Haemorrhoids and anal fissure
Dr. Yee-Man LEE
Dr. Kin-Wah CHU

Management of Malignant Pleural Effusion
Dr. CHUI Wing Hung
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Treatment of diabetes mellitus in adults. Potentially applicable to: pioglitazone, metformin, insulin, sulfonylurea. Allergic reactions may potentially be life threatening. Injection site reactions are usually mild, transient and normally disappear during continued treatment.

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References:

3. Tresiba® FlexTouch®. All presentations contain insulin degludec. Tresiba® 100 units/mL – 1 mL of solution contains 100 units insulin degludec, 0.3 mL of solution contains 300 units of insulin degludec in 3 mL solution. Indications: Treatment of diabetes mellitus in adults. Potentially applicable to: pioglitazone, metformin, insulin, sulfonylurea. Allergic reactions may potentially be life threatening. Injection site reactions are usually mild, transient and normally disappear during continued treatment.

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Please read the following articles and answer the questions. Participants in the HKMA CME Programme will be awarded credit points under the Programme for returning the completed answer sheet via fax (2865 0943) or by mail to the HKMA Secretariat on or before 15 February 2018. Answers to questions will be provided in the next issue of the HKMA CME Bulletin. (Questions may also be answered online at www.hkmacme.org)

HKMA CME Enquiry Hotline
Tel: 2527 8452/2861 1979
CME Bulletin & Online Editorial Board

Editorial

Happy New Year!

Happy learning!

In 2018, we are facing some changes in CME activities. Some of them are good, some are not as good. Among the better ones, we are working on a new mode of CME delivery. As you may know, for doctors who are not specialists, if they want to attain the CME Certified status, they need to obtain 30 CME points a year for 3 consecutive years. For the 30 CME points, 20 can be obtained via self-study, such as reading this Bulletin and answering the assessment questions. For the remaining 10 points, you have to be physically present to attend lectures. That would transcribe to 10 hours or 10 one-hour sessions. One of the reasons for such arrangement is to have interactions and discussions for a topic studied.

However, insisting on the physical presence poses limitations to CME activities in terms of costs and venues; and it also cause inconvenience to doctors. We are now developing a new mode of CME delivery which fits in the 10 points of attendance while addressing the above limitations. In 2018, we shall launch online live CME by broadcasting CME lectures in real time via internet. Doctors can “attend” CME activities in their office and join in the discussion by sessions posing questions on-line.

Please look out for further announcement.

Dr. CHENG Chi Man
Chairman, CME Organizing Sub-Committee
Haemorrhoids:

Introduction

Haemorrhoids, also known as piles, develop from anal cushions which normally play a role in stool control. The exact etiology of haemorrhoidal disease is unknown, factors that increase abdominal pressure may increase the risk of having haemorrhoids, these include constipation which leads to straining, chronic diarrhea or frequent bowel motions, sit on the toilet for long time and pregnancy. During pregnancy, pressure from the fetus on the abdomen and hormonal changes can cause congestion of the haemorrhoidal vessels, spontaneous delivery of baby causes significant increase in intra-abdominal pressure and straining, as a result, there may be severe prolapse of haemorrhoids but most subside quickly.

Pathophysiology

Anal cushions are a part of normal anatomical structure in the anal canal, there are three main cushions located classically at left lateral, right anterior and right posterior positions. Imagine the patient in left lateral position, then the three cushions sit at 3, 7 and 11 o’clock positions. They are composed of sinusoids, connective tissue, and smooth muscle. Sinusoids do not have muscle tissue in their walls and this set of blood vessels is known as the hemorrhoidal plexus. Anal cushions are important for continence as they contribute 15-20% of anal closure pressure at rest. Symptoms occur when the cushions slide downwards or the venous pressure increased excessively, clinically manifested as prolapse of haemorrhoids and per rectal bleeding. There are two types of hemorrhoids known as internal haemorrhoids which develop from the superior hemorrhoidal plexus and external haemorrhoids which develop from the inferior hemorrhoidal plexus. The terminology is confusing as the two types of haemorrhoids are not really “in” or “out” of the anus, indeed they are divided by the dentate line which is located at 1.5-2cm from the anal opening.

Symptoms

Not all patients with haemorrhoids have symptoms. The aggravating factors for attack include constipation, diarrhoea, significant straining and consumption of spicy food. Unlike colonic polyps, haemorrhoids will not turn into colorectal cancers.

External haemorrhoids situate below the dentate line, they are covered by anoderm and distally by perianal skin, therefore they are more sensitive. External haemorrhoids can bleed but seldom profuse. One classical symptom is thrombosis typically caused by straining, the patient presented with sudden perianal swelling and marked pain due to contained blood clots, especially in the first 48 hours after attack. The swelling then subsides gradually and may leave a skin tag at the anus. Thrombosed haemorrhoid cannot and should not be reduced, attempt would only result in pain. Other common complaints related to external haemorrhoids include bleeding, pruritus ani, swollen perianal skin tags and difficulty in cleansing around the anus.

Internal haemorrhoids situate above the dentate line and usually present with painless bright red rectal bleeding. They are covered by columnar epithelium and lack of pain receptors. Internal haemorrhoids can cause significant bleeding, some patients may present with painless rectal bleeding for a few days or up to a week and result in acute anaemia. According to the severity of prolapse, it can be classified into four grades:

- Grade I: no prolapse, prominent vessels that can cause bleeding
- Grade II: prolapse after defecation, but can be spontaneously reduced
- Grade III: prolapse after defaecation and required manual reduction
- Grade IV: prolapse and cannot be reduced

Management

The management should be tailored to patient according to their main symptoms and aggravating factors, not only the severity of prolapse which may not cause any symptom.
Conservative:

- Life style modification: avoid straining to defaecate, reduce toilet time
- Diet: sufficient intake of fibre and water to avoid constipation, avoid spices and food that can cause diarrhoea, also avoid “hot” food such as hotpot, barbeque, deeply fried food
- Sitz bath: bathing with warm water at 40 °C or 50 °C for ten minutes can relieve anorectal pain
- Medical: Topical ointment and suppository which include a combination of active ingredient, these include steroid, local anaesthetic, vasoconstrictor and barrier cream. Daflon is an oral medication, it is a micronized purified fraction containing 90% diosmin and 10% other flavonoids expressed as hesperidin. It is a venotonic and effective for relieving symptom of thrombosed haemorrhoid and haemorrhoidal bleeding.

