

## CME Bulletin

### 香港醫學會持續醫學進修專訊

April 2001

二零零一年四月

## Pap Smear Screening

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### Case 1

*Miss Lee, 30-year-old office lady presents as a new patient requesting a Pap smear screening. She has seen some publicity that cervical cancer is very common and all women should have Pap smear annually. She never has Pap smear done before. Her elder sister was found to have cervical cancer recently.*

*She is sexually active, has had 4 partners in the past 15 years since she first became sexually active, and has been monogamous for the past 3 years. She has no complaints and had no history of sexually transmitted diseases, abnormal vaginal discharge, or abnormal vaginal bleeding. She has regular menses and has never been pregnant. She uses oral contraceptive all along. She enjoys good health and she has no history of allergy. She consumes 10 cigarettes per day.*

1. How common is cervical cancer among women with cancers in Hong Kong?

**(Please choose the best answer for each question.)**

*Its incidence ranks*

- A. 1<sup>st</sup>
- B. 2<sup>nd</sup>
- C. 3<sup>rd</sup>
- D. 4<sup>th</sup>
- E. 5<sup>th</sup>

Cervical Cancer is an important public health problem in Hong Kong. Despite a decrease in age standardized incidence, it is the 4<sup>th</sup> commonest malignancy in females and ranks 7<sup>th</sup> as a cause of cancer death in females. The incidence of clinical cancer increases with age and, reaches a peak in the 60 to 65 years age group. It affects about 500 women and causes the death of about 150 women in HK each year.

Cervical cytology screening can reduce the incidence and mortality of cervical cancer. Its effectiveness is increased when it forms part of an organized program of screening.

Several features of the disease make it an ideal target for a screening program. It has long pre-invasive phase that may extend from 10 to 15 years. A safe, widely acceptable and inexpensive test, the Pap smear, is available to detect early-stage disease, and effective

treatment of early- stage lesions can be accomplished with minimally invasive techniques.

### ***Target population***

The target population encompasses all women from the time of commencing sexual activity until they reach 65 years of age. Screening may be discontinued in women aged 65 or more if previous smear have been consistently normal, although the upper limit beyond which screening ceases to be effective is unknown. Women over 65 years old who have never had a cervical smear, or who request a cervical smear, should be screened.

2. Which of the following is NOT a risk factor of cervical cancer for Miss Lee?
- A. First intercourse in young age
  - B. Smoking
  - C. Never has Pap smear before
  - D. Family history of cervical cancer
  - E. Multiple sex partners

Speculum and pelvic examinations were normal. Pap smear was done and the result was normal.

3. When should she go for her next Pap smear screening?
- A. No need
  - B. 6 months later
  - C. 1 year later
  - D. 2 years later
  - E. 3 years later

### ***Screening interval***

Screening at 2 or 3-yearly intervals does not significantly reduce the chance of finding invasive cervical cancer below that found using annual screening and it results in considerable reduction in the cumulative incidence of cervical cancer is 93% with annual or biannual screening intervals, 91% if performed every 3 years, 84% if performed every 5 years and 64% if performed every 10 years. Screening at 3-yearly intervals, after 2 consecutive normal smears are obtained by annual screening, is recommended. However in persons at higher risk for carcinoma of the cervix, e.g. immunosuppressed women, annual screening is advised.

Particular emphasis should be given to recruit those women at greatest risk for cervical cancer and women who have never had a cervical smear, or those who have not had one for more than 3 years.

Risk factors for cervical cancer include:

- Human papillomavirus infection, particularly HPV 16,18, 45, 56
- HIV infection
- History of sexually transmitted disease
- Multiple sexual partners
- Immunosuppressed women
- Smoking

### ***Methods of screening***

There are various methods of screening for cervical cancer including cervical cytology, cervicography, HPV typing and polar probe. Apart from cervical cytology, the effectiveness of

the other methods has not been established in cervical cancer screening. At the moment, cervical cytology remains the gold standard for cervical cancer screening.

### ***Optimization of effective cervical cytology sample collection***

The quality of the smear has a major impact on the sensitivity of the cervical smear. The presence of inflammatory cells, blood or debris, the type of instrument used and the skill of the operator may affect the quality of the smear. Avoid taking a smear during menstruation.

