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*Towards 2025: Strategy and Action Plan to
Prevent and Control Non-communicable Diseases
in Hong Kong*





大腸癌篩查計劃

Colorectal Cancer Screening Programme



Colorectal cancer (CRC) is the commonest cancer in Hong Kong and is preventable through adopting a healthy lifestyle and well-organised screening.

Regularised in August 2018, the **Colorectal Cancer Screening Programme** (CRCSP) is being implemented in phases to subsidise asymptomatic Hong Kong residents aged 50 to 75 to undergo screening tests in private sector for CRC prevention.

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- ▶ Advising your patients to adopt healthy lifestyle
- ▶ Joining the CRCSP as enrolled service providers
- ▶ Encouraging your patients to enroll in the CRCSP to get screened if they are eligible

For further information about CRCSP, please visit www.colonscreen.gov.hk or call 3565 5665 during office hours.





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The Cover Shot



The photo was taken with a drone by Dr Wing-kwun Lam, Senior Medical Officer, Chai Wan Families Clinic. On the summit of Mount Parker, a small drone reached the height where birds usually could, to appreciate the magnificent view of the sun. Sometimes we need to get over hurdles and be rewarded with the wonders of nature.

Inspiration from the photo:
Lifestyle changes involve a process that take time and require support. When one is ready to make a change, be prepared to get through a difficult path, and the resolution will be rewarding.



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Editorial

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Editor

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Non-communicable diseases (NCDs) are major causes of ill-health, disabilities and deaths. Worldwide, the World Health Organization (WHO) estimated that NCDs kill 41 million people each year, accounting for 71% of all deaths. Premature death is the salient trait, as 15 million people die from a NCD between the ages of 30 and 69 years globally each year.¹

Among 45,883 registered deaths in Hong Kong in 2017, 59.3% were attributed to six major but preventable NCDs, including cancer (31.3%), diseases of heart (13.4%), stroke (6.8%), injury and poisoning (3.7%), chronic lower respiratory diseases (3.3%) and diabetes (0.9%). The importance of these six major NCDs is also underlined in terms of inpatient discharges and deaths. Altogether, they accounted for 23.0%, or 505,660 episodes, of all hospital inpatient discharges and deaths in 2017.²

Many NCDs are closely related to behavioural risk factors such as inadequate intake of fruits and vegetables, high salt diet, physical inactivity, and alcohol consumption. An upstream approach to reduce the risk of NCDs through behavioural changes to a healthier lifestyle has proven benefits. It is evident that at least 80% of all heart diseases, stroke and type 2 diabetes would be prevented; over 40% of cancer would be prevented through a healthy lifestyle.³

The second Population Health Survey (PHS) conducted in 2014-16 in Hong Kong reported that over nine-tenths (94.4%) of people aged 15 or above failed to meet the WHO recommendation of having at least five servings of fruits and vegetables per day; 86.3% of people aged 15-84 had salt intake above the WHO recommended limit of less than 5 grams per day (mean salt intake was 8.8 grams per day); and 2.2% of people aged 15 or above had binge drinking at least once a month.⁴ These findings have revealed that behavioural risk factors are common in our general adult population.

As far as physical inactivity is concerned, the PHS revealed that the majority (87.0%) of people aged 18 or above could meet the WHO's recommended level of physical activity for adults. On the other hand, the proportion of students who were insufficiently physically active was 94% in the 2017/18 school year according to the data collected by the Student Health Service of the Department of Health.⁵

Besides behavioural risk factors, biomedical risk factors such as overweight and obesity, high blood pressure, impaired fasting glucose or diabetes and high blood cholesterol levels are associated with NCDs. The PHS collected data on biomedical risk factors through physical and biochemical measurements and reported that half (50.0%) of people aged 15-84 were overweight/obese (BMI ≥ 23); and the prevalence of hypertension, diabetes mellitus and hypercholesterolaemia were 27.7%, 8.4% and 49.5% respectively.

In light of global development in prevention and control of NCDs, the Food and Health Bureau and the Department of Health published "Towards 2025: Strategy and Action Plan to Prevent and Control



Non-communicable Diseases in Hong Kong” in May 2018, to align with the WHO recommendations. The publication proposes a portfolio of actions that Hong Kong will pursue to achieve the committed 9 NCD targets as we move towards 2025.⁶ The Government will continue to foster co-operation across sectors and work in close partnership with the community and members of the public to build a health-enhancing physical and social environment to reduce the burden of NCDs.

In this issue of the Hong Kong Medical Diary, I have invited an array of specialists in public health medicine and family medicine, a pharmacist and a retired athlete to discuss pragmatic interventions at the primary care level to empower the general public to reduce their risks of NCDs. I believe you will find these interventions simple and constructive in your day-to-day practice.

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Hypercholesterolaemia: From Public Health Perspective to Patient Care

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This article has been selected by the Editorial Board of the Hong Kong Medical Diary for participants in the CME programme of the Medical Council of Hong Kong (MCHK) to complete the following self-assessment questions in order to be awarded 1 CME credit under the programme upon returning the completed answer sheet to the Federation Secretariat on or before 30 June 2019.

INTRODUCTION

The increasing prevalence of hypercholesterolaemia has become a worldwide public health problem. High serum level of cholesterol, especially low-density lipoprotein cholesterol (LDL-C), is a potent risk factor for atherosclerotic cardiovascular disease (CVD), including ischaemic heart disease and stroke.¹ Between 2007 and 2017, the Global Burden of Diseases, Injuries, and Risks Factors Study (GBD) reported that the number of ischaemic heart disease deaths attributable to high LDL-C increased by 20.7% from 3.14 million to 3.79 million. The number of ischaemic stroke deaths attributable to high LDL-C also increased by 21.2% to 532 000 over the same period. In 2017, 4.32 million deaths and 94.9 million disability-adjusted life-years (i.e. years lost due to ill-health, disability or early death) were attributable to high LDL-C.²

PUBLIC HEALTH PERSPECTIVE

Epidemiology

In 2008, the prevalence of elevated total cholesterol was highest in the World Health Organization (WHO) Region of Europe (54% for both sexes), followed by the WHO Region of the Americas (48% for both sexes). The WHO African Region (AFR) and the WHO South East Asian Region (SEAR) showed the lowest percentages (22.6% for AFR and 29.0% for SEAR). Moreover, it is noted that the elevated total cholesterol increased noticeably according to the income level of the country.³ In fact, total cholesterol levels are rising in many regions in the East and South Eastern Asia. The increase is compatible with economic growth and associated lifestyle changes, such as increased supply and intake of high-fat diets, reduced physical activity, and increased obesity.⁴

In Hong Kong, the Department of Health (DH) conducts territory-wide household surveys regularly to collect data on population health, including biochemical information on blood lipid profile. The Population Health Survey (PHS) 2014/15 showed that the mean total cholesterol among people aged 15–84 was 5.1 mmol/L. Among persons aged 15–84, 49.5% had never been diagnosed with hypercholesterolaemia and 70.2% of those with hypercholesterolaemia

were unaware of their condition. The prevalence of hypercholesterolaemia generally increased with age with the highest prevalence observed in the age group 55–64 in both genders.⁵ Compared with the Heart Health Survey (HHS) 2004/05 conducted by the DH⁶, there was an increase of 26.0% in the crude prevalence of hypercholesterolaemia among persons aged 15–84 and 19.3% increase when the age factor was adjusted (Table 1).

Table 1: Hypercholesterolaemia among population aged 15–84 in Hong Kong based on results of health surveys

	HHS 2004/05	PHS 2014/15	Relative Increase
Number of persons ('000)	1 856.4	2 946.3	58.7%
Crude prevalence of hypercholesterolaemia	39.3%	49.5%	26.0%
Age-standardised* prevalence of hypercholesterolaemia	35.3%	42.1%	19.3%

* Age-standardised rate is compiled based on the world standard population specified in GPE Discussion Paper Series: No.31, EIP/GPE/EBD, World Health Organization, 2001.

Risk Factors and Causes of Hypercholesterolaemia

Lifestyle, genetics, diseases, medications, or a combination can lead to lipid metabolism disorders. While the genetic factor (i.e. familial hypercholesterolaemia) is not modifiable, there are many modifiable behavioural risk factors associated with an increased risk of hypercholesterolaemia, including a diet high in saturated or trans fats, physical inactivity, smoking, and obesity, etc. Secondary causes of hypercholesterolaemia include alcoholism, diabetes mellitus, biliary obstruction, hypothyroidism, Cushing's syndrome, nephrotic syndrome, and chronic renal failure. Certain medications such as glucocorticoids, combined oral contraceptive pills, diuretics, atypical antipsychotics and retinoic acid derivatives, can also contribute to hypercholesterolaemia.

Prevention of Hypercholesterolaemia

To tackle hypercholesterolaemia, the best population-based strategy is primary prevention by promoting a healthy lifestyle that not only has the potential to



decrease its incidence but also is likely to use far fewer resources than treating the disorder and managing its consequences. Intervening upstream on a cluster of behavioural risk factors such as unhealthy diet, physical inactivity, smoking and drinking can induce parallel changes in biomedical risk factors including hypercholesterolaemia, thereby reducing the risk of developing of CVD or other complications. Physicians and other front-line healthcare professionals are uniquely positioned to advise and assist patients and the general public to choose healthy ways of living.

Moreover, early detection for hypercholesterolaemia can lead to more favourable prognosis because earlier intervention can be taken. The Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings recommends periodic screening of blood lipid in adults aged 50–75 years and every 3 years thereafter if the result is within optimal range.⁷

TREATMENT

There is solid evidence that lowering the LDL-C reduces the risk in patients with and without atherosclerotic CVD. However, the clinical benefit is not as well proven in managing elevated triglycerides or high density lipoprotein-cholesterol (HDL-C) in patients without manifesting CVD.¹ The main focus below is therefore to reduce LDL-C.

