• Prioritize if there are multiple options. |
| **4. To achieve shared understanding** | • ***Finding common ground:*** diagnosis, problem list, goals, roles. |
| **5. To involve patient in management, sharing appropriate responsibility** | • ***Informed decisions.***<br>• Being realistic. |
| **6. To use time and resources effectively** | • ***Time management*** during consultation.<br>• Use time as a diagnostic tool: watchful waiting and arrange follow-ups.<br>• Continuing care for chronic illnesses.<br>• Involve family, other resources. |
| **7. To establish and maintain a positive doctor-patient relationship** | • 4 elements: [22]<br>o Trust: the patient's faith in the doctor's competence and caring, and the doctor's trust in the patient and his or her beliefs and report of symptoms.<br>o Mutual knowledge: the doctor's knowledge of the patient and the patient's knowledge of the doctor.<br>o Regard: the patients feel as though the doctor likes them as individuals and is "on their side."<br>o Loyalty: the patient's willingness to forgive a doctor for any inconvenience or mistake and the doctor's commitment not to abandon a patient. |

Table 4: Pendleton Model[23] (with elaborations)

With a patient-centred clinical approach, doctor-patient relationship will be nurtured through continuing care. With time, you may understand the patient better and better as a person by attending to the patient's agenda during each consultation (Table 5). The doctor-patient relationship will become increasingly therapeutic (the doctor as a "drug") and enhance the quality of the future patient care.

| PATIENT-CENTRED CARE: Perspectives & Potentials | Knowing the Patient's Agenda of each Consultation | Knowing the Patient more completely through Continuing Care |
|---|---|---|
| **Cognitive** | Ideas | Health literacy; Thoughts, Beliefs & Core Values (View on oneself, others, our environment, and the future.) |
| | Expectations | |
| **Emotional** | concerns | Feelings |
| **Behavioural** | | Behaviours, Habit, Lifestyle |
| **Interpersonal** | | Relationship |

Table 5: Perspectives & Potentials in Understanding a patient through repeated patient-centred consultations.

## Consultation Competences

Seven categories of consultation competences (and relative weightings) have been shown to be valid and acceptable in the setting of PHC.[24,25] Details of each category are listed in Table 6 to facilitate step-by-step crafting of a consultation. Through self-directed or group-learning, and repeated practice, you may gradually develop a better consultation habit and become more and more complete as a family doctor.

| 7 Categories of Consultation Competences (relative weightings of the importance) | |
|---|---|
| **Interview/history-taking (20%)** | • Introduces self to patients;<br>• Puts patients at ease;<br>• Allows patients to elaborate presenting problem fully;<br>• Listens attentively;<br>• Seeks clarification of words used by patients as appropriate;<br>• Phrases questions simply and clearly;<br>• Uses open and closed questioning technique, appropriately moving from open to closed;<br>• Uses silence appropriately;<br>• Recognizes and follows up on patients' verbal and non-verbal cues;<br>• Identifies patients' reasons for consultation;<br>• Elicits relevant and specific information from patients and/or their records to help distinguish between working diagnoses;<br>• Considers physical, social, and psychological factors as appropriate;<br>• Exhibits well-organized approach to information gathering with a clear line of enquiry. |
| **Physical Examination (10%)** | • Performs examination and elicits physical signs correctly and sensitively;<br>• Uses the instruments commonly used in the relevant clinical setting in a competent and sensitive manner. |

| | |
|---|---|
| **Patient Management (20%)** | • Formulates management plans appropriate to findings and circumstances in collaboration with patients;<br>• Makes discriminating use of investigations, referral, and drug therapy;<br>• Is prepared to use time appropriately;<br>• Demonstrates understanding of the importance of reassurance and explanation and uses clear and understandable language;<br>• Periodically summarizes to check patients' level of understanding;<br>• Arranges appropriate follow-up;<br>• Attempts to modify help-seeking behaviour of patients as appropriate. |
| **Problem-solving (20%)** | • Generates appropriate working diagnoses or identifies problem(s) depending on circumstances;<br>• Seeks relevant and discriminating physical signs to help confirm or refute working diagnoses;<br>• Correctly interprets and applies information obtained from patient records, history, physical examination, and investigation;<br>• Is capable of applying knowledge of basic, behavioural, and clinical sciences to the identification, management, and solution of patients' problems;<br>• Recognizes limits of personal competence and responds appropriately. |
| **Behaviour/ relationship with patients (10%)** | • Maintains friendly but professional relationship with patients with due regard to the ethics of medical practice;<br>• Conveys sensitivity to the needs of patients;<br>• Demonstrates an awareness that the patient's attitude to the doctor (and vice versa) affects management and achievement of levels of co-operation and compliance. |
| **Anticipatory care (10%)** | • Acts on appropriate opportunities for health promotion and disease prevention;<br>• Provides sufficient explanation to patients for preventive initiatives taken;<br>• Sensitively attempts to enlist the co-operation of patients to promote change to healthier lifestyles. |
| **Record-keeping (10%)** | • Makes timely, accurate, legible, and appropriate record of every doctor-patient contact and referral;<br>• The minimum information recorded should include date of consultation, relevant history and examination findings, any measurement conducted (E.g., BP, peak flow, weight, etc.), the diagnosis/problem (preferably 'boxed'), outline of management plan, investigations ordered and follow-up arrangements;<br>• If a prescription is issued, the name(s) of drug(s), dose, quantity provided, and special precautions intimated to the patient should be recorded;<br>• Manages patient confidentiality appropriately. |

Table 6: The 7 Categories of Consultation Competences and their Details (used in assessing consultation skills)[18,24,25]

## The Process of Diagnosis and Management

We all use a selection of strategies to produce a list of differential diagnoses, varying them depending on the degree of familiarity with the condition and the severity of the patient's illness.[26] *Thinking, fast and slow* by Daniel Kahneman discussed a two-system approach to judgement and choice, which is also applicable to medical decision making: (1) System 1: intuitive, fast, automatic, emotional, stereotypic, used frequently and operates subconsciously; (2) System 2: logical, slow, effortful, analytical, used infrequently and requires conscious thought.[27-29]

### A. The Hypothetico-deductive method

The hypothetico-deductive method, belongs to the system 2 approach, has become the dominant problem-solving method in diagnosis and management taught in medical school. When presented with a problem, the doctor responds to cues by formulating one or more hypotheses about what is wrong with the patient early in the consultation.[17,30] This hypothesis is then tested through a search of positive and negative evidence from history-taking, physical examination, investigation; if the hypothesis is refuted, it is revised and the search begins again.[17] As shown in Diagram 3, the process of diagnosis and management is a cyclical one, with revising, testing, and further revising the hypothesis during different stages as needed.

We are aiming at formulating a rational list of differential diagnoses including most likely, less likely, unlikely, and "can't miss" diagnoses.[32] Generating and ranking provisional diagnostic possibilities/problem list can be assisted by attending to (1) ***pattern recognition*** (cardinal/typical features, important positives and negatives – specificity, sensitivity, and predictive values), (2) ***diagnostic checklists*** to trigger memory (based on pathophysiology, system, anatomy), (3) ***probability and seriousness/significance*** (prevalence, red flags, aware of the influence of novelty and the rule-out syndrome: limiting the "most likely" diagnoses to five, and the "less likely but important to consider" diagnoses to two), (4) ***treatability*** (higher pay-off: the more amenable to treatment, the more likely to include and rank it high a condition as a diagnostic possibility), and (5) ***patient and contextual factors*** (age, occupation, lifestyle, risk factors, psychosocial factors).[17,18,25] As a general rule, (1) uncommon manifestations of common conditions are more common than common manifestations of uncommon conditions, (2) simple conditions are caused by simple conditions, and (3) diverse symptoms and signs are commonly caused by a single disease or entity.[33]

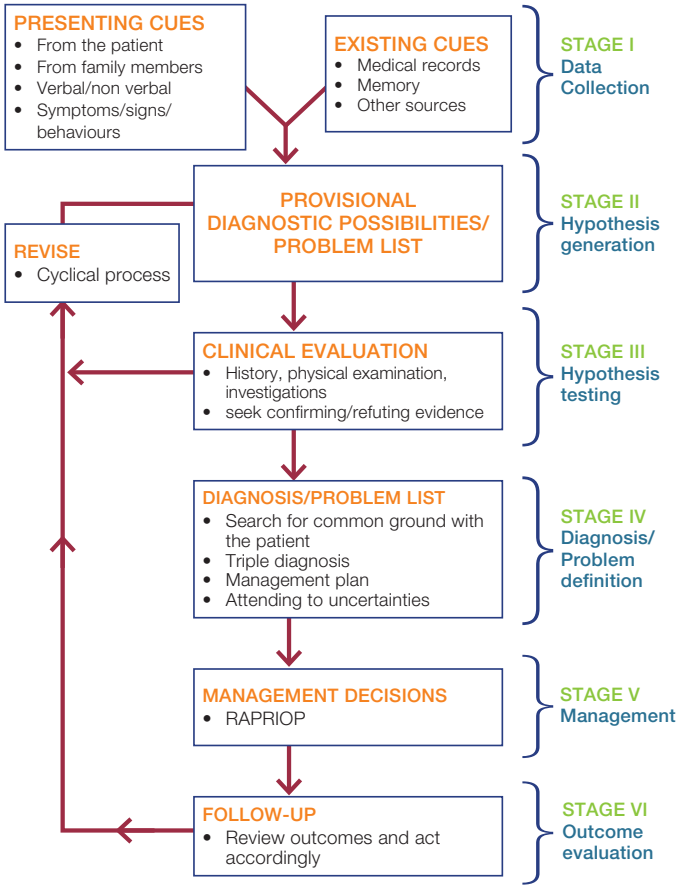


Diagram 3: Hypothetical-Deductive Method of diagnosis and management[17,18,30,31]

Accumulating clinical experiences, we become better and quicker at pattern recognition, and then capable of making accurate diagnoses more frequently and with less stress.[19] Spot diagnoses are made, such as Shingles, acute gouty attack, and cough related to angiotensin-converting enzyme inhibitor (ACEI). System 1 thinking is being employed, and we may short-circuit the process (jumping stages as in Diagram 3) without truly evaluating the hypothesis. Hence, we should be cautious about the pros and cons of this development, and to make a balance between saving time and increasing the chance of errors.

Establishing the correct diagnosis is fundamental to effective patient care. However, undifferentiated, atypical, and hidden presentations are common in PHC. Making a definite diagnosis is not always a realistic goal, hence family doctors have to learn how to live with uncertainty by generating diagnostic possibilities/ problem list in physical, psychological, and social terms (Triple diagnosis).[30]

## B. Patient Management – RAPRIOP

Patient management (not the disease) can be considered as a stage of the hypothetical-deductive method, highlighting the need to review the progress of any management and to adjust accordingly, and the importance of follow-up and continuing care. Management goes hand in hand with the diagnostic process, both involve the communication and the search for common ground with the patient (diagnostic and management negotiation). The diagnoses/problem list should be clear, prioritized while complete, and mutually acceptable by the patient and the doctor through a patient-centred discussion on the causes, prognosis, treatment options, and other details. Given the variety and complexity of problems in PHC, patient management is required to address the diverse needs of the patient – physical, psychological, social, and functional needs – through a comprehensive management plan. In general, we may broadly categorize clinical problems into four types, which call for different management tasks as shown in Table 7.