Use a device that will optimize sampling of the endocervical canal and ectocervix and thus the transformation zone and is cost effective. The broom type device is more expensive but gives better yield of endocervical cell than the conventional Ayres' spatula.

Despite adequate collection of cervical cells, poor transfer of cells to the slide may result in samples which are too thick or uneven for assessment. The cervical cells may be obscured by mucus, blood or inflammatory cells.

The smear should be fixed properly, either in 95% alcohol or using a spray fixative, immediately after the slide is prepared.

Factors that are important and can affect the interpretation of a smear include age, hormonal status, use of OC pills, pregnancy, presence of IUCD, and date of last menstrual period. Such information should be provided on the request form. Ensure proper labeling of the sample.

Liquid based preparations have assisted in decreasing the problems mentioned in above and have reduced the unsatisfactory smears rate but at a price.

The use of estrogen in postmenopausal women and the treatment of pre-existing infection may help to improve the quality when a smear needs to be repeated.

### ***Laboratory screening***

Smear should be screened by a laboratory with documented good quality control. Random re-screening of 10% of negative cases, targeted re-screening and rapid re-screen are methods used in quality control. Computer assisted re-screening and primary screening are now available but at a cost.

#### **Case 2**

*Mrs. Wong, 36-year-old asymptomatic multiparous housewife returns to her family doctor for Pap smear screening. Her last Pap smear 3 years ago was normal.*

*Speculum and pelvic examinations were all normal and Pap smear was taken. The cytopathology report showed atypical squamous cells of undetermined significance (ASCUS).*

*She uses oral contraceptives and has no history of sexually transmitted diseases. She does not smoke and has no significant past medical history.*

4. Which of the following terminology is **NOT** commonly used in the reporting of cervical smears by the Bethesda System (TBS)?
  - A. Within normal limits
  - B. Cervical intraepithelial neoplasia I (CIN I)
  - C. Low grade squamous intraepithelial lesion (LSIL)
  - D. Atypical squamous cells of undetermined significance (ASCUS)

- E. Squamous cell carcinoma
- 
- 5. How would you manage Mrs. Wong?
    - A. Repeat Pap smear 6 months later
    - B. Repeat Pap smear 1 year later
    - C. Repeat Pap smear 3 years later
    - D. Refer for colposcopy and biopsy
    - E. Refer for loop electrosurgical excision procedure (LEEP)

***Reporting of abnormal smears***

Various terminology is used in the reporting of cervical smears. An understanding of the meaning of a smear report is essential for proper management of abnormal results.

Most laboratories in HK are now reporting cervical smears using The Bethesda system (TBS). A strength of this system is that it requires an evaluation of the adequacy of the specimen and encourages a descriptive diagnosis of abnormalities. For uniformity, this should be the default reporting system in the cervical screening program.

## Comparison of the Bethesda System to the Former Cytopathology Reporting Systems for Pap Smears

World Health Organization system	Cervical intraepithelial neoplasia system (CIN)	The Bethesda system (TBS)
Normal	Normal	Within normal limits
Inflammation		Other <ul style="list-style-type: none"> <li>• Infection</li> <li>• Reactive and reparative</li> </ul>
Dysplasia <ul style="list-style-type: none"> <li>• Mild</li> <li>• Moderate</li> <li>• Severe</li> </ul>	<ul style="list-style-type: none"> <li>• CIN – I / HPV</li> <li>• CIN – II</li> <li>• CIN – III</li> </ul>	Squamous intraepithelial lesions (SIL) <ul style="list-style-type: none"> <li>• Low grade</li> <li>• High grade</li> <li>• High grade</li> </ul>
Carcinoma in situ	CIN - III	High grade
<ul style="list-style-type: none"> <li>• Invasive squamous cell carcinoma</li> <li>• Adenocarcinoma</li> </ul>	<ul style="list-style-type: none"> <li>• Invasive squamous cell carcinoma</li> <li>• Adenocarcinoma</li> </ul>	<ul style="list-style-type: none"> <li>• Squamous cell carcinoma</li> <li>• Adenocarcinoma</li> </ul>
		<ul style="list-style-type: none"> <li>• Atypical Squamous Cells of Undetermined Significance (ASCUS)</li> <li>• Abnormal glandular cells of undetermined Significance (AGUS)</li> </ul>

The term Atypical Squamous Cells of Undetermined Significance (ASCUS) applies to squamous cell abnormalities that cannot be accounted for by reactive changes but do not fulfill the criteria for a specific squamous lesion. Some patients with ASCUS will harbour HSIL or rarely invasive cancer.