Office based procedures:

2. Injection sclerotherapy: the commonly used sclerosing agent is phenol, the agent is injected directly into the haemorrhoidal vessels, the vessel wall then collapse jeopardizing the blood supply and the haemorrhoidal tissue shrinks slowly.
3. Other less effective procedures include electrocautery, infrared treatment, laser surgery or cryosurgery.

Surgery:

1. Haemorrhoidal artery ligation (HAL) or transanal haemorrhoidal dearterialization (THD): in this procedure an ultrasound doppler is used to accurately locate the position of haemorrhoidal vessels which are then ligated to achieve dearterialization. The prolapsed tissue is sutured back to its normal position. This procedure can also be done in clinic, it has higher operative pain is usually less and recovery is quicker.
2. Conventional haemorrhoidectomy: this procedure is usually performed under general anaesthesia. A circumferential cuff of haemorrhoidal tissue is resected using the haemorrhoidectomy stapler. If the fissure is located at unusual sites or it is multiple, other differential diagnoses should be considered. These diagnoses include inflammatory bowel disease (Crohn’s disease and ulcerative colitis), tuberculosis, carcinoma, acquired immunodeficiency syndrome and anal sex trauma.
3. Stapled haemorrhoidopexy: the stapler is inserted via the anus, the number markings on the stapler is guideline on the position of the stapled line from anus.

Anual fissure:

Pathophysiology

Anal fissure is a tear on the skin of anus, the patient usually complained of sharp pain and small amount of per rectal bleeding after defecation. The most common sites of fissure are located at anterior (12 o’clock) and posterior site (6 o’clock) due to less blood supply. Acute fissure is usually caused by passing hard or large bulk of stool and chronic diarrhea. When there is spasm of the underlying internal sphincter muscles, the blood supply will be reduced, the fissure may not heal and become chronic.

Non-surgical:

- Encourage water and fibre intake, stool softeners to prevent constipation. Treat the underlying cause for diarrhoea
- Topical ointment composes of local anesthetic and calcium channel blockers (nifedipine, diltiazem) and muscle relaxing agents to reduce sphincter muscle spasm, such as nitroglycerine (may cause headache) and calcium channel blockers (nifedipine, diltiazem) are usually less and recovery is quicker. However, the chance of relapse is higher when compared to conventional haemorrhoidectomy.

For acute anal fissures, it takes days to few weeks to heal. If the fissure become chronic, surgical treatment should be considered:

Surgical:

- Lord’s dilatation: this is stretching of anal canal and aim at reducing the muscle spasm, however this procedure may cause faecal incontinence. This procedure is getting less popular nowadays.
Lateral internal sphincterectomy: this is the gold standard surgical treatment for chronic anal fissure. The internal sphincter muscle is exposed via a small skin incision at right lateral position of anus, the muscle is then divided up to the proximal margin of the fissure or not exceeding the dentate line. The aim is to reduce muscle spasm and improved blood supply so that the fissure can heal itself.

Per rectal bleeding is a common complaint encountered in daily consultations, local citizens are now very aware of the symptom as the annual incidence of colorectal cancer is rising rapidly in Hong Kong. In the clinical setting, there is limited investigative tools to differentiate colorectal cancers from other benign perianal diseases that cause per rectal bleeding. The table below gives some hint on when to refer the patient to the specialist for further investigation. For all patients presented with per rectal bleeding, a digital examination should always be performed to exclude low rectal cancer!

<table>
<thead>
<tr>
<th>Haemorrhoids</th>
<th>Anal fissure</th>
<th>Colorectal cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Color of blood</td>
<td>Fresh</td>
<td>Fresh</td>
</tr>
<tr>
<td>Amount of blood</td>
<td>Usually passed out before or after bowel motion</td>
<td>Usually spots or few drops of blood Noted after bowel motion or on toilet paper</td>
</tr>
<tr>
<td>Perianal discomfort</td>
<td>May or may not present</td>
<td>Sharp pain</td>
</tr>
<tr>
<td>Aggravating factor</td>
<td>Constipation, diarrhoea, straining, spicy food</td>
<td>Hard stool</td>
</tr>
</tbody>
</table>

**Differences on presentation between colorectal cancers and other benign perianal conditions**

**References**

8. Rivadeneira, DE; Steele, SP; Ternent, C; Chalasani, S; Bule, WD; Rafferty, J; Standards Practice Task Force of The American Society of Colon and Rectal Surgeons (September 2011). “Practice parameters for the management of hemorrhoids (revised 2010)”. Diseases of the colon and rectum. 54 (8): 1165-84. Epub 2011 Jul 1.

**Q&A Self-Assessment Questions:**

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

Answer these on page 13 or make an online submission at: www.hkmacme.org. Please indicate whether the following statements are true or false.