Lifestyle Modification

Modifications of lifestyle such as diet control, weight reduction in overweight patients and aerobic exercise are generally recommended. Among the various known modifiable risk factors for CVD, the importance of nutrition and dietary pattern has been repeatedly emphasised.⁸⁻¹² A study in the United Kingdom found that taking a cholesterol-lowering diet was associated with 5–7% reductions in serum total cholesterol and LDL-C in 60% of 2,508 subjects.¹³ The individual response to diet varies and may be determined by factors including genetic factors. Evidence has shown that an increased body mass index is associated with less response to dietary changes.¹⁴ In addition, compared with advice from clinicians, dietary counselling provided by dietitians may have greater success in lowering LDL-C in the short term.¹⁵ As for dietary compliance, a study on women showed that being married, smoking, a sedentary lifestyle and a higher body mass index were all associated with reduced compliance.¹⁶

Specific dietary patterns are also beneficial to lowering LDL-C. In 2013 the American College of Cardiology (AHA) /American Heart Association (ACC) Guideline on Lifestyle Management to Reduce Cardiovascular Risk,¹⁷ four dietary recommendations are offered:

1. Consume a dietary pattern that emphasises intake of vegetables, fruits, and whole grains; include low-fat dairy products, poultry, fish, legumes, non-tropical vegetable oils, and nuts; and limit intake of sweets, sugar-sweetened beverages, and red meat. (Level of evidence: A)

2. Aim for a dietary pattern that limits saturated fat to at most 5–6% of calories. (Level of evidence: A)
3. Reduce percentage of calories from saturated fat. (Level of evidence: A)
4. Reduce percentage of calories from trans fat. (Level of evidence: A)

Dietary supplements for cholesterol reduction are widely publicised and frequently asked by patients. Nevertheless, not all the products are proved to be effective based on current evidence. Table 2 is a review of some commonly encountered supplements with supporting evidence of favourable effect on lipid profile.

Table 2: Dietary supplement with evidence of favourable outcome on lipid profile

Dietary supplement	Type of food / dose used in studies	Effect
Fish oil /Marine omega-3 fatty acids	≥ 1g/day ¹⁸	1) Lower serum triglyceride concentrations by 25–30% ¹⁸⁻²¹ with noticeable linear dose-response relationship 2) Lower LDL-C and raises HDL-C ²²
Red yeast rice	2.4g/day ²³ to 3.6g/day ²⁵	Lowers total cholesterol and LDL-C ²³⁻²⁵
Tea	Green tea catechins:1315mg/day ²⁶	Lowers total cholesterol and LDL-C ²⁶⁻²⁸
Nuts	Walnuts ²⁹⁻³¹ , almonds ³² , pistachios ³³ , hazelnuts ³⁴ 30g/day ³⁴ to 67g/day ³⁵	Lower total cholesterol and LDL-C ²⁹⁻³⁶ The effect appears to be nut dose-dependent rather than nut type-dependent. ³⁶
Soluble fibre	Oat-based fibre ³⁷ , psyllium ^{37,38} , pectin ³⁷ , guar gum ³⁷ , whole grain oat ³⁸	Lowers total cholesterol and LDL-C by 10–14% ³⁷⁻³⁹
Plant sterols	Margarine fortified with sitostanol ^{40,41}	Lower total cholesterol and LDL-C by 8–14% ^{40,41}

Pharmacological Treatment

There are various guidelines worldwide that calculate individual CVD risks as a tool to guide the use of drug treatment in the prevention of lipid disorders. Risk algorithms of various guidelines usually include lipid levels with some combination of certain traditional risk factors (Table 3). Physicians could offer drug treatment to patients after balancing the risks and benefits of pharmacological treatment with thorough explanation of the estimated cardiovascular risks.

Table 3: Traditional risk factors for CVD risk

• Age	• Hypertension	• Obesity
• Gender	• Diabetes status	• Family history of premature ischaemic heart disease
• Smoking	• Sedentary lifestyle	

Statins-HMG-CoA Reductase Inhibitors (statins)

Statins are the key drugs for treating lipid disorder. They inhibit HMG-CoA reductase competitively thus inhibiting the rate-limiting step in cholesterol biosynthesis. Examples include atorvastatin, fluvastatin, lovastatin, pitavastatin, pravastatin, rosuvastatin and simvastatin. They reduce LDL-C, but their LDL-lowering efficacy differs among different statins (Table 4).

Table 4: Relative LDL-lowering efficacy of statin therapies⁴²

Atorvastatin	Rosuvastatin	Simvastatin	%↓ LDL-C
-----	-----	10 mg	30%
10 mg	-----	20 mg	38%
20 mg	5 mg	40 mg	41%
40 mg	10 mg	80 mg	47%
80 mg	20 mg	-----	55%
	40 mg	-----	63%

Source: U.S. Food and Drug Administration

Statin-associated Adverse Muscle Events

These includes myalgia, myopathy, myositis, myonecrosis and rhabdomyolysis.⁴³ Factors associated with an increased risk of statin-associated adverse muscle events are listed out in Table 5.⁴⁴

Table 5: Risk factors for statin-associated adverse muscle events⁴⁴

• advanced age (>80)	• small body frame	• hypothyroidism
• frailty	• severe renal disease	• female
• drug - drug interactions	• acute or decompensated liver disease	• alcohol consumption

Most significant muscle-related adverse reactions are related to drug-drug interactions. The risk of muscle injury is substantially increased when taking a statin that is extensively metabolised by cytochrome P450 3A4 such as simvastatin, atorvastatin, etc., together with a drug that interferes with P450 3A4 (Table 6).⁴⁵ Statins not rely mainly on P450 3A4 for metabolism such as rosuvastatin is preferred when concurrent therapy with a strong inhibitor of P450 3A4 cannot be avoided.

Table 6: Cytochrome P450 3A4 (CYP3A4) inhibitors commonly encountered⁴⁵ (this list is not complete; please check drug interaction information before prescription)

• amiodarone	• erythromycin	• ketoconazole
• amlodipine	• fluconazole	• sertraline
• ciprofloxacin	• fluoxetine	• telithromycin
• clarithromycin	• grapefruit juice*	• verapamil
• cyclosporine	• isoniazid	• ticagrelorants
• diltiazem	• itraconazole	• tricyclic antidepressants

* Grapefruit juice inhibits intestinal CYP3A4; however, daily consumption of eight ounces (240 mL) or less of grapefruit juice, or one-half of a grapefruit or less, is unlikely to increase the risk of an adverse interaction or muscle injury.⁴⁶

Dosage of statin with concurrent use of common chronic medications in general practice is listed out in Table 7.

Table 7: Maximum allowable dosage of statin during concurrent use of common chronic medications in general practice (source: <https://doi.org/10.18578/BNF.413004542>)

Dosage of Statin	Concurrent use chronic medications
Max. simvastatin 10 mg daily	bezafibrate or ciprofibrate
Max. simvastatin 20 mg daily	verapamil, diltiazem or amlodipine
Max. simvastatin 40 mg daily	lomitapide (lipid lowering agent) or ticagrelor (antithrombotic)
Max. simvastatin 20 mg daily	elbasvir (treatment of HCV) or grazoprevir (treatment of HCV)
Max. simvastatin 20 mg daily	amiodarone or ranolazine

Effects on Liver Function

Baseline measurement of transaminase (alanine transaminase; ALT) levels should be performed before initiation of statin therapy. There is no recommendation to monitor transaminase (ALT) levels since there was no significant difference between placebo and statin treatment in the rates of ALT elevations.⁴⁷

Contraindications

They include hypersensitivity, active liver disease, pregnancy and lactation.⁴⁷

CONCLUSION

Hypercholesterolaemia is common in Hong Kong but many people are unaware of their harbouring this condition. In primary care setting, it is a problem commonly encountered and frequently asked by the public. For individual patient with hypercholesterolaemia, diet control, regular physical activity and weight reduction, together with pharmacological treatment where indicated, are effective in managing the condition. As hypercholesterolaemia is one of the key modifiable risk factors of atherosclerotic CVD, it is of paramount importance to prevent and control this problem on all fronts.

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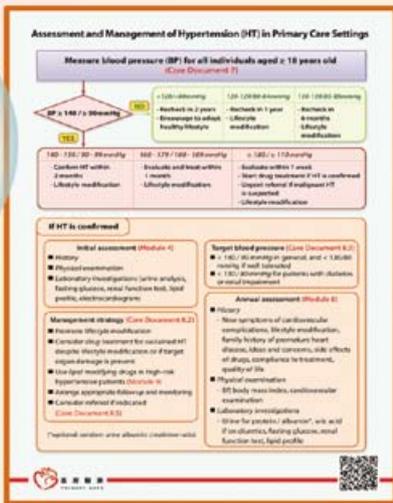


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MCHK CME Programme Self-assessment Questions

Please read the article entitled "Hypercholesterolaemia: From Public Health Perspective to Patient Care" by Dr Eddy Kwok-po NG, Dr Dominic Man-wai LAU and Dr Wai-man WONG and complete the following self-assessment questions. Participants in the MCHK CME Programme will be awarded CME credit under the Programme for returning completed answer sheets via fax (2865 0345) or by mail to the Federation Secretariat on or before 30 June 2019. Answers to questions will be provided in the next issue of The Hong Kong Medical Diary.

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

1. There is evidence that the number of ischaemic heart disease deaths attributed to high LDL-cholesterol is on a rising trend.
2. Nephrotic syndrome is not a cause of hypercholesterolaemia.
3. Clients with a higher body mass index respond better to dietary changes for lowering blood LDL-cholesterol.
4. Reduction of percentage of calories from trans fat in daily diet is effective in lowering blood LDL-cholesterol.
5. Consumption of plant sterol can increase blood HDL-cholesterol level effectively.
6. Risk factors for statin associated adverse muscle events include hyperthyroidism and smoking.
7. Consumption of 100mL grapefruit juice every day will likely increase the risk of adverse muscle events with statin.
8. Baseline liver function test is generally not required before starting statins.
9. Simvastatin and atorvastatin are metabolised by cytochrome P450 3A4.
10. Concomitant use of simvastatin or atorvastatin together with a drug which is a P450 3A4 inhibitor will increase the side effects of the statin.