During daily practice, we may try to differentiate all the problems which we faced into the above four types and act accordingly. For the sake of clarity, seven interrelated management tasks are identified and listed in Table 8, using an acronym RAPRIOP to act as an aide-memoire.[18] Effective patient management requires the application of the evidence-based, patient-centred, and family-oriented approach to all the seven tasks below. While bearing all the tasks in mind, we will choose and use them in different combinations and with different emphasis for different problems. For example, a patient who is suffering from low back pain may proceed with watchful waiting, investigations (X-ray vs MRI), referral to physiotherapist/orthopaedic surgeon, or drug treatment upon discussion with the family doctor (an informed decision).

| 4 Categories of Clinical Problems | Different Management Tasks |
|---|---|
| **Problem which is not really a problem.** E.g., minor aliments which are incorrectly perceived or over-worried. | • Assessment (including proper Investigations as needed);<br>• Explanation (attending to misconceptions and anxiety);<br>• Reassurance;<br>• Follow-up as needed. |
| **Problem which requires prompt attention – assessment, diagnosis, and treatment.** E.g., Newly diagnosed DM, smoking cessation. | • Explanation (dealing with patient denial, promoting acceptance and therapeutic alliance);<br>• Assessment (including proper and prompt Investigations);<br>• Treatment (Advice, Prescription);<br>• Follow-up;<br>• Referral as needed. |
| **Problem which is long-term/difficult to change/incurable.** E.g., Bereavement, terminal cancer. | • Explanation (correcting misconceptions and negotiation);<br>• Counseling (emotional care, acceptance, and adjustment);<br>• Treatment, Advice (long-term coping, avoid unnecessary/inappropriate investigations and treatment);<br>• Follow-up;<br>• Tertiary Prevention. |
| **Problem which is uncertain in terms of the diagnosis or management.** E.g., Undifferentiated, early, or atypical presentation of problems commonly encountered in PHC. | • Explanation (reaching common ground and understanding; may need to formulate a management plan in the absence of a diagnosis);<br>• Assessment (balance between under and over investigating and treatment);<br>• Referral as needed;<br>• Treatment (Advice, Refrain from treatment whenever watchful waiting is applicable vs Prescription -therapeutic trial);<br>• Follow-up and safety-netting. |

Table 7: Different Categories of Clinical Problems and the corresponding Management Tasks

**7 Patient Management Tasks**

1. R-Reassurance and Explanation

- Clear and patient-centred explanation and discussion is usually the first step of any management task.
- Use a variety of communication techniques and materials (E.g., written, or electronic) to adapt explanations to the needs of the patient.[32]
- Try to check understanding, reach a shared understanding of the nature of the problem and what can be done.
- Reassurance should be accurate and based on current best evidence.
- Good reassurance was shown to influence patient satisfaction, cooperation and even health outcomes.
- Inappropriate or premature reissuance may damage doctor-patient relationship, promote doctor-shopping, and improper investigations and treatment.

2. A-Advice and Counseling

- Promote patient's understanding, insight, and responsibility; empower coping.
- The content, style, and skills in giving advice should be tactfully tailored to each patient.
- Take on the role of counselor as needed, to help the patient to develop the necessary insight, and to identify and implement their solutions to a particular problem effectively.
- For advising on behaviour change, need to attend to the patient's stage of change and apply the strategies of motivational interviewing.
- Include some forms of non-pharmaceutical therapies: E.g., advice and counseling on diet, exercise, smoking cessation, sleep hygiene, activity planning, problem-solving, etc.

3. P-Prescription

- Quality use of medicine: (1) ***judicious*** (selecting management options wisely), (2) ***appropriate*** (choosing suitable medicines only if a medicine is considered necessary), (3) ***safe*** (using medicines safely and effectively to get the best possible results), (4) ***efficacious*** (choosing medicines that benefit the patient).[34]
- Practice rational prescribing:
  - o Clear indications and goals: curing a disease (E.g., Tinea pedis, Cystitis), relieving symptoms without affecting the underlying condition (E.g., headache, diarrhoea), combining both of the above goals (E.g., Asthma, Thyrotoxicosis), long-term prevention (E.g., Hypertension, Osteoporosis), replacing deficiencies (E.g., Iron-deficiency anaemia), addressing lifestyle wishes (E.g., hormonal contraception) and, occasionally, therapeutic trials to aid diagnosis (E.g., β-Blockers for essential tremor).[35]
  - o Consider the choice (evidence on effectiveness and side effects, pharmacodynamics, pharmacokinetics, cost-effectiveness), dosage, regime, duration, side effects, precautions, contraindications, drug/food interactions, and co-morbidities.
  - o Clearly explain the relevant details and discuss with the patient; involve family members as needed.
  - o Monitoring progress, check compliance, offer on-going supervision.
  - o Obtain accurate information on all the medicines currently taking (E.g., check eHealth record).
  - o Document clearly.
  - o "Start low, go slow," in particular for elders.
  - o Avoid polypharmacy.
  - o Try not to prescribe a new drug for treating the side effects of another medicine.
- Other non-pharmaceutical therapies are included here: E.g., minor surgical procedures, prescription of aids and appliances.

4. R-Referral

- Gatekeeper's role: consider referral based on what is the best for the patient.
- Reasons for referral: for diagnoses, for confirming/revising a diagnosis (as second opinion), access to certain diagnostic and therapeutic facilities, specialist treatment, collaborative care, emergency care, poor progress in treatment, and patient request.
- Proper referral taking the availability and accessibility of other care providers into consideration when referring: hospital vs community care; different specialists, different specialists, other members of the PHC team, and other related professionals.
- Remember the family doctor's continuing responsibility on patient care; avoid collusion of anonymity – the phenomenon where a patient sees multiple providers for their care, with each looking only at one aspect of a problem and none of whom take any responsibility for actually looking after the patient as a person, even for important decisions.[36]
- Transfers information about patients carefully.

5. I-Investigation

- Investigation is generally a blunt tool with on average only 1% of screening investigations such as routine chest X-rays or cervical smears reveal a diagnosis.[19]
- Reasons for investigation: to confirm/refine a diagnosis, to exclude a diagnosis, for complete assessment such as staging and looking for underlying causes, to monitor treatment progress or side effects of treatment, to screen asymptomatic patients, to reassure an anxious patient effectively, and to convince a skeptical patient that something is wrong and early treatment should be made.
- Avoid a "scattergun" approach in the context of undifferentiated presentations.[37]
- Framework for analysis of investigation ordering:[38]
  - o Why did you order this test?
  - o How will the result alter your management?
  - o What are the risks of ordering/not ordering this test?
  - o Is there a risk of overdiagnosis?
  - o What is the likelihood of a positive result?
  - o What is the prevalence of the provisional diagnosis?
  - o Did any other factors influence your decision to order the test?
  - o Does this presentation have any guidelines for testing?
- Interprets investigation results accurately in the context of the patient's presentation.[32]

| 6. O-Observation and follow-up |
|---|
| • Clear follow-up guidance should be given to patients routinely and barriers to access care facilities are addressed.[32]<br>• Time has been described as the best investigation in PHC, and family doctors can institute watchful waiting (use time as a diagnostic tool) in many cases.[36] However, it may also create a period of uncertainty and risk for patients with serious underlying conditions.[39]<br>• Arrange short-term follow-up/open follow-up with comprehensive safety-netting advice given.<br>• Safety-netting advice: Information shared with a patient or their carer, designed to help them identify the need to seek further medical help if their condition fails to improve, changes, or if they have concerns about their health.[40,41]<br>• Traffic light framework Safety-netting advice:[39]<br>o Green flags – Promote self-care at home.<br>o Amber flags – Primary care review.<br>o Red flags – Urgent or emergency care review.<br>• Long-term follow-up for chronic illnesses: frequency and content matching with the natural history of the condition and treatment progress. |
| 7. P-Prevention |
| • Planned and opportunistic approaches.<br>• Provide preventive advice targeting to specific risk factors and at-risk population groups and relating to the problem(s) presented. E.g., advice on lifting for patients presenting with backache.<br>• 4 levels of opportunistic preventive activities:[42]<br>o Primary Prevention: preventing a disease from ever occurring. E.g., immunization, advice on healthy lifestyle, infection control measures, sun protection.<br>o Secondary Prevention: early disease detection at subclinical stage by screening. E.g., Colorectal screening, Papanicolaou (Pap) smear.<br>o Tertiary Prevention: reducing the severity of the disease as well as of any associated sequelae in symptomatic patients. E.g., Rehabilitation efforts.<br>o Quaternary Prevention: action taken to protect individuals from medical interventions that are likely to cause more harm than good.<br>• Coordinates a team-based approach and use recall systems if feasible.[32]<br>• The Wilson-Jungner criteria for appraising the validity of a screening programme:[43]<br>1. The condition being screened for should be an important health problem.<br>2. The natural history of the condition should be well understood.<br>3. There should be a detectable early stage.<br>4. Treatment at an early stage should be of more benefit than at a later stage.<br>5. A suitable test should be devised for the early stage.<br>6. The test should be acceptable.<br>7. Intervals for repeating the test should be determined.<br>8. Adequate health service provision should be made for the extra clinical workload resulting from screening.<br>9. The risks, both physical and psychological, should be less than the benefits.<br>10. The costs should be balanced against the benefits. |

Table 8: Tasks/components of Patient Management

## To Serve, To Excel

Hong Kong people needs competent family doctors. I hope this article can serve as a quick reference tool or a catalyst for your transformation or advancement to become a better family doctor. A list of books is provided below for further reading. Apart from self-directed learning, participation in structured training courses is advocated and the learning experience can be very fruitful and interesting, such as the Certificate Course in Essential Family Medicine (CCEFM) and the Diploma Course in Family Medicine (DFM) organized by the Hong Kong College of Family Physicians. Preparing and taking professional examinations in Family Medicine/General Practice is also recommended. For young doctors who would like to serve for PHC, they are encouraged to pursue the vocational training program to become a specialist in family medicine. To family doctors and all those working on the development of PHC, I would like to share with you the Bible verse, "*Let us not become weary in doing good, for at the proper time we will reap a harvest if we do not give up.*" (Galatians 6:9). Your effort will not be wasted.

## Suggested extended reading


1. Fraser R. Clinical Methods: A General Practice Approach. 3rd ed. Butterworth-Heinemann, 1999.
2. Freeman TR. McWhinney's Textbook of Family Medicine. 4th ed. Oxford University Press 2016.
3. Murtagh J. General Practice. 8th ed. McGraw Hill 2021.
4. Straus SE, Glasziou P, Richardson WS, Haynes RB. Evidence Based Medicine: How to Practice and Teach EBM. 5th ed. Churchill Livingstone 2018.


## Learning Points

1. "Family Doctor for All" concept is a fundamental guiding principle for the development of various primary healthcare policy under the Primary Healthcare Blueprint in Hong Kong, with the goal of pairing all members of the public with a family doctor of their own, along with their family members, who would act as their personal health manager for development of personalized care plan with support and assistance of District Health Centres.
2. An evidence-based, patient-centred, and family-oriented clinical approach is advocated for PHC.
3. According to WONCA EUROPE, 6 core competencies identified for family doctors include (1) primary care management, (2) person-centred care, (3) specific problem-solving skills, (4) comprehensive approach, (5) community orientation, and (6) holistic modelling.

4. The aim of Evidence based medicine is to integrate the experience of the clinician, the patient's values, and the best available scientific information to guide clinical decision-making.

5. Stott and Davis Model is a 4-point comprehensive PHC consultation model which includes (1) management of presenting problems, (2) management of continuing problems, (3) opportunistic health promotion, and (4) modification of help seeking behaviour.

6. Pendleton model is a patient-centred consultation model which consists of 7 steps: (1) define the reason(s) for consultation and to assess the presenting problem and the patient, (2) to consider other problems, (3) to choose "with the patient" the appropriate action for each problem, (4) to achieve shared understanding, (5) to involve patient in management, sharing appropriate responsibility, (6) to use time and resources effectively, and (7) to establish and maintain a positive doctor-patient relationship.

