



MONTHLY SELF-STUDY SERIES

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每月自修資料

請細閱以下文章，並利用第十三頁之答題紙完成自我評估測驗。香港醫學會持續醫學進修計劃參加者如於二零零四年一月十五日前，將已填妥之答題紙傳真或寄回本會秘書處，將可獲持續醫學進修一個積分點；至於是期自我評估測驗之答案，將刊於下一期《持續醫學進修專訊》之中。（本會秘書處傳真號碼：2865 0943）



A Lady with Bilateral Pleural Effusion

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Initial Presentation

A 73 year old housewife, non-smoker, non-drinker, living with family and with no known drug allergy was seen in consultation in a private hospital.

Her significant past surgery was total hysterectomy and bilateral salpingo-oophorectomy at the age of 40 in Princess Margaret Hospital. She also has NIDDM treated with oral hypoglycemic agents and followed up in GOPD.

Her current illness dated back to March 2003 when she presented with "polyarthritis" involving small joints of hands with redness, heat and pain. There was also leg swelling at that time. She was treated by various private doctors. She developed a rash over her hands and feet that was diagnosed as vasculitis or NSAID allergy.

She developed ulcer pain due to the NSAID and was admitted to a private hospital. Upper endoscopy showed HP+ gastric ulcer. Abdominal ultrasound revealed splenomegaly and cystitis. Chest X ray was normal. Her hemoglobin was low (10.8 g/dl), WBC raised (15 x 10⁹/L

with 82% neutrophils. Renal and liver functions were normal. Hb_{A1C} was raised to 8.2% and serological markers for autoimmune diseases were negative including RA factor and ANF. Urine protein -ve, sugar 4+, bile -ve, UB not raised, WBC 0-3/hpf, RBC -ve, MSU no growth.

First Admission

She switched to herbal medicine in view of absence of response till 2 July 2003 when she was admitted through A&E Department to a public hospital due to shortness of breath and bilateral lower limb edema. No abnormal physical signs other than pleural effusion, ankle oedema and emaciation were documented in the charts.

Investigations there showed **bilateral pleural effusion on Chest X ray**. ECG was normal and echocardiogram showed good LV function and ejection fraction 72%. **Hgb 10.6 g/dl** and white cell count again showed neutrophilia with total **WBC 16.1 x 10⁹/L**. **Reticulocyte count 4.4%**. **Albumin 27 g/L, sodium 130 mmol/L**, creatinine clearance 56.7 ml/minute. Thyroid function and clotting profile were normal. Autoimmune markers including RF, ANF, Anti-DNA, Anti-ENA, ANCA were again all negative but **C-reactive protein was raised to 33.4 ug/dl (normal < 8)**. C3 was normal at 1.1 g/L and C4 low at 0.12 g/L (normal 0.2-0.59) on 16 July 2003. LDH: 281 IU/L. Toxoplasma and Rickettsiae antibody were negative. 24 hours urine protein was 370 mg. **Pleural fluid: transudate (protein 25g/L, LDH 93 IU/L, sugar 16.7 mmol/L)**, no growth, cytology negative, red cells 270, white cells 954 with 74% lymphocytes), AFB smear was negative with no growth on culture. Repeated OGD showed no lesion up to D2, antral biopsy revealed chronic gastritis with no further

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HP infection. Ultrasound again showed **splenomegaly** at 15 cm size with small **ascites and bilateral pleural effusion**.

Cold agglutinins was raised to 512 titre with +ve **direct and indirect antiglobulin** test. **Plasma regain** was +ve and **haptoglobin** was raised to 2.06 (normal 0.16-2.0).

Dermatologist's view on skin lesion suggested the differential diagnosis of chronic urticaria or urticarial vasculitis secondary to autoimmune disease. She was afebrile all along but was put on sulperazone for 1 week after admission. She developed increasing pleural effusion despite treatment and developed **Klebsiella UTI** due to catheterization. She was then put on levofloxacin.

Second Admission

She discharged herself from the public hospital because of SARS. She was then admitted to a private hospital, the following laboratory data was confirmed: low sodium of 130mmol/L, normal urea and creatinine, normal liver enzymes except LDH which was raised to 413 IU/L (normal 200-360). Albumin was low at 28.7 g/L and total protein was normal at 65.6 g/L. Neutrophilia (87% of $20 \times 10^9/L$) and a high ESR of 118 mm/hr. Urinalysis confirmed the persistence of ESBL Klebsiella infection which was sensitive to ofloxacin, netromycin, tienam and maxipime. Bilateral lower lobe effusion was again confirmed on X-ray.

Over 4 litres of pleural fluid was tapped bilaterally over the next 2 weeks. This confirmed the absence of AFB on smear, absence of organisms on gram stain, and negative cultures from aerobic and anaerobic medium. Pleural fluid showed a predominance of small lymphocytes admixed with occasional macrophage suggestive of chronic inflammation. Immunostaining study of the lymphocytes showed positive staining of both Kappa and Lambda light chains (the result was against lymphoma as a diagnosis because the latter should yield a monoclonal population of lymphocytes). Pleural fluid pH was 7.5, SG 1023 (exudates SG usually >1015), red cells 3660 /cu.mm, white cell 1530 /cu. mm, polymorphs 12%, lymphocytes 88%. CEA 2.0 ng/ml (blood level 1.8, elevation 20 ng/ml may be seen in adenocarcinoma of breast, lung, GIT), protein 32.6 g/L (blood 56.3 = 58%, exudates usually protein content >50% of blood level), sugar 11.1 mmol/L (blood 17.3 = 64%, exudative fluid should have a lower sugar level), LDH 598 IU/L (blood 518 = 115%, exudates usually more than 60% of serum level), amylase <30 IU/L (blood <30 IU/L).

Pleural biopsy showed fibrous tissue focally covered by mildly atypical cells that favor reactive mesothelium with mild inflammatory cell infiltration.

Cold agglutinin titre > 1:1024 was demonstrated on 2 August 2003 and direct Coombs test vs AHG and anti-C3d was positive (vs anti-IgG -ve). Indirect Coombs test was positive. No warm antibody was detected in serum and red cells eluate though cold autoantibody was detected in serum at room temperature and at 4°C. Anti-Mi was detected in patient's serum by gel IgG technique. Reticulocyte count was 2.2%. Immunoelectrophoresis was normal. C4 was low 7.9 mg/dL (normal 20-50) though C3 was normal 67.3 mg/dL. Cholesterol was 2.78 mmol/L.

Marrow and Trepchine biopsies showed no evidence of lymphoma infiltration and reactive erythropoiesis was noted. Abdominal ultrasound confirmed multiple lymph nodes in the mesentery and marked splenomegaly. CT showed lymphadenopathy in the root of the celiac axis and in the para-aortic regions and in the small bowel mesentery with one to two loops of slightly thick walled small bowel.

Physical examination confirmed the cervical lymphadenopathy not previously noted. PET/CT confirmed extensive lymphadenopathy in the neck, both axillae and more markedly in the abdomen as well as in the groins and left iliac chains. Some lymph nodes were also seen in the thorax. Lymph node biopsies confirmed angioimmunoblastic T-cell lymphoma.

Though there are still effusions in both lungs, the patient seemed to respond well to steroid therapy for the autoimmune hemolytic anemia. Oncology consultation was asked for at this time for chemotherapy.

An Update on the Diagnosis and Management of Malignant Lymphoma

Malignant lymphoma (ML) is the most common haematological neoplasm in Hong Kong. In year 2000 about 670 new cases of ML were diagnosed with 311 patients died in year 2001, and the incidence was rising in the past 10 years.¹⁻² Malignant lymphomas (non-Hodgkin's lymphoma (NHL) and Hodgkin's disease (HD)) are a clinically and pathologically diverse group of neoplasms of largely unknown cause. However, the incidence has increased over the last 30 years worldwide, this is partly accounted for by HIV-related lymphoma.³⁻⁴ Other microorganisms are also recognised as causative agents including human T cell lymphotropic virus 1 (HTLV-1), Epstein-Barr virus (EBV) and Helicobacter pylori infections. ML are highly treatable and curable, however the management of the ML is complex and is best carried out in specialised treatment centres.

Pathology and Classification

ML is a heterogeneous group of malignant diseases characterized by replacement of normal lymphoid structure by diffuse or nodular collections of abnormal lymphocytes. The NHL arise from malignant transformation of lymphocytes, deriving from B cells in about 85% of cases and T cells in most of the rest. However, the cell of origin of the Reed Sternberg cell, which characterizes HD, remains uncertain. Histopathologically, lymphomas comprise an admixture of identical (monoclonal) malignant cells with variable amounts of reactive lymphoid cells and stroma. The lymphomas are variably sub-categorized by pathologists into about 20 different types on the basis of conventional cytological staining, immunological and genetic information to determine subtype and lineage.