1. Bleeding from internal or external haemorrhoids is always accompanied with pain.
2. The choice of management for haemorrhoids is governed by the severity of prolapse.
3. When a patient develops thrombosis of haemorrhoid, the first treatment is manual reduction.
4. Haemorrhoidal bleeding can lead to acute anaemia, especially internal haemorrhoids.
5. Single injection of Botulinum toxin A (Botox) can be a definitive treatment for chronic anal fissure.
6. Stapled haemorrhoidopexy is superior to conventional haemorrhoidectomy regarding to the chance of recurrence.
7. Acute anal fissure is caused by anal sphincter muscle spasm.
8. Haemorrhoidal bleeding can lead to acute anaemia, especially internal haemorrhoids.
9. Lateral internal sphincterectomy is the gold standard surgical treatment for acute anal fissure.
10. For all patients who present with per rectal bleeding, it is important to perform digital rectal examination to exclude low rectal cancers.

**Answer to December 2017**

**Spotlight 1 – Long-Term Care of Kidney Transplant Recipients – can we do better?**

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

**Spotlight 2 – Childhood febrile seizures**

1) T 2) T 3) F 4) F 5) T 6) F 7) F 8) F 9) T 10) F
Let them go well!!

TOSS Shows Pletaal® benefits stroke patients
(Trial of Cilostazol in Symptomatic Intracranial Arterial Stenosis)†

Pletaal® is indicated for prevention of recurrence of cerebral infarction (excluding cardiogenic cerebral embolism)†.

Reference:
1. Pletaal® package insert

Otsuka Pharmaceutical (H.K.) Ltd.
10/F, Phase 1, China Taiping Tower, 8 Sunning Road, Causeway Bay, Hong Kong. Tel: 2881 6299 Fax: 2577 5206
Management of Malignant Pleural Effusion

Introduction

Malignant pleural effusion (MPE), which is diagnosed by the identification of malignant cells in pleural fluid or on pleural biopsy, represents an advanced malignant disease associated with high morbidity and mortality precluding the possibility of a curative treatment approach. Although almost all types of cancers can cause an MPE, more than 75% of MPEs are due to metastases originating from tumours in the lung, breast, ovary as well as from lymphomas. Metastatic adenocarcinoma is the most frequent histological finding. However, the primary tumour cannot be identified in approximately 10% of patients with MPEs (1).

MPE is a common clinical problem faced by physicians, oncologists and cardiothoracic surgeons. Patients with MPE can be debilitated with dyspnoea, decreased exercise tolerance and impaired quality of life. The management options for MPEs depend on several factors including patient’s symptoms, performance status, underlying primary tumour and the potential response to anti-cancer therapy. The overall aim is for the alleviation of symptoms and improved quality of life (2).

Management of MPE

Management options of MPE include observation, repeated therapeutic thoracocentesis, tube thoracostomy with pleurodesis, medical thoracoscopy/video-assisted thoracoscopic surgery (VATS) with pleurodesis, indwelling pleural catheter (IPC) and pleuroperitoneal shunting (3). The ideal management would offer immediate and long-term relief of symptoms and have minimal side effects. It would involve a procedure that requires the least amount of time spent in the hospital and clinic, avoids repeated and uncomfortable procedures and has the least cost. The British Thoracic Society (BTS) guidelines suggested that if the patient is asymptomatic and the tumour type is known to be responsive to systemic chemotherapy, observation is recommended (4).

Therapeutic thoracocentesis

Thoracocentesis is typically the first step in the management of newly diagnosed MPE. Although symptoms can improve after thoracocentesis, almost all patients with MPE experience reaccumulation of fluid and recurrence of symptoms within 30 days. The potential complications related to thoracocentesis include vasovagal reactions, cough, chest pain, haemothorax, pneumothorax and reexpansion pulmonary oedema. In addition, repeated thoracocentesis can result in fluid loculation which can make further thoracocentesis or subsequent pleurodesis difficult. Thus, repeated therapeutic thoracocentesis should be performed in patients with slowly reaccumulating pleural effusion, low life expectancy (1-3 months), cancers that commonly respond to therapy with resolution of the associated effusions, and who cannot tolerate other more interventional procedures to control pleural fluid such as pleurodesis. To prevent reexpansion pulmonary oedema, the amount of fluid removed by thoracocentesis should be assessed by patient’s symptoms (cough, chest discomfort) and limited to 1.5 litres on a single occasion (5).

Tube thoracostomy with pleurodesis

Tube thoracostomy is performed with the intent to evacuate pleural fluid from the pleural space and enable apposition of the visceral and parietal pleura. Rarely is complete evacuation of the pleural cavity sufficient to control the effusion in the long-term, and compared with instillation of a sclerosing agent, drainage alone is less effective in preventing reaccumulation (6). Consequently, the primary role of tube thoracostomy is to empty the pleural space prior to instillation of a sclerosing agent, with the goal of obliterating the tube thoracostomy and preventing reaccumulation of fluid.

The effectiveness of thoracostomy with pleurodesis using a number of different sclerosing agents has been studied in clinical trials (7,8), and all have found thoracostomy with pleurodesis to be effective in reducing dyspnoea and improving quality of life. In these trials, with follow-up of 3-12 months, pleurodesis was unsuccessful in up to 10-30% of patients, mainly due to ongoing or incomplete pleural drainage (>300 mL/day), presence of trapped lung, chest tube displacement or death. Once pleurodesis had been obtained, the rate of sustained pleurodesis (no need for further pleural interventions) was 68-78%.

Multiple sclerosing agents have been studied including doxycycline, tetracycline, bleomycin and talc, with the preferred and most common agent used now being talc (9). A network meta-analysis published in 2016 reviewed 41 studies evaluating 16 pleurodesis methods and included 2,345 participants (10). In the majority of cases, there was no evidence to support any difference among agents in terms of pleurodesis. However, in 10 direct comparisons of individual methods, a number of agents were less effective than talc poudrage at inducing pleurodesis, including bleomycin and doxycycline.

Risks of thoracostomy with pleurodesis include pain and fever in approximately 26% and 30% respectively (10). Respiratory failure has been reported in 4% of patients receiving talc slurry (11).