7. The hypothetico-deductive method is commonly used in clinical problem-solving, and it is a cyclic process comprising of various stages: (1) data collection, (2) hypothesis generation, (3) hypothesis testing, (4) diagnosis/problem definition, (5) management, and (6) outcome review.

8. There are 7 interrelated tasks identified for patient management and they are used in different combinations and with different emphasis in different clinical problems, namely (1) R-reassurance and explanation, (2) A-advice and counseling, (3) P-prescription, (4) R-referral, (5) I-investigation, (6) O-observation and follow-up, and (7) P-prevention – using an acronym RAPRIOP to act as an aide-memoire.

9. Quality use of medicine is defined as the use of medicines that is: (1) judicious (selecting management options wisely), (2) appropriate (choosing suitable medicines only if a medicine is considered necessary), (3) safe (using medicines safely and effectively to get the best possible results), and (4) efficacious (choosing medicines that benefit the patient).

10. Preventive care can be delivered opportunistically during consultations with reference to four categories: (1) Primary Prevention – preventing a disease from ever occurring, (2) Secondary Prevention – early disease detection at subclinical stage by screening, (3) Tertiary Prevention – reducing the severity of the disease as well as of any associated sequelae in symptomatic patients, and (4) Quaternary Prevention – action taken to protect individuals from medical interventions that are likely to cause more harm than good.

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## Q&A Assessment Questions

Complete Spotlight, **1 CME Point** will be awarded for at least five correct answers

Answer these on page 18 or make an online submission at: www.hkma.org.

Please indicate whether the following statements are true or false.

1. To appraise a clinical evidence, there are three essential questions to address: “What is it?” “Is it true/valid?” “Is it important/relevant?”
2. As identified in the Stott and Davis model, modification of help-seeking behaviour is a task that should be achieved in every consultation.
3. Patient’s agenda includes the reason for the attendance; the patient’s ideas, concerns, expectations; the meaning/effects of the problems on the patient.
4. Pendleton model specifically encourages the doctor to involve the patient in the management plan, and help the patient accept an appropriate level of responsibility for each problem.
5. Doctors who employ the hypothetical-deductive method in clinical problem-solving will usually generate several diagnostic hypotheses based on the cues in the early few minutes of consultation.
6. Inappropriate or premature reissuance may damage doctor-patient relationship, promote doctor-shopping, and improper investigations and treatment.
7. Factors which influence the prescribing behaviour of family doctors may comprise (1) doctor factors – clinical knowledge, experience, confidence, problem-solving skills, consultation approach; (2) patient factors – health literacy, needs, expectations, financial concern, factors affecting compliance, contextual factors including occupation and family; (3) clinical factors – practice management, previous adverse events; (4) medication factors (based on evidence and guidelines) – efficacy, safety, alternatives, cost; (5) systems factors – marketing, pharmaceutical representative visits, clinical information sources.
8. Safety-netting advice includes communicating the uncertainty with the patient, explaining what to look out for (red flags, amber flags, green flags) and how to seek further help and what to expect about the progress.
9. It is a good practice to consider discussing Herpes Zoster vaccination and colorectal cancer screening with a 54-year-old adult during consultation.
10. The use of annual Chest X-ray as a screening tool for Carcinoma of Bronchus in healthy non-smoking adults fulfills the Wilson-Jungner criteria.

The answer will be shown in next edition

Answer to September 2023

Spotlight - Atrial Fibrillation Catheter Ablation – Myths, Misconceptions and New Milestones

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

# SHINGRIX
## (ZOSTER VACCINE RECOMBINANT, ADJUVANTED)

A NEW GENERATION OF HERPES ZOSTER VACCINE

# PREVENT SHINGLES
## DON'T GIVE IT A CHANCE [2]

**ELIGIBLE GROUPS[2]**

**18+** YEARS OLD AT INCREASED HZ RISK

**50+** YEARS OLD

**THE ONLY RZV* WITH OVER 90% VACCINE EFFICACY[2-3^]**

^Efficacy in adults aged 50 years or above

# The US CDC Recommends SHINGRIX
# As The Preferred Vaccine For The Prevention Of SHINGLES[1]

CDC = Centers for Disease Control and Prevention

**Indication:** SHINGRIX is indicated for prevention of herpes zoster (HZ) and post-herpetic neuralgia (PHN), in adults 50 years of age or older; and adults 18 years of age or older at increased risk of HZ. The use of Shingrix should be in accordance with official recommendations.

**Safety information:** SHINGRIX is for intramuscular injection only, preferably in the deltoid muscle. The vaccine is given as a 2-dose series. The second dose can be administered as soon as 2 months after the first dose (and if necessary, anytime between 2-6 months). In adults aged 50 years or above, the most frequently reported adverse reactions include pain at the injection site, myalgia, fatigue and headache. Most of these reactions were not long-lasting. In adults 18 years or above who are immunodeficient or immunosuppressed due to disease or therapy (referred to as immunocompromised (IC)), the safety profile was consistent with that observed in adults 50 years and above. There are limited data in adults aged 18-49 years at increased risk of HZ who are not IC.

**Abbreviated Prescribing Information**

Name of the Medicinal Product: Shingrix vaccine powder and suspension for suspension for injection. Herpes zoster vaccine (recombinant, adjuvanted) Qualitative and Quantitative Composition: After reconstitution, 1 dose (0.5 ml) contains 50 micrograms of gE antigen adjuvanted with AS01B. Varicella Zoster Virus (VZV) glycoprotein E (gE) produced by recombinant DNA technology in Chinese Hamster Ovarian (CHO) cells. The GlaxoSmithKline proprietary AS01B Adjuvant System is composed of the plant extract Quillaja saponaria Molina, fraction 21 (QS-21) (50 micrograms) and 3-O-desacyl-4'-monophosphoryllipid A (MPL) from Salmonella minnesota (50 micrograms) Indications: Shingrix is indicated for prevention of herpes zoster (HZ) and post-herpetic neuralgia (PHN), in adults 50 years of age or older and adults 18 years of age or older at increased risk of HZ. Posology and Administration: The primary vaccination schedule consists of two doses of 0.5 ml each: an initial dose followed by a second dose 2 months laterFor subjects who are or might become immunodeficient or immunosuppressed due to disease or therapy, and whom would benefit from a shorter vaccination schedule, the second dose can be given 1 to 2 months after the initial dose Method of administration: Intramuscular injection. Contraindications: Hypersensitivity to the active substances or to any component of the vaccine. Special Warnings and Precautions for Use: As with all injectable vaccines, appropriate medical treatment and supervision should always be readily available in case of an anaphylactic event following the administration of the vaccine. As with other vaccines, vaccination with Shingrix should be postponed in subjects suffering from an acute severe febrile illness. However, the presence of a minor infection, such as a cold, should not result in the deferral of vaccination. As with any vaccine, a protective immune response may not be elicited in all vaccinees. Do not administer the vaccine intravascularly or intradermally. Subcutaneous administration is not recommended. Maladministration via the subcutaneous route may lead to an increase in transient local reactions. Shingrix should be given with caution to individuals with thrombocytopenia or any coagulation disorder since bleeding may occur following intramuscular administration to these subjects. Syncope (fainting) can occur following, or even before, any vaccination as a psychogenic response to the needle injection. This can be accompanied by several neurological signs such as transient visual disturbance, paraesthesia and tonic-clonic limb movements during recovery. It is important that procedures are in place to avoid injury from faints. Interactions: Shingrix can be given concomitantly with unadjuvanted inactivated seasonal influenza vaccine, 23-valent pneumococcal polysaccharide vaccine (PPV23) or reduced antigen diphtheria-tetanus-acellular pertussis vaccine (dTpa). The vaccines should be administered at different injection sites. Fertility, pregnancy and Lactation: Pregnancy: There are no data from the use of Shingrix in pregnant women. The effect on breast-fed infants of administration of Shingrix to their mothers has not been studied. Undesirable effects: lymphadenopathy, hypersensitivity reactions including rash, urticaria, angioedema, headache, gastrointestinal symptoms (including nausea, vomiting, diarrhoea and/or abdominal pain), myalgia, arthralgia, injection site reactions (such as pain, redness, swelling), fatigue, chills, fever, injection site pruritus, malaise. Incompatibility: This medicinal product must not be mixed with other medicinal products. Use and handling: The powder and suspension should be inspected visually for any foreign particulate matter and/or variation of appearance. If either is observed, do not reconstitute the vaccine. Shingrix must be reconstituted prior to administration. 1. Withdraw the entire contents of the vial containing the suspension into the syringe. 2. Add the entire contents of the syringe into the vial containing the powder. 3. Shake gently until the powder is completely dissolved. The reconstituted vaccine is an opalescent, colourless to pale brownish liquid. The reconstituted vaccine should be inspected visually for any foreign particulate matter and/or variation of appearance. If either is observed, do not administer the vaccine. After reconstitution, the vaccine should be used promptly; if this is not possible, the vaccine should be stored in a refrigerator (2°C – 8°C). If not used within 6 hours it should be discarded. Before administration: 1. Withdraw the entire contents of the vial containing the reconstituted vaccine into the syringe. 2. Change the needle so that you are using a new needle to administer the vaccine. Please read the full prescribing information prior to administration. Full prescribing information is available on request from GlaxoSmithKline Ltd, 23/F, Tower 6, The Gateway, 9 Canton Road, Tsimshatsui, Kowloon, Hong Kong. Abbreviated Prescribing Information prepared in 26 May 2022 based on version HK072021(GDS04/EMA20210311).

**References:** 1. Centers for Disease Control and Prevention. MMWR. 2018 Jan;67(3):103-8. 2. GSK. SHINGRIX Hong Kong Prescribing Information GDS04. 3. MSD Live-attenuated Zoster Vaccine Product Circular.

For adverse event reporting, please call GlaxoSmithKline Limited at (852) 3189 8989 (Hong Kong) [or (853) 2871 5569 (Macau)], or send an email to us at HKAdverseEvent@gsk.com. Please read the full prescribing information prior to administration. Full Prescribing Information is available upon request at GSK, 23/F, Tower 6, The Gateway, 9 Canton Road, Tsim Sha Tsui, HK.



PM-HK-SGX-ADVT-220001 (05/2024) Date of preparation: 01/06/2022

**Discover the power of SHINGRIX at gskpro.com/en-hk**

GSK

The content of the October 2023 Cardiology Series is provided by:
**Dr CHEUNG, Ling Ling**
*MBBS(HK), MRCP(UK), FHKCP, FHKAM(Med), Specialist in Cardiology*
**Dr Karl CHAN**
*MBBS(HK), MRCP(UK), FHKCP, FHKAM(Med), Specialist in Cardiology*
十月臨床心臟科個案研究之內容承蒙**張玲玲醫生**及**陳斯畧醫生**提供

Complete Cardiology case,
**0.5 CME POINT** will be awarded for
at least 2 correct answers in total

# What Is the Cause of the Cardiac Arrest?

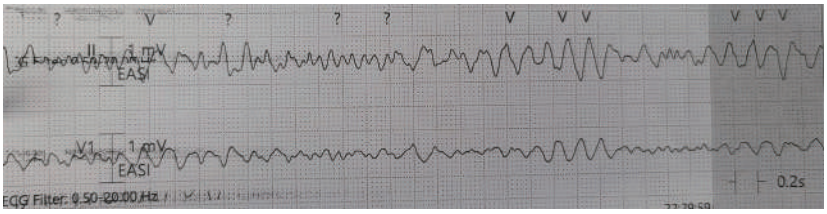


Figure 1

A 65-year-old male with history of asthma, allergic rhinitis and eczema presented to the A&E department, complaining of epigastric pain and an episode of syncope while travelling on the bus on his to work. It was the second episode of syncope in his lifetime with the previous one occurring many years ago. While waiting for medical attention in the triage area, he collapsed again and was found pulseless. Cardiopulmonary resuscitation was started soon after witnessed arrest by medical staff during which the cardiac monitor showed the rhythm displayed in Figure 1.