Figure 1
REAL classification of non-Hodgkin's lymphoma

| |
|---|
| B cell |
| Indolent (low grade) |
| <ul style="list-style-type: none"> • Small lymphocytic lymphoma • Lymphoplasmacytic lymphoma / Waldenstrom's macroglobulinaemia • Marginal zone lymphomas Extranodal, mucosa-associated lymphoid tissue Splenic lymphoma with villous lymphocytes Monocytoid B cell lymphoma • Follicular lymphoma (grade I and II) |
| Aggressive (intermediate-grade) |
| <ul style="list-style-type: none"> • Mantle cell lymphoma • Follicular lymphoma (grade III) • Diffuse large B cell lymphoma • Primary mediastinal B cell lymphoma |
| Aggressive with high risk of CNS disease (high-grade) |
| <ul style="list-style-type: none"> • Precursor B lymphoblastic • Burkitt's lymphoma |
| T cell |
| Indolent (low-grade) |
| <ul style="list-style-type: none"> • Sezary's syndrome / mycosis fungoides • Smouldering/chronic adult T cell leukaemia / lymphoma |
| Aggressive (intermediate-grade) |
| <ul style="list-style-type: none"> • Peripheral T cell lymphoma (unspecified) • Angioimmunoblastic lymphoma • Angiocentric lymphoma • Intestinal T cell lymphoma • Anaplastic large cell lymphoma |
| Aggressive with high risk of CNS disease (high-grade) |
| <ul style="list-style-type: none"> • Precursor T lymphoblastic • Adult T cell leukaemia / lymphoma |

There has been confusion over the classification of NHL. The most recent approach, based on the Kiel classification, is the Revised European-American Lymphoma (REAL) system⁵ (Figure 1), which aims to define entities that are both pathologically and clinically relevant, and includes immunological and genetic information. The REAL system divides NHL into precursor (immature) and peripheral (mature) neoplasms, and into T and B cell lymphomas based on immunological markers. Distinct subtypes of NHL may be identified by characteristic gene rearrangement. The new WHO classification⁶ is currently refining and extending the REAL system as part of a more comprehensive classification of all neoplasms of haematopoietic and lymphoid tissues. The distinct diseases are defined according to a combination of morphology, immunophenotype, genetic features, and clinical syndromes, and finally the cell origin is postulated. Lymphatic leukemia is included in lymphoma, and the lymphoid malignancies are grouped into B cell lymphoma, T/NK cell lymphoma and Hodgkin lymphoma.

Whatever the systems we adopt, the lymphomas are classified into three clinically relevant groups:

1. Indolent (low-grade) disease represents about 30% of all NHL; most cases (80%) are follicular lymphoma.
2. Aggressive (intermediate-grade) disease comprises about 60% of NHL; diffuse large cell is the most common histology.
3. Aggressive with high risk of CNS disease (high-grade) lymphomas constitute less than 10% of NHL and include lymphoblastic lymphoma, Burkitt's lymphoma, Adult T cell leukaemia / lymphoma (ATLL), and NHL in immunodeficient patients (e.g. HIV-related lymphoma).

Clinical Features

The median age of presentation with low-grade and large cell NHL is 55-60 years. Lymphoblastic lymphomas, which share features with acute lymphoblastic leukaemia, usually occur in children and young adults.

The most common presentation of NHL is with painless lymphadenopathy, which is often widespread and is not necessarily contiguous. This may be accompanied by constitutional B symptoms such as fever, sweats, anorexia and weight loss. Hepatosplenomegaly is often found at diagnosis. Patients may present with symptoms and signs caused by involvement of unusual sites; for example, skin (Sezary's syndrome / mycosis fungoides), tonsil and adenoids, salivary glands, gastrointestinal tract, lung, CNS (HIV-related and lymphoblastic), jaw (Burkitt's lymphoma) and testis. Sometimes the presentation is rather non-specific with only pyrexia of unknown origin.

Investigations

Haematology

The following may occur, particularly in more advanced disease:

- Normochromic, normocytic anaemia
- Leucoerythroblastic anaemia due to bone marrow infiltration
- Hypersplenism
- Neutropenia and thrombocytopenia
- Autoimmune cytopenias with positive direct antiglobulin test
- Circulating lymphoma cells in follicular, mantle cell and large cell lymphoma
- Raised ESR and C-reactive protein

Biochemistry

- Raised lactate dehydrogenase (LDH) and hypoalbuminaemia are features of advanced disease and have prognostic significance
- Paraproteins (IgM, IgG or IgA) are more common in indolent lymphomas (15%)
- B-2 microglobulin may be elevated
- Normal immunoglobulins are reduced
- Hypercalcaemia is often seen in ATLL
- Abnormalities of liver or renal function may reflect involvement with disease

Diagnosis and Staging

A diagnosis of lymphoma gives no clue to the natural course of the disease in an individual patient. Clinicians treating these patients take account of the histopathology and the history provided by the patient, as well as many other factors (for example, stage and age), before recommending treatment or advising about prognosis. The complexity of NHLs requires a simplified management approach, on the basis of division of cases into low-grade, intermediate-grade and high-grade disease. All patients with lymphoma require careful initial staging, usually comprising physical examination, chest radiology, computed tomography of abdomen and pelvis and a bone marrow biopsy. Lumbar puncture is required for high-grade lymphoma. Lymphomas are staged with the Ann Arbor system (Figure 2), and treatment is decided on the basis of allocated stage together with an examination of other known prognostic factors.

Prognostic Features

Prognosis depends on the NHL subtype. An International Prognostic Index has been developed in which each of the following features are associated with a poor prognosis:

- Stage III/IV
- Age >60 years
- WHO classification performance status 2-4
- LDH above normal
- More than one extranodal site

Other poor prognostic features including raised B2 microglobulin, bulky disease (>10 cm in diameter), transforming from low-grade to high-grade NHL and AIDS-related disease.

Figure 2

Ann Arbor Staging System for Lymphoma

| Site | |
|-----------|--|
| Stage I | – Single lymphoid area or extranodal site (stage IE) |
| Stage II | – Two lymphoid areas or extranodal sites on the same side of the diaphragm |
| Stage III | – Lymphoid areas (including the spleen) on both sides of the diaphragm |
| Stage IV | – Diffuse involvement of an extranodal organ(s) (liver, bone marrow) |
| Symptoms | |
| A | – No symptoms |
| B | – >10% weight loss, drenching night sweats, or unexplained fevers >38°C |

Low-grade Lymphoma

Low grade NHLs are rare in patients aged under 40 years and are predominantly diseases of elderly people (90% of patients are aged >50 years). This group includes most of the follicular lymphomas and constitutes about 30% of the cases of NHL. The relative incidence in Hong Kong is low in comparing with the Caucasian population. The diagnosis may be incidental or may follow a period of (often fluctuating) localized or generalized enlargement of lymph nodes or splenomegaly. These lymphomas are usually widespread at diagnosis, commonly involving the bone marrow. Because of their indolent nature, there may be little or no initial effect on quality of life. Some patients, however, may present with B symptoms or bulky widespread disease and need early treatment.

The management of these diseases is adjusted to their natural course. Cure can rarely be achieved, and the median overall survival in most series is five to eight years. Prognosis relates to age (poorer when older) and particularly to the extent of disease judged in terms of bulk and effect of tumour. Patients who are well with non-threatening disease may initially be watched without treatment for many years. Initial treatment when needed generally comprises an alkylating agent, usually intermittent chlorambucil, with or without steroids for four to six months and will often be highly successful in causing disease regression; relapse is, however, inevitable.

After several years these lymphomas may become refractory to treatment or may “transform” with change in histology and clinical course to an intermediate-grade NHL. If this occurs, then combination chemotherapy is recommended, but the outlook is usually poor.

Promising new treatment that are being evaluated include monoclonal antibody treatment. The currently available climeric mouse-human monoclonal antibody, rituximab, is specific for the CD20 antigen and produces antibody-dependent cell-mediated and complement-mediated cytotoxicity against normal and malignant B lymphocytes. The CD20 antigen is found on all cells of the B-cell lineage, including more than 85% of B-cell NHL.⁸ It appears to be effective in patients with untreated, relapsed or refractory indolent lymphoma,⁹⁻¹⁰ particular those with follicular histology, and its use has been approved for this indications in Hong Kong, the US and Europe. Its minimal toxicity and the high chance of achieving complete remission has changed the current treatment strategy for patients with indolent NHL, more clinicians prefer to use rituximab earlier for the above indications. Latest studies showed that rituximab in combination with conventional chemotherapy (CHOP) achieved even better results in patients with indolent lymphoma.¹¹ High dose therapy with stem cell transplantation can also be considered for relapsed and refractory indolent NHL.

Intermediate-grade Lymphoma

This is the most common grade of NHL (60%) and affects any age group. It is rapidly increasing in incidence, although the reasons for this are uncertain. Two thirds of patients present with lymph node enlargement. The remaining cases may arise in almost any other tissues or organs (for example, gastrointestinal tract, spleen, skin, brain, and bone), with symptoms appropriate to each site. Lymphomas however can present in various ways and be difficult to diagnose.

The most common type is diffuse large cell lymphoma, a B cell neoplasm. These lymphomas occur at any age (median 65 years) and are rapidly progressive that they are often associated with B symptoms. Diagnosis and staging for the NHL should be urgently performed and chemotherapy treatment should be started early. The lymphomas are curable in about 40% of cases with conventional chemotherapy. The prognosis relates to the patient's age, extent of spread, lactate dehydrogenase concentration, and performance status.