### **Criteria for referral for colposcopy**

The decision to refer for colposcopy depends on the likelihood that a patient has CIN II/III or more advanced disease. The following table is a guide to this decision.

Cervical Smear	Significance	Suggested actions
Normal	0.1% CIN II - III	Normal screening program (Once every 3 years after 2 normal annual smears)
Inflammatory	May mask HGSIL or invasive cancer	Treat confirmed infection. Repeat smear in 3-6 months and refer for colposcopy if abnormality persists
Atypical squamous cells of undetermined significance (ASCUS)	In persistent ASCUS: 14% CIN II- III** 0.7% microinvasive 0.2% invasive	Repeat smear in 3-6 months. Refer for colposcopy if abnormality persists.
Low grade squamous	13.4% CIN II – III*	Refer for colposcopy and

intraepithelial lesion (LSIL)	0.1% microinvasive	biopsy
High grade squamous intraepithelial lesion (HSIL)	69.5% CIN II – III* 2.3% microinvasive 3.5% invasive	Refer for colposcopy and biopsy
Invasive cancer	53.8% microinvasive or invasive*	Biopsy if frank growth, otherwise early referral for colposcopy and biopsy
Abnormal glandular cells of undetermined significance (AGUS)	17% high grade, 5% AIS, 2% invasive adenocarcinoma	Refer for colposcopy and biopsy, then cone biopsy and D & C may be required
Endometrial cells at inappropriate time	(if menopause) 7% adenocarcinoma 13% hyperplasia 38% endometrial polyp	Investigate for Endometrial pathology

\* 1996 HK colposcopy data, some data with colposcopy performed only after persistent ASCUS

\*\* HK colposcopy data includes persistent ASCUS at second or third smears

The colposcopist's role is to examine the transformation zone, define the extent of the lesion, and to biopsy the most abnormal area for a tissue diagnosis. In addition to the cervix, the vagina should also be inspected.

### ***Treatment for CIN and basis of treatment***

Since 85% of low grade lesions (HPV, CIN I) will regress over 2 years without treatment, these patients can be observed. About 15% of these patients may progress to CIN II or III and require treatment later.

If a low-grade lesion is confirmed by colposcopy and biopsy, the patient can be regularly followed-up every 6 months until the smear returns to normal. After that, the patient can be followed annually. If the smears are normal for 5 consecutive years, the patient can return to the routine screening program.

If the patient is unable or unwilling to return for follow-up, then treatment should be considered. If the lesion persists without treatment for more than 2 years, options for treatment should be discussed with the patient.

Treatment for CIN can be carried out under local anaesthesia on an outpatient basis.

The reason for treating high-grade cervical intraepithelial neoplasia (CIN – II or III) is that these lesions are likely to progress to invasive cancer if left untreated. The time of progression to cancer is variable and can take from months to years. The risk of CIN III progressing to an invasive lesion was > 12%.

If high-grade lesion is found, and obvious invasive cancer has been excluded, local treatment can be performed with a success rate of more than 90%.

Ablative methods include electrocoagulation diathermy, cryosurgery, cold coagulation and laser vaporization and all suffer the disadvantage of not producing a specimen for histology examination.

The currently preferred method is the loop electrosurgical excision procedure (LEEP). This has the advantage of providing a tissue specimen that is generally of sufficient quality for histologic exclusion of occult invasion. Complications include intraoperative and postoperative

bleeding (1-8%), infection, cervical stenosis (1%), cervical deformity and cervical incompetence.

Hysterectomy is not recommended for the treatment of CIN II/III unless there are concomitant gynecological problems that warrant a hysterectomy or if the patient is unreliable for follow-up surveillance.

After treatment for HSIL, patients should be followed up by cervical cytology for 3 times at 6-monthly intervals and then annually.

The diagnosis and indication for treatment, treatment procedures and possible treatment complications, should be discussed with the patient before colposcopic examination and treatment. All counseling, cytology/ histology/ colposcopy results, consent, and the management plan should also be documented. Patients with high grade lesions should be informed of the result as soon as possible and preferably within 4 weeks.