## Q&A Please answer ALL questions

Answer these on page 18 or make an online submission at: www.hkma.org.

1. **What was the cardiac rhythm shown in Figure 1 and what would be your next course of action?**
   A) Monomorphic ventricular tachycardia, perform immediate defibrillation.
   B) Polymorphic ventricular tachycardia, perform immediate defibrillation.
   C) Ventricular fibrillation, perform immediate defibrillation.
   D) Pre-excited atrial fibrillation, perform immediate defibrillation.

2. **The patient was resuscitated and arranged for immediate coronary angiogram with intention for percutaneous coronary intervention in case there was culprit occluded coronary artery. The relevant coronary angiograms were shown in Figures 2,3,4. What was the finding?**
   A) Essentially normal coronary arteries
   B) A severe ostial left main occlusion
   C) Severe right coronary artery disease
   D) Severe left anterior descending artery disease

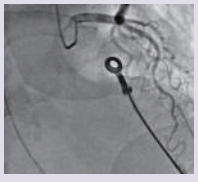

Figure 2

Figure 3

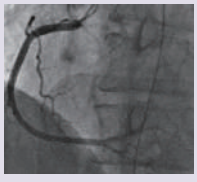

Figure 4

3. **An ECG done many years ago was retrieved from old notes and was shown in Figure 5. What was the diagnosis and subsequent management?**
   A) Ischaemic heart disease for percutaneous coronary intervention.
   B) Catecholaminergic polymorphic ventricular tachycardia for implantable cardioverter-defibrillator.
   C) Brugada syndrome in view of the type 1 pattern as seen on old ECG for implantable cardioverter-defibrillator.
   D) Brugada syndrome in view of the type 2 pattern as seen on old ECG for implantable cardioverter-defibrillator.

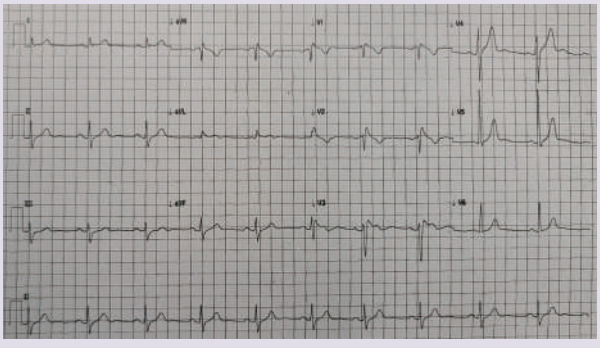

Figure 5

## Cardiology September Answers

**Explanation:**

This lady has chronic rheumatic heart disease with severe mitral stenosis, resting pulmonary hypertension. Her left ventricular ejection is preserved. Due to inflow obstruction, the left atrial pressure is chronically elevated. The longer the diastolic filling time, the lower the mean transmitral valve gradient and vice versa. Patients with severe mitral stenosis frequently have atrial fibrillation and they may have poor tolerance to tachycardia, which would result in further elevation of left atrial pressure, pulmonary congestion and worsening of pulmonary hypertension. Therefore, apart from decongestion by diuretics, the most useful strategy to alleviate the symptoms would be optimal heart rate control and avoid tachycardia.

Once the patient with mitral stenosis develops atrial fibrillation, anticoagulation for stroke prevention should be initiated regardless of CHA2DS2-VaSc score. Use of warfarin with target INR 2-3 should be considered. For those with mild mitral stenosis and atrial fibrillation, direct oral anti-coagulant could be a reasonable choice, but regular monitoring of disease progression is need and one should switch back to warfarin the there is evidence of progression to moderate to severe mitral stenosis.

**Answers: 1: A, 2: D, 3: E**

Percutaneous transvenous mitral commissurotomy (PTMC) is a treatment using a special design balloon to open up the stenotic and fused mitral valve leaflet. The procedure could be done under local anesthesia with a small groin incision as access, and the recovery is usually more rapid the open heart surgery. However, there are several anatomical features of the valve, assessed by echocardiography, that need to be considered for feasibility of PTMC. These include:

1) Pliability of the valve – valve thickness, calcification, mobility and subvalvular anatomy
2) Presence of more than mild mitral regurgitation
3) Presence of left atrial or appendage thrombus

A non-pliable valve, presence of more than mild mitral regurgitation and thrombus are contraindications of PTMC. Surgical referral for valvular replacement should be considered.

The content of the September 2023 Cardiology Series is provided by:
**Dr WONG, Chi Yuen**
*MBBS (HK), FHKCP, FHKAM (Medicine), FRCP (Edin), Specialist in Cardiology*
**Dr CHUI, Shing Fung**
*MBChB (CUHK), FRCP (Glasg, Edin), FACC, FHKCP, FHKAM (Medicine), Specialist in Cardiology*
九月臨床心臟科個案研究之內容承蒙黃志遠醫生及徐城烽醫生提供。

香港醫學會 THE HONG KONG MEDICAL ASSOCIATION

## Seminar of Child Health and Development

九龍醫院同僑會 Kowloon Hospital Alumni Society

**Date** : 11th November, 2023 (Saturday)
**Venue** : Conference Rooms 1&2, 2/F., Main Building, Kowloon Hospital, 147A Argyle Street, Kowloon
**Time** : 11:45 – 15:00 **Light refreshment**

| | |
|---|---|
| 13:00 – 13:10 | **Welcome Remarks** by Dr CHOY Yuen Chung, *President of Kowloon Hospital Alumni Society* |
| 13:10 – 13:30 | **Introduction** by Dr Lillian Yang Yang KO, *FRCP, FHKAM(Paediatrics), Former Consultant Paediatrician, QEH & Arran Street Assessment Centre* |
| 13:30 – 13:50 | **Practical Solutions from a Paediatrician in Optimising the Development of Children Currently in Hong Kong**<br>Dr CHENG Man Yung, *MBBS(HK), FHKCPPaed, FHKAM(Paediatrics), DCH(Lond), FRCP(Glasg)(Edin)* |
| 13:50 – 14:10 | **Make the Best of the Elementary Education System in Hong Kong**<br>Mrs WONG LUK Wing Yan, Winnie, *Founder, Supervisor & CEO of various educational institutes including Creative Kindergarten and Day Nursery, Chan's Creative School, Crystal Children & Teacher Supply* |
| 14:10 -14:40 | **Raising a Secure Child**<br>Dr Nicky YU, *PsyD, Clinical Psychologist, KWH* |
| 14:40 – 15:10 | **Social Worker Perspective in Child Care**<br>Ms LAU Sin Yi, Stanley, *SWO Medical Social Service Unit/QEH, Social Welfare Department* |
| 15:10 – 15:40 | **Q&A & discussion** |
| 15:40 – 15:50 | **Concluding remarks** by Dr Lillian Yang Yang KO |
| 15:50 – 16:00 | **Vote of thanks & photo taking** |

**Capacity** : 100

All medical & health professionals are welcome. Registration is not required.
MCHK/HKMA CME Accreditation: pending CNE/CPE: pending

Light refreshment is co-sponsored by late Dr YIP Ka Chee, *Former Chief of Service of Department of Psychiatry, Kowloon Hospital*

*Please contact Ms. CHOI Siu King by 9461 2640 for enquiries*

Dermatology Series for October 2023 is provided by:
**Dr KOH, Chiu Choi, Dr TANG, Yuk Ming William, Dr CHAN, Hau Ngai Kingsley, Dr LEUNG, Wai Yiu, Dr KWAN, Chi Keung, Dr NG, Shun Chin and Dr CHENG, Hok Fai**
*Specialists in Dermatology & Venereology*
十月皮膚科個案研究之內容承蒙**許招財醫生、鄧旭明醫生、陳厚毅醫生、梁偉耀醫生、關志強醫生、吳順展醫生及鄭學輝醫生**提供。

Complete Dermatology case,
**0.5 CME POINT** will be awarded for at least 2 correct answers in total

## A 60 Years-Old Man with Facial Rash

A 60-year-old man who enjoyed good past health developed facial rash for few years. No fever, joint pain, heat intolerance, muscle weakness, weight loss and diarrhoea were noted. No local cosmetic facial product/medication/history of prolonged use of topical steroid was reported before onset of rash. It was precipitated by hot environment and sunlight exposure. Mild facial erythema with telangiectasia was found over bilateral cheek, nose, and forehead. No comedone, papule nor pustule was found. No other area was involved with sparing of scalp, eye, trunk, limbs, and hand. He was clinically euthyroid. (Figure 1 & 2).

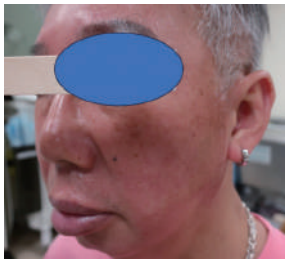

Figure 1

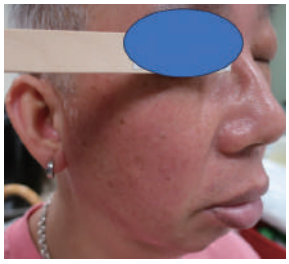

Figure 2

### Q&A Please answer ALL questions

Answer these on page 18 or make an online submission at: www.hkma.org.

**1. What investigation must be done?**

A) Blood x ANA, anti-ds DNA, anti ENA, CK
B) Patch test
C) Skin scraping x fungal element
D) Skin biopsy
E) None of the above

**2. What is the most likely clinical diagnosis?**

A) Contact dermatitis
B) Acne vulgaris
C) Seborrheic dermatitis
D) Acute lupus erythematous
E) Rosacea

**3. What are the precipitation factors?**

A) Alcohol
B) Sunlight
C) Hot environment
D) Exercise
E) All of the above

**4. What are the treatment options?**

A) Pulsed dye laser
B) Topical brimonidine
C) Sun protection
D) Emollient
E) All of the above

## Dermatology September Answer

**1. A.**

The clinical features are otherwise typical of an eccrine poroma, a benign sweat gland tumour derived from acrosyringium. It is commonly found on the sides and plantar surface of foot. Most of these tumours are asymptomatic and assumes a benign clinical course. The pathogenesis is unknown. It is called Hidroacanthoma simplex when the tumour is strictly localized within the epidermis, or dermal duct tumour if entirely within the dermis. There is no clinical feature to suggest viral wart, amelanotic melanoma, or squamous cell carcinoma in this case.

**2. B.**

Apart from scalp, head and neck, hands are another common site for eccrine poroma.

**3. A.**

Dermoscopic features of eccrine poroma are non-specific. Hence, distinction between eccrine poroma and eccrine porocarcinoma based solely on dermoscopic criteria alone is not recommended. Both the eccrine poroma and its malignant counterpart are devoid of melanin pigment although exception may arise. Therefore, wood's lamp has no role to play in bedside diagnosis of eccrine poroma. Diascopy is a handy bedside tool to illustrate the integrity of lesional vascularity. Its diagnostic utility is questionable however, given the varied vascular patterns one can find in eccrine poroma. Excisional skin biopsy for histopathology is perhaps the only way to exclude the differential diagnosis of malignant neoplasms, in particular amelanotic melanoma.