Medical thoracoscopy/Video-assisted thoracoscopic surgery (VATS) with pleurodesis

Medical thoracoscopy or pleuroscopy is a procedure performed under conscious sedation and local anaesthesia whereby one or more trocars are inserted into the pleural cavity (12). It offers direct access to the pleural space, allows resection of tumours or biopsy for histological diagnosis (13). The effectiveness of VATS with pleurodesis depends on the presence of trapped lung, the extent of pleural thickening and adhesions, and the volume of pleural fluid. In a meta-analysis of 17 studies including 419 patients, VATS with pleurodesis was successful in 86% of patients (14). However, VATS with pleurodesis is associated with higher costs and morbidity compared to thoracostomy with pleurodesis (15).

The BTS guidelines recommend the use of a talc slurry for pleurodesis in patients with MPE who do not respond to therapeutic thoracocentesis or tube thoracostomy, or who have underlying conditions that preclude these interventions (4). The BTS guidelines also recommend the use of talc slurry for pleurodesis in patients with MPE who have undergone previous pleurodesis with other agents and have recurrent effusions (4). In patients with MPE who have undergone previous pleurodesis with other agents and have recurrent effusions, the BTS guidelines recommend the use of doxycycline, bleomycin or talc for pleurodesis (4).

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space in the midaxillary line (between the fourth and seventh ribs), with the patient lying in the lateral decubitus position. VATS is similar to medical thoracoscopy, except that it is performed using larger trocars, under general anaesthesia in the operating room and involves single-lung ventilation through a dual-lumen tube (3).

Advantages of these two procedures over traditional tube thoracostomy is that visualization and drainage of the pleural space can occur, pleural biopsies can be obtained and delivery of a sclerosing agent can occur before a chest tube is inserted through the trocar.

There are even more advantages by using the VATS approach. These include more complete view of the pleural surface and obtaining pleural and/or lung biopsy as well as obtaining biopsy of selected hilar lymph nodes. For complicated pleural spaces, including trapped lung due to adhesions, lysis of adhesions and surgical pleurodesis can be performed and in some selected cases, more advanced techniques, such as pleurectomy and decortication, may be performed (9). In a retrospective study reporting treatment outcomes for patients undergoing VATS talc pleurodesis for MPE, successful pleurodesis was reported in 93% with median follow-up of 64 months (12). Although generally considered safe with low morbidity, VATS cannot be tolerated by every patient and would not be an option for patients who could not tolerate single-lung ventilation or who have poor performance status.

Indwelling pleural catheter (IPC)
IPC is also known as a tunneled or small gauge catheter. Generally, the IPC system is composed of a silicone catheter, allowing ambulatory pleural drainage into plastic vacuum bottles, with fenestrations on the distal margin and a one-way valve on the proximal margin (13). Placement is simple and is generally performed on an outpatient basis with local anaesthesia.

A recent unblinded randomized control study comparing IPC and talc slurry pleurodesis via chest tube demonstrated that there was no significant difference in relieving patient-reported dyspnoea between the two methods (7). However, while the IPC-treated group spent reduced time in the hospital, it was associated with an excess number of adverse events. In light of the limited life span of patients with MPE, IPCs show promise in requiring fewer hospital stays, improving dyspnoea and decreasing the need for additional procedures (7, 13).

Long-term IPCs may lead to spontaneous pleurodesis in 40-58% of patients with IPC (4, 13). Therefore, sclerosants can be instilled through the catheter if spontaneous pleurodesis does not occur after several weeks of drainage. In addition, IPC placement and maintenance are safe and free of complications in the vast majority of patients. Complications include infections, clogging of the catheter, or other rare events, such as empyema or tumour spread along the catheter track (13).

Pleuroperitoneal shunting
Pleuroperitoneal shunting facilitates the transfer of pleural effusion from the chest to the peritoneal cavity. It requires patient’s compliance to pump up the pleural fluid. With the availability of IPC, it has now fallen out of favour (2).

**Conclusion**

The choice of therapy for a patient with MPE is influenced by many factors, the most crucial being the therapy’s effectiveness. Given the limited resources faced by almost every health system, cost and cost-effectiveness have become the major considerations when new therapeutic options are adopted. The management options available to patients with MPE have increased in the past decade, and there have been a growing number of prospective studies demonstrating the comparative effectiveness of these therapies in terms of important patient outcomes.

**References**


**Q&A Self-Assessment Questions:**

Answer these on page 13 or make an online submission at: www.hkmacme.org.

Please indicate whether the following statements are true or false.

1. MPE is most commonly caused by pleural metastases from colorectal cancers.
2. Metastatic adenocarcinoma is the most frequent histological/cytological finding in MPE.
3. Reexpansion pulmonary oedema can occur with rapid drainage of MPE.
4. Fever can occur after chemical pleurodesis for MPE.
5. Bleomycin is the most effective sclerosing agent used for chemical pleurodesis.
6. General anaesthesia with single lung ventilation is needed in VATS pleurodesis.
7. Decortication may be needed in trapped lung condition.
8. IPC system can allow ambulatory pleural drainage on an outpatient basis.
9. Spontaneous pleurodesis would not occur in patients with long-term IPC.
10. Pleuroperitoneal shunting is not commonly performed nowadays.
A patient with acute limb swelling

A 65-years-old male taxi driver with good past health presented with one-day onset of acute left lower limb swelling and pain. Figure 1 showed his both lower legs upon presentation. Clinical examination showed palpable 2+ femoral, popliteal and pedal pulses on both lower limbs.