The standard chemotherapy is still the combination of cyclophosphamide, doxorubicin, vincristine, and prednisone (CHOP) given intravenously at intervals of three to four weeks in outpatient clinics on six occasions and sometimes supplemented by radiotherapy.

Current study showed that the combination of rituximab with CHOP was proved to be a highly active regimen for patients with aggressive diffuse large B-cell lymphoma and a better disease free survival was achieved with no significant additional toxicity.¹²

Relapse is not uncommon and it was associated with a poor outlook in the past. However, younger patients aged less than 65 years with disease that has remained sensitive to salvage chemotherapy may now be cured in up to 50% of cases using high dose chemotherapy (HDT) with autologous stem cell transplantation.¹³⁻¹⁴ Survival in remaining patients not suitable for HDT is often poor and is measurable in months.

High-grade Lymphomas

High-grade lymphoma is rare (less than 10% of all cases) and comprises rapidly progressive NHL of children and young adults. Lymphoblastic lymphoma is a T cell lymphoma predominantly occurs in young males and usually presents with a mediastinal mass. Involvement of the bone marrow and central nervous system is common. Burkitt's lymphoma as seen in Europe and America is a rare B cell neoplasm of young adults, it usually arises at extranodal sites most commonly in the gastrointestinal tract e.g., the ileocaecal region. This lymphoma also commonly spreads to the bone marrow and the central nervous system.

Both these lymphoma types are curable with intensive combination chemotherapy; the role of high dose therapy is under evaluation. Treatment of these NHLs is urgent and may, if adequate precautions are not taken, be complicated by the acute tumour lysis syndrome resulting from breakdown of the lymphoma. This can lead to renal failure and possible death. Prophylaxis against relapse in the central nervous system by repeated intrathecal chemotherapy injection is routinely used. Overall cure rates generally exceed 50%.

HIV-related Lymphoma

The immunosuppression associated with HIV infection has been associated with a noticeable increase in the incidence of NHL. These diseases arise in many cases because of uninhibited expansion of multiple clones of lymphocytes infected with Epstein-Barr virus. They are commonly high grade B cell neoplasms that arise at extranodal sites e.g., the brain and the ileocaecal area. Treatment of AIDS-related NHL is often difficult because of pre-existing immunosuppression and AIDS related infection.¹⁵ Chemotherapy is usually indicated and the prognosis relates to the degree of immunosuppression at diagnosis. Cure of these lymphomas is possible with intensive chemotherapy or HDT, although the outlook is usually very poor.

Hodgkin's Disease (HD)

HD is an uncommon form of lymphoma occurring mainly at ages 15-35 years and affects slightly more men than women.

HD has classically been divided into four types according to their histopathology:

1. Lymphocytic-predominant
2. Nodular sclerosing
3. Mixed cellularity
4. Lymphocyte-depletion

Patients with lymphocyte predominance histology often present with isolated enlargement of a peripheral lymph node and better prognosis. The nodular sclerosing type constitutes 70-80% of cases of HD and classically presents in young women with mediastinal and cervical nodal disease. Mixed cellularity disease occurs predominantly in older males and is more commonly widespread. Lymphocyte depleted HD is rare.

Clinical Presentation and Management of HD

HD most commonly presents as enlargement of supra-diaphragmatic lymph nodes with or without B symptoms. Generalized pruritus can be a presenting feature in some cases. The spleen is involved in at least 30% of cases. Modern management relies on assessment of prognostic factors and proper staging; which are used to assess the likelihood of early stage disease in which radiotherapy alone may result in a reasonable chance of cure.

Staging is, as for NHL, with the Ann Arbor system. Patients with early stage disease (non-bulky stage I and IIA) are managed with radiotherapy alone. Treatment confined to the involved area is used for localized lymphocyte predominant disease. The remaining cases receive at least mantle radiotherapy for the treatment of bilateral cervical and axillary nodes combined with treatment to the mediastinum, resulting in cure in 60-70% of cases. Patients with more extensive or symptomatic disease and those for whom initial radiotherapy fails receive combination chemotherapy incorporating doxorubicin. About two thirds of patients receiving chemotherapy will remain permanently free of disease as a result of this treatment. At the time of relapse treatment may comprise further chemotherapy or HDT with peripheral stem cell transplantation.

Long term studies suggest that the overall cure rates for HD are stable at 70-80%, although it is hoped that high dose chemotherapy may improve these figures. In the past chemotherapy was invariably associated with infertility and premature menopause, newly used chemotherapy combination and better mode of radiotherapy carry much less risk of these problems. Late toxicity like second malignancy remains the source of concern in patients that have been treated with wide field radiotherapy or chemotherapy. Patients with early stage disease are increasingly being managed with limited radiation fields combined with brief courses of chemotherapy in an attempt to avoid this complication.

Conclusion

The REAL Classification of Lymphoid Neoplasms is a major improvement over previous systems and has been shown to define "real" clinical entities that can be diagnosed by expert hematopathologists. Important advances also have recently been made in the staging of lymphomas with the development of the International Prognostic Index, which accurately defines prognostic subgroups and can be used to identify patients who may benefit from more aggressive experimental treatment. With respect to treatment, there remains considerable controversy over the most effective options for patients with indolent lymphomas. However, several novel approaches appear very promising, including monoclonal antibody-based therapy, particularly radioimmunotherapy and purine analogues. In patients with aggressive lymphomas, the treatment options are less controversial. Combination chemotherapy remains the standard of care, but relapse with the development of drug resistance continues to be a problem. Recent data suggest that high-dose therapy with stem cell transplantation may be the treatment of choice for patients with relapsed aggressive lymphomas that remain chemosensitive.

Comments

In our discussed case, actually the patient presented with splenomegaly, skin rash and hemolytic anaemia due to cold agglutination at her early presentation. The possibility of lymphoma should be raised as a differential diagnosis. The associated **bilateral pleural effusion** may not be related to her lymphoma but may be due to her debilitated state and marked hypoalbuminaemia.

Self-Assessment Questions

(Please indicate true or false to the following questions)

- 1) *Idiopathic autoimmune hemolytic anemia would be included in differential diagnosis.*
- 2) *In an exudative pleural effusion the sugar level should be higher than that of the blood.*
- 3) *The incidence of malignant lymphoma has increased over the last 30 years worldwide and is partly accounted for by HIV-related lymphoma.*
- 4) *Malignant lymphoma is classified based on histopathology, immunology and molecular biology.*
- 5) *A low serum LDH level is a poor prognostic feature in malignant lymphoma.*
- 6) *Malignant lymphoma are in general highly treatable and curable and is best managed by specialist.*

- 7) *The currently available climeric mouse-human monoclonal antibody, rituximab is only effective in patients with untreated, relapsed or refractory indolent lymphoma.*
- 8) *Relapse of disease in malignant lymphoma is common and is associated with very poor outlook.*
- 9) *High dose chemotherapy with autologous stem cell transplantation plays a very important role in the management of relapse in malignant lymphoma.*
- 10) *Treatment of AIDS-related NHL is impossible because of pre-existing immunosuppression and AIDS related infection.*

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| Dr. Lee Kin Hung | 李健鴻 醫生 |
| Dr. Leung Chi Chiu | 梁子超 醫生 |
| Dr. Li Sum Wo | 李深和 醫生 |
| Dr. Liu Shao Haei | 劉少懷 醫生 |
| Dr. Lo Wing Lok | 勞永樂 醫生 |
| Dr. Lo Chung Yau | 盧寵猷 醫生 |
| Dr. Mok Shu Kam, Tony | 莫樹錦 醫生 |
| Prof. Sham Shun Tong, Jonathan | 岑信棠 教授 |
| Dr. Wong Shou Pang, Alexander | 王壽鵬 醫生 |
| Dr. Yeung Chiu Fat, Henry | 楊超發 醫生 |

CME Accreditation Sub-Committee

持續醫學進修評審委員會

| | |
|--|-------------|
| Prof. Young Tse Tse, Rosie (Chairperson) | 楊紫芝 教授 (主席) |
| Dr. Chow Pak Chin | 周伯展 醫生 |
| Dr. Foo Kam So, Stephen | 傅鑑赫 醫生 |
| Dr. Law Chi Lim, Robert | 羅致廉 醫生 |
| Dr. Lee Kin Hung | 李健鴻 醫生 |
| Dr. Li Siu Lung, Steven | 李少隆 醫生 |

CME Organizing Sub-Committee

持續醫學進修策劃委員會

| | |
|------------------------------------|-------------|
| Dr. Shih Tai Cho, Louis (Chairman) | 史泰祖 醫生 (主席) |
| Dr. Au Yiu Kai | 歐耀佳 醫生 |
| Dr. Cheng Chor Ho, Alvin | 鄭楚豪 醫生 |
| Dr. Cheng Ngok | 鄭岳 醫生 |
| Dr. Ching Cheuk Tuen, Regina | 程卓端 醫生 |
| Dr. Choi Kin, Gabriel | 蔡堅 醫生 |
| Dr. Kwan Ka Mei, Betty | 關嘉美 醫生 |
| Dr. Law Chi Lim, Robert | 羅致廉 醫生 |
| Dr. Li Siu Lung, Steven | 李少隆 醫生 |
| Dr. Li Sum Wo | 李深和 醫生 |
| Dr. Tang Kuen Yan, Alfred | 鄧權恩 醫生 |
| Dr. Wong Cheuk Fai | 黃焯輝 醫生 |
| Dr. Wong Cho Yiu, Peter | 王祖耀 醫生 |

Panel on CME Bulletin

| | |
|--------------------------------------|------------|
| Dr. Choi Kin, Gabriel (Co-ordinator) | 蔡堅 醫生 (統籌) |
| Dr. Kan Chi Leung | 簡志亮 醫生 |
| Dr. Leung Koon Chit, Lawrence | 梁貫哲 醫生 |
| Dr. Li Sum Wo | 李深和 醫生 |

Clinical Case Study

專科個案剖析

Please answer the questions for each quiz below by returning the completed answer sheet printed on page 13. This exercise will attract 0.5 CME point for participants completing BOTH quizzes. Answers and explanations will be provided in the next issue.