**4. B.**

Besides expectant management, complete excision is also a sensible treatment option here. Majority of the eccrine poroma are found on face, acral regions and occasionally scalp where skin laxity is always an issue. If excisional skin biopsy is contemplated, the operating clinician must be aware of issues like relaxed skin tension lines, free margin, and loco-regional anatomy before removing tumour over the face or scalp region. Surgery is indicated when the tumour is symptomatic, and when alternative diagnosis such as malignancy cannot be ruled out. Completeness of excision is always a concern with shave excision or electrocautery/curettage. Recurrent lesion may cast doubt on potential misdiagnosis in the first place, complicating subsequent management. Cryotherapy will not work here, given the size of the tumour, its anatomical location, and the need for microscopic assessment for such kind of lesion. The clinical management will be very much different when the pathological diagnosis is malignant melanoma. In that case, it would involve a wide local excision, sentinel lymph node biopsy if the melanoma has invaded beyond the dermo-epidermal junction, and considerations of various options of defect reconstruction.

Dermatology Series for September 2023 is provided by:
**Dr CHENG, Hok Fai, Dr TANG, Yuk Ming William, Dr CHAN, Hau Ngai Kingsley, Dr LEUNG, Wai Yiu, Dr KWAN, Chi Keung, Dr NG, Shun Chin,** and **Dr KOH, Chiu Choi**
*Specialists in Dermatology & Venereology*
九月皮膚科個案研究之內容承蒙**鄭學輝醫生、鄧旭明醫生、陳厚毅醫生、梁偉耀醫生、關志強醫生、吳順展醫生及許招財醫生**提供。

Name

HKMA Membership No.

HKID No. ☐☐ - ☐☐☐ xxx(x)

Signature:

Contact Tel No.:

# Answer Sheet

October 2023

## ANSWER SHEET

Please answer ALL questions and write the answers in the space provided.

### SPOTlight

Complete Spotlight, 1 CME point will be awarded for **at least 5** correct answers

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

### Cardiology

Complete Cardiology, 0.5 CME point will be awarded for **at least two** correct answers

| 1 | 2 | 3 |
|---|---|---|
| | | |

### Dermatology

Complete Dermatology, 0.5 CME point will be awarded for **at least two** correct answers

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| | | | |

A maximum of 20 points can be awarded for self-study per year and no upper limit of CME points for attending CME lectures

Please return the completed answer sheet to the HKMA Secretariat (email: cme@hkma.org or Fax: 2865 0943) on or before 15 November 2023 for documentation.

If you want to complete the exercise online, please scan the below QR code and you are NOT required to return the answer sheet by fax/email.

## CME Self-Studies Series

You can register the CME Lectures and finish the CME Self-Studies Series within the webpage (https://www.thkma.org/cme/continuous_medical_education/).

Don't wait! Please register and create your own account through https://www.thkma.org/members/register.phpc (*1st time register account is limited on desktop ONLY*) to experience our new Members Portal.

**Please scan the QR code below to access the latest CME Self-Studies Series online.**

# HKMA CME Lecture Policy and Procedure

## Lecture in Physical Attendance Mode

1. Unless otherwise specified, registrations are accepted from HKMA Members or Medical Practitioners in Hong Kong ONLY. Non-Medical Practitioners will not be served.
2. Prior registration is strictly required.
3. Registration is basically on a first-come-first-served basis except for district-based lectures that registration priorities will be given to doctors practicing in the related districts.
4. No walk-in will be accepted. Attendance without registration will not be recognized and no CME point(s) will be awarded. (*Please refer to the policy of "Non-registrants at CME Lecture in Physical Attendance Mode")
5. HKMA Members and Medical Practitioners intending to register for CME lectures must complete the online registration form at https://www.thkma.org/cme/continuous_medical_education/and return to HKMA Secretariat before deadline.
6. Confirmation emails will be sent out by the HKMA Secretariat to successful registrants before each lecture. Please ensure that registration is confirmed before coming to CME lecture.
7. Successful registrants must attend the lecture in real-time and sign in person the attendance form(s) for obtaining the CME point(s).
8. Successful registrants can only attend ONE lecture at a time regardless of which CME providers. Only 1 Lecture will be counted if the doctor watches multiple CME Lectures conducted at the same time.

## Non-registrants at CME Lecture in Physical Attendance Mode

1. Basically, all CME lectures require prior registration and entertain no non-registrant. But under exceptional circumstances that non-registrants come to CME lecture without prior registration, a non-registrant fee will be charged.
2. If under such exceptional circumstances, non-registrants must produce proof of personal identity together with MCHK registration for verification by the on-site HKMA staff.
3. Non-registrants must settle the exact amount of the non-registrant fees in cash or cheque before accessing the lecture. Electronic payment is not accepted, and no change will be provided.
4. The non-registration fees schedule is shown below:

| | HKMA Premises | Venues outside HKMA Premises |
|---|---|---|
| HKMA Member | HK$150 per person | HK$300 per person |
| Non-HKMA Member | HK$300 per person | HK$600 per person |

5. Any non-registrants in breach of the above policy will have to bear full legal responsibilities. The HKMA serves rights to take action against non-registrants for loss incurred for the non-observance.
6. This policy takes effect from 1 June 2023.

## Lecture in Online (via ZOOM)

1. Registration is open to HKMA Members or Medical Practitioners in Hong Kong ONLY. Non-Medical Practitioners will not be served.
2. Prior registration is strictly required.
3. Registration is basically on a first-come-first-served basis.
4. No walk-in will be accepted. Attendance without registration will not be recognized and no CME point(s) will be awarded.
5. Please complete the online registration form at https://www.thkma.org/cme/continuous_medical_education/ and return to HKMA Secretariat before deadline.
6. Confirmation / notification emails will be sent out by the HKMA Secretariat to successful registrants 1 day and 1 hour before each lecture. Please ensure that registration is confirmed before attending the CME lecture online.
7. CME accreditation will apply to both specialist and non-specialist doctor for each lecture. If the CME accreditation is for non-specialist doctors only, there will be a notice showing in the registration form.
8. CME point(s) will be awarded to successful registrants after attending the lecture and completing the quiz with at least 50% correct answers.
9. Successful registrants must watch the lecture in real-time and complete the online quiz within the designated time after the lecture. Late submission of the quiz will not be accepted.
10. Successful registrants can only attend ONE lecture at a time regardless of which CME providers. Only 1 Lecture will be counted if the doctor watches multiple CME Lectures conducted at the same time.
11. Successful registrants may install ZOOM app/launcher system to join the lecture online.
12. Wi-Fi connection is recommended on your mobile device or computer while watching the lecture via ZOOM. Unstable internet connection may cause interruption to the broadcasting.
13. In case of technical issue and broadcast interruption, please be patient while the HKMA Secretariat works on fixing the problem; the video should resume in a few minutes.

## Lecture in Hybrid Format (Online + Physical Attendance)

1. Registration policy applies the same statements as above.
2. Please ensure that registration is confirmed before attending the lecture.

## General lecture policy

1. Doctor should sign for own CME.
2. Registration will cease when Q & A Session starts.
3. No recording unless permission is granted by the HKMA.
4. If doctor has attended CME Lecture in physical attendance and CME online at the same point of time, only CME Point(s) for the Lecture in physical attendance would be counted.
5. The HKMA will investigate when non-compliance at CME Session is reported, further action will be considered to ensure all CME activities are properly held.

### Typhoon/Black Rainstorm/Extreme Conditions Policy

When Tropical Storm Warning Signal No. 8 (or above) or the Black Rainstorm signal or Extreme Conditions Warning Signal is hoisted within 3 hours of the commencement time, the relevant CME function will be cancelled. (i.e. CME starting at 2:00 pm will be cancelled if the warning signal is hoisted or in force any time between 11:00 am and 2:00 pm).

The function will proceed as scheduled if the signal is lowered three hours before the commencement time. (i.e. CME starting at 2:00 pm will proceed if the warning signal is lowered at 11:00 am, but will be cancelled even if it is lowered at 11:01 am).

When Tropical Storm Warning Signal No. 8 (or above) or Black Rainstorm signal or Extreme Conditions Warning Signal is hoisted after CME commencement, announcement will be made depending on the conditions as to whether the CME will be terminated earlier or be conducted until the end of the session.

The above are general guidelines only. Individuals should decide on their CME attendance according to their own transportation and work/home location considerations to ensure personal safety.

### Contact

For enquiries, please contact the CME Department of the HKMA Secretariat at 2527-8452 or cme@hkma.org.

# HKMA Monthly Self-Study Video

**Dear HKMA Members,**

## The HKMA Monthly Self-Study Video is launched in HKMA website!

This is to acknowledge you that the HKMA Monthly Self-Study Video had been launched in our website for non-specialist doctors to gain 1 CME point for each video. Interested doctors, please click **www.hkma.org** for more details!

**(HKMA Website Homepage → Login to Members Home Page → CME → Monthly Self-Study Series)**

Remarks: A maximum of 20 points can be awarded for self-study per year and no upper limit of CME points for attending CME lectures per year.

Please contact the HKMA Secretariat at 2527 8452 or by email **cme@hkma.org** for assistance.

Important Note:

1. CME point is accredited for non-specialist ONLY.
2. No extra CME point will be granted if you have already attended the same lecture through Live broadcasting.
3. Quiz submission period: 16th of each month to 15th of next month (Submission before/after the stated dates will NOT be considered)
4. Complete each quiz, 1 CME point will be awarded for at least FIVE correct answers (only 1 attempt). A confirmation email will be automatically sent to doctors once who have submitted the quiz.
5. No CME point will be granted for incorrect personal information. Data collected will be used and processed for the purposes related to this self-study only. All personal information will be used to process CME records, and if required, may transfer to other CME Administrators for cross-checking and recording purposes.

香港醫學會
THE HONG KONG MEDICAL ASSOCIATION

# Seminar on Infectious Diseases 2023

Saturday, 4 November 2023

Physical

| PROGRAMME | |
|---|---|
| 1:30 – 2:00 p.m. | Registration and Light Refreshment |
| 2:00 – 2:05 p.m. | Welcoming Speech |
| 2:05 – 2:55 p.m. | Lecture 1: Ending the AIDS Epidemic, Can You Be a Game Changer Too?<br><br>Dr WONG, Chun Kwan Bonnie<br>*Specialist in Infectious Diseases* |
| 2:55 – 3:05 p.m. | Coffee Break |
| 3:05 – 3:55 p.m. | Lecture 2: Management of Adults with Chronic Hepatitis B Infection in Primary Care<br><br>Dr MAK, Lung Yi Loey<br>*Specialist in Gastroenterology & Hepatology* |
| 3:55 – 4:45 p.m. | Lecture 3: Vaccines and Immunisation Updates<br><br>Dr LAI, Chun Yip Leo<br>*Specialist in Infectious Diseases* |
| 4:45 – 5:00 p.m. | Pannel Discussion |

**Co-Chairpersons:**

**Dr TSO, Raymond**
*Co-Chairperson, Advisory Committee On Communicable Diseases, The Hong Kong Medical Association*
*Specialist in Respiratory Medicine*

**Dr LIN, Wai Chi Ada**
*President, The Hong Kong Society for Infectious Diseases*
*Specialist in Infectious Disease, HKSH Medical Group*

**Venue:** Lecture theatre, 7/F, Block H, Princess Margaret Hospital, 2-10 Princess Margaret Hospital Road, Lai Chi Kok, Kowloon

**Capacity:** The capacity is 150. Registration is strictly required on a first-come, first served basis.

**Fee:** Free-of-charge

**Registration Deadline:** Tuesday, 31 October 2023

**Registration:** Please register through https://forms.gle/vKELLKJHAR4Bh3Nq9 or scan the QR code if you are interested to attend.