### ***Recall system***

It is a good practice that a record system is available to keep track of the outcome of patients with an abnormal smear. A recall system should ideally be in place to make sure patients with abnormal smears are properly managed.

A recall system to remind women with normal cytology that they are due for another cervical smear will optimize the efficacy of a screening program.

### *Reference:*

*Guidelines on the management of an abnormal cervical smear. 1999, The Hong Kong College of Obstetricians and Gynecologists (HKCOG)*

## **CERVICAL CANCER SCREENING**

### ***Who should be screened?***

- Women start having sexual activity until the age of 65

### ***Frequency of cervical smear***

- Yearly cervical smear for 2 consecutive years, if the results are normal, space it out to every 3 years
- Immunosuppressed patients and those who have history of abnormal smear, annual smear is advisable.

### ***Taking a smear***

- Use a clean speculum of appropriate size, normal saline is the preferred lubricant
- Expose the cervix properly and identify the squamo-columnar junction with adequate lighting
- Use a modified Ayre's spatula and rotate it through the full circumference of the cervix
- Endocervical brush sample should be considered if the anatomy of the cervix has been altered by previous treatment or when part of the transformation zone is up in the endocervical canal, endocervical brush sampling alone is not an adequate examination and it should follow the spatula sampling
- The spatula should immediately be stroked across the surface of the slide and the smear should be evenly spread, cells obtained with the endocervical brush should be deposited on the slide by rolling the brush across the glass surface
- Prompt immersion in adequate volume of 95% alcohol or fixation of the slide with aerosol spray
- The alternative way of taking a smear is to use broom shaped brush or equivalent and put it into a liquid based medium
- Both the slide or bottle of liquid and the form should be properly labelled
- Relevant information as stated in the smear test request form should be provided
- If gross tumour is seen, refer the patient to gynaecologist for cervical biopsy and cervical smear is unnecessary

### ***Reporting a smear***

- Most of the laboratories in Hong Kong are now using the Bethesda system to report cervical smears, doctors should understand the terminology used in this system

### ***Management of abnormal cervical smears***

- If inflammation is shown, treat infection if confirmed, repeat another smear in 3-6 months and refer for colposcopy if abnormality persists
- If the report showed atypical cells of undetermined significance (ASCUS), cervical smear should be repeated in 3-6 months, refer for colposcopy if abnormality persists
- When low grade or high grade squamous intraepithelial lesion (L/HSIL) is reported, refer the patient for colposcopy
- Atypical glandular cells of undetermined significance (AGUS) shown on the smear warrants referral to colposcopy clinic for the exclusion of endocervical and endometrial pathologies
- If invasive cancer is suggested, refer to gynaecologist for cervical biopsy if frank growth is seen, otherwise, urgent referral for colposcopy is mandatory
- The presence of endometrial cells in postmenopausal patient who are not taking hormones should be referred to gynaecologist to exclude endometrial pathology
- Before referral to the colposcopy clinic, the patient should be explained of the cervical smear report in order to alleviate their anxiety

### ***Call system***

- Women belonging to the targeted population, cervical smear should be offered
- Informing patient of a normal result would be reassuring and might make the screening programme more successful
- Patients having abnormal cervical smears should be called and managed accordingly

CME Event 講課簡介	Venue & Time 地點及時間
<p><b>Treating Osteoporosis in the New Century – Scientific Symposium to celebrate the First Anniversary of the Osteoporosis Centre</b> 12 May 2001 (Saturday)</p> <p><i>This symposium is co-organized with the Osteoporosis Centre, Department of Medicine, HKU, QMH and sponsored by Merck Sharp and Dohme</i> Please refer to the April issue of the HKMA CME Bulletin for details of the Symposium.</p>	<p>Ballroom, Sheraton HK Hotel &amp; Towers, 20 Nathan Road, TST 尖沙咀喜來登酒店 三樓宴會廳</p> <p>Lunch: 12:00 p.m. Lecture: 1:45 p.m. 午宴: 中午十二時正 講課: 下午一時四十五分</p>
<p><b>The Role of Calcium Breaker in Coronary Diseases</b> 14 May 2001 (Monday)</p> <p>Speaker: Dr. Victor W. T. Yam M.B., B.S., M.R.A.C.P., F.R.A.C.P., F.H.K.C.P., F.H.K.A.M.</p> <p><i>This lecture is sponsored by Pfizer Corporation</i></p>	<p>Crystal Ballroom, B3 Holiday Inn Golden Mile HK 50 Nathan Road, TST 尖沙咀金域假日酒店 地庫三樓麗晶殿</p>
<p><b>Management of Orthopaedic Pain</b> 30 May 2001 (Wednesday)</p> <p>Speaker: Prof. Leung Ping Chung D. Sc., M.B., B.S., M.S., F.R.A.C.S., F.R.C.S.(Edin.), F.H.K.C.O.S., F.H.K.A.M.(Orth.), Professor of Orthopaedics &amp; Traumatology, Faculty of Medicine, C.U.H.K.</p> <p><i>This lecture is sponsored by Merck Sharp and Dohme</i></p>	<p>Lunch: 1:00 – 2:00 p.m. Lecture: 2:00 – 3:00 p.m. 午宴: 下午一時正 講課: 下午二時至三時</p>