請回答下列問題並填妥第十三頁之答題紙交回本會秘書處，參加者將可獲持續醫學進修積分點零點五分，請注意，參加者必須同時回答兩個小測驗之問題。至於今期之答案將刊於下一期《持續醫學進修專訊》之中。

>> Clinical Cardiology Series 臨床心臟科個案研究

A 67 year old lady with chronic congestive heart failure comes to your office. Her left ventricular ejection fraction was 30% by echocardiogram and she also has chronic renal insufficiency with a creatinine level of 250 $\mu\text{mol/l}$. She is currently put on an ACE inhibitor (ACEI), an angiotensin – receptor blocker (ARB), a beta-blocker, spironolactone and digoxin.

1. *Is ACE inhibitor contraindicated in heart failure patients with mild to moderate renal impairment?*
2. *Is ARB contraindicated in heart failure patients with mild to moderate renal impairment?*
3. *Is beta-blocker contraindicated in heart failure patients with mild to moderate renal impairment?*
4. *Is spironolactone contraindicated in heart failure patients with mild to moderate renal impairment?*
5. *Is digoxin contraindicated in heart failure patients with mild to moderate renal impairment?*

The content of the Clinical Cardiology Series is provided by:

Dr. Wong Shou Pang, Alexander

F.R.C.P., F.H.K.A.M.(Med.), F.H.K.C.P., Specialist in Cardiology

Dr. Li Siu Lung, Steven

M.B., B.S.(H.K.), M.R.C.P.(U.K.), F.H.K.A.M., F.H.K.C.P., F.R.C.P.(Glasg.), F.R.C.P. (Edin.), Specialist in Cardiology

臨床心臟科個案研究之內容誠蒙王壽鵬醫生及李少隆醫生提供。

>> Answers to November 2003 Clinical Cardiology Series 臨床心臟科個案研究 二零零三年十一月份答案

A 45 year old man with a history of heart failure presented to you with exertional dyspnea. His coronary arteries were known to be normal and his left ventricular ejection fraction was 35% by echocardiography. He was taking a loop diuretic and an angiotensin converting enzyme inhibitor. Physical examination was unremarkable.

1. *Is beta-blockade therapy contraindicated?*
No.
2. *What is the mechanism of beneficial effects of beta-blockers in chronic heart failure?*
Beta-blockade therapy reduces the increased sympathetic nervous system activation that is frequently associated with heart failure. Such activation may accelerate left ventricular remodeling, worsen myocardial function and lower the threshold of life-threatening arrhythmias. It also inhibits the activity of the rennin-angiotensin system and reduces atrial and ventricular arrhythmias.
3. *Which beta-blockers have been proven to be beneficial?*
Carvedilol (US Carvedilol, COPERNICUS, COMET trials), Metoprolol CR/XL (MERIT-HF) and Bisoprolol (CIBIS-II) have been proven to be beneficial. Starting dose should be low initially and gradually titrated up to maximum target dose. If a higher target dose is not tolerated, then the highest tolerated dose should be maintained.
4. *What are the contraindications for beta-blockers?*
Advanced heart block, asthma or reactive airways disease that is not related to heart failure and requires bronchodilator therapy, a heart rate <50 bpm and a systolic blood pressure <85 mmHg.
5. *What are the side effects of beta-blocker therapy?*
Fatigue, depression, dizziness, bradycardia and worsening heart failure. Beta-blockers should not be initiated in patients with moderate to severe fluid retention. In these patients, beta-blockers should be started when fluid overloading problem is resolved.



>> Dermatology Series 皮膚科病例研究

A 50 year old British engineer presented with a nodule on his right cheek. The lesion was only noted for two weeks. This started as a pea-sized papule which rapidly enlarged over this period. The lesion was asymptomatic. He denied any history of trauma or insect bite. He enjoyed good general health with no significant medical or surgical illness. Physical examination revealed a nodule measuring 1.2 cm in diameter.

1. *What is the clinical diagnosis?*
2. *What is the most important differential diagnosis?*
3. *What is classical description of this condition?*
4. *What are the risk factors for this condition?*
5. *What are the treatments?*



The content of the Dermatology Series is provided by:
Dr. Tang Yuk Ming, William and **Dr. Chan Loi Yuen**
Specialist in Dermatology & Venereology
皮膚科病例研究之內容誠蒙鄧旭明醫生及陳來源醫生提供。

>> Answers to November 2003 Dermatology Series 皮膚科病例研究 二零零三年十一月份答案

A 52 year old male restaurant worker presented with mildly painful ulcer on his right ankle for three months. The ulcer was preceded by scratching for relieving his leg itch and enlarged progressively. He had varicose veins for over ten years.



He is a non-smoker and he enjoyed otherwise good health in the past. Physical examination revealed a deep ulcer over his lateral malleolus measuring three centimeter in diameter. The border was irregular and the base was yellowish. There was purulent discharge from the wound. Brown speckled pigmentation and engorged veins were also present. His feet were warm and pedal pulses were normal.

1. *What is the clinical diagnosis?*

The diagnosis is varicose ulcer. It is caused by increased venous pressure from incompetent superficial communicating veins.

2. *What are the clinical differential diagnoses?*

Other possible causes for leg ulcer include arterial ulcer, infection, malignancy, vasculitis and pyoderma gangrenosa.

3. *What are the investigations?*

Swab for bacterial culture should be taken if there is purulent discharge or healing is slow. Radiological imaging including conventional X-rays of the ankle for bone abnormalities and Doppler ultrasonography to assess blood flow. Biopsy of the ulcer for histopathology and cultures should be considered as appropriate.

4. *What are the possible complications of this condition?*

Possible complications include secondary bacterial infection, lymphoedema, periostitis / osteomyelitis and contact dermatitis to topical medication.

5. *What is the treatment?*

Factors interfering with wound healing should be corrected and these include smoking, ankle oedema, infection, anaemia, malnutrition and diabetes mellitus. The legs should be elevated and trauma should be avoided. Antibiotic is required to treat superimposed bacterial infection and analgesic to control pain. Debridement, either mechanical or chemical, should be performed to promote wound healing. Opinion on surgical management of varicose veins should be sought. Elastic compression stockings, wound dressing, topical silver sulfadiazine cream or zinc oxide cream, skin graft may also be needed.

CME Lecture

for December 2003 & January 2004 二零零三年十二月及二零零四年一月之 進修講課

CME Event 講課簡介

Venue & Time 地點及時間


18 December 2003 (Thursday)

Medical Approach to Erectile Dysfunction

Dr. Ronald F. Tan

M.D., F.R.C.P.C.

Chairman, Society for Healthy Aging Research and Education (THE SHARE GROUP)

This symposium is free of charge. The luncheon and registration fee are sponsored by Pfizer Corporation Hong Kong Ltd. 

This luncheon is also mentioned in **Circular 1172**.

The Ballroom, Level 3
Sheraton Hotel
20 Nathan Road, Kln
Lunch : 1:00 - 2:00 p.m.
Lecture: 2:00 - 3:00 p.m.
九龍彌敦道二十號
喜來登酒店三樓宴會廳
午宴：下午一時至二時正
講課：下午二時至三時正

8 January 2004 (Thursday)

HKMA Structured CME Programme with HKS&H Noninvasive Cardiac Imaging – CT & MRI

Dr. Chan Ka Fat, John

M.B.B.S., D.M.R.D., F.R.C.R., F.H.K.C.R., F.H.K.A.M. (Rad)

Consultant Radiologist, Department of Radiology, HKS&H

This symposium is co-organized with Hong Kong Sanatorium Hospital. 

The HKMA Dr. Li Shu Pui Professional Education Centre
2/F, Chinese Club Building
21-22 Connaught Road Central, HK
Lecture: 2:00 - 3:00 p.m.
(Light lunch: 1:15 p.m.)