ANSWER SHEET FOR JUNE 2019

Please return the completed answer sheet to the Federation Secretariat on or before 30 June 2019 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

Hypercholesterolaemia: From Public Health Perspective to Patient Care

Dr Eddy Kwok-po NG

Dr Dominic Man-wai LAU

Dr Wai-man WONG

1 2 3 4 5 6 7 8 9 10

Name (block letters): _____ HKMA No.: _____ CDSHK No.: _____

HKID No.: ___ - ___ - ___ X X (X) HKDU No.: _____ HKAM No.: _____

Contact Tel No.: _____ MCHK No.: _____ (must fill in)

Answers to May 2019 Issue

Novel Biologics in Allergy Practice

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

Controlling the Obesity Epidemic

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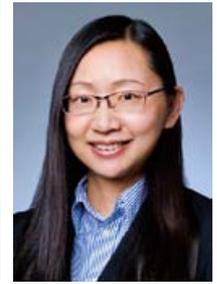
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Obesity is a global public health issue in many jurisdictions. The prevalence of obesity and overweight is rapidly increasing worldwide. Over the past 40 years, the world prevalence of obesity among adults has nearly tripled. Estimates in 2016 showed that 39% of adults aged 18 years and older were overweight and 13% were obese.¹ Among children and adolescents aged 5–19, the prevalence of overweight and obesity also increased markedly from just 4% in 1975 to over 18% in 2016.² In Hong Kong, the Population Health Survey 2014/15 of the Department of Health estimated that 50.8% of Hong Kong adults aged 18–84 were overweight or obese³, an increase of over 25% since 2003/04⁴, using local classification of Body Mass Index (“BMI”) categories for Chinese adults at BMI ≥ 23 kg/m².⁵ In 2017/18 school year, the overweight and obesity detection rates for primary and secondary school students were 17.6% and 19.9% respectively. Despite the fact that a levelling off and downturn in the prevalence of overweight and obesity among primary school students has been noted in recent years, the figure for secondary school students continues to grow.⁶

IMPACTS OF OBESITY

Obesity leads to serious non-communicable diseases (NCD), including diabetes mellitus, cardiovascular diseases (mainly heart disease and stroke), several types of cancer (endometrial, breast, ovarian, prostate, colon, liver, gallbladder and kidney), musculoskeletal disorders (especially osteoarthritis) and respiratory symptoms.^{7,8} The health consequences of obesity range from increased risk of premature death to disability, diminished quality of life, increased medical expenses and sick leaves for individuals, leading to lower productivity and higher costs for the society.^{9,10,11} Earlier local studies estimated that the hospitalisation costs of obesity in Hong Kong’s public hospitals were HK\$ 2.29 billion in 1998 and HK\$ 3.36 billion in 2002, accounting for 8.2–9.8% of the total public expenditure on health in Hong Kong.¹² Of around HK\$ 2 billion healthcare costs for diabetes per year, about half is related to overweight and obesity among adults.¹³

CAUSES OF OBESITY EPIDEMIC

Obesity is caused by a chronic energy imbalance involving both dietary intake and physical activity patterns. A Lancet series on obesity indicated that the rise in obesity is a result of changes in the global food system: the movement from individual to mass preparation “lowered the time price of food

consumption”; production of more highly processed food (with added sugar, fats and salt), and marketing them with increasingly effective techniques which are especially effective among children.^{14,15}

GLOBAL & LOCAL RESPONSES TO OBESITY EPIDEMIC

Beware that obesity is a complex multifactorial condition and predominantly a “social and environmental disease”, the World Health Organization (WHO) has been helping to develop strategies for obesity prevention and management since 1990s.⁷ Facing the challenges posed by obesity, all countries have agreed on a set of global targets for a zero increase in the prevalence of obesity by 2025 (from 2010 levels) among both adults and children.^{16,17} Action to reverse the obesity epidemic is the focus of the recommendations made by the WHO Commission on Ending Childhood Obesity¹⁸ and forms part of the WHO’s Global Action Plan for the Prevention and Control of NCD 2013–2020¹⁹, the WHO’s Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition²⁰, and the United Nations Decade of Action on Nutrition 2016–2025.²¹

In Hong Kong, tackling obesity has been accorded high priority. In May 2018, the Government launched “Towards 2025: Strategy and Action Plan to Prevent and Control Non-communicable Diseases in Hong Kong” (SAP) announcing a list of committed actions and clear targets. Among the 9 local NCD targets to be achieved by 2025, Target 7 is dedicated to halt the rise in obesity and diabetes.

PRIMARY PREVENTION

Family physicians can and should play a vital role to help with healthy weight maintenance. Providing whole-person, patient-centred care, family physicians are uniquely positioned to raise the public awareness to obesity and to screen, counsel, and refer patients.

Screening of Obesity

Primary care providers are recommended to screen all patients for BMI during opportunistic clinic visits. For adult Asians, the BMI cut-off is lowered compared with Caucasians due to higher body fat content in Asians. Therefore, BMI above 25.0 kg/m² is defined as obesity, while BMI between 23.0 to 24.9 kg/m² is defined as overweight in Hong Kong.⁵ For children, overweight,

BMI is defined as a person’s weight in kilograms divided by the square of his height in meters (kg/m²).



including obesity, is defined as >120% of the median weight-for-height, or BMI ≥ 25 kg/m² for male students with height >175 cm and female students with height >165 cm.⁶

Measuring the waist circumference is recommended for individuals with overweight to provide additional risk information. The cut-off of waist circumference for increased cardiometabolic risk are >80 cm for women and >90 cm for men in Hong Kong Chinese.⁵

Family physicians can also support other interventions at the population level that focus primarily on building a conducive environment for healthy eating habits (Box 1) and adequate levels of physical activity (Box 2); and programmes that directly influence behaviours in the settings of daily life such as at schools, home environment, workplaces and community, by actively involving different levels of stakeholders.^{7,22,23} There is an array of cost-effective interventions that are being implemented/advocated globally include restriction of the marketing of food aimed at infants and children (e.g. implementing the International Code of Marketing of Breast-milk Substitutes), regulation of food nutritional quality and availability, labelling of the front of packages with nutritional values, taxes on sugar-sweetened beverages, mass media campaigns on healthy dietary practices and physical activity, provision of financial incentives to improve food retail environments, private-public partnerships to encourage food industry reformulation, quality physical education in schools, urban design to support active transport strategies, provision of convenient and safe access to quality public open space and adequate infrastructure to support walking and cycling, etc.^{24,25}

Box 1: Constitution of a Healthy Diet^{26,27}

Adults:

- ✓ Including the five basic food groups (i.e. grains; fruit; vegetables; meat, fish, egg and alternatives; milk and alternatives);
- ✓ At least 400 grams (5 servings) of fruit and vegetables a day;
- ✓ Less than 10% of daily total energy intake from free sugars, i.e. 50 grams (or about 10 teaspoons) per day for a 2 000 calories meal plan;
- ✓ Less than 30% of total energy intake from fats, i.e. about 60 grams per day for a 2 000 calories meal plan. Unsaturated fats (e.g. vegetable oil, olive oil) are preferable to saturated fats (e.g. butter, lard). Industrial trans fats are not part of a healthy diet and should be avoided;
- ✓ Less than 5 grams of salt (or about 1 teaspoon) per day

Infants and children:

- ✓ Infants should be breastfed exclusively during the first 6 months of life; and breastfed continuously until 2 years of age and beyond.
- ✓ From 6 months of age, breast milk should be complemented with a variety of adequate, safe and nutrient-dense foods. Salt and sugars should not be added to complementary foods;
- ✓ Advice on a healthy diet for children is similar to that for adults.

Box 2: Recommendations on Physical Activity for Health²⁸

Adults:

- ✓ Do at least 150 minutes a week of moderate-intensity aerobic physical activity, or at least 75minutes a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate and vigorous-intensity activity

Children and Adolescents aged 5 – 17 years:

- ✓ Accumulate at least 60 minutes a day of moderate- to vigorous-intensity aerobic physical activity

SECONDARY PREVENTION

Several evidence-based guidelines from overseas emphasised the importance of primary care physicians as a coordinator of this multidisciplinary approach to manage obesity^{29,30,31}.

The Barriers Encountered

Contrary to the usual belief, studies showed that most of overweight and obese patients did not receive any advice about their weight during their medical encounters³². What are the barriers for that? The literature is consistent in identifying the following provider barriers: lack of time, insufficient training, lack of incentives, low expectations of success, and fear of being offensive to patients. The following patient barriers are also repeatedly cited in the literature: feeling stigmatised, lack of motivation and readiness for change³³. To tackle these challenges, primary care providers should be empowered to broach the topic of obesity proactively. Obesity should be considered as a multifactorial chronic disease instead of simply a lifestyle choice. The essential roles of primary care professionals in prevention and long-term management of obesity have to be reiterated.

Studies confirmed that patients with overweight or obesity feel stigmatised and disrespected by primary care providers. This is particular problematic in those with higher degree of obesity.³⁴ Therefore, training on how to communicate with obese patients in a sensitive and tactful manner is crucial to avoid stigmatisation or perceived discrimination. To motivate and raise the readiness for change, practitioners should be empathic, patient focused and non-judgemental when discussing the weight issues. Evidence-based and patient-centred tools, e.g. Motivational Interviewing (MI) and Five A's Framework, are effective and essential for weight management.

TOOLS TO HELP FIGHTING OBESITY

MI is a time limited, goal oriented, patient centred counselling used to change behaviour. It can be used effectively by primary care providers without prior psychotherapy training. MI can strengthen a person's motivation and commitment to behavioural change. It is based on Carl Rogers' humanistic theories about patients' ability for change. They can exercise freedom of choice and change through self-actualisation.³⁵ There are evidences supporting the use of MI for weight management in primary care.³⁶ MI technique is easy to learn within a reasonable time frame. It has four core principles, namely, express empathy, support the patient's self-efficacy, roll with resistance, and develop discrepancy.³⁷ Steps to use MI:

1. determine the patient's desire and confidence for change;
2. obtain a commitment to making the change;
3. do not oppose a patient if he is resistant to change;
4. summarise the patient's change talk;
5. create a patient-directed plan for making the changes.³⁷

The Five A's is a useful framework for lifestyle counselling on modifiable risk factors. It was initially used in smoking cessation with proven effectiveness. Therefore, it has been adapted for obesity counselling and is widely promoted in US, Canada and Australia guidelines on obesity management.

In brief, the Five A's are:³⁸

- Ask permission to discuss weight, explore readiness to change;
- Assess BMI and waist circumference, explore drivers and complications;
- Advise on health risks, benefits of weight loss and need for long term strategies;
- Agree realistic goals, behavioural changes and treatment options; and
- Assist in identifying barriers, provide resources/appropriate providers and arrange follow-up.