**CME Accreditation:** For Non-specialist Doctors: 3 CME points
Accreditation for Specialist Doctors: Yes #
# *Accreditation from various colleges are pending.*

**CNE Accreditation:** 3 CNE points (Pending)

**Enquiry:** Please contact the HKMA Secretariat at 2527 8452 or email to cme@hkma.org.

香港醫學會
THE HONG KONG MEDICAL ASSOCIATION

# The Hong Kong Medical Association District Health Network (Yau Tsim Mong) CME Seminar on Mental Health

**Saturday, 11 November 2023**

Physical

| PROGRAMME | |
|---|---|
| 1:00 – 2:00 p.m. | Registration & Lunch |
| 1:50 – 2:00 p.m. | Welcoming Speech |
| 2:00 – 2:40 p.m. | **Lecture 1: No Health Without Mental Health – Destigmatisation and Human Rights Advocacy**<br><br>**Professor WONG, Tak Hing Michael**<br>*Specialist in Psychiatry*<br>*Honorary Clinical Professor, Department of Psychiatry, School of Clinical Medicine, LKS Faculty of Medicine, The University of Hong Kong*<br>*Chair, Hong Kong Holistic Popular Mental Health Association* |
| 2:40 – 3:20 p.m. | **Lecture 2: A lecture on Legal Perspective on De-Stigmatisation in Mental Health**<br><br>**Dr NG, Tat Ming Simon**<br>*Senior Programme Director in Law, School of Professional and Continuing Education, The University of Hong Kong*<br>*Honorary Research Associate, The Centre for Advancement in Inclusive and Special Education, The University of Hong Kong* |
| 3:20 – 3:40 p.m. | Q&A Session |

**Co-chairpersons:** **Dr CHONG, King Yee and Dr LAI, Wing Him**
*Co-chairpersons, Task Force on Mental Health, The Hong Kong Medical Association*

**Venue:** Maggie, 2/F, Eaton Hotel, 380 Nathan Road, Kowloon, Hong Kong

**Capacity:** The capacity is 60. Registration is strictly required on a first-come, first served basis.

**Fee:** Free-of-charge

**Registration Deadline:** Tuesday, 31 October 2023

**Registration:** Please register through https://forms.gle/3GBEutJ5ns7K9Xcf9 or scan the QR code if you are interested to attend.

**CME Accreditation:** For Non-specialist Doctors: 2 CME points
Accreditation for Specialist Doctors: Yes #
# *Accreditation from various colleges are pending.*

**Enquiry:** Please contact the HKMA Secretariat at 2527 8452 or email to cme@hkma.org.

香港醫學會
THE HONG KONG MEDICAL ASSOCIATION

CME LIVE
zoom LIVE

# The Update of the HKMA CMS 5.0 in the Era of Primary Healthcare Development

**Friday, 17 November 2023**

**The HKMA Clinic Management System 5.0 (CMS 5.0) is targeted to be launched this year to offer an up-to-date solution for doctors to manage their clinics. CMS 5.0 is currently engaged in a more comprehensive process to align with the goals of primary healthcare development and its potential to enhance patient outcomes and healthcare delivery. To familiarise doctors with our system, an additional CME lecture with live demonstrations will be held on Friday, 17 November 2023. Interested members please refer to the details below for registration.**

## PROGRAMME

| | |
|---|---|
| 2:00 – 2:05 p.m. | **Introduction** |
| 2:05 – 2:45 p.m. | **Dr CHAN, Tsz Tai**<br>*Co-Chairman, Information Technology Committee,*<br>*The Hong Kong Medical Association*<br><br>**Representative from System Aid Medical Services Ltd.** |
| 2:45 – 3:00 p.m. | **Q&A Session** |
| Fee: | Free-of-charge |
| Registration Deadline: | **Thursday, 16 November 2023** |
| Registration | Please register through **https://forms.gle/AwJsDF2JRCF4JkFZ6** or scan the QR code if you are interested to attend. |
| CME Accreditation: | For Non-specialist Doctors: 1 CME point<br>Accreditation for Specialist Doctors: Yes #<br># *Accreditation from various colleges are pending.* |
| Enquiry: | Please contact the HKMA Secretariat at 2527 8452 or email to cme@hkma.org. |

## The HKMA CME Live Lecture in October 2023

**All lectures start at 2:00-3:00 p.m.**

| | Date | Organiser and Topic | Speaker | CME Points | CME Accreditation from Colleges (Pending) # |
|---|---|---|---|---|---|
| 1. | 24 October (Tue) | **The Hong Kong Medical Association**<br>Practical Approach on the Management of Lower Urinary Tract Symptoms<br>*Sponsor: Synmosa Biopharma (HK) Co. Ltd* | **Dr POON, Yick Kwan Vincent**<br>*Specialist in Urology* | 1 | Yes |
| 2. | 31 October (Tue) | **The Hong Kong Medical Association**<br>Prevention and Risk Reduction of CRC with the Recent Advancement of Gut Microbiome Research & Guideline<br>*Sponsor: G-NiiB, Genie Biome Limited* | **Dr WU, Ping Ying Brian**<br>*Specialist in Gastroenterology & Hepatology* | 1 | Yes |

## The HKMA CME Live Lecture in November 2023

**All lectures start at 2:00-3:00 p.m.**

| | Date | Organiser and Topic | Speaker | CME Points | CME Accreditation from Colleges (Pending) # |
|---|---|---|---|---|---|
| 1. | 6 November (Mon) | **The Hong Kong Medical Association**<br>Innovative Approach to Solve the Problems on LUTS<br>*Sponsor: Synmosa Biopharma (HK) Co. Ltd* | **Dr YU, Cheong**<br>*Specialist in Urology* | 1 | Yes |
| 2. | 13 November (Mon) | **The Hong Kong Medical Association**<br>Chronic Constipation Management in Elderly Patients<br>*Sponsor: Abbott Laboratories Limited* | **Dr CHOW, Chi Wing**<br>*Specialist in Gastroenterology & Hepatology* | 1 | Yes |
| 3. | 14 November (Tue) | **The Hong Kong Medical Association**<br>Individualised Management of Male Lower Urinary Tract Symptoms (LUTS) in Primary Care Setting<br>*Sponsor: GlaxoSmithKline Limited* | **Dr LAW, Tak Tsun Vincent**<br>*Specialist in Urology* | 1 | Yes |
| 4. | 15 November (Wed) | **The Hong Kong Medical Association**<br>Updated Management on Atopic Dermatitis with Oxidative Stress Concept<br>*Sponsor: A. Menarini Hong Kong Limited* | **Dr CHAN, Yung Davis**<br>*Specialist in Dermatology & Venereology* | 1 | Yes |
| 5. | 16 November (Thu) | **The Hong Kong Medical Association**<br>Navigating the Management of Atopic Dermatitis<br>*Sponsor: AbbVie Limited* | **Dr WONG, Hing Wing**<br>*Specialist in Dermatology & Venereology* | 1 | Yes |
| 6. | 20 November (Mon) | **The Hong Kong Medical Association**<br>Management of Heavy Menstrual Bleeding: Diagnosis, Treatment Options and Patient Counseling<br>*Sponsor: Bayer HealthCare Limited* | **Dr SO, Chun Hong**<br>*Specialist in Obstetrics & Gynaecology* | 1 | Yes |
| 7. | 22 November (Wed) | **The Hong Kong Medical Association**<br>Topic in Lung Cancer Screening<br>*Sponsor: AstraZeneca Hong Kong Limited* | *Doctor Who is Specialist in Family Physicians* | 1 | Yes |

# The HKMA CME Live Lecture in November 2023 (continued)

| | Date | Organiser and Topic | Speaker | CME Points | CME Accreditation from Colleges (Pending) # |
|---|---|---|---|---|---|
| 8. | 27 November (Mon) | **The Hong Kong Medical Association**<br>The Role of Probiotics in the Treatment of NAFLD and Metabolic Disease<br>*Sponsor: G-NiiB, Genie Biome Limited* | **Dr CHAN, Nor Norman**<br>*Specialist in Endocrinology, Diabetes & Metabolism* | 1 | Yes |
| 9. | 28 November (Tue) | **The Hong Kong Medical Association**<br>1. Updates on Colorectal Cancer Screening<br>2. Multitarget FIT-DNA Technology as the Latest Colorectal Cancer Screening Option in Hong Kong<br>*Sponsor: Prenetics Limited* | **Dr LAM, Yuk Fai Frank**<br>*Specialist in Gastroenterology & Hepatology*<br>**Dr MA, Wu Po Mike**<br>*Chief R&D Officer, Prenetics, Ltd.* | 1 | Yes |
| 10. | 29 November (Wed) | **The HKMA District Health Network (Central, Western & Southern)**<br>Diagnosis and Management of Common Skin Infections in Primary Care<br>*No Sponsor* | **Dr HO, King Man**<br>*Hon Clinical Associate Professor, Department of Medicine, the University of Hong Kong* | 1 | Yes |

## Physical Participation

**Points to note for CME Lecture with Physical Participation:**

1. **Enrolment for CME lecture with physical attendance will be given to HKMA Members or Medical Practitioners in Hong Kong ONLY.**
2. **On behalf of the policy for lecture with physical participation, please refer to P. 19 for more details.**

| | Date | Organiser and Topic | Speaker | CME Points | CME Accreditation from Colleges (Pending) # |
|---|---|---|---|---|---|
| 1. | 24 November (Fri)<br>2:00-3:00 pm | **The HKMA District Health Network (Yau Tsim Mong)**<br>Osteoarthritis of Knees: Drugs? Injection? Others?<br>Venue: Maggie, 2/F, Eaton Hong Kong, 380 Nathan Road, Kowloon, Hong Kong<br>*Sponsor: DKSH Hong Kong Limited* | **Dr HO, Cham On**<br>*Specialist in Orthopaedics & Traumatology* | 1 | Yes |
| 2. | 30 November (Thu)<br>2:00-3:00 pm | **The HKMA District Health Network (Hong Kong East)**<br>Changing Paradigms in Hyperlipidemia Management: What are the Available Evidence in CV Risk Reduction and Long Term Safety?<br>Venue: Wanchai Premises, 5/F, Duke of Windsor Social Building, 15 Hennessy Road, Wan Chai, Hong Kong<br>*Sponsor: Amgen Hong Kong Limited* | **Dr CHEUNG, Chi Yeung**<br>*Specialist in Cardiology* | 1 | Yes |

Please register through https://forms.gle/qiwmsPVbiKo8DibQA or scan the QR code if you are interested to attend. For enquiry, please contact the Secretariat at 2527 8452.

# **Accreditation from various colleges pending, for specialists, please complete the quiz online within two hours after the lecture with at least 50% correct for CME/CPD points. For lecture without "Yes", CME Accreditation is for Non-Specialists Only. Non-Specialists doctors must complete lecture quiz (10 Q&A) and answer questions within two hours after the lecture with at least 50% correct.**

CME Hybrid

# HKMA-HKSH CME Programme 2023-2024

| | | |
|---|---|---|
| **Time** | : | **1:00 - 2:00 pm Lunch**<br>**2:00 - 2:45 pm Lecture**<br>**2:45 - 3:00 pm Q&A** |
| **Format** | : | **Hybrid; ZOOM / The Hong Kong Medical Association Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, Hong Kong** |
| **Fee** | : | **Free-of-charge** |
| **Capacity** | : | **The capacity for physical attendance is 40. Registration for both physical attendance and virtual format are strictly required on a first-come, first-served basis.** |
| **Registration Deadline** | : | **Friday, 3 November 2023** |
| **Registration** | : | **Please register through https://forms.gle/vR61p9L8pffZLQ9SA or scan the QR c ode if you are interested to attend.** |
| **CME Accreditation** | : | **For Non-specialist Doctors: 1 CME point for each lecture #**<br>**Accreditation for Specialist Doctors: Yes #**<br>*# Accreditation from various colleges are pending. For specialists, please completed the quiz online within two hours after the lecture with at least 50% correct for CME/CPD points. Non-Specialists doctors must also complete lecture quiz (10 Q&A) within two hours after the lecture with at least 50% correct.* |
| **Enquiry** | : | **Please contact the HKMA Secretariat at 2527 8452 or email to cme@hkma.org.** |

| Date (Tuesday) | Topic | Speaker |
|---|---|---|
| 7 November 2023 | Hallux Valgus: An Overview and Updates on Management | Dr CHAN, Wai Chung<br>*Specialist in Orthopaedics & Traumatology* |
| 5 December 2023 | Advances in Proton Therapy for Cancer Treatment | Dr CHANG, Tien Yee Amy<br>*Specialist in Clinical Oncology* |
| 2 January 2024 | Novel Diagnostics & Therapeutics in Allergy Practice | Dr HO, Hok Kung Marco<br>*Specialist in Paediatric Immunology, Allergy and Infectious Diseases* |
| 6 February 2024 | Updates in Interventional Endoscopy | Dr TEOH, Yuen Bun Anthony<br>*Specialist in General Surgery* |
| 5 March 2024 to 3 September 2024 | The remaining lectures shall be announced in coming CME Bulletin issues. | |

# HKMA-CUHK Medical Centre CME Programme 2023

**Time** : 1:00 – 2:00 pm Lunch
2:00 – 2:45 pm Lecture
2:45 – 3:00 pm Q&A

**Format** : Hybrid; ZOOM/The Hong Kong Medical Association Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, Hong Kong

**Fee** : Free-of-charge

**Capacity** : The capacity for physical attendance is 40. Registration for both physical attendance and virtual format are strictly required on a first-come, first-served basis.