香港中環干諾道中二十一至二十二號
華商會所大廈二樓
香港醫學會李樹培醫生專業教育中心會
講課：下午二時至三時正
[茶點於下午一時十五分開始]

Registration: Please fill in and return the Registration Form together with a cheque of adequate amount made payable to "The Hong Kong Medical Association" to 5/F Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong. Each lecture will carry 1 CME point under the MCHK/HKMA CME Programme. Accreditation from other colleges is pending. (The Secretariat fax no.: 2865 0943)

報名方法：請填妥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，支票抬頭請書明支付「香港醫學會」。參加者可獲醫務委員會/香港醫學會持續醫學進修計劃積分一分。其他專科學院之學分尚在申請中。(秘書處傳真號碼：2865 0943)

Please register for participation. First come, first served. 名額有限 請早登記

I would like to register for the following CME lecture(s):

本人欲報名參加以下講課：

Please "✓" as appropriate. 請在適用處加上「✓」號

Free of charge lecture

18 Dec 2003 : Medical Approach to Erectile Dysfunction

HKMA Structured CME Programme with HKS&H

8 Jan 2004 : Noninvasive Cardiac Imaging – CT&MRI

HKMA Members
HK\$50

CME Participants
HK\$80

I enclose herewith a cheque of
現隨表格附上支票一張作為講課之報名費用：

HK\$港幣 _____

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 MCHK/HKMA CME Programme only. All registration fees are not refundable or transferable. 個人資料將用於有關香港醫學會持續醫學進修計劃之事宜。所有報名費用將不給予退還或轉授予其他會員。

Answer Sheet for December 2003

二零零三年十二月號答題紙

Please return completed answer sheet to the HKMA Secretariat on or before 15 January 2004 for documentation. 1 CME point will be awarded for answering the Monthly Self-Study Series (I) and an extra 0.5 CME point for completing the Clinical Case Study (II). (Fax: 2865 0943)

請回答所有問題，並於二零零四年一月十五日前將答題紙傳真或寄回至香港醫學會。參加者將可獲持續醫學進修積分—每月自修系列：一分；「專科個案剖析」系列：零點五分。(傳真號碼：2865 0943)

(I) A Lady with Bilateral Pleural Effusion

(Please indicate "T" or "F" in each box.)

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

ANSWERS TO NOVEMBER 2003 ISSUE 香港醫學會持續醫學進修計劃 每月自修資料二零零三年十一月號答案

An Update on the Diagnosis and Management of Multiple Myeloma

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

姓名
Name: _____

香港醫學會會員編號
或持續進修編號
HKMA Membership No.
or HKMA CME No.: _____

香港身份證號碼 - X X (X)
HKID No.: _____

簽名
Signature: _____

聯絡電話
Contact Tel. No.: _____

(II) Clinical Case Study

(Please answer both quizzes and write down the answers in the space provided.)

(A) Clinical Cardiology Series

- _____
- _____
- _____
- _____
- _____

(B) Dermatology Series

- _____
- _____
- _____
- _____
- _____



The Hong Kong Medical Association



Kwong Wah Hospital



醫院管理局
HOSPITAL
AUTHORITY

| Lecture | Date | Topic |
|---------|-------------|--|
| IX | 28 Dec 2003 | Paediatrics <ul style="list-style-type: none"> - The Value of Digital EEG in the Diagnosis of Epileptic Disorders Dr. Ho Che Shun, Jackson <i>Chief of Service (Paediatrics), KWH</i> - Delayed Developmental Milestones: Diagnosis and Management Dr. Yuen Kar Ngai, Robert <i>Consultant (Paediatrics), KWH</i> |
| X | 25 Jan 2004 | Dermatology <ul style="list-style-type: none"> - Common Skin Diseases Encountered by General Practitioners Dr. Au Tak Shing <i>Senior Medical Officer, Social Hygiene Service, DH</i> - Contact Dermatitis - A Practical Approach Dr. Lam Wai Sun, Alex <i>Medical Officer, Social Hygiene Service, DH</i> |
| XI | 29 Feb 2004 | Gastronenterology & Hepatology |
| XII | 28 Mar 2004 | Pathology & Radiology |

- **Venue** : Lecture Theatre, 10/F, Yu Chun Keung Memorial Medical Centre, KWH
- **Date** : April 2003 to March 2004
- **Time** : 2:00 – 5:00 pm
- **Fee** : HK\$50 per lecture for HKMA members
HK\$80 per lecture for CME Participants
- **地點** : 廣華醫院余振強紀念中心十樓演講廳
- **日期** : 二零零三年四月至二零零四年三月
- **時間** : 下午二時至五時正
- **報名費用** : 醫學會會員－每課堂港幣五十元正
持續進修參加者－每課堂港幣八十元正

Light snacks and lecture notes will be provided.

敬備茶點及講義

Registration: Please fill in and return the Registration Form on the next page together with a cheque of adequate amount made payable to "The Hong Kong Medical Association" to 5/F Duke of Windsor Social Service Building, 15 Hennessy Road, Hong Kong. Each lecture will carry 3 CME points under the **MCHK/HKMA CME Programme**.

報名方法：請填妥鄰頁之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，支票抬頭請書明支付「香港醫學會」。參加者可獲醫務委員會／香港醫學會持續醫學進修計劃積分三分。



The Hong Kong Medical Association



Queen Elizabeth Hospital

| Lecture | Date | Topic |
|---------|-------------|--|
| X | 11 Jan 2004 | Eye – Ophthalmology for Non-ophthalmologists Prof. Lam Shun Chiu <i>Professor and Chairman, Dept of Ophthalmology and Visual Sciences, CUHK</i> – Dr. Fan Shu Ping, Dorothy <i>Assistant Professor, Dept of Ophthalmology and Visual Sciences, CUHK</i> |
| XI | 8 Feb 2004 | Dermatology – Common Skin Disease in Childhood Dr. Ho King Man <i>Senior Medical Officer, Social Hygiene Service, DH</i> – Cutaneous Manifestations of Systemic Disease Dr. Mak Kam Har <i>Medical Officer, Social Hygiene Service, DH</i> |
| XII | 14 Mar 2004 | Clinical Oncology & CTS |

- **Venue:** Lecture Theatre, G/F, Block M, QEH
- **Date :** April 2003 to March 2004
- **Time :** 2:00 – 5:00 pm
- **Fee :** HK\$50 per lecture for HKMA members
HK\$80 per lecture for CME Participants

- **地點 :** 伊利沙伯醫院M座地下演講廳
- **日期 :** 二零零三年四月至二零零四年三月
- **時間 :** 下午二時至五時正
- **報名費用 :** 醫學會會員 – 每課堂港幣五十元正
持續進修參加者 – 每課堂港幣八十元正

Light snacks and lecture notes will be provided.

敬備茶點及講義

HKMA Structured CME Programme at QEH/KWH – Registration Form

香港醫學會分科進修課程報名表格

I would like to register for the following lecture(s):

本人欲報名參加以下講課：

Please "✓" as appropriate 請在適用處加上「✓」號

| | | | HKMA Member HK\$50 | CME participants HK\$80 |
|-----|-------------|-------------|--------------------------|----------------------------|
| KWH | 28 Dec 2003 | Paediatrics | <input type="checkbox"/> | <input type="checkbox"/> |
| | 25 Jan 2004 | Dermatology | <input type="checkbox"/> | <input type="checkbox"/> |
| QEH | 11 Jan 2004 | Eye | <input type="checkbox"/> | <input type="checkbox"/> |
| | 8 Feb 2004 | Dermatology | <input type="checkbox"/> | <input type="checkbox"/> |

I enclose herewith a cheque of

現隨表格附上支票一張作為講課之報名費用：HK\$港幣_____

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 MCHK/HKMA CME Programme only. All registration fees are not refundable or transferable.
個人資料將用於有關香港醫學會持續醫學進修計劃之事宜。所有報名費用將不給予發還或轉授予其他會員。