This brief intervention model can be implemented in 5 to 10 minutes which is especially suitable in the setting of a busy clinic. A recent study showed that this can also change providers' clinical approach and personal understanding of obesity management.³⁹

The Goal of Therapy

The primary goal of weight management is to improve the present health and reduce the future risk of developing obesity-related comorbidities. Sustained weight loss of 3-5% can translate into clinically meaningful reduction in blood levels of triglycerides, glucose and glycated haemoglobin and in risk of developing type 2 diabetes.²⁹ Therefore, a reasonable goal of treatment is to maintain a reduction of 5-10% of baseline body weight as suggested by international guideline.²⁹

The Obesity Treatment

The treatment of obesity includes lifestyle, pharmacological and surgical interventions. Lifestyle intervention consists of diet, exercise and behavioural therapy. Diet therapy and exercise are the well-known and commonly used intervention for weight management.

Diet

Obviously, it is not helpful and ineffective if primary care physicians just said, "eat less and move more". Guidelines recommend a reduction of dietary calorie intake by 500-1000 kcal per day plus at least 150 min of moderate intensity physical activity per week will result in a weight loss of 1 to 2 lb per week.³³ The success rate of weight loss and weight loss maintenance were greater when combined with behavioural therapy, compared with diet and exercise alone.⁴⁰ The risk of progression from pre-diabetes to type 2 diabetes has also been shown to be reduced by using behaviour-based weight loss intervention.⁴⁰ However, primary care physicians may not be able to provide intensive counselling and detailed dietary advice in a busy clinic.

Multidisciplinary approach is hence suggested to connect with other health care providers, e.g. dietician, psychologist, physical activity specialist etc. New technologies, e.g. smartphone applications, wearable devices, and mobile connected health devices, can also be used to assist patients' self-tracking.

There is a wide range of calorie-restricted dietary interventions. A systemic review found no superiority for any of the 15 diets reviewed, including low-carbohydrate, low-fat, high-protein, and Mediterranean-style approaches²⁹. Very low energy diet (less than 800kcal/day) is very effective as an initial weight loss strategy but it has potential adverse effects on health. Therefore, guidelines suggest it to be used as part of a multicomponent weight management programme under close medical supervision, for obese patients who have a clinically-assessed need for rapid weight lost.³¹

Physical activity

Although physical activity has little effect on body weight unless it is combined with dietary change, it has a wide range of health benefits even if no weight loss is achieved.³⁰ Exercise can improve cardiorespiratory fitness, mood, self-esteem, and reduce risk of cardiovascular disease and cancer.⁴¹ Muscle strengthening activities are also important for metabolic and musculoskeletal health, maintaining functional status in older age.³⁰

Pharmacotherapy

Pharmacotherapy should be used as an adjunct to diet, exercise and behavioural therapy for individuals with severe obesity or overweight with at least one comorbidity, who fail to lose weight or maintain weight loss.⁴¹ Current available anti-obesity drugs are phentermine, orlistat, lorcaserin, Qysmia (phentermine/topiramate), and Contrave (naltrexone/bupropion). Some oral hypoglycaemic agents also have weight reduction effect, e.g. metformin, sodium-glucose cotransporter type 2 inhibitor (SGLT2i) and glucagon-like peptide-1 (GLP-1) receptor agonist. Although these medications were associated with more weight loss and weight loss maintenance compared with placebo, all of them had adverse effects. Therefore, a shared decision-making approach should be adopted when prescription of anti-obesity agents is needed.

Surgery

Bariatric surgery has been shown to achieve the greatest degree of weight reduction, reaching 20-30% of body weight.³⁰ It has beneficial effects on quality of life and multiple obesity-related comorbidities, e.g. type 2 diabetes, hypertension, dyslipidaemia, obstructive sleep apnoea.⁴¹ Bariatric surgery is regarded as a therapeutic tool and should only be considered for patients with severe obesity and comorbidities, who fail to have sufficient response to behavioural treatment with or without pharmacotherapy. However, it is not without risk and also requires subsequent long term follow-up.



CHALLENGES AND OPPORTUNITIES FOR TACKLING OBESITY

There is no simple solution and no country has yet been successful in significantly reducing obesity prevalence.²⁴ But one thing is clear, the fundamental causes of the obesity epidemic are societal, resulting from an environment that promotes the consumption of high-fat, energy-dense diets and sedentary lifestyles.⁴² In this connection, obesity is largely preventable through lifestyle changes, although some individuals may become overweight and obese because of other non-modifiable factors.⁴³ People need to be supported by a health-enhancing physical and social environment and, thus, a concerted approach, involving actions by the Government, the communities, the food industry, and the media, is required for its effective prevention and management.^{7,14} Given childhood obesity is associated with a higher chance of premature death and disability from various NCD in adulthood, the effective prevention of adult overweight and obesity should also begin early in life.^{44,45}

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Preventing Colorectal Cancer: What can be done in the primary care setting?

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COLORECTAL CANCER IN HONG KONG

Colorectal cancer (CRC) is the commonest cancer in Hong Kong. According to the Hong Kong Cancer Registry, there were 5,437 newly registered CRC cases in 2016, representing 17.3% of all new cancer cases¹. The age-standardised incidence rates (ASIR) were 50.6 per 100,000 population for men and 31.4 per 100,000 population for women². The median age at diagnosis of CRC was 68 years in men and 69 years in women. The age-specific incidence rates increased significantly starting from age 50. CRC is more common in men with the male-to-female ratio for new cases in 2016 of 1.4:1.³ Separately, the Death Registry registered 2,138 deaths caused by CRC in 2017, representing 14.9% of all cancer deaths and ranking it the second leading cause of cancer deaths in Hong Kong⁴.

Colorectal Cancer is preventable through primary and secondary prevention.

PRIMARY PREVENTION

Primary prevention is of utmost importance for the prevention of CRC as many of the risk factors are lifestyle-related and are hence modifiable. Studies have shown that the risk of CRC can be markedly lowered through lifestyle modification such as maintaining a healthy body weight, being physically active, limiting alcohol consumption, quitting smoking and eating a healthy diet⁵⁻⁷. For preventing CRC, the local Cancer Expert Working Group (CEWG)¹ on Cancer Prevention and Screening recommends:

- Increasing intake of dietary fibre (e.g. fibre from at least five servings of fruits and vegetables daily);
- Decreasing consumption of red and processed meat;
- Taking part in moderate-intensity aerobic physical activities for at least 150 minutes per week;
- Maintaining a healthy body weight with body mass index between 18.5 to 22.9 and waist circumference <80 cm (~ 32inches) for women and <90 cm (~ 36 inches) for men;
- Avoiding or quitting tobacco smoking; and
- Avoiding alcoholic drinks.

Doctors have key roles in the primary prevention of CRC. They are in a unique position that allows them to

help their clients identify lifestyle risks that may place them at elevated risk of CRC, and thus can help them adopt and adhere to a healthier lifestyle. Studies have consistently demonstrated that doctors' brief advice or intervention can influence their patients' behaviour and increase their chance to successfully adopt the healthy lifestyle⁸⁻¹⁰.

Tools are available to aid doctors in opportunistic health promotion during their routine clinical encounters with patients. Examples are tabulated below:

Lifestyle	Intervention	Description
Smoking	"ABC"	Perform "ABC" to help clients who are smokers to quit smoking. ABC stands for Ask, Brief advice, and Cessation support. For details, please refer to the webpage of Department of Health's (DH) Tobacco and Alcohol Control Office accessible at https://www.taco.gov.hk/t/english/quitting/elearning_abc.html
Drinking	"AUDIT"	The Alcohol Use Disorders Identification Test (AUDIT) is an alcohol screening tool developed by the World Health Organization, and then locally validated by DH to assist doctors to identify individuals with a higher risk of harmful drinking and to provide a framework for brief intervention. For details, please refer to the webpage of DH's Change of Health accessible at: https://www.change4health.gov.hk/en/alcoholfails/toolkits.html#2

SECONDARY PREVENTION

Secondary prevention involves screening individuals without symptoms in order to detect disease or identify individuals who are at increased risk of disease for early intervention.

Since CRC arises predominantly from precancerous adenomatous polyps developed over a long latent period, it is one of the few cancers that can be effectively prevented through organised and evidence-based screening.

The CEWG recommends that average-risk individuals who are aged 50 to 75 years and without significant family history should consult their doctors to consider one of the following screening methods:

- Annual or biennial faecal occult blood test (FOBT);

¹ In Hong Kong, the Cancer Coordinating Committee is a high-level committee chaired by the Secretary for Food and Health to steer the direction of work on prevention and control of cancer. Under the Cancer Coordinating Committee, the Cancer Expert Working Group (CEWG) on Cancer Prevention and Screening was established to review local and international scientific evidence and practices with a view to making recommendations on cancer prevention and screening suitable for Hong Kong.



- Sigmoidoscopy every 5 years;
- Colonoscopy every 10 years.

To reduce the burden arising from CRC, the Hong Kong Government launched a Pilot Programme on 28 September 2016 to subsidise average-risk Hong Kong residents aged 61 to 70 years to receive subsidised CRC screening service in the private sector. The Pilot Programme was then regularised and named as the Colorectal Cancer Screening Programme (CRCSP) on 6 August 2018 to further extend subsidised screening to individuals aged 50 to 75 in phases. At present, Hong Kong residents aged 56 to 75 are eligible to join the programme, while the next phase will further extend the coverage to those aged 50 to 75. Details and commencement date of the next phase will be announced in due course.

The CRCSP adopts a two-tier approach, offering the faecal immunochemical test (FIT), a newer version of faecal occult blood test (FOBT), as first-line screening followed by colonoscopy examination for cases with positive FIT results. FIT is non-invasive and safe, and does not require diet and medication restriction before testing.

In a meta-analysis, FOBT has a pooled sensitivity of 79% for detecting CRC in asymptomatic average-risk adults, and a specificity of 94%¹¹. According to large-scale randomised controlled trials, FOBT screening has been shown to decrease CRC mortality by 15% to 33%,¹²⁻¹⁴. Another Cochrane review showed that screening by FOBT might reduce CRC mortality in the average-risk population by 16%¹⁵. Many countries such as the United Kingdom, Italy, Australia, Korea, Japan and Singapore are using FOBT as the primary screening tool for CRC¹⁶⁻²¹.