Q&A
Please answer ALL questions
Answer these on page 13 or make an online submission at: www.hkmacme.org

1. What is your diagnosis?
   A. Acute limb ischemia
   B. Critical limb ischemia
   C. Phlegmasia Cerulea Dolens
   D. Phlegmasia Alba Dolens
   E. None of the above

2. What imaging will you order?
   A. Lower limb venous duplex ultrasound
   B. Lower limb arterial duplex ultrasound
   C. MR Angiography of lower limb
   D. XR lower limb
   E. A and/or C

3. What will be your initial treatment option?
   A. Amputation
   B. Unfractionated heparin
   C. Leg elevation
   D. Open fasciotomy
   E. B & C

4. What will be your next step of management?
   A. Amputation
   B. Open fasciotomy
   C. Refer to Interventional Cardiology for endovascular thrombolysis
   D. Systemic thrombolysis
   E. Oral anticoagulation

December Answers

1) B
   Patient was presented with malignant HT and therefore must be admitted to ICU/CCU for close monitor with intra-arterial line.

2) C
   CORNELL Voltage Criteria for LVH
   (Sensitivity = 22%, specificity = 95%)
   • S in V3 + R in aVL > 24 mm (men)
   • S in V3 + R in aVL > 20 mm (women)

3) A
   Cardiorhachic ratio is more than 50%.

4) A, B

5) A, B
   Renal artery stenosis is the cause of renal impairment and poor controlled HT and the definitive treatment is renal artery stenting.

The content of the December Cardiology Series is provided by: Dr. CHEUNG Ling Ling MBBS(HK), MRCP(UK), FHKCP, FHKAM(Med), Specialist in Cardiology

The content of the January Cardiology Series is provided by: Dr. TAN GuangMing MBChB, MRCP, FHKAM (Med), Specialist in Cardiology

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This clinic will be closed from ____________

to ____________ for Lunar New Year.

In an emergency, please contact: __________________________
A six-year-old child presented with six months history of progressive papules on his trunk. Similar lesions were found in his elder brother two months ago. It raised his parent’s concern for growing itchiness and pain. On examination, there were multiple pearly papules of 1mm to 3mm on his trunk, and dome shape umbilicus appeared in some individual lesion. No other skin manifestations were found.

Q&A
Please answer ALL questions
Answer these on page 13 or make an online submission at: www.hkmacme.org

1. What is the clinical diagnosis?
   a. Molluscum contagiosum
   b. Milia
   c. Verrucae
   d. Skin tags

2. These lesions is not contagious. (T/F)

3. How are they transmitted?
   a. Direct skin contact
   b. Autoinoculation
   c. Sexual contact
   d. All of the above

4. All of the following findings are compatible with the above clinical diagnosis EXCEPT
   a. Involvement of sole and palm
   b. Involvement of genitalia
   c. May regress spontaneously in months
   d. Systemic involvement does not occur

5. What are the treatment options?
   a. Topical treatment such as tretinoin cream and trichloroacetic acid
   b. Physical treatment including curettage, cryotherapy and CO₂ laser
   c. Reassurance
   d. All of the above

December Answers

1. B
   The clinical diagnosis is thermal burn. This lady used an electric blanket while she was sleeping. She subsequently developed the painful patches afterwards.

2. T
   Thermal burn can be diagnosed clinically by medical history and physical examination. Only for complicated case or suspicious case, skin biopsy may be needed to exclude other medical diseases – drug eruption, psoriasis.

3. C
   Burns can be classified according to the depth of the skin lesions into first, second, third and fourth degree burns. Also ‘the Rules of nines’ can be used to estimate the extent of total body surface area. This approach divides the different body into percentages of total body surface area.

4. B
   The electric blanket causes a secondary thermal burn for this patient complicated by secondary infection. Topical and oral antibiotics are the best treatments to manage the wound.
## ANSWER SHEET

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

**SPOTlight - 1**

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

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**SPOTlight - 2**

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

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**Cardiology**

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

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**Dermatology**

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

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</table>

Please return the completed answer sheet to the HKMA Secretariat (Fax: 2865 0943) on or before 15 February 2018 for documentation. If you complete the exercise online, you are NOT required to return the answer sheet by fax.

請回答所有問題，並將答題紙傳真或寄回香港醫學會（傳真號碼：2865 0943）。如選擇在網上完成練習，便無需將答題紙傳真到秘书處。
HKMA CME Lecture Online Scheme

To facilitate members in joining CME Lectures, the HKMA is going to launch the HKMA CME Lecture Online Scheme. As approved by the Medical Council of Hong Kong, the Online Lectures provided through this scheme will be counted as **attending the lectures physically** in earning CME points for **non-specialists** under the “CME Programme for Practising Doctors who are not taking CME Programme for Specialist.”

Starting from 1 February 2018, the HKMA will arrange for CME Lecture Online through Facebook Live for CME Lectures that take place in HKMA Wanchai and Central Premises. Please note that you can only either attend in person or watch one lecture online at one time. For enquiry of the Scheme, please contact the HKMA Secretariat at 3104-9055 or email to cme@hkma.org.

### Step 1:
Fill in Enrolment reply slip on CME Bulletin for specific lecture(s) available for CME Lecture Online (Must provide Email Address used for Facebook Registration)

### Step 2 & 3
Receive Facebook private group invitation sent by Secretariat to your Facebook registered email. Accept and join the Facebook group.