CME Calendar

持續進修日程

| Date/Time 日期/時間 | Function 活動 | CME Accreditation 進修積分 | | | | | | | | | | | Remarks/ Contact Info 備註及聯絡電話 | | | | |
|--|--|------------------------|------|-------|-------|-------|-------|------|-------|--------|---------|---------|-------------------------------------|------|--------|---|---|
| | | MCHK & HKMA | HKCA | HKCCM | HKCEM | HKCFP | HKCOG | COHK | HKCOS | HKCORL | HKCPaed | HKCPath | | HKCP | HKCPsy | HKCR | CSHK |
| Dec 2003 | HKMA CME Programme Monthly Self-Study Series – A Lady with Bilateral Pleural Effusion | 1 | | | | | | | | | | | | | | Fax answer sheet to Fax: 2865 0943 by 15 Jan 2004 | |
| 13 – 16 Dec 2003 (Sat – Tue) | Asian Pacific Society of Cardiac Rehabilitation, Hong Kong College of Cardiology 8th Asian Pacific Congress of Cardiac Rehabilitation cum Hong Kong Preventive Cardiology Conference and 5th Certificate Course in Cardiac Rehabilitation <i>Hong Kong Convention and Exhibition Centre, HK</i> | 10 | 15 | | | 16 | 5 | 10 | | 2 | | 9 | 7 | | 24 | 23.5 | Ms. Dora Ho Tel: 2527 8285 * |
| 15 Dec 2003 (Mon) 1:30 – 3:30 pm | Eisai (HK) Co., Ltd. Parkinsonism; Degenerative Joint Disorders in Elderly <i>Capital Seafood Restaurant, Fortune Plaza, Tai Po, NT</i> | 2 | | | | | | | | | | | | | | | Tel: 2516 6128 |
| 15 Dec 2003 (Mon) 6:30 – 9:30 pm | HKU – Sau Po Centre on Ageing Care Management in Long Term Care (XIV) Main Campus, HKU | 3 | | | | | | | | | | | | | | | Tel: 2241 5150 |
| 15 Dec 2003 (Mon) 7:00 – 8:30 pm | The Federation of Medical Societies of Hong Kong Certificate Course on Continence Care for Health Care Professionals – (V) 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, HK | 2 | | | | | | | | | 1 | | | | | | Tel: 2527 8898 |
| 16 Dec 2003 (Tue) 8:30 – 9:30 am | Queen Elizabeth Hospital – Dept of Clinical Oncology Journal Club Room 1203, Block R, 12/F, Queen Elizabeth Hospital, Kln | 1 | | | | | | | | | | | | | | | Ms. Diane Lee Tel: 2871 8830 |
| 16 Dec 2003 (Tue) 9:15 – 10:45 am | HA – Pok Oi Hospital, Dept of Medicine Educational Seminar / Journal Club <i>Conference Room 1AB, 1/F, Admin Building, Pok Oi Hospital, NT</i> | 1 | | | | | | | | | | | | | | | Dr. Leung Chun Keung Tel: 2486 8000 |
| 16 Dec 2003 (Tue) 12:45 – 3:15 pm | HKU – Dept of Psychiatry The 5th Certificate Course on Psychological Medicine 2003-2004 – Diagnosis & Management of Common Mental Disorders <i>Holiday Inn Golden Mile Hotel, Crystal Rooms, 50 Nathan Road, TST, Kln</i> | 2 | | | | | | | | | | 2 | | | | | Ms. Kandy Wan Fax: 2807 2496 |
| 16 Dec 2003 (Tue) 1:00 – 3:00 pm | Servier HK Ltd Optimizing Clinical Management of Ischaemic Heart Disease <i>Sheraton Hotel, 4/F, Sung Room, 20 Nathan Road, TST, Kln</i> | 1 | | | | | | | | | | | | | | | Ms. Jessie Chang Tel: 2577 1922 |
| 16 Dec 2003 (Tue) 1:00 – 5:30 pm | WHO Western Pacific Regional Office, WHO South East Asia Regional Office, Asia-Pacific National Health Accounts Network, Health, Welfare and Food Bureau, HKSAR, HKU Health Care Financing Academic Exchange <i>Cheung Kung Hai Conference Centre, HKU, Faculty of Medicine, HK</i> | 4 | | | | | | | | | | | | | | 3 | Ms. Cecilia Sie Tel: 2819 9911 |
| 17 Dec 2003 (Wed) 12:30 – 1:45 pm | Our Lady of Maryknoll Hospital - Dept of Medicine and Geriatrics Grand Round: Medical Ethics <i>Training Room I, 1/F, OPD Block, Our Lady of Maryknoll Hospital, Kln</i> | 1 | | | | | | | | | | | | | | | Tel: 2354 2250 |
| 17 Dec 2003 (Wed) 1:00 – 3:00 pm | Servier HK Ltd Practical Management of the Dizzy Patient <i>Langham Hotel, 2/F, Ballroom A, 8 Peking Road, TST, Kln</i> | 1 | | | | | | | | | | | | | | | Ms. Jessie Chang Tel: 2577 1922 |
| 17 Dec 2003 (Wed) 1:00 – 3:00 pm | Bristol-Myers Squibb HK, Sanofi-Synthelabo From Pathophysiology to Long-term Risk Management <i>Capital Seafood Restaurant, 1/F, Fortune Plaza, On Chee Road, Tai Po, NT</i> | 1 | | | | | | | | | | | | | | | Fax: 2510 6177 |
| 18 Dec 2003 (Thu) 1:00 – 3:00 pm | HKMA CME Programme Medical Approach to Erectile Dysfunction <i>The Ballroom, Level 3, Sheraton Hotel, 20 Nathan Road, TST, Kln</i> | 1 | | | | | | | | | | | | | | | Free of charge Tel: 2861 1979 * Pls refer to p.12 or Circular 1172 |
| 18 Dec 2003 (Thu) 4:30 – 5:30 pm | HA – Pamela Youde Nethersole Eastern Hospital, Dept of Paediatric & Adolescent Medicine Education Program on Paediatric Rehabilitation – Management of Spasticity in Cerebral Palsy <i>Room 01, G/F, Multi-centre Block B, Pamela Youde Nethersole Eastern Hospital, HK</i> | | | | | | | | | | | | | | | | Ms. Suki Tsang Tel: 2595 6860 |
| 18 Dec 2003 (Thu) 6:00 – 8:00 pm | Hong Kong Thoracic Society, American College of Chest Physicians (Hong Kong & Macau Chapter) Clinical Meeting <i>Lecture Theatre, LG1, Ruttonjee Hospital, HK</i> | 1.5 | | | | | | | | | | | | | | | Dr. WM Chan Tel: 2855 5840 |
| 19 Dec 2003 (Fri) 3:30 – 5:00 pm | HA – Yan Chai Hospital, Dept of O&T Problem Case Discussion <i>Conference Room, 9/F, Block B, Yan Chai Hospital, NT</i> | 2 | | | | | | | | | | | | | | | Ms. Daisy Chan Tel: 2417 8357 |
| 20 Dec 2003 (Sat) 11:00 – 12:30 pm | Kowloon East Cluster, HKCOG Laparoscopic Ovarian Drilling <i>Conference Room, Dept of O&G, 3/F, Tseung Kwan O Hospital, NT</i> | 2 | | | | | | 1 | | | | | | | | | Ms. Cochinna Young Tel: 2208 0948 |
| 20 Dec 2003 (Sat) 1:30 – 3:45 pm | United Christian Hospital & Kwun Tong District Health Committee Refresher Course for Health Personnel 2003 – (X) <i>Seminar Room 1, 1/F, Block F, United Christian Hospital, Kln</i> | 1.5 | | | | | | | | | | | | | | | Ms. Marina Pun Tel: 2379 4888 * |
| 20 Dec 2003 (Sat) 2:00 – 4:15 pm | HKMA Lecture with Tzu Chi International Medical Association Compassion and Service to Humanity through Medicine (Speaker: Dr. Ling Sing Yew) <i>HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, HK</i> | — | | | | | | | | | | | | | | | Free of charge Not CME accredited Tel: 2861 1979 |
| 21 Dec 2003 (Sun) 1:00 – 4:00 pm | CUHK – Dept of Medicine & Therapeutics CUHK Diploma Programme in Advanced Internal Medicine 2003-04 – Advances in Radiology <i>Kai Cheong Tong, G/F, Postgraduate Education Centre, Prince of Wales Hospital, Shatin, NT</i> | 3 | | 10# | | | 5# | 0.5 | | | 18# | 10# | | | | 18# | Ms. Suzanne Shek Tel: 2632 3127 |
| 21 Dec 2003 (Sun) 1:00 – 5:00 pm | The Association of Licensates of Medical Council of Hong Kong The Current Opinions in Female Urinary Tract Infection <i>M/F, HA Building, 147B Argyle Street, Kln</i> | 3 | | | | | | | | | | | | | | | Tel: 2327 2869 |
| 21 Dec 2003 (Sun) 4:30 – 7:30 pm | CUHK – Dept of Medicine & Therapeutics CUHK Diploma Programme in Advanced Internal Medicine 2003-04 – Medical Ethics <i>Kai Cheong Tong, G/F, Postgraduate Education Centre, Prince of Wales Hospital, Shatin, NT</i> | 3 | | 10# | | | 5# | 0.5 | | | 18# | 10# | | | | 18# | Ms. Suzanne Shek Tel: 2632 3127 |
| 22 Dec 2003 (Mon) 9:30 – 11:00 am | Queen Mary Hospital, HKCOG Menopause <i>G/F, Lecture Theatre, Professional Block, Queen Mary Hospital, HK</i> | 2 | | | | | | 2 | | | | | | | | | Ms. Kathy Chang Tel: 2855 4648 |