**Please register for participation. First come first served. 名額有限 請早登記**  
Accreditation: HKMA CME Programme (1 pt); Accreditation from various colleges pending

Reply Slip 回條

**To: The Hong Kong Medical Association [Fax: 2865 0943]**  
致: 香港醫學會 [傳真號碼:2865 0943]

I would like to register for the following CME lecture to be held in May 2001:  
本人欲報名參加以下講課: (Please "tick" the lecture(s) interested. 請在欲參與的講課旁加" "號)

12 May (Sat): **Treating Osteoporosis in the New Century**  
14 May (Mon): **The Role of Calcium Breaker in Coronary Diseases**  
30 May (Wed): **Management of Orthopaedic Pain**

Name 姓名: \_\_\_\_\_ Tel No 電話: \_\_\_\_\_ Fax No.傳真: \_\_\_\_\_

HKMA Membership No. 會員編號  
or HKMA CME No.或進修號碼: \_\_\_\_\_ Signature 簽名: \_\_\_\_\_

Data collected will be used and processed for the purposes related to the HKMA CME Programme only.

## Practical Ophthalmology for General Practitioner

The Hong Kong Medical Association and the College of Ophthalmologists of Hong Kong jointly offer a comprehensive workshop on ophthalmology for general practitioners in May 2001. The workshop comprises of 2 half-day lectures plus a one-hour session of clinical attachment at private ophthalmologic clinics.

### ~ L E C T U R E S ~

Sunday, 13 May 2001

**Topics**

Anatomy & Physiology  
Basic P/E & Investigations  
Refractive Error & Amblyopia  
Eye Injury  
Retinoblastoma, ROP, Epiphora  
Red Eyes/Chalazion/Pterygium  
Entropion/Ectropion/Trichiasis  
Squint

**Speakers**

Dr. Shiu Chi Yuen  
Dr. Alvin Young  
Dr. Chow Pak Chin  
Dr. Joan Wu  
Dr. Agnes Tse  
Dr. Kwok Sek Keung  
Dr. Godfrey Lam  
Dr. David Wong

Sunday, 27 May 2001

**Topics**

POAG  
PCAG  
2° Glaucoma  
Cataract  
ARMD  
Diabetic Eye Diseases  
CRAO/CRVO  
Floaters & RD  
Eye Tumour

**Speakers**

Dr. Vincent Lee  
Dr. Alfred Leung  
Dr. Joan Ng  
Dr. John Chang  
Dr. Chan Wai Man  
Dr. Tsang Moon Kwong  
Dr. Alvin Kwok  
Dr. Rupert Lee  
Dr. Ko Tak Chuen

2:00 – 5:00 p.m.

Seminar Room I

Hospital Authority Building

147B Argyle Street, Kowloon

下午二時至五時

九龍亞皆老街一四七號B

醫管局大樓 M 字樓

一號研討室

### ~ CLINICAL ATTACHMENT 臨床實習 ~

To be arranged starting from June 2001 二零零一年六月份起 (日期將個別安排)

Course Fee 費用 : HK\$1,000 港幣一千元正

Accreditation 進修積分 : The workshop will be accredited under the HKMA CME Programme 參加者可獲香港醫學會持續醫學進修計劃積分點; 其他專科學院之學分在申請中

Registration 報名方法 : Please fill in and return the Registration Form below together with a cheque made payable to "The Hong Kong Medical Association" to the Hong Kong Medical Association, 5/F Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong. 請填妥以下表格連同支票寄交香港灣仔軒尼詩道十五號溫莎公爵社會服務大廈五樓香港醫學會, 支票抬頭請書明支付「香港醫學會」。

First come first served for 100 participants. 名額一百 請早登記

### Registration Form 報名表格

I would like to register for the Ophthalmology Workshop and I enclose herewith a cheque of HK\$1,000 being course fee for the workshop.