To promote screening participation, the CRCSP is heavily subsidised by the Government:

(1) Eligible persons first make an appointment with a Primary Care Doctor (PCD) participating in CRCSP. After enrolment in the CRCSP, the participant will receive a government subsidy to undergo the FIT. A Government subsidy of \$280 per consultation applies including the second consultation to follow up on a positive FIT test result. About 97% of enrolled PCD clinics do not charge any co-payment. Hence, programme participant can easily get the FIT screening service free of charge.

(2) If the FIT result is positive, the participant will be referred to see a colonoscopy specialist who has enrolled in CRCSP to receive the standard colonoscopy examination service subsidised by the Government in order to find out the cause of bleeding. The Government subsidy amount is \$8,500 if polyp removal is necessary, while the amount is \$7,800 if no polyp removal is needed. Colonoscopy specialists may charge a co-payment not exceeding \$1,000 when providing the standard colonoscopy examination service. About 70% of locations providing the colonoscopy service under CRCSP do not charge any co-payment irrespective of polyp removal. Hence, FIT positive participants can easily find a healthcare institution to receive the subsidised colonoscopy services free of charge.

The screening outcomes as at 31 December 2018 reveal that:

- Among the participants who had submitted FIT tubes with analysed results, around 13% had FIT positive results;
- Among the FIT-positive participants who had received colonoscopy examination, about 68% had colorectal adenomas (8,241 cases) and around 6.6% had colorectal cancer (802 cases).
- Preliminary analysis of 458 colorectal cancer cases diagnosed under the CRCSP revealed obvious "stage migration" (early staging of the disease: 60% in screen-detected cancer in the CRCSP versus 40% in non-screen detected cancer)

The preliminary screening outcome results are encouraging as the CRCSP proceeded well to pick up a significant number of adenomas and early stage colorectal cancer cases. These individuals received clinical management well before symptoms occur, thus offering protection against cancer formation and better prognosis for cancer cases. It also reflects the importance of undergoing timely screening tests for identifying people at increased risk of disease or at early stage of disease for early intervention. As a doctor, you can play a significant role in this meaningful endeavour through:-

- Joining the CRCSP as enrolled service providers
- Encouraging your patients to enroll in the CRCSP to get screened if they are eligible.

CONCLUSION

In Hong Kong, CRC is the commonest cancer which is preventable through primary and secondary prevention. Doctors are in a unique position to recognise the need for as well as to recommend appropriate cancer prevention interventions to their patients. Their simple advice is instrumental in motivating an individual to take up preventive measures including screening and hence can be potentially life-saving. Doctors are encouraged to advise their patients on CRC preventive measures if opportunities arise during their daily clinical encounters.

For further information about CRCSP and related doctors' enrollment, please visit www.colonscreen.gov.hk or call 3565 5665 during office hours.

Doctor's sharing

Dr Pui-kwong Chan works in the private sector. He has joined CRCSP as an enrolled Primary Care Doctor (PCD) since September 2016. Dr Chan recalled that he joined the CRCSP because it can provide him with the opportunity to advise his patients to receive government-subsidised and evidence-based screening service for disease prevention. Since the launch of CRCSP, Dr Chan has already come across at least five of his patients who took his advice to join CRCSP and subsequently were found to have adenocarcinoma. They had received treatment at an early stage of the illness and were grateful to Dr Chan's invitation to join the CRCSP.

When asked about advice to fellow doctors and healthcare workers in CRC prevention, Dr Chan was happy to share his secret of success and stressed the importance of repeatedly watching out for any opportunity to advise his patients to modify their unhealthy lifestyles and grabbing the right moment to motivate them to receive evidence-based screening during daily clinical encounters.

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Radiology Quiz

Radiology Quiz

Dr Edward CHU

FRCR

Resident in Department of Radiology, QMH



Questions

1. Posteroanterior radiograph of the pelvis of a young adult. What are your findings?
2. What is your diagnosis?
3. What are the common symptoms seen in this condition?
4. What would be the major differential diagnosis and what further investigations could help to differentiate between the two?

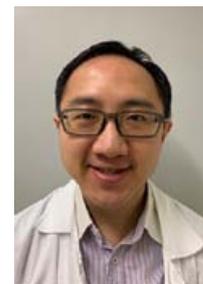
(See P.32 for answers)



How Diet would Affect the Efficacy of Common Drugs for Non-communicable Diseases

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Mr Jacky Ka-chung CHAN

INTRODUCTION

Many patients with non-communicable diseases (NCDs) are on chronic medications. One of the most commonly asked questions at the dispensary is how diet would affect the drugs. There are many instructions on the drug labels and patients would ask for clarification. I would like to use this opportunity to discuss some common diet-drug interactions.

Grapefruit and Grapefruit Juice

Grapefruit juice contains potent inhibitors, furanocoumarins, of the cytochrome P450 (CYP) 3A4 system and may markedly increase the bioavailability of drugs that undergo significant presystemic metabolism by CYP3A4¹⁻⁵. Simvastatin (lipid lowering drug), one of the HMG-CoA reductase inhibitors, is strongly affected by grapefruit juice. Patients may experience more side effects of myalgia, myopathy or rhabdomyolysis. Rosuvastatin and atorvastatin would be alternatives with relatively fewer side effects. Cardiovascular drugs such as calcium channel blockers (CCB) including felodipine and nifedipine are affected by grapefruit and grapefruit juice too. Grapefruit juice could increase the Area Under Curve (AUC) of felodipine as high as 284%.⁵ Amlodipine would be an alternative choice in the class of non-dihydropyridine CCB less affected by grapefruit juice. Other examples are cyclosporine and tacrolimus which are immunosuppressants and would interact with grapefruit and grapefruit juice. There is also a list of oral anticancer drugs which could be affected by grapefruit and grapefruit juice. The recommendation is to avoid grapefruit and grapefruit juice when taking the above-mentioned drugs. Seville oranges, pomelos and tangelos may have similar effects as grapefruit juice and these should be avoided while on drugs that may interact with grapefruit juice.^{1,2}

Warfarin and Vitamin K

Warfarin is easily affected by vitamin K^{3,4,6}. Vitamin K, being an antagonist, would affect warfarin efficacy and result in INR change. Green leafy vegetables such as cabbage and broccoli are rich in vitamin K. Certain dietary supplements for the liver and for other reasons may also be rich in Vitamin K. We recommend patients to take a constant amount of green vegetables to avoid fluctuating level of vitamin K intake.

Bisphosphonates and Food

Bisphosphonates are indicated for osteoporosis. Examples are alendronate, risedronate, ibandronic acid and disodium clodronate. Food and milk may cause chelation and lead to treatment failure. Therefore, milk is not recommended to be taken with oral bisphosphonates; bisphosphonates should be taken 30 to 60 minutes before meal.^{3,6}

MAOI and Tyramine

The use of a monoamine oxidase inhibitor (MAOI) is much less nowadays due to availability of many other drug choices for depression and social anxiety. One example is moclobemide. Tyramine is rich in cheese and stale food. MAOI would affect the metabolism of tyramine causing hypertensive crisis. Patients on MAOI should not take cheese or stale food.^{3,4,7}

Levodopa and Food

Levodopa is used for Parkinson's disease. High-protein meals should be avoided as it would affect the absorption of Levodopa. It is recommended to take the drug 1 hour before meal or on an empty stomach for better absorption. However, it may also be taken with food if there is stomach upset.^{3,8}

Alcohol

Alcohol would enhance the sedating effects of a list of drugs including benzodiazepines, antidepressants, barbiturates, antihistamines, opiates, muscle relaxants, antipsychotics and anticonvulsants. Alcohol should be avoided while taking these medications.

For diabetic patients who are on sulfonylurea or metformin, alcohol would increase the chance of hypoglycaemia. For sulfonylurea, alcohol may cause disulfiram reaction including facial flushing, vomiting and tachycardia. There is also risk of lactic acidosis if metformin is taken with alcohol.³

Before or After Meal

Some medications which would affect the stomach, e.g. steroids, aspirin and NSAIDs (non-steroidal anti-inflammatory drugs), are recommended to be taken after meal so as to minimise irritation to the stomach.^{4,9} Sulfonylurea and especially glipizide is recommended

to be taken 30 minutes before meal time for optimal postprandial blood sugar reduction and to minimise hypoglycaemia.^{4,9} Another diabetic drug, acarbose, should be taken at the start of meal as it delays the carbohydrate absorption by inhibiting the enzyme alpha-glucosidase.⁴ For drugs which would have the side effect of nausea or vomiting, e.g. allopurinol, it is recommended to take them after meal. On the other hand for drugs with unstable absorption after meal (especially after a fibre-rich meal) such as thyroxine, it is recommended to take the drug before meal to enhance stability.³

CONCLUSION

As food-drug interactions are important for many drugs used in patients with NCDs, doctors and pharmacists should counsel the patients on possible interactions to ensure optimum therapeutic efficacy and minimise the avoidable side effects.

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Table 1: Drugs which may have food-drug interactions

Drugs	Food interaction	Reference
Simvastatin, felodipine, nifedipine, cyclosporine, tacrolimus, oral anticancer drugs	Avoid grapefruit and grapefruit juice	1-5
Warfarin	Avoid vitamin K rich food (e.g. green leafy vegetable)	3,4,6
Bisphosphonates (e.g. alendronate, risedronate, ibandronic acid and disodium clodronate)	Avoid milk and advise to be taken 30-60mins before meal	3,6
MAOI (e.g. moclobemide)	Avoid tyramine rich food (e.g. cheese and stale food)	3,4,7
Levodopa	Avoid high protein food and with empty stomach (but after meal could minimize stomach upset)	3,8
Sedating drugs (e.g. benzodiazepines, antidepressants, barbiturates, antihistamines, opiates, muscle relaxants, antipsychotics and anticonvulsants), sulphonylurea and metformin	Avoid alcohol	3
Steroids, aspirin, NSAIDs and allopurinol	Advise to be taken after meal	3,4,9
Thyroxine	Advise to be taken before meal	3
Sulphonylurea	Advise to be taken 30mins before meal	4,9
Acarbose	Advise to be taken at the start of the meal	4

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Nicotine Replacement Therapy is an Effective Treatment Modality for Chronic Smokers

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Dr Kam-wing CHING

Tobacco use has been cited as the chief avoidable cause of illness and death in our society¹. Since the establishment of the Tobacco Control office in the Department of Health in 2001, strategic health education on detrimental health effects of smoking has been launched in various sectors of the community. The prevalence rate of smoking has been decreasing in the past few decades². However, there are still more than 600,000 smokers in Hong Kong.