* Colleges accreditation pending
Total CME points for entire course

| Date/Time 日期/時間 | Function 活動 | CME Accreditation 進修積分 | | | | | | | | | | | Remarks/ Contact Info 備註及聯絡電話 | | | | |
|---|---|------------------------|------|-------|-------|-------|-------|------|-------|--------|---------|---------|-------------------------------------|------|--------|------|---|
| | | MCHK & HKMA | HKCA | HKCCM | HKCEM | HKCFP | HKCOG | COHK | HKCOS | HKCORL | HKCPaed | HKCPATH | | HKCP | HKCPsy | HKCR | CSHK |
| 22 Dec 2003 (Mon) 1:30 – 3:30 pm | Eisai (HK) Co., Ltd. Fall in Elderly; Congestive Heart Failure <i>Capital Seafood Restaurant, Fortune Plaza, Tai Po, NT</i> | 2 | | | | | | | | | | | | | | | Tel: 2516 6128 |
| 22 Dec 2003 (Mon) 6:30 – 9:30 pm | HKU – Sau Po Centre on Ageing Care Management in Long Term Care (XV) Main Campus, HKU | 3 | | | | | | | | | | | | | | | Tel: 2241 5150 |
| 22 Dec 2003 (Mon) 7:00 – 8:30 pm | The Federation of Medical Societies of Hong Kong Certificate Course on Continence Care for Health Care Professionals – (VI) <i>4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, HK</i> | 2 | | | | | | | | 1 | | | | | | | Tel: 2527 8898 |
| 23 Dec 2003 (Tue) 9:15 – 10:45 am | HA – Pok Oi Hospital, Dept of Medicine Educational Seminar / Journal Club <i>Conference Room 1AB, 1/F, Admin Building, Pok Oi Hospital, NT</i> | 1 | | | | | | | | | | | | | | | Dr. Leung Chun Keung Tel: 2486 8000 |
| 27 Dec 2003 (Sat) 9:00 – 10:00 am | Kwong Wah Hospital, HKCOG Obs Audit <i>Seminar Room, N10, Kwong Wah Hospital, Kln</i> | 1 | | | | 1 | | | | | | | | | | | Dr. NC Poddar Tel: 2781 5056 |
| 28 Dec 2003 (Sun) 2:00 – 5:00 pm | HKMA CME Programme, Kwong Wah Hospital HKMA Structured CME Programme at KWH (IX) – Paediatrics <i>Lecture Theatre, 10/F, Yu Chun Keung Memorial Medical Centre, Kwong Wah Hospital, Kln</i> | 3 | 3 | — | 1 | 2 | 3 | 1.5 | — | 1.5 | 3 | 3 | — | 3 | 1 | 3 | Members: \$50 Non-M: \$80 Tel: 2861 1979 |
| 29 Dec 2003 (Mon) 6:30 – 9:30 pm | HKU – Sau Po Centre on Ageing Care Management in Long Term Care (XVI) Main Campus, HKU | 3 | | | | | | | | | | | | | | | Tel: 2241 5150 |
| 30 Dec 2003 (Tue) 8:30 – 9:30 am | Pamela Youde Nethersole Eastern Hospital, HKCOG Topic Seminar <i>Venue: to be advised</i> | 1 | | | | 1 | | | | | | | | | | | Ms. Angel Hui Tel: 2595 6408 |
| 30 Dec 2003 (Tue) 9:15 – 10:45 am | HA – Pok Oi Hospital, Dept of Medicine Educational Seminar / Journal Club <i>Conference Room 1AB, 1/F, Admin Building, Pok Oi Hospital, NT</i> | 1 | | | | | | | | | | | | | | | Dr. Leung Chun Keung Tel: 2486 8000 |
| 30 Dec 2003 (Tue) 12:45 – 3:15 pm | HKU – Dept of Psychiatry The 5th Certificate Course on Psychological Medicine 2003-2004 – Diagnosis & Management of Common Mental Disorders <i>Holiday Inn Golden Mile Hotel, Crystal Rooms, 50 Nathan Road, TST, Kln</i> | 2 | | | | | | | | | | | | | | | Ms. Kandy Wan Fax: 2807 2496 |
| 30 Dec 2003 (Tue) 1:30 – 2:45 pm | Hong Kong College of Family Physicians, Caritas Medical Centre Joint Medical Programme CA Colon: Screening and Management <i>Staff Lounge, 1/F, Wai Oi Block, Caritas Medical Centre, 111 Wing Hong Street, Shamshuipo, Kln</i> | 1 | | | | 1 | | | | | | | | | | | Ms. Helen Lo Tel: 3408 7921 |
| 31 Dec 2003 (Wed) 12:30 – 1:45 pm | Our Lady of Maryknoll Hospital – Dept of Medicine and Geriatrics Grand Round: Case Presentation <i>Training Room I, 1/F, OPD Block, Our Lady of Maryknoll Hospital, Kln</i> | 1 | | | | | | | | | | | | | | | Tel: 2354 2250 |
| 31 Dec 2003 (Wed) 1:00 – 2:00 pm | Queen Elizabeth Hospital, HKCOG Topic Seminar <i>B3, Seminar Room, Queen Elizabeth Hospital, Kln</i> | 1 | | | | 1 | | | | | | | | | | | Ms. Betty Cheng Tel: 2958 6049 |
| 3 Jan 2004 (Sat) 8:45 – 9:45 am | HA – Caritas Medical Centre, Dept of Anaesthesia Departmental CME Program <i>Operating Theatre Conference Room, 6/F Wai Shun Block, Caritas Medical Centre, Kln</i> | 1 | | | | | | | | | | | | | | | Ms. Flora Wong Tel: 3408 7844 |
| 3 Jan 2004 (Sat) 9:00 – 7:30 pm | HKU – Centre for the Study of Liver Disease (CSLD) 5th Annual Scientific Meeting <i>Chantham Room, Level 7, Conrad Hong Kong, Pacific Place, Queensway, HK</i> | 5 | | | | | | | | | 3 | | | | | | Ms. Irene Chan Tel: 2855 3995 |
| 4 Jan 2004 (Sun) 10:00 – 11:30 am | Dept of Surgery, St. Teresa's Hospital Laparoscopic Inguinal Hernia Repair <i>9/F Conference Room, Hospital Building, St. Teresa's Hospital, Kln</i> | 2 | | | | | | | | | | | | | | | Dr. Chan Siu Hang Tel: 2771 2318 |
| 4 Jan 2004 (Sun) 2:00 – 5:15 pm | HKMA CME Programme, Hong Kong Advisory Council on AIDS, Hong Kong College of Obstetricians and Gynaecologists, The Obstetrical and Gynaecological Society of Hong Kong, HKU – Dept of Paediatrics and Adolescent Medicine Scientific Meeting of Universal Antenatal HIV Testing Programme in Hong Kong <i>Hospital Hall, 8/F, Block G, Princess Margaret Hospital, Kln</i> | 2.5 | | | | | | | | | | | | | | | Free of Charge Tel: 2861 1979 * |
| 5 Jan 2004 (Mon) 1:15 – 2:15 pm | HA – Pamela Youde Nethersole Eastern Hospital, Dept of Surgery and Radiology X-ray Meeting <i>Conference Room, X-Ray Department, Pamela Youde Nethersole Eastern Hospital, HK</i> | 1 | | | | | | | | | | | | | | | Ms. Jelly Cheng Tel: 2595 6419 |
| 5 Jan 2004 (Mon) 7:00 – 8:30 pm | The Federation of Medical Societies of Hong Kong, Hong Kong Dietitians Association Ltd. Certificate Course on Clinical Nutrition & Therapeutic Diets – Diabetes Mellitus <i>4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, HK</i> | 2 | | | | | | | | | | | | | | | Tel: 2527 8898 |
| 5 Jan 2004 (Mon) 7:15 – 8:45 pm | Hong Kong Society of Endocrinology, Metabolism and Reproduction Men's Health in Diabetes <i>Level 3, Ballroom, J W Marriot Hotel, HK</i> | 1.5 | | | | | | | | | | | | | | | Dr. Grace Kam Tel: 2379 4000 |
| 6 Jan 2004 (Tue) 3:30 – 4:30 pm | HA – Queen Elizabeth Hospital, Dept of CTS, Kowloon Hospital, Dept of RMD Combined Thoracic Surgery, Clinical-Radiological Meeting, Case Discussion and Management Direction <i>Conference Room 17, 6/F, Block R, Queen Elizabeth Hospital, Kln</i> | 1 | | | | | | | | | | | | | | | Ms. Lorraine Chan Tel: 2958 5055 |
| 7 Jan 2004 (Wed) 1:00 – 2:00 pm | HA – Shatin Hospital, Dept of M&G Clinical Audit Meeting <i>Conference Room I, Shatin Hospital, NT</i> | 1 | | | | | | | | | | | | | | | Ms. Chiu Lai Fong Tel: 2636 7688 |
| 7 Jan 2004 (Wed) 1:00 – 2:00 pm | HA – United Christian Hospital Journal Club <i>Seminar Room, Block G, 9C, United Christian Hospital, Kln</i> | 1 | | | | | | | | | | | | | | | Ms. Aileen Tang Tel: 2379 4822 |
| 8 Jan 2004 (Thu) 2:00 – 3:00 pm | HKMA CME Programme, Hong Kong Sanatorium & Hospital HKMA Structured CME Programme with Hong Kong Sanatorium & Hospital – Noninvasive Cardiac Imaging – CT & MRI <i>HKMA Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road Central, HK</i> | 1 | | | | | | | | | | | | | | | Members: \$50 Non-M: \$80 Tel: 2861 1979 * |