### Step 4:
Watch live broadcast at designated time (Real Time)

### Step 5:
Complete Lecture Quiz (10 Q&As in Google Form) and answer questions within two hours after the lecture

### Step 6:
Receive CME point(s) if doctors got **ALL answers correct**
Policy for HKMA CME Lecture Online Scheme

1. As approved by the Medical Council of Hong Kong, the CME Accreditation for CME Lecture Online is for non-specialists only.
2. Doctors must have a Facebook Account to join the CME Lecture Online.
3. Registration can be done by filling in the reply slip on HKMA CME Bulletin and return by email/fax.
4. Doctors can only either attend in person or watch one lecture online at one point in time.
5. Doctors must watch the lecture at real time and complete the online quiz within 2 hours after the lecture. Late submission of the quiz will not be accepted. 1 CME point will be awarded for 100% correct answers in the quiz.
6. One Facebook Group is intended for one specific CME Lecture only. Doctors must register with the HKMA Secretariat in order to be invited to the Facebook group and to gain CME point after completion.
7. You are recommended to connect to Wi-Fi on your mobile device or computer while watching the lecture through Facebook Live. Unstable internet connection will cause interruption to your viewing.
8. In case of technical issue and broadcast interruption, please be patient while our technicians will work on fixing the problem; the video should resume in a few minutes.
9. Due to copyright issue, the Facebook group is exclusive for doctors who have registered; and the video recording, powerpoint slides and quiz link MUST not be shared with non-registrants.

www.hkmacme.org

Hong Kong Doctors Homepage

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.

www.hkdoctors.org

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。
## Antibiotic Stewardship Programme in Primary Care

### Co-organizer
- HKMA Kowloon East Community Network and the Centre for Health Protection of the Department of Health
- HKMA Shatin Doctors Network and the Centre for Health Protection of the Department of Health

### Date
- Thursday, 1 February 2018
- Wednesday, 7 February 2018

### Speaker
- Dr. LAM Tin Keung, Edman
  - Senior Medical & Health Officer, Infection Control Branch, Centre for Health Protection, Department of Health
- Dr. MAK Wing Kin
  - CME Convenor, HKMA Shatin Doctors Network

### Time
- 1:00 – 2:00 p.m. Registration & Lunch
- 2:00 – 2:45 p.m. Lecture
- 2:45 – 3:00 p.m. Q&A Session

### Venue
- Lei Garden Restaurant (利苑酒家), Shop no. L5-8, apm, Kwun Tong, No. 418 Kwun Tong Road, Kowloon
- Royal Park Chinese Restaurant, Level 1, Royal Park Hotel, 8 Pak Hok Ting Street, Shatin

### Moderator
- Dr. LEUNG Wing Hong
  - Hon. Treasurer, HKMA Kln East Community Network
- Dr. MAK Wing Kin
  - CME Convenor, HKMA Shatin Doctors Network

### Deadline
- Friday, 19 January 2018
- Friday, 26 January 2018

### Fee/Capacity
- Free-of-charge. Capacity is 48
- Free-of-charge. Capacity is 60

### Enquiry
- Mr. Ian YAU, Tel: 2527 8285
- Ms. Candice TONG, Tel: 2527 8285

*Please call and confirm that your facsimile has been successfully transmitted to the HKMA Secretariat if you do not receive confirmation 7 days before the event.

### CME Accreditation
- 1 CME point

## REPLY SLIP

### HKMA Kowloon East Community Network & Shatin Doctors Network

**Fax:** 2865 0943

CME Lectures in February 2018

I would like to register for the following lecture(s):
- 1 February 2018 (Kln East)
- 7 February 2018 (Shatin)

`Please “✓” as appropriate`

<table>
<thead>
<tr>
<th>Date</th>
<th>Lecture Location</th>
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<tr>
<td>1 Feb 2018</td>
<td>Kowloon East districts</td>
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<tr>
<td>7 Feb 2018</td>
<td>Shatin districts</td>
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</tbody>
</table>

### Name: [ ]

### HKMA No.: [ ]

### Mobile No.*: [ ]

### Fax: [ ]

*Please fill in your updated mobile number so that you can be notified of your application via SMS. If you do not have a mobile phone, the Secretariat will still issue a confirmation letter to you.

### Practising location:
- In Kowloon East districts (Please specify *):
- In Shatin districts (Please specify *):
- Others (Please specify *):

* Null entry will be treated as non-Kowloon East or Shatin member registration.

### Signature: [ ]

### Date: [ ]

*Data collected will be used and processed for the purposes related to these events only.*
CME Lectures in February 2018

Organizer/ Co-organizer : HKMA Kowloon City Community Network
HKMA Kowloon West Community Network and the Hong Kong College of Cardiology

Date : Friday, 2 February 2018
Tuesday, 27 February 2018

Topic : Improving Cardiovascular Outcomes in Patients with Type 2 Diabetes: Applying New Evidence in Practice
An Update on AF Management and Screening

Speaker : Dr. WU, Enoch
Specialist in Endocrinology, Diabetes & Metabolism
Dr. YUEN Ho Chuen
Consultant Cardiologist, St. Paul’s Hospital

Time : 1:00 – 2:00 p.m. Registration & Lunch
2:00 – 2:45 p.m. Lecture
2:45 – 3:00 p.m. Q&A Session

Venue : President’s Room, Spotlight Recreation Club (博藝會),
4/F., Screen World, Site 8,
Whampoa Garden, Hunghom
Fulum Palace (富臨皇宮),
Shop C, G/F, 85 Broadway Street,
Mei Foo Sun Chuen, Mei Foo

Moderator : Dr. CHAN Man Chung, JP
District Coordinator,
Kln City Community Network
Dr. WONG Wai Hong
Hon. Secretary,
Kln West Community Network

Deadline : Monday, 22 January 2018
Thursday, 15 February 2018

Fee/Capacity : Free-of-charge. Capacity is 36
Free-of-charge. Capacity is 60

Registration is strictly required on a first come, first served basis. Priority will be given to doctors practising in Kowloon City districts (for lecture on 2 Feb)/ Kowloon West districts (for lecture on 27 Feb)

Enquiry : Ms. Candice TONG, Tel: 2527 8285
Mr. Ian YAU, Tel: 2527 8285
*Please call and confirm that your facsimile has been successfully transmitted to the HKMA Secretariat if you do not receive confirmation 7 days before the event.