According to the Thematic Household Survey on smoking behaviour³ (conducted by the Census and Statistical Department at every 3-year interval), many smokers are knowledgeable about the availability of the smoking cessation service and treatment products for tobacco dependence, but the majority harbour misunderstanding about the treatment and opt not to use the service.

This paper attempts to discuss the reasons that may hinder smokers' actions toward desirable sustainable behaviour changes.

CARE PROVIDER LACKING IN SENSITIVITY TO THE PSYCHOLOGY OF SMOKERS

Many smokers attribute their smoking behaviour to a "bad habit" that has developed at teenage years. They might have tried to quit smoking by willpower, but failed. They then blame themselves for being weak-minded. Hence they may appear impatient when the healthcare provider(s) keep on harping to them the harmful effects of smoking (hoping that such repeated "lectures" may make the smokers change their mind). At times such "lectures" may ruin the rapport between the care provider and the smoker, which may explain why some medical colleagues will altogether avoid advising smokers to quit smoking until some kind of health crisis erupts.

SMOKERS' IGNORANCE OF THE NEUROBIOLOGY OF NICOTINE CHEMICAL ADDICTION

The ambivalence of those so-called "die-hard" smokers needs to be addressed.⁴ They keep justifying their smoking behaviour with the reason that they stay on smoking whenever they are bombarded by various health advice on smoking. However, when smokers are invited to articulate the joy or pleasure of smoking, many of them may find difficulty in naming any. If the care provider chooses to use an empathic approach

helping the smoker to analyse and understand their knowingly undesirable smoking behaviour, such an approach may facilitate a smoker to explore the possibility of change. If these CHANGE talks keep going, most of the time the participating smoker would conclude that he/she smokes to avert suffering from nicotine withdrawal symptoms (poor attention span when they stop smoking, rather than the misconception that smoking speeds up their minds).

Many chronic smokers are ignorant of the neurobiology of nicotine chemical addiction. We as care providers should translate the sophisticated science into an understandable language, so as to lower smokers' threshold to try nicotine replacement therapy (NRT). Inhaled nicotine products contain a high concentration of nicotine that can be absorbed within a few seconds and activate nicotine receptors in the brain. The "up-regulation" of nicotine receptors can be problematic. The higher concentration of nicotine in the inhaled product, and more rapid absorption, the higher activities of the nicotine receptors will have. The half life of nicotine is short (less than 2 hours). Intense smoking urge occurs upon drastic drop of nicotine in the few subsequent hours, becoming manifested as nicotine withdrawal symptoms (Table 1) if the urge is not satisfied.

Table 1: Nicotine Withdrawal Symptoms

Psychological:-	Physical:-
<ul style="list-style-type: none">• Anxiety• Restlessness• Irritability• Insomnia• Headache• Poor concentration• Depressed mood	<ul style="list-style-type: none">• Sweating• Palpitations• Muscle tension• Chest tightness• Difficulty in breathing• Nausea, vomiting, or diarrhoea• Tremors

Nicotine withdrawal is a physical condition associated with intense suffering and torturing, and has nothing to do with personal willpower. The early introduction of NRT can greatly alleviate the suffering. The working principle is to provide a sustainable long-acting nicotine release modality that facilitates quitting smoking. The nicotine receptor activities turn dormant after more than 4-6 weeks of smoke-free period, following which the care provider can taper down the NRT dosage over the subsequent 2-month period. It is unlikely for quitters to get dependent on nicotine replacement products.

ILL-FOUNDED FEAR OF ERUPTION OF SINISTER ILLNESS UPON ABRUPT SMOKING CESSATION

There is a myth, widespread among smokers,



that sinister illness will erupt upon abrupt smoking cessation. This incorrect belief is at times unintentionally reinforced when medical colleagues advise patients to cut down daily cigarette consumption as far as possible, instead of total abstinence. The health benefits of reduced smoking are limited and offer no help to reduce nicotine dependence because of the human compensatory deep inhalation when the daily cigarette dose is restricted.

Real Case Scenario

Mr X accepted family encouragement to stop smoking by willpower. He complained of "flu-like" illness 5 days after stopping smoking. Attending family doctor affirmed his quit attempt and prescribed him with remedies for his upper respiratory infection. Symptoms got worse upon taking the antihistamine. Mr X was so frustrated by his suffering and his will power to quit smoking lapsed. Rather he resumed smoking as an emotional outlet. He felt so grateful that he got cured when he resumed smoking.

Similar unpleasant sufferings were repeated when he tried to stop smoking a few months later. He concluded that it was dangerous to have abrupt cessation. He even believed that more sinister illness would happen if he stayed smoke-free for the whole year.

When I enquired about his appetite in the past quit attempts, he said he had exceptionally great appetite and significant weight gain within a 2-week interval. Nicotine withdrawal was the main culprit which had brought about his suffering. He enjoyed a marvelous pleasant experience when NRT was prescribed.

WEIGHT GAIN IS AVOIDABLE IN THE PROCESS OF SMOKING CESSATION

Many current smokers have strong hesitation to stop smoking because they have experienced excessive hunger drive and drastic weight gain in their past quit attempts. The problem lies in nicotine withdrawal as well. It happens when smokers attempt to stop smoking by willpower or when they are underdosed in NRT.

When people stop smoking, the active nicotine receptor may give smokers a strong urge for throat stimulation. The neurological pathway that generate pleasurable feel by sugar or nicotine is similar, hence snack of strong taste and high sugar content is common substitute used by quitters. These phenomena can be effectively averted by early introduction of NRT. With NRT, weight gain can be limited to 2-3 kg throughout the 3-months treatment period.

PEARLS IN ADMINISTRATION OF NRT

Nicotine is a peculiar chemical that can exert dual opposite effects on brain at different doses. High-dose nicotine can have calming effect while low-dose nicotine can have stimulatory effect. Hence some smokers may experience poor sleep quality (easy awakening) if they increase smoking before bedtime, while some other smokers may experience difficulty in falling asleep if smoking is withheld before bedtime.

Before the initiation of smoking cessation treatment, a thorough assessment of the smoker's sleep pattern is essential as such assessment can offer a rough guide for NRT choice. Patch of 24 hours' duration is a better choice for those who often nocturnal lapse smoking habit, while NRT patch should be removed before bed if NRT induces insomnia.

Skin care advice is needed to prevent delayed pruritic skin reaction to NRT patch. Patients are advised to have liberal emollient application after evening bath if the patch is removed at bedtime.

Occupation is another consideration before NRT patch prescription. Chefs working in hot kitchen and construction site workers with excessive sweating are not suitable candidates, as they tend to fail to keep the patches firmly attached. Oral pharmacotherapy, namely bupropion or varenicline, can be the alternatives.

NRT patch is more preferable than NRT gum or lozenge for people who are anxiety prone. Short acting nicotine from NRT gum or lozenge is absorbed through buccal mucosa (like trinitroglycerin (TNG)). Anxious people tend to have frequent saliva swallowing and hence increased NRT induced throat irritation.

ROLE OF RELAPSING COUNSELLING IN THE PROCESS OF SMOKING CESSATION TREATMENT

With the advancement in pharmacotherapy for smoking cessation, we can assist smokers to stop smoking whenever they are willing to quit. The great challenge lies in relapse prevention.

Many people have maladaptive stress coping by smoking or binge drink. Self efficacy to prevent cigarette access is markedly decreased upon heavy alcohol influence. People admit it is a quick fix emotional relief when they opt to lapse smoking at times of stress. We always remind patients that smoking is just one of their options, not the ONLY option. Exploration for other stress coping strategies help to equip themselves in relapse prevention.

In the counselling process for relapse prevention, we treasure that people find it a portal to review their lifestyle striving for work-life balance, appreciation of self achievement and gratitude, rather than chasing after unnecessary desire and excitement.⁴

May I wish for a healthy & smoke-free society in Hong Kong!

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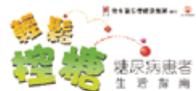


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衛生署長者健康服務編著

健康家常食譜(中英文版本)

60款中英對照食譜，除附有營養分析，更為各慢性疾病患者提供個別菜式的烹調貼士。



輕鬆控糖

《輕鬆控糖》一書，為讀者介紹正確的糖尿病知識，和如何將糖尿病的飲食原則活用於日常生活中。



控糖美饌

糖尿病患者提供居家和外出飲食指南。內容包括：如何編排餐單、選購食材、合適的烹調方法、外出和旅遊時的飲食原則等。



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衛生署長者健康服務編著

不少人誤以為中風所引致的身體殘障是無法改善的，但其實透過復康鍛煉，中風患者的身體功能可以有不少進步空間。

到底中風之後，生活可以如何重整？

在本書中將可找到答案。





Towards 2025: Strategy and Action Plan to Prevent and Control Non-communicable Diseases in Hong Kong

Ms Amy Lim-chee CHAN

BEM, JP, Hon Fellow, EdUHK
Chairperson, Hong Kong Elite Athletes Association



Ms Amy Lim-chee CHAN

INTRODUCTION

There is no doubt that young people are the future pillars of society. However, there have been increasing number of young people showing signs of unhappiness and apathy. One of the major reasons is that the socio-cultural values have focused so much on academic performance that physical education has been marginalised.¹ According to Article 31.1 of the Convention on the Rights of the Child, "States Parties recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child..."² Hence, to encourage the young people to develop an active lifestyle and to grow in a happy environment, as well as to lower their chances of suffering from non-communicable diseases (NCD) down the road, I initiated the project Active School in 2013.