* Colleges accreditation pending
Total CME points for entire course

CME Calendar 持續進修日程

| Date/Time 日期/時間 | Function 活動 | CME Accreditation 進修積分 | | | | | | | | | | | Remarks/ Contact Info 備註及聯絡電話 | | | | |
|--|--|------------------------|------|-------|-------|-------|-------|------|-------|--------|---------|---------|-------------------------------------|------|--------|------|--|
| | | MCHK & HKMA | HKCA | HKCCM | HKCEM | HKCFP | HKCOG | COHK | HKCOS | HKCORL | HKCPaed | HKCPath | | HKCP | HKCPsy | HKCR | CSHK |
| 8 Jan 2004 (Thu) 8:00 – 9:30 am | Hong Kong Baptist Hospital Natural History and Treatment of BPH <i>Nursing School Lecture Room, 2/F, ASHHC, Hong Kong Baptist Hospital, Kln</i> | 1.5 | | | | | | | | | | | | | | | Dr. L.T. Yung Tel: 2339 8888 |
| 8-9, 15-16 Jan 2004 (Thu-Fri) 9:00 – 6:00 pm | HKU – Sau Po Centre on Ageing Understanding of RAI2.0 – Application of Long-term Care Assessment Instrument <i>LG102, KK Leung Building, HKU, HK</i> | 20 | | | | | | | | | | | | | | | Tel: 241 5150 |
| 8-9 Jan 2004 (Thu-Fri) | Hong Kong College of Paediatricians, Hong Kong Polytechnic University – School of Nursing, Hong Kong Paediatric Nurse Association Precongress workshop – Skills Training in Adolescent Program Design, Monitoring and Evaluation <i>The Hong Kong Polytechnic University</i> | 8 | | 9 | | 6 | 8 | | | | 9 | | — | | | | Fax: 2364 9663 |
| 9 Jan 2004 (Fri) 1:00 – 3:15 pm | Hong Kong College of Cardiology Symposium on New Perspectives in the Management of Myocardial Ischemia <i>Sheraton Hong Kong Hotel & Tower, 20 Nathan Road, Kln</i> | 1 | | | | | | | | | | | | | | | Tel: 2899 2035 |
| 9 Jan 2004 (Fri) 2:00 – 5:00 pm | HAHO, HA Institute of Health Care Induction Workshop in Clinical Epidemiology for HA Health Care Professionals <i>Seminar Room 1, M/F, Hospital Authority Building, Kln</i> | 10# | | | | | | | | | | | | | | | Sunny Choi Tel: 2300 6983 |
| 9-10 Jan 2004 (Fri-Sat) | HKU – Faculty of Medicine Hong Kong Surgical Forum – Winter 2004 <i>5/F Lecture Theatre, Professional Block, Queen Mary Hospital, HK</i> | 9 | | | | | | | | | 9 | | | | | | Tel: 2855 4885 |
| 10 Jan 2004 (Sat) 2:30 – 4:30 pm | HKMA CME Programme, Our Lady of Maryknoll Hospital Refresher Course for Health Care Providers 2003/2004 (V) – Management of Common Renal Problems in General Practice <i>Training Room II, 1/F, OPD Block, Our Lady of Maryknoll Hospital, Kln</i> | 2 | 2 | — | 1 | 1 | 1 | 1 | — | — | 2 | 6# | — | — | — | 2 | Ms. Clara Tsang Tel: 2354 2440 |
| 10-12 Jan 2004 (Sat-Mon) 8:30 – 5:30 pm | Hong Kong College of Paediatricians, Hong Kong Polytechnic University – School of Nursing, Hong Kong Paediatric Nurse Association First Asia-Pacific Regional Adolescent Health Congress Towards Healthy Adolescent: Intersectoral Collaboration <i>Hong Kong Polytechnic University, Kln</i> | 10 | | 10 | | | | | | | 18 | | | | | | Ms. Esther Lau Fax: 2364 9663 |
| 11 Jan 2004 (Sun) 2:00 – 5:00 pm | HKMA CME Programme, Queen Elizabeth Hospital HKMA Structured CME Programme at QEH (X) – Eye <i>Lecture Theatre, G/F, Block M, Queen Elizabeth Hospital, Kln</i> | 3 | 3 | — | 2 | 2 | 3 | 1.5 | — | 1.5 | 2 | 3 | — | 3 | 1 | 3 | Members: \$50 Non-M: \$80 T: 2861 1979 |
| 12 Jan 2004 (Mon) 1:15 – 2:15 pm | HA – Pamela Youde Nethersole Eastern Hospital, Dept of Surgery and Radiology X-ray Meeting <i>Conference Room, X-Ray Department, Pamela Youde Nethersole Eastern Hospital, HK</i> | 1 | | | | | | | | | | | | | | | Ms. Jelly Cheng Tel: 2595 6419 |
| 12 Jan 2004 (Mon) 7:00 – 8:30 pm | The Federation of Medical Societies of Hong Kong, Hong Kong Dietitians Association Ltd. Certificate Course on Clinical Nutrition & Therapeutic Diets – Lipid Lowering Diets <i>4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, HK</i> | 2 | | | | | | | | | | | | | | | Tel: 2527 8898 |
| 13 Jan 2004 (Tue) 12:45 – 3:15 pm | HKU – Dept of Psychiatry The 5th Certificate Course on Psychological Medicine 2003-2004 – Diagnosis & Management of Common Mental Disorders <i>Holiday Inn Golden Mile Hotel, Crystal Rooms, 50 Nathan Road, TST, Kln</i> | 2 | | | | | | | | | 2 | | | | | | Ms. Kandy Wan Fax: 2807 2496 |
| 13 Jan 2004 (Tue) 1:00 – 2:00 pm | HA – Haven of Hope Hospital Medical Grand Round: Chronic Pain Management <i>4/F CMT Conference Room, Haven of Hope Hospital, NT</i> | 1 | | | | | | | | | | | | | | | Ms. Connie Ng Tel: 2703 8201 |
| 13 Jan 2004 (Tue) 3:30 – 4:30 pm | HA – Queen Elizabeth Hospital, Dept of CTS, Kowloon Hospital, Dept of RMD Combined Thoracic Surgery, Clinical-Radiological Meeting, Case Discussion and Management Direction <i>Conference Room 17, G/F, Block R, Queen Elizabeth Hospital, Kln</i> | 1 | | | | | | | | | | | | | | | Ms. Lorraine Chan Tel: 2958 5055 |
| 14 Jan 2004 (Wed) 8:00 – 9:30 am | HA – Pamela Youde Nethersole Eastern Hospital, Dept of Clinical Oncology Lecture - Recent Advances in Upper Gastrointestinal Tract Oncology – Part I <i>Room 048, Clinical Oncology Dept, Pamela Youde Nethersole Eastern Hospital, HK</i> | 2 | | | | | | | | | | | | | | | Ms. Clara Chang Tel: 2595 4175 |
| 14 Jan 2004 (Wed) 1:00 – 2:00 pm | HA – United Christian Hospital Journal Club <i>Seminar Room, Block G, 9C, United Christian Hospital, Kln</i> | 1 | | | | | | | | | | | | | | | Ms. Aileen Tang Tel: 2379 4822 |
| 15 Jan 2004 (Thu) 4:00 – 5:00 pm | HA – Queen Elizabeth Hospital, Dept of A&E Thursday Academic Meeting <i>A&E MO Office, Queen Elizabeth Hospital, Kln</i> | 1 | | | | | | | | | | | | | | | Ms. Eva Lui Tel: 2958 6473 |
| 15-16 Jan 2004 (Thu-Fri) 9:15 – 5:15 pm | Hong Kong Catholic Marriage Advisory Council Transforming Emotions – Creating Connections in Individuals, Couples and Families <i>Wei Hing Theatre, City University of Hong Kong, Kln</i> | 10 | | 10 | | 8 | | | | | | | — | | | | Ms. Susan Chan Tel: 2810 1104 |
| 16 Jan 2004 (Fri) 8:00 – 9:00 am | HA – Queen Mary Hospital, Dept of Surgery Surgical Pathology Meeting <i>5/F Lecture Theatre, Professional Block, Queen Mary Hospital, HK</i> | 1 | | | | | | | | | | | | | | | Dept Secretary Tel: 2855 4238 |
| 16 Jan 2004 (Fri) 2:00 – 5:00 pm | HAHO, HA Institute of Health Care Induction Workshop in Clinical Epidemiology for HA Health Care Professionals <i>Seminar Room 2, M/F, Hospital Authority Building, Kln</i> | 10# | | | | | | | | | | | | | | | Sunny Choi Tel: 2300 6983 |
| 16-18 Jan 2004 (Fri-Sun) | Jockey Club Centre for Osteoporosis Care and Control of CUHK, Asian Pacific Osteoporosis Foundation Second Asian Regional IOF Conference on Osteoporosis <i>Hong Kong Convention and Exhibition Centre, HK</i> | 10 | | | | | | | | | | | | | | | Ms. Shirley Lam Tel: 2821 3520 |

* Colleges accreditation pending
Total CME points for entire course

Note: For each issue of the CME Bulletin, we shall try our best to include all the CME activities for the month, which are made known to the Association Secretariat. The credit points awarded by each college are herein indicated for members' reference only. While we try our best to ensure the information to be most accurate and up-to-date, members interested in any of these functions are advised to check with the respective organizers for confirmation of the details.

Pharmaceutical advertisements are welcome. For advertising rates and placement details, please contact Ms. Cynthia Chan, Executive Officer at Tel: 2527 8452, Fax: 2865 0943 or email: cynthia@hkma.org

Your comments to the HKMA CME Bulletin are mostly welcome. Please send your opinion to **Dr. Choi Kin, CME Bulletin Co-ordinator**, at cme@hkma.org.