Sponsor : Boehringer Ingelheim

CME Accreditation : 1 CME point

REPLY SLIP

HKMA Kowloon City and Kowloon West Community Networks
CME Lectures in February 2018
Fax: 2865 0943

I would like to register for the following lecture(s):
[] 2 February 2018  (Kln City)  [] 27 February 2018  (Kln West)

Name: ____________________________________________  HKMA No.: __________________________
Mobile No.: __________________________  Fax No.: __________________________

*Please fill in your updated mobile number so that you can be notified of your application via SMS. If you do not have a mobile phone, the Secretariat will still issue a confirmation letter to you.

Practising location:  
[ ] In Kowloon City districts (Please specify *): __________________________
[ ] In Kowloon West districts (Please specify *): __________________________
[ ] Others (Please specify): __________________________

* Null entry will be treated as non-Kowloon City or Kowloon West member registration.

Signature: __________________________  Date: __________________________

Data collected will be used and processed for the purposes related to these events only.
CME Lectures in February 2018

Organizer: HKMA Central, Western & Southern Community Network

Date: Wednesday, 7 February 2018

Topic: Asthma – What Should be Done to Help Patients Achieving Disease Control?

Speaker: Dr. WONG King Ying
Specialist in Respiratory Medicine

Time: 1:00 – 2:00 p.m. Registration & Lunch
2:00 – 2:45 p.m. Lecture
2:45 – 3:00 p.m. Q&A Session

Venue: The HKMA Central Premises,
Dr. Li Shu Pui Professional Education Centre,
2/F., Chinese Club Building, 21-22 Connaught Road Central

Moderator: Dr. TSANG Kin Lun
Committee Member,
HKMA CW&S Community Network

Deadline: Friday, 26 January 2018

Fee/Capacity: Free-of-charge. Capacity is 80. Registration is strictly required on a first come, first served basis. Priority will be given to doctors practising in CW&S district (for lecture on 7 Feb)/HK East district (for lecture on 8 Feb)

Enquiry: Mr. Ian YAU, Tel: 2527 8285
Ms. Candice TONG, Tel: 2527 8285
*Please call and confirm that your facsimile has been successfully transmitted to the HKMA Secretariat if you do not receive confirmation 7 days before the event.

CME Accreditation: 1 CME Point (For CME Lecture Online, 1 CME Point is available for non-specialist only)

REPLY SLIP

HKMA CW&S and HK East Community Networks
CME Lectures in February 2018

Fax: 2865 0943

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

Please choose ONE attending method for each lecture only

<table>
<thead>
<tr>
<th>To attend the Lecture In Person</th>
<th>To attend the Lecture through Facebook Live</th>
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<tr>
<td>7 February 2018 (CW&amp;S)</td>
<td>7 February 2018 (CW&amp;S)</td>
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<td>8 February 2018 (HKE)</td>
<td>8 February 2018 (HKE)</td>
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</tbody>
</table>

1 CME point for non-specialists

* Please fill in your updated mobile number so that you can be notified of your application via SMS. If you do not have a mobile phone, the Secretariat will still issue a confirmation letter to you.

* Please fill in the email address you used to login to Facebook if you want to attend the lecture through Facebook Live.

Practising location:
- In Central, Western & Southern districts (Please specify *:)
- In Hong Kong East districts (Please specify *:)
- Others (Please specify:)

* Null entry will be treated as non-Central, Western & Southern or Hong Kong East member registration.

Signature: ____________________________ Date: ____________________________
Certificate Course in Psychiatry for Community Primary Care Doctors

The Certificate Course in Psychiatry for Community Primary Care Doctors co-organized by the HKMA and the Hong Kong Society of Biological Psychiatry was successfully held from September to December 2017. The 12-session Certificate Course covered the topics including mood disorders, anxiety, psychosis, dementia, sleep problems and common psychiatric drugs etc.

HKMA-HKSH CME Programme 2017-2018 “Update in Medical Practice”

Dr. LAW Chun Key, Stephen, Specialist in Radiology, delivered a luncheon lecture on “Modern Radiotherapy” on Thursday, 7 December 2017 at the HKMA Central Premises. Dr. LIU Shao Haei kindly acted as the moderator for the event.

The HKMA Hong Kong East Community Network (HKECN) ~ Dr. CHAN Nim Tak, Douglas

Dr. Stephen YAU, Specialist in Clinical Oncology, presented on “Update in Management of Lung Cancer” on Thursday, 7 December 2017.

Dr. CHEN Wai Tsan, Tracy, Associate Consultant Physician of Haven of Hope Sister Annie Skau Holistic Care Centre, will deliver a talk on “Palliative Treatment and Care in the Community” on Thursday, 8 February 2018. Interested members please refer to the announcement on p.18 for details and enrolment.

The HKMA Central, Western and Southern Community Network (CW&SCN) ~ Dr. YIK Ping Yin

Dr. CHEONG Yan Yue, Adrian, Specialist in Cardiology, presented on “Local Experience in Managing Heart Failure with ARNI” on Wednesday, 6 December 2017. Dr. LEUNG Hon Bong, Specialist in Orthopaedics & Traumatology, presented on “Update in Joint Pain Management” on Wednesday, 13 December 2017.

Dr. WONG King Ying, Specialist in Respiratory Medicine, will deliver a lecture titled “Asthma – What Should be Done to Help Patients Achieving Disease Control?” on Wednesday, 7 February 2018. Interested members please refer to the announcement on p.18 for details and enrolment.
The HKMA Shatin Doctors Network (SDN) ~ Dr. FUNG Yee Leung, Wilson and Dr. MAK Wing Kin

Dr. WU, Enoch, Specialist in Endocrinology, Diabetes & Metabolism, presented on “Option of Oral Antidiabetic Agent for a Better CV Outcome” on Friday, 1 December 2017. Dr. SHUM Chung Nin, Specialist in General Surgery, delivered a lecture on “Management of Haemorrhoids” on Friday, 15 December 2017.