SITUATION IN HONG KONG

According to the World Health Organization (WHO), NCD are the cause of death of 41 million people annually, taking up 71% of the global death rate. In the 2013, WHO publication entitled the Global Action Plan – For the Prevention and Control of Non-communicable Diseases 2013 – 2020, physical inactivity is named as one of the four behavioural risk factors for NCD.³

It is a well-known fact that Hong Kong students lack physical activities: they spend far too much time indoors studying and video-game playing. Many social issues can be at play for this tendency to stay indoors. First, working parents may not have time to bring their children to play outdoors. Secondly, given the five developmental elements to be nurtured in school, including moral, physical, social, aesthetic, and intellectual development, our education system is putting too much emphasis on intellectual development. Thirdly, there has not been strong voices in the community to raise the social awareness of the importance of exercising.

Children benefit from staying physically active in many ways: they become more self-confident when their basic competencies are built up robustly; the self-release of endorphins during exercise would make the children happier. Furthermore, when children have built up a habit of playing sports, it would be less likely for them to suffer from obesity, osteoporosis, heart diseases and other NCD. However, in 2013, I visited a primary school and I was surprised that the students appeared rather depressed showing no interest in playing at all. They looked unhappy and did not care about things around them. These findings were rather alarming to me!





SPORTSMANSHIP

To equip our children with a healthy mind-set and body for handling hectic daily issues and problems, our community must allow playing sports to work the magic. To be a physically well-built sportsman, youngsters are obliged to devote time in aerobic and strength training. However, this kind of training demands extremes of hard work. Furthermore, many sports require such precise and yet delicate skills that sportsmen have to practise at times just one motion repeatedly in order to reach perfection. To be able to make achievements in both mental and physical aspects, sportsmen need to have very strong will to face disappointments and failures. Over time, sportsmen would have developed an attitude in doing things in a proficient manner. If children can develop such an attitude, they will have much stronger motivation in learning, because they would be confident and know the way to achieve targets.

Not only can the practice of sports help to train up the children's physical and mental fitness, sports can also strengthen the children's social skills including a character of inclusiveness. Sports very often require teamwork, even for individual sports such as swimming and running, these sports often involving team training. In a team, each member has to accept varying levels of proficiency among team members. To achieve targets together, they have to be supportive of and willing to share with each other. Character building starts from young age; if children could grow in a mutually supportive peer environment, not only could they gain some very precious peer friendship, they could embrace the spirit of sportsmanship, a most important character trait which could enable them to ride through adversity thrivingly.

ACTIVE SCHOOL

To facilitate our students to grow up in a happy environment, I initiated the project Active School in 2013. I first met with six School Heads Associations' Chairmen to explore the feasibility. We all agreed that the project was feasible, even though there would be barriers ahead of us. Having seen our students getting inactive and apathetic, we believed that it would be a worthwhile cause to work on.

In September 2013, the Hong Kong Elite Athletes Association (HKEAA) established the project Active School, aiming to induce vitality and positive energy into schools by promoting interesting activities along the lines of professional sports training and holistic development. The objective of the project was to foster opportunities for our children to grow up healthily in a happy environment. For starters, all kindergartens, primary and secondary schools, and special schools in Hong Kong were invited to participate in the project.⁴

Active School would arrange for professional coaches to teach students to appreciate the sports and to make sure all students can play the sports. We have modified at least 40 sports games to suit students of different age groups. Moreover, the project would also invite volunteers, coaches and uniform services groups to design programmes for students. For example, karate lessons by the police were offered to students. Opportunity was created for students to perform the Active Dance on stage at the Hong Kong Coliseum in front of thousands of audience. Such activities not only boost the confidence in the young, but also give them an unforgettable memory of being an actively participating person. Photographers were present in many of the sports sessions and special events to capture those happy faces.



From the humble beginning of 12 primary schools participating in the Active School, project, the total number of participating schools has now reached 180. Over 10,000 of students have benefited from the project. The project has grown by word of the mouth especially when the principals see happier students and more relaxed teachers, appreciating what good this project has done to their schools.

MOVING FORWARD

After successful promotion of the importance of physical activity to our students, our next target would be Active Community, which is to promote physical activity to every individual in our community.

The Centre for Health Protection has published a collection of promotion materials on physical activity.⁵ Nevertheless, there is still room for improvement in terms of thoroughness and effectiveness compared to the existing physical activity guidelines that can be found from, and not limited to, Australia,⁶ Singapore,⁷⁻⁸ Taiwan,⁹ the United Kingdom,¹⁰⁻¹³ and the USA.¹⁴ Furthermore, it is hoped that the Education Bureau would put more weight on encouraging these policies in schools.

If Hong Kong people are better educated on the merits of exercise and physical activity, over time, not only would we see a healthier and happier community, the prevalence of NCDs would drop, the utilisation of public hospital services would lessen, and the strain on our medical system would lighten up.



CONCLUSION

In my opinion, the best way to prevent and control NCD is to go back to basics to be physically active. It is essential that our community, especially our young, takes an interest in sports, even in the form of simple exercises. If each one of us can keep a healthier body, jointly we can build a healthier community.

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Certificate Course in Allergy 2019

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Hong Kong
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Objectives: To have more understanding in hot topics of allergy.

Date	Topics	Speakers
4 Jul	Personalized management in allergy	Dr. CHAN Wai Ming, Alison Honorary Consultant in Allergy Hong Kong Sanatorium & Hospital
11 Jul	Recent advances in allergy diagnostic tests	Dr. WU Young Yuen, Adrian Specialist in Allergy & Immunology Private Practice
18 Jul	Food allergy: the burden and the way to go	Dr. HO Hok Kung, Marco Specialist in Paediatric Immunology & Infectious Diseases Private Practice
25 Jul	New practical approach in allergy prevention	Ms. CHAN King Chi, June Senior Dietitian Hong Kong Sanatorium & Hospital
1 Aug	Severe asthma: the challenge and the hope	Prof. LEUNG Ting Fan Chair Professor in Paediatrics The Chinese University of Hong Kong
8 Aug	Recent advances in eczema management	Dr. CHAN Chun Yin, Johnny Honorary Consultant & Director in Dermatology Hong Kong Sanatorium & Hospital

Dates : 4, 11, 18, 25 Jul & 1, 8 Aug, 2019 (Every Thursday)

Time : 7:00 pm – 8:30 pm

Venue : Lecture Hall, 4/F., Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong

Language Media : Cantonese (Supplemented with English)

Course Fee : HK\$750 (6 sessions)

Certificate : Awarded to participants with a minimum attendance of 70%

Enquiry : The Secretariat of The Federation of Medical Societies of Hong Kong
Tel: 2527 8898 Fax: 2865 0345 Email: info@fmshk.org



Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<p>★ The 27th Annual Scientific Congress</p> <p>2</p>	<p>★ HKMA Kowloon West Community Network – Treatment of Osteoarthritis in the Elderly</p> <p>★ HKMA-HKS&H CME Programme 2018-2019 (Live) – Suspicious Symptoms for Gynaecological Cancer?</p> <p>★ FMSHK Officers' Meeting</p> <p>★ HKMA Council Meeting</p> <p>3</p>	<p>★ HKMA Shatin Community Network – 1. Timely Diagnosis and Management of Dementia: Can We Do Better?</p> <p>2. Pitfalls in Renal Function Interpretation</p> <p>5</p>	<p>★ HKMA Hong Kong East Community Network (Live) – Physiotherapy for Pain Management (Back)</p> <p>6</p>	<p>★ HKMA Kowloon East Community Network – 1 See What You See In My Eye Clinic</p> <p>13</p>	<p>★ HKMA Kowloon City Community Network – Go Beyond the Status Quo with PCSK9: the Challenging Journey after a CV Event</p> <p>★ HKMA Shatin Community Network – Are you Ready for the Flu Challenge? Latest Epidemiology and Options for Flu Prevention in Hong Kong</p> <p>14</p>	<p>★ The 27th Annual Scientific Congress</p> <p>★ Refresher Course for Health Care Providers 2018/2019 – Upper Gastrointestinal / Liver Diseases - An Update for Primary Care</p> <p>1</p>
<p>★ Symposium on End of Life Care</p> <p>9</p>	<p>★ HKMA Yau Tsim Mong Community Network – Lecture Series on Rheumatology (Session 3) – Recent Advance in the Management of Psoriatic Arthritis</p> <p>11</p>	<p>★ The Hong Kong Neurosurgical Society Monthly Academic Meeting – Facial pain syndromes</p> <p>12</p>	<p>★ HKMA New Territories West Community Network (Live) – Primary Care for Pain Management (Common Knee Problems)</p> <p>★ HKMA New Territories West Community Network – Improving Diagnostic Accuracy: Early Identification of Cognitive Impairment Made Easy with an Evidence-Based Brief Cognitive Screen</p> <p>★ FMSHK Executive Committee Meeting</p> <p>20</p>	<p>★ HKMA Kowloon East Community Network – Advances for Hypertension Guideline and Case Sharing</p> <p>27</p>	<p>★ HKMA Central, Western & Southern Community Network (Live) – Non-DM Endocrinological / DM Perspective in LDL Management After CV Event</p> <p>26</p>	<p>★ HKMA Kowloon West Community Network – The Use of Anticholinergics in Chronic Urticaria</p> <p>★ HKMA CME - The interrelationship between obesity, bariatric surgery and gastroesophageal reflux disease (GERD)</p> <p>25</p>
<p>16</p>	<p>17</p>	<p>19</p>	<p>20</p>	<p>21</p>	<p>22</p>	<p>23</p>
<p>23</p>	<p>24</p>	<p>26</p>	<p>27</p>	<p>28</p>	<p>29</p>	<p>30</p>