本人參加香港眼科醫學院及香港醫學會合辦之眼科課程, 隨函付上港幣一千元支票作為課程之報名費用。

Name 姓名 : \_\_\_\_\_ Tel No 電話 : \_\_\_\_\_ Fax No. 傳真 : \_\_\_\_\_

Address 地址 : \_\_\_\_\_

HKMA Membership No. 會員編號

or HKMA CME No.或進修號碼: \_\_\_\_\_ Signature 簽名: \_\_\_\_\_

## HKMA CME Programme—Monthly Self-Study Series

香港醫學會持續醫學教育計劃—每月自修資料

Answer Sheet for April 2001

二零零一年四月號答題紙

### Pap Smear Screening

(Please write down the alphabet indicating the best answer in each question.)

1.	
2.	
3.	
4.	
5.	

Please return completed answer sheet to the HKMA Secretariat on or before 10 May 2001 for documentation. 1 CME point will be awarded. (Fax: 2865 0943)

請回答所有問題，並於二零零一年五月十日前將答題紙傳真或寄回香港醫學會。所有交回答題紙之參加者將可獲持續醫學進修積點一分。(傳真號碼: 2865 0943)

### Answers to March 2001 Issue

香港醫學會持續醫學教育計劃

每月自修資料二零零一年三月號答案

### Helicobacter Pylori Infection

1.	F	11.	T	21.	T
2.	F	12.	T	22.	T
3.	F	13.	T	23.	F
4.	T	14.	T	24.	T
5.	T	15.	T	25.	T
6.	T	16.	F	26.	F
7.	T	17.	T	27.	T
8.	T	18.	F	28.	T
9.	F	19.	F	29.	T
10.	F	20.	T	30.	T

## Guidelines

### The Hong Kong Medical Association Regulations for the Award of Certificate of CME (CCME)

#### 香港醫學會持續醫學進修計劃章則(英文版)

(Academic Year: 1 July - 30 June)

1. All members of the Association (except Student and Associate Members) are automatically registered with the HKMA Continuing Medical Education (CME) Program at the beginning of each academic year. Non-members can also register upon payment of a fee to be determined by the Council of the Association.
2. The CME Program is structured on a yearly basis in accordance with the academic year from 1 July to 30 June of the following year. Accreditation will be recorded throughout the academic year in the form of credit points awarded for participation in various continuing medical education activities. At the end of each academic year, the total score will be recorded in the member's record.
3. A Certificate of CME will be awarded to those who have earned at least 15 credit points within an academic year, irrespective of their date of registration, upon payment of an administrative fee to be determined by the Council of the Association. The total number of "credit points" accumulated during the year and those during the previous year, if any, will be reported on the Certificate as recognition of performance in CME.
4. Credit points will be awarded to participants of CME activities organized by the Association as well as of those organized by other medical organizations, as determined by the CME Accreditation Sub-Committee. As a general guidance, credit points may be awarded as follows:
  - 4.1 Self-study (*per set of MCQs returned via fax, mail or internet*) 1 point
  - 4.2 Lectures / seminars / symposia / workshops / refresher courses  
Maximum 6 points per day  
*Per hour of active participation* 1.5 point  
*Per hour of passive participation* 1.0 point
  - 4.3 Discussion groups (*per hour of interactive participation*) 1 point
  - 4.4 Clinical attachment in hospital up to 10 points
  - 4.5 Medical conference overseas up to 10 points
  - 4.6 Publications such as journal articles, books, thesis up to 10 points
  - 4.7 Postgraduate courses up to 15 points
  - 4.8 Public medical education, various forms up to 2 points
5. All CME participants shall have to apply in writing to the CME Accreditation Sub-Committee within one month of the end of the academic year providing all details with relevant proof of attendance issued by the organizing institutions in support of the application, if they want to obtain accreditation for their other educational activities not already recorded. Decision of the CME Accreditation Sub-Committee shall be final.

\* \* \*