**Registration Deadline** : Friday, 3 November 2023

**Registration** : [If you have already registered for this CME Programme, you are already registered for the whole Programme. You will receive the notification email 1 day and 1 hour before each lecture. Therefore, you are not advised to register the Programme repeatedly.]

Please register through https://forms.gle/5azipM5jaxmfdqjg6 or scan the QR code if you are interested to attend.

**CME Accreditation** : For Non-specialist Doctors: 1 CME point for each lecture #
Accreditation for Specialist Doctors: Yes #

*# Accreditation from various colleges are pending. For specialists, please completed the quiz online within two hours after the lecture with at least 50% correct for CME/CPD points. Non-Specialists doctors must also complete lecture quiz (10 Q&A) within two hours after the lecture with at least 50% correct.*

**Enquiry** : Please contact the HKMA Secretariat at 2527 8452 or email to cme@hkma.org.

| Date (Wednesday) | Theme | Topic | Speaker |
|---|---|---|---|
| 8 November | Women's Health | Common Breast Pathology | Dr CHENG, Shui Ying<br>*Specialist in Pathology* |
| 13 December | | Breast Health And Breast Surgery | Dr CHAN, Ho Yan Yolanda<br>*Specialist in General Surgery* |

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# HKMA-GHK CME Programme 2023

Gleneagles Hospital HONG KONG 港怡醫院

zoom LIVE

**Time** : 1:00 – 2:00 pm Lunch
2:00 – 2:45 pm Lecture
2:45 – 3:00 pm Q&A

**Format** : Hybrid; ZOOM/The Hong Kong Medical Association Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, Hong Kong

**Fee** : Free-of-charge

**Capacity** : The capacity for physical attendance is 40. Registration for both physical attendance and virtual format are strictly required on a first-come, first-served basis.

**Registration Deadline** : Friday, 10 November 2023

**Registration** : [If you have already registered for this CME Programme, you are already registered for the whole Programme. You will receive the notification email 1 day and 1 hour before each lecture. Therefore, you are not advised to register the Programme repeatedly.]

Please register through
https://forms.gle/sutCWaBkf4Ky8w9HA
or scan the QR code if you are interested to attend.

**CME Accreditation** : For Non-specialist Doctors: 1 CME point #
Accreditation for Specialist Doctors: Yes #

\# *Accreditation from various colleges are pending. For specialists, please completed the quiz online within two hours after the lecture with at least 50% correct for CME/CPD points. Non-Specialists doctors must also complete lecture quiz (10 Q&A) within two hours after the lecture with at least 50% correct.*

**Enquiry** : Please contact the HKMA Secretariat at 2527 8452 or email to cme@hkma.org.

| Date (Tuesday) | Topic | Speaker |
|---|---|---|
| 21 November | Topic on General Surgery | Dr CHOK, Siu Ho<br>*Specialist in General Surgery* |

# HKMA-HKSTP CME Programme 2023

**Time** : 1:00 – 2:00 pm Lunch
2:00 – 2:45 pm Lecture
2:45 – 3:00 pm Q&A

**Format** : Hybrid; ZOOM/The Hong Kong Medical Association Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, Hong Kong

**Fee** : Free-of-charge

**Capacity** : The capacity for physical attendance is 40. Registration for both physical attendance and virtual format are strictly required on a first-come, first-served basis.

**Registration Deadline** : Friday, 27 October 2023

**Registration** : [If you have already registered for this CME Programme, you are already registered for the whole Programme. You will receive the notification email 1 day and 1 hour before each lecture. Therefore, you are not advised to register the Programme repeatedly.]

Please register through
https://forms.gle/AMe1QGz6ymVzg3ft7
or scan the QR code if you are interested to attend.

**CME Accreditation** : For Non-specialist Doctors: 1 CME point for each lecture #
Accreditation for Specialist Doctors: Yes #

\# *Accreditation from various colleges are pending. For specialists, please completed the quiz online within two hours after the lecture with at least 50% correct for CME/CPD points. Non-Specialists doctors must also complete lecture quiz (10 Q&A) within two hours after the lecture with at least 50% correct.*

**Enquiry** : Please contact the HKMA Secretariat at 2527 8452 or email to cme@hkma.org.

| Date (Thursday) | Theme | Topic | Speaker |
|---|---|---|---|
| 2 November 2023 | Series 3: Neuro & Infectious Disease Diagnosis + Treatment/ Rehabilitation Solution | A Novel Urinary DNA Isolation Method to Improve HPV Detection | 1. Dr TAM, Ching Ting *Specialist in Obstetrics and Gynaecology*<br>2. Dr Kent CHENG *Senior Director, Product Management, PHASE Scientific International Limited* |
| 23 November 2023 | Series 4: Cancerous Disease Diagnosis + Treatment/ Rehabilitation Solution | DNA Methylation and Its Role in Health and Disease: Implications for Early Prediction, Prevention and Intervention | Dr Moshe SZYF *Founder, HKG Epitherapeutics; Professor, Department of Pharmacology & Therapeutics, McGill University, Canada* |
| 14 December 2023 to 29 February 2024 | | The remaining lectures shall be announced in coming CME Bulletin issues. | |

## The Hong Kong Medical Association

*Dr TSU, Hok Leung James giving a CME Live lecture on 4 September 2023*

*Dr YAU, Chun Chung giving a CME lecture on 5 September 2023*

*Dr SZETO, Ka Ho giving a CME lecture on 13 September 2023*

*Dr YEUNG, Sze Wai giving a CME lecture on 19 September 2023*

*Dr HOU, See Ming Simon giving a CME Live lecture on 26 September 2023*

*Dr SUEN, Wai Leung Langston giving a CME lecture on 28 September 2023*

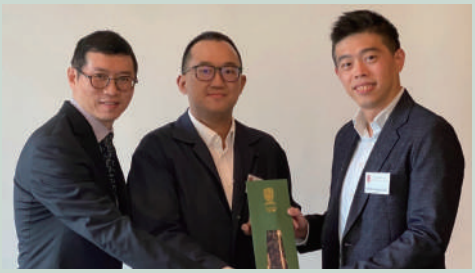
## The HKMA Medio-legal Conference 2023

*From Left: Ms Christine TSANG (Speaker), Ms Mary LAU (Speaker), Ms Binaca WU (Speaker), Dr LAI, Wing Him (Moderator), Dr SO, Yui Chi (Moderator), Mr HO, Ching Him (Speaker), Dr LEE, Wai Hung Danny (Speaker), Dr YEUNG, Hip Wo Victor (Speaker) and Mr Woody CHANG (Speaker) giving the panel discussion in the conference on 23 September 2023*

*Back Row from left: Ms Yvonne CHAN (Guest), Mr Woody CHANG (Speaker), Dr LAI, Wing Him (Moderator), Ms Mary LAU (Speaker), Mr Martin HUI S.C. (Speaker), Mr HO, Ching Him (Speaker) and Dr LEE, Wai Hung Danny (Speaker)*
*Front Row from left: Dr Jovi LAM, Dr YEUNG, Hip Wo Victor (speaker), Dr CHENG, Chi Man (President), Dr Anthony FUNG (Guest) and Ms Joeky LEUNG (Guest)*

## The HKMA District Health Network – Central Coordination Committee

### CME lecture of the HKMA District Health Network (New Territories West)



*Moderator Dr CHEUNG, Kwok Wai Alvin (Left) and the HKMA DHN Central Coordinator Dr LING, Siu Chi Tony (Middle) presenting a souvenir to Speaker Dr CHENG, Pak Wing Calvin (Right) on 7 September 2023*

### CME lecture of the HKMA District Health Network (Central, Western & Southern)

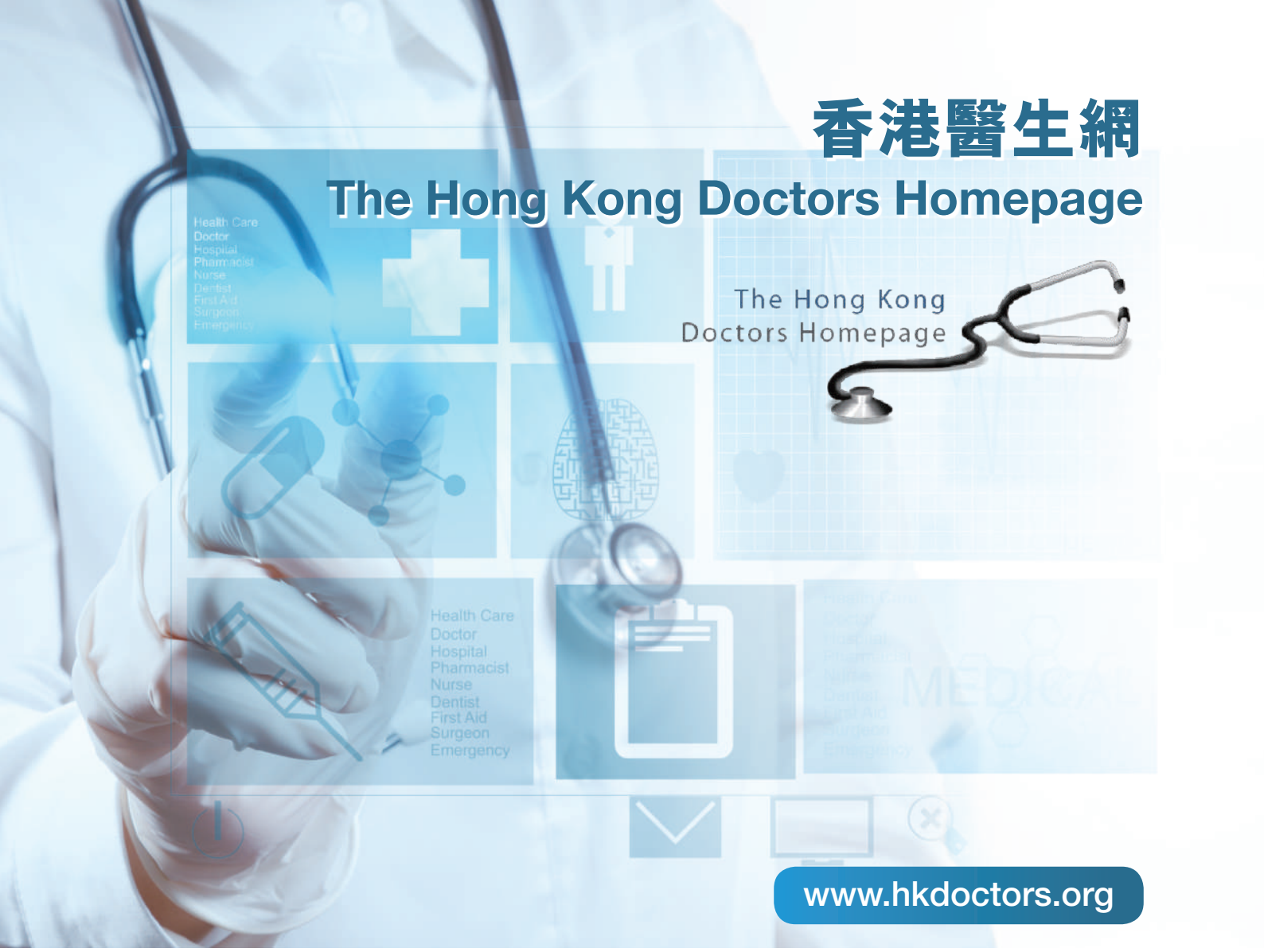
*Dr KWOK, Hau Yan giving a CME Live lecture on 20 September 2023*