Date / Time	Function	Enquiry / Remarks
1 SAT (31/5-2/6) 2:15 PM	The 27th Annual Scientific Congress Organizer: Hong Kong College of cardiology; Chairman: Dr. Chan Ngai Yin; Venue: Hong Kong Convention and Exhibition Centre Refresher Course for Health Care Providers 2018/2019 – Upper Gastrointestinal / Liver Diseases - An Update for Primary Care Organiser: Hong Kong Medical Association; HK College of Family Physicians; HA-Our Lady of Maryknoll Hospital; Speaker: Dr. WONG Wai Chuen; Venue: Training Room II, 1/F, OPD Block, Our Lady of Maryknoll Hospital, 118 Shatin Pass Road, Wong Tai Sin	Stephy CHAN Tel: 2559 9973 Fax: 2547 9528 Ms. Clara TSANG Tel: 2354 2440 2 CME Point
4 TUE 1:00 PM 1:00 PM 8:00 PM 9:00 PM	HKMA Kowloon West Community Network – Treatment of Osteoarthritis in the Elderly Organiser: HKMA Kowloon West Community Network; Speaker: Dr. YIP Wai Man; Venue: Fulum Palace, Shop C, G/F, 85 Broadway Street, Mei Foo Sun Chuen HKMA-HKS&H CME Programme 2018 -2019 (Live) – Suspicious Symptoms for Gynaecological Cancer? Organiser: Hong Kong Medical Association; Hong Kong Sanatorium & Hospital; Speaker: Dr. TAM Kar Fai; Venue: HKMA Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road, Central FMSHK Officers' Meeting Organiser: The Federation of Medical Societies of Hong Kong; Venue: Gallop, 2/F, Hong Kong Jockey Club Club House, Shan Kwong Road, Happy Valley, Hong Kong HKMA Council Meeting Organiser: The Hong Kong Medical Association; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, HK	Miss Antonia LEE Tel: 2527 8285 1 CME Point HKMA CME Dept Tel: 2527 8285 1 CME Point Ms. Nancy CHAN Tel: 2527 8898 Ms. Christine WONG Tel: 2527 8285
5 WED 1:00 PM	HKMA Shatin Community Network – 1. Timely Diagnosis and Management of Dementia: Can We Do Better? 2. Pitfalls in Renal Function Interpretation Organiser: HKMA Shatin Community Network; Speaker: Dr. CHUANG Lai, Lily; Dr. HO Chung Ping; Venue: Sapphire Room, 2/F, Royal Park Hotel, 8 Pak Hok Ting Street, Shatin	Ms. Candice TONG Tel: 2527 8285 1 CME Point
6 THU 1:00 PM	HKMA Hong Kong East Community Network (Live) - Physiotherapy for Pain Management (Back) Organiser: HKMA Hong Kong East Community Network; Speaker: Ms. Maggie KONG; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, HK	Ms. Candice TONG Tel: 2527 8285 1 CME Point
9 SUN 1:00 PM	Symposium on End of Life Care Organiser: Hong Kong Medical Association & The Hospital Authority; Speaker: Various; Venue: Lecture Theatre, G/F, Centre for Health Protection, 147C Argyle Street, Kowloon	Miss Antonia LEE Tel: 2527 8285 3 CME Point
11 TUE 1:00 PM	HKMA Yau Tsim Mong Community Network – Lecture Series on Rheumatology (Session 3) – Recent Advance in the Management of Psoriatic Arthritis Organiser: HKMA Yau Tsim Mong Community Network & Hong Kong Society of Rheumatology; Speaker: Dr. CHAN Pak To; Venue: Crystal Ballroom, 2/F, The Cityview Hong Kong, 23 Waterloo Road, Kowloon	Ms. Candice TONG Tel: 2527 8285 1 CME Point
12 WED 7:30 PM	The Hong Kong Neurosurgical Society Monthly Academic Meeting – Facial pain syndromes Organiser: Hong Kong Neurosurgical Society; Chairman: Dr CHAN Yung; Speaker: Dr KO Man-wai, Natalie; Venue: Seminar Room, G/F, Block A, Queen Elizabeth Hospital	1.5 points College of Surgeons of Hong Kong Dr. WONG Sui To Tel: 2595 6456 Fax. No.: 2965 4061
13 THU 1:00 PM	HKMA Kowloon East Community Network – I See What You See In My Eye Clinic Organiser: HKMA Kowloon East Community Network; Speaker: Dr. LEUNG Tsz Wang; Venue: King Duck, APM Shop L3-1, Level 3, Millennium City 5, 418 Kwun Tong Road, Kowloon	Miss Antonia LEE Tel: 2527 8285 1 CME Point
14 FRI 1:00 PM 1:00 PM	HKMA Kowloon City Community Network – Go Beyond the Status Quo with PCSK9i : the Challenging Journey after a CV Event Organiser: HKMA Kowloon City Community Network; Speaker: Dr. CHOI Man Chun; Venue: President's Room, Spotlight Recreation Club, 4/F, Screen World, Site 8, hampoa Garden, Hungghom, Kowloon HKMA Shatin Community Network – Are you Ready for the Flu Challenge? Latest Epidemiology and Options for Flu Prevention in Hong Kong Organiser: HKMA Shatin Community Network; Speaker: Dr. CHU Wai Sing, Daniel; Venue: Diamond Room, 2/F, Royal Park Hotel, 8 Pak Hok Ting Street, Shatin	Ms. Candice TONG Tel: 2527 8285 1 CME Point Ms. Candice TONG Tel: 2527 8285 1 CME Point
20 THU 1:00 PM 1:00 PM 7:00 PM	HKMA Hong Kong East Community Network (Live) - Annual Meeting cum CME on Physiotherapy for Pain Management (Common Knee Problems) Organiser: HKMA Hong Kong East Community Network; Speaker: Mr. Joseph LAM; Venue: HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, HK HKMA New Territories West Community Network – Improving Dyslipidaemia Management: Early Identification of Cognitive Impairment Made Easy with an Evidence-Based Brief Cognitive Screen Organiser: HKMA New Territories West Community Network; Speaker: Prof. Adrian WONG; Venue: Pak Loh Chiu Chow Restaurant, Shop A316, 3/F, Yoho Mall II, Yuen Long FMSHK Executive Committee Meeting Organiser: The Federation of Medical Societies of Hong Kong; Venue: Council Chamber, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms. Candice TONG Tel: 2527 8285 1 CME Point Miss Antonia LEE Tel: 2527 8285 1 CME Point Ms. Nancy CHAN Tel: 2527 8898
25 TUE 1:00 PM	HKMA Kowloon West Community Network – The Use of Antihistamines in Chronic Urticaria Organiser: HKMA Kowloon West Community Network; Speaker: Dr. LAI Yik Kiu; Venue: Fulum Palace, Shop C, G/F, 85 Broadway Street, Mei Foo Sun Chuen	Miss Antonia LEE Tel: 2527 8285 1 CME Point



Date / Time	Function	Enquiry / Remarks
25 TUE 1:00 PM	HKMA CME - The interrelationship between obesity, bariatric surgery and gastroesophageal reflux disease (GERD) Organiser: Hong Kong Medical Association; Speaker: Dr. CHAN Siu Yin, Fion; Venue: HKMA Central Premises, Dr. Li Shu Pui Professional Education Centre, 2/F, Chinese Club Building, 21-22 Connaught Road, Central	HKMA CME Department Tel: 2527 8285 1 CME Point
26 WED 1:00 PM	HKMA Central, Western & Southern Community Network (Live) – Non-DM Endocrinological / DM Perspective in LDL Management After CV Event Organiser: HKMA Central, Western & Southern Community Network; Speaker: Dr. TING Zhao Wei, Rose; Venue: The Chinese Banks' Association Ltd, 5/F, South China Building, 1 Wyndham Street, Central	Miss Antonia LEE Tel: 2527 8285 1 CME Point
27 THU 1:00 PM	HKMA New Territories West Community Network – Advances for Hypertension Guideline and Case Sharing Organiser: HKMA New Territories West Community Network; Speaker: Dr. LI Cho Shan, Eric; Venue: Atrium Function Rooms, Lobby Floor, Hong Kong Gold Coast Hotel, 1 Castle Peak Road, Gold Coast, Hong Kong	Miss Antonia LEE Tel: 2527 8285 1 CME Point
28 FRI 1:00 PM	HKMA Kowloon East Community Network – Biological Therapy for Moderate to Severe Atopic Dermatitis Organiser: HKMA Kowloon East Community Network; Speaker: Dr. LAI Yik Kiu, Dominic; Venue: V Cuisine, 6/F, Holiday Inn Express Hong Kong Kowloon East, 3 Tong Tak Street, Tseung Kwan O	Ms. Candice TONG Tel: 2527 8285 1 CME Point



Answers to Radiology Quiz

Answers:

1. There are numerous small, sclerotic, round opacities, a few millimetres in width, scattered symmetrically through the pelvis and femora. The opacities vary slightly in size and some are confluent. These lesions characteristically cluster around joints and align themselves parallel to surrounding trabeculae.
2. Osteopoikilosis.
3. This is a rare inherited condition. It is usually asymptomatic and is often diagnosed incidentally on radiologic examinations performed for other reasons. Some associations with joint pains and joint effusion have been reported.
4. The main differential diagnosis is osteoblastic metastasis. Typical features such as familial occurrence and symmetrical, periarticular distributions help to differentiate osteopoikilosis from osteoblastic metastasis. Osteopoikilosis shows no radiotracer uptake in bone scan and this can be problem-solving in equivocal cases. Osteopoikilosis is a benign condition that does not require treatment.

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By using brief intervention among primary care population, there is a mean reduction of 55.77g of alcohol consumption per week compare with control.¹



75.6%
of patients completed
the questionnaire
within 3 minutes

Alcohol Screening and Brief Intervention

For Healthcare Professionals



Summary Guide for ASBI



A Guide for
Use in Primary Care: ASBI



Change4Health Website

LOVE Yourself! CHERISH Your Health!

Women aged 25 - 64 • Go for cervical cancer screening

30+



40+



50+



The **Cervical Screening Programme** (CSP) was launched by the Department of Health in March 2004 with the aim of increasing the coverage of cervical screening among women aged 25 to 64 years who ever had sex, in order to reduce the incidence of and mortality from cervical cancer.

If you are providing cervical smears, why not register with the CSP online and enjoy the following benefits:-

- Have your clinic information displayed on the CSP website
- Have access to your clients' past cervical smear results via Cervical Screening Information System (CSIS) online upon their authorisation (CSIS is compatible with IE/Chrome/Safari/Edge)
- Have reminder letters for next smear sent to your clients if they have registered with CSP
- Receive an all-in-one health educational resource kit on cervical screening and supply of additional educational materials
- Enable registered women to access their serial smear results



Online Registration

ALL these are FREE of charge
More importantly, you can help more women stay free of cervical cancer!

www.cervicalscreening.gov.hk