Dr. LAM Tin Keung, Edman, Senior Medical & Health Officer of Infection Control Branch of the Centre for Health Protection (CHP) of the Department of Health (DH), will deliver a lecture on “Antibiotic Stewardship Programme in Primary Care” on Wednesday, 7 February 2018, which is co-organized by the Network and the CHP of DH. Interested members please refer to the announcement on p.16 for details and enrolment.

The HKMA Kowloon City Community Network (KCCN) ~ Dr. CHIN Chu Wah and Dr. CHAN Man Chung, JP

Dr. LEUNG Kwong Chuen, Angus, Consultant in Clinical Oncology of Radiotherapy & Oncology Centre of the Hong Kong Baptist Hospital, presented on “Local Experience in Cancer Immunotherapy” on Friday, 8 December 2017.

Dr. WU, Enoch, Specialist in Endocrinology, Diabetes & Metabolism, will deliver a lecture on “Improving Cardiovascular Outcomes in Patients with Type 2 Diabetes: Applying New Evidence in Practice” on Friday, 2 February 2018. Interested members please refer to the announcement on p.17 for details and enrolment.

The HKMA Yau Tsing Mong Community Network (YTMCN) ~ Dr. CHENG Kai Chi, Thomas

Dr. CHAN Leung Kwok, Specialist in Obstetrics and Gynaecology, presented on “Osteoporosis for Menopause Women 2017” on Tuesday, 5 December 2017.

The third session of the “Certificate Course on Allergy” titled “Co-morbidities of Allergic Rhinitis in Children” will be delivered by Dr. LEUNG Ngan Ho, Theresa, Specialist in Paediatrics, on Tuesday, 6 February 2018. Doctors who attended 2 sessions or more will be given a Certificate of Completion.

The HKMA New Territories West Community Network (NTWCN) ~ Dr. CHEUNG Kwok Wai, Alvin

Prof. WONG Yeung Shan, Samuel, Professor and Head of Division of Family Medicine and Primary Healthcare of Faculty of Medicine of CUHK, presented on “Assessment and Management of Older Adults’ Cognitive Impairment in Primary Care Setting” on Thursday, 7 December 2017. Dr. LAM Tin Keung, Edman, Senior Medical & Health Officer of Infection Control Branch of the Centre for Health Protection (CHP) of the Department of Health (DH), presented on “Antibiotic Stewardship Programme in Primary Care” on Thursday, 14 December 2017. This lecture was co-organized by the Network and the CHP of DH.
The HKMA Kowloon West Community Network (KWCN) ~ Dr. TONG Kai Sing

Dr. LO Cheuk Kin, Specialist in Cardiothoracic Surgery and Associate Consultant of Department of Cardiothoracic Surgery of Queen Elizabeth Hospital, presented on “Pectus Excavatum (Funnel Chest): What is it and How Do We Manage?” on Tuesday, 5 December 2017. Dr. LAM Tin Keung, Edman, Senior Medical & Health Officer of Infection Control Branch of the Centre for Health Protection (CHP) of the Department of Health (DH), presented on “Antibiotic Stewardship Programme in Primary Care” on Tuesday, 19 December 2017. This lecture was co-organized by the Network and the CHP of DH.

Dr. YUEN Ho-Chuen, Consultant Cardiologist of St. Paul’s Hospital, will present on “An Update on AF Management and Screening” on Tuesday, 27 February, 2018. This lecture is co-organized by the Network and the Hong Kong College of Cardiology. Interested members please refer to the announcement on p.17 for details and enrolment.

The HKMA Kowloon East Community Network (KECN) ~ Dr. AU Ka Kui, Gary

Dr. CHOW Pok Yu, Specialist in Paediatrics, presented on “MMRV: Importance of Vaccination” on Thursday, 14 December 2017.

Dr. LAM Tin Keung, Edman, Senior Medical & Health Officer of Infection Control Branch of the Centre for Health Protection (CHP) of the Department of Health (DH), will deliver a lecture titled “Antibiotic Stewardship Programme in Primary Care” on Thursday, 1 February 2018. This lecture is co-organized by the Network and the CHP of DH. Interested members please refer to the announcement on p.16 for details and enrolment.

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.

For further information, please contact Miss Alison Hui at 2527 8452 or by email at alisonhui@hkma.org.

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.
   (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.
<table>
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<tr>
<th>Date</th>
<th>Event</th>
<th>Location</th>
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<tr>
<td>16 Jan</td>
<td>HA-PYNEH-Dept of Anaesthesia</td>
<td>Conference Room, MB 02.41, PYNEH</td>
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<td>Continuing Medical Education Meeting (January)</td>
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<td>Ms. Karman Wong – Tel: 2595 7143</td>
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<td>16 Jan</td>
<td>HKMA-Tai Po Community Network</td>
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<td>Ms. Hannah Lee – Tel: 6620 0185</td>
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<td>16 Jan</td>
<td>HKMA-KLN West Community Network</td>
<td>Update on Rheumatic Disease–Common Important Presentation of uncommon</td>
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<td>17 Jan</td>
<td>HK College of Family Physicians</td>
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<td>18 Jan</td>
<td>Federation of Medical Societies of HK</td>
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<td>1 Feb</td>
<td>Federation of Medical Societies of HK</td>
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<td>3 Feb</td>
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<td>6 Feb</td>
<td>HK College of Emergency Medicine</td>
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<td>7 Feb</td>
<td>HKMA-Shatin Doctors Network</td>
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<td>10 Feb</td>
<td>HKMA-KLN West Community Network</td>
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<td>13 Feb</td>
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<td>15 Feb</td>
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<td>16 Feb</td>
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<td>20 Feb</td>
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* For whole function