### CME lecture of the HKMA District Health Network (Hong Kong East)


*Moderator Dr YIP, Yuk Pang Kenneth (Right) presenting a souvenir to Speaker Dr KWOK, Yuk Lung (Left) on 21 September 2023*

### CME lecture of the HKMA District Health Network (Central, Western & Southern)

*The HKMA DHN Central Coordinator Dr SO, Yui Chi (Right) and Moderator Dr TONG, Kai Sing (Left) presenting a souvenir to Speaker Dr WONG, King Ying (Middle) on 29 September 2023*




This web site is developed and maintained by the Hong Kong Medical Association for all registered Hong Kong doctors to house their Internet practice homepage. The format complies with the Internet Guidelines which was proposed by the Hong Kong Medical Association and adopted by the Medical Council of Hong Kong.

We consider a practice homepage as a signboard or an entry in the telephone directory. It contains essential information about the doctor including his specialty and how to get to him. This facilitates members of the public to communicate with their doctors.

This website is open to all registered doctors in Hong Kong. For practice page design and upload, please contact the Hong Kong Medical Association Secretariat.

由香港醫學會成立並管理的《香港醫生網》，是一個收錄本港註冊西醫執業網頁的網站。內容是根據由香港醫學會擬訂並獲香港醫務委員會批准使用的互聯網指引內的規定格式刊載。

醫生的「執業網頁」性質與電話索引內刊載的資料相近。目的是提供與醫生執業有關的基本資料，例如註冊專科及聯絡方法等，方便市民接觸個別醫生。

任何香港註冊西醫都可以參加《香港醫生網》。關於網頁版面安排及上載之詳情，請與香港醫學會秘書處聯絡為荷。

# HKMA CME Bulletin
# Monthly Self-Study Series
# Call for Articles

Since its publication, the HKMA CME Bulletin has become one of the most popular CME readings for doctors. This monthly publication has been serving more than 10,000 readers each month through practical case studies and picture quizzes. To enrich its content, we are inviting articles from experts of different specialties. Interested contributors may refer to the General Guidance below. Other formats are also welcome.

## General Guidance for Authors

| | | |
|---|---|---|
| Intended Readers | : | General Practitioners |
| Length of Article | : | Approximately 8-10 A-4 pages in 12-pt fonts in single line spacing, or around 1,500-2,000 words (excluding references). |
| Review Questions | : | Include 10 self-assessment questions in true-or-false format.<br>(It is recommended that analysis and answers to most questions be covered in the article.) |
| Language | : | English |
| Highlights | : | It is preferable that key messages in each paragraph/section be highlighted in bold types. |
| Key Lessons | : | Recommended to include, if possible, a key message in point-from at the end of the article. |
| Others | : | List of full name(s) of author(s), with qualifications and current appointment quoted, plus a digital photograph of each author. |
| Deadline | : | All manuscripts for publication of the month should reach the Editor before the 1st of the previous month. |

**All articles submitted for publication are subject to review and editing by the Editorial Board.**

**For further information, please contact CME Dept. at 2527 8452 or by email at cme@hkma.org.**

# CME Calendar

## October 2023

**24 October (Tue) 2:00-3:00 p.m.**
**The Hong Kong Medical Association**
Practical Approach on the Management of Lower Urinary Tract Symptoms
*HKMA CME Live Lecture*
HKMA CME Dept. – Tel: 2527 8452
1

**26 October (Thu) 2:00-3:00 p.m.**
**The Hong Kong Medical Association and the Hong Kong Science and Technology Park**
ID Microbes Using Metagenomic and Big Data Bioinformatics
*HKMA CME Hybrid Lecture*
HKMA CME Dept. – Tel: 2527 8452
1 Hybrid

**27 October (Fri) 2:00-3:00 p.m.**
**The Hong Kong Medical Association**
The HKMA Adult Immunisation Campaign 2023
The Impact of Introducing Higher Pneumococcal Conjugate Vaccine
*HKMA CME Live Lecture*
HKMA CME Dept. – Tel: 2527 8452
1

**31 October (Tue) 2:00-3:00 p.m.**
**The Hong Kong Medical Association**
Prevention and Risk Reduction of CRC with the Recent Advancement of Gut Microbiome Research and Guideline
*HKMA CME Live Lecture*
HKMA CME Dept. – Tel: 2527 8452
1

## November 2023

**2 November (Thu) 2:00-3:00 p.m.**
**The Hong Kong Medical Association and the Hong Kong Science and Technology Park**
A Novel Urinary DNA Isolation Method to Improve HPV Detection
*HKMA CME Hybrid Lecture*
HKMA CME Dept. – Tel: 2527 8452
1 Hybrid

**4 November (Sat) 2:00-5:00 p.m.**
**The Hong Kong Medical Association and the Hong Kong Society for Infectious Diseases**
Seminar on Infectious Diseases 2023
1. Ending the AIDS Epidemic, Can You Be a Game Changer Too?
2. Management of Adults with Chronic Hepatitis B Infection in Primary Care
3. Vaccines and Immunisation Updates
*HKMA CME Physical Lecture*
HKMA CME Dept. – Tel: 2527 8452
3 Physical

**6 November (Mon) 2:00-3:00 p.m.**
**The Hong Kong Medical Association**
Innovative Approach to Solve the Problems on LUTS
*HKMA CME Live Lecture*
HKMA CME Dept. – Tel: 2527 8452
1

**7 November (Tue) 2:00-3:00 p.m.**
**The Hong Kong Medical Association and the Hong Kong Sanatorium & Hospital**
Hallux Valgus: An Overview and Updates on Management
*HKMA CME Hybrid Lecture*
HKMA CME Dept. – Tel: 2527 8452
1 Hybrid

**8 November (Wed) 2:00-3:00 p.m.**
**The Hong Kong Medical Association and the CUHK Medical Centre**
Common Breast Pathology
*HKMA CME Hybrid Lecture*
HKMA CME Dept. – Tel: 2527 8452
1 Hybrid

**11 November (Sat) 2:00-3:40 p.m.**
**The HKMA District Health Network (Yau Tsim Mong)**
CME Seminar on Mental Health
1. No Health Without Mental Health – Destigmatisation and Human Rights Advocacy
2. A Human Rights Approach to Psychosocial Disabilities
*HKMA CME Physical Lecture*
HKMA District Health Network Dept. – Tel: 2861 1979
2 Physical

**11 November (Sat) 1:00-3:40 p.m.**
**The Hong Kong Medical Association and Kowloon Hospital Alumni Society**
Seminar of Child Health and Development
*CME Physical Lecture*
For registration, please contact Ms CHOI - Tel: 9461 2640
2 Physical

**13 November (Mon) 2:00-3:00 p.m.**
**The Hong Kong Medical Association**
Chronic Constipation Management in Elderly Patients
*HKMA CME Live Lecture*
HKMA CME Dept. – Tel: 2527 8452
1

**14 November (Tue) 2:00-3:00 p.m.**
**The Hong Kong Medical Association**
Individualised Management of Male Lower Urinary Tract Symptoms (LUTS) in Primary Care Setting
*HKMA CME Live Lecture*
HKMA CME Dept. – Tel: 2527 8452
1

**15 November (Wed) 2:00-3:00 p.m.**
**The Hong Kong Medical Association**
Updated Management on Atopic Dermatitis with Oxidative Stress Concept
*HKMA CME Live Lecture*
HKMA CME Dept. – Tel: 2527 8452
1

**16 November (Thu) 2:00-3:00 p.m.**
**The Hong Kong Medical Association**
Navigating the Management of Atopic Dermatitis
*HKMA CME Live Lecture*
HKMA CME Dept. – Tel: 2527 8452
1

**17 November (Fri) 2:00-3:00 p.m.**
**The Hong Kong Medical Association**
The Update of the HKMA CMS 5.0 in the Era of Primary Healthcare Development
*HKMA CME Live Lecture*
HKMA CME Dept. – Tel: 2527 8452
1

**20 November (Mon) 2:00-3:00 p.m.**
**The Hong Kong Medical Association**
Management of Heavy Menstrual Bleeding: Diagnosis, Treatment Options and Patient Counseling
*HKMA CME Live Lecture*
HKMA CME Dept. – Tel: 2527 8452
1

**21 November (Tue) 2:00-3:00 p.m.**
**The Hong Kong Medical Association and the Gleneagles Hong Kong Hospital**
Topic on General Surgery
*HKMA CME Hybrid Lecture*
HKMA CME Dept. – Tel: 2527 8452
1 Hybrid

**22 November (Wed) 2:00-3:00 p.m.**
**The Hong Kong Medical Association**
Topic in Lung Cancer Screening
*HKMA CME Live Lecture*
HKMA CME Dept. – Tel: 2527 8452
1

**23 November (Thu) 2:00-3:00 p.m.**
**The Hong Kong Medical Association and the Hong Kong Science and Technology Park**
DNA Methylation and Its Role in Health and Disease: Implications for Early Prediction, Prevention and Intervention
*HKMA CME Hybrid Lecture*
HKMA CME Dept. – Tel: 2527 8452
1 Hybrid

**24 November (Fri) 2:00-3:00 p.m.**
**The HKMA District Health Network (Yau Tsim Mong)**
Osteoarthritis of Knees: Drugs? Injection? Others?
*HKMA CME Physical Lecture*
HKMA District Health Network Dept. – Tel: 2861 1979
1 Physical

**27 November (Mon) 2:00-3:00 p.m.**
**The Hong Kong Medical Association**
The Role of Probiotics in the Treatment of NAFLD and Metabolic Disease
*HKMA CME Live Lecture*
HKMA CME Dept. – Tel: 2527 8452
1

**28 November (Tue) 2:00-3:00 p.m.**
**The Hong Kong Medical Association**
1. Updates on Colorectal Cancer Screening
2. Multitarget FIT-DNA Technology as the Latest Colorectal Cancer Screening Option in Hong Kong
*HKMA CME Live Lecture*
HKMA CME Dept. – Tel: 2527 8452
1

**29 November (Wed) 2:00-3:00 p.m.**
**The HKMA District Health Network (Central, Western and Southern)**
Diagnosis and Management of Common Skin Infections in Primary Care
*HKMA CME Live Lecture*
HKMA District Health Network Dept. – Tel: 2861 1979
1

**30 November (Thu) 2:00-3:00 p.m.**
**The HKMA District Health Network (Hong Kong East)**
Changing Paradigms in Hyperlipidemia Management: What are the Available Evidence in CV Risk Reduction and Long Term Safety?
*HKMA CME Physical Lecture*
HKMA District Health Network Dept. – Tel: 2861 1979
1 Physical