The Hong Kong Geriatrics Society Newsletter

The Hong Kong Geriatrics Society

c/o Department of Medicine, Yan Chai Hospital
7-11 Yan Chai Street, Tsuen Wan, NT, Hong Kong
Tel: (852) 24178383 Fax : (852) 24116536
Website: http://medicine.org.hk/hkgs/

Feb 2004 issue

Editorial

Wish you all a Happy New Year of the Monkey. SARS and Aivan flu are at our doorsteps and but apparently they are not coming in. Thus, only still have the time and energy to deal with our own business of Geriatrics, besides tackling the burning topic of infection. Our external examiner of the PDCG, Dr. SC Allen, complimented us on our effort to organize the course successfully (Foreign News). In our members' corner, Dr. S Wong shared with us his training experience in Australia. Dr. Lum CM also shared with us his updated knowledge acquired while attending the 8th Asian Pacific Society of Respirology Congress sponsored by HKGS. We also have updated literature review on topics of geriatrics interesting local news related to older people in Hong Kong and. After all the exhaustive daily work and the academic tonics, why not relax and have a cup of tea? Dr. SL Szeto has written an article to share with us his deep appreciation on Chinese tea drinking. The first part is printed in this issue. Our council announced that the come ASM cum AGM was to be held on 19/6/04. Please see the circular enclosed calling for free paper submission. Hope that we can all have a good start for the year of 2004.

Mok CK Editor

President's address: Are we prepared for community care?

Last November, the BBC Panorama[1] hit the news with the problem of home care in Britain. The Panorama Assistant Producer Fran Baker secretly recorded her experiences as an undercover careworker and investigated what life is like for frail elders living in their own homes. Fran was sent out alone with little or no formal training into the homes of frail elders whose needs she was not qualified to meet. Fred recorded in her diary, "When I started as a carer I had no idea that I'd be as upset by what I saw as I have been. More than anything else, it's made me absolutely terrified of getting old." "The thing that I find hard is realising that I'm becoming hardened and it's almost like the more I work as a carer, the less caring I become." "You can't genuinely care. If you did you would constantly be running late and getting later and later. In the end, you just have to become hardened and go in, do your job, rush through," a phenomenon termed "call-cramming." "There's anxiety, stress and a loss of dignity and I just don't think that people deserve that at the end of their lives."

Back in Hong Kong, community care for elders is high on the health and social care agenda. Are we prepared to meet the challenge? Initiatives like enhanced home and community care, skills upgrading scheme for elderly care workers, postgraduate diploma course on community geriatrics for family doctors, CGAT/VMO collaboration scheme and VMO training, voluntary accreditation for residential care homes for the elderly, …. are being rolled out. How all these will impact on community care have yet to be seen.

Meanwhile, residential care homes for the elderly are flourishing in Hong Kong, currently accommodating about sixty-five thousand elders. Geriatricians have for long realized the wisdom of pre-admission assessment to uncover medical problems with social presentation, aptly described in the words of the late Prof. Bernard's, ***"Elderly patients are admitted not because of social problems, but because of medical problems with social consequences, or social problems with medical consequences."*** The wisdom and value of "assess first, admit second" has been backed up by evidence as early as the 1970's from Professor John Brocklehurst's study[2], and recently by the research of Professor David Challis[3], who has demonstrated that a specialist clinical assessment prior to care home placement led to benefits for elders and their carers, less contact with nursing homes and emergency services and cost savings. How and when this evidence base can be translated into practice in Hong Kong? Elsewhere, overseas Geriatrics Societies are lobbying for specialist geriatrics assessment prior to entry to residential care homes, and the corresponding increase in geriatricians.

Frail elders who get stuck in hospitals are often referred to as "bed-blockers" with "placement problem." We may well reflect on the words of Stephen Watkins, "The purpose of community care is to promote privacy, dignity and independence and provide resources for living. It is a philosophy, not a place." Kong

TK Kong

References

1. Baker F. A carer's diary. BBC News, 16 Nov. 2003. http://news.bbc.co.uk/1/hi/programmes/panorama/3270993.stm
2. Brocklehurst JC et al. Care of the elderly: medical screening of old people accepted for residential care. Lancet 1978;ii:141-2.
3. Challis D, et al. The value of specialist clinical assessment of older people prior to entry to care homes. Age Ageing 2004;33:25-34

Report on the 8th Asian Pacific Society of Respirology Congress

Dr. Lum Chor Ming, SH

I was sponsored by the Hong Kong Geriatrics Society to attend the captioned meeting in Kuala Lumpar, Malaysia in 1-4/12/03. Having received the privilege to attend the meeting, I am obliged to share information of the Congress with the HKGS members. I hope that I can be a catalyst towards a sharing attitude among members so that we all learn together how to provide better care to our elderly patients.

From the administrative point of view, the Congress was divided into 4 categories:

a) Pre-congress workshops for trainees: Interventional Bronchoscopy, Obstructive Sleep Apnoea Syndromes, Mechanical Ventilations and Allergies in Diseases;

b) Major Diseases / Syndromes:
Neurogenic / Upper Airway Diseases: Sleep-related Breathing Disorders;
Lower airway diseases / infections: Chronic Obstructive Pulmonary Diseases, Bronchiectasis, Asthma;
Parenchymal Diseases: Acute Lung Injury; Interstitial Lung Diseases
Infections: Tuberculosis, SARS, Update Infection in Asian Pacific region;
Pleural Diseases and Pleural Effusions;
Pulmonary Circulation Diseases;
Others: Lung Cancers, Pulmonary Rehabilitation, Lung Transplant.

c) Conditions encountered in clinical practice: Chronic Cough Syndrome, "Resistant" Asthma, Haemoptysis, Vocal Cord Dysfunctions.

d) Radiological Grand Rounds.

I shall summarize below several aspects of which are considered more relevant to our daily practice.

COPD: Current concept of COPD has shifted from merely a lung disease towards a systemic disease that affects not only the lung, but also skeletal muscles that resulted in deconditioning, poor exercise tolerance and quality of life (QoL). Though conventional bronchodilator therapy does not improve FEV1 (by definition), there is evidence that it improves symptoms and QoL Recent studies have shown that it improves inspiratory capacity and it is through this action that leads to an improvement in symptomatolgy and exercise tolerance. There were studies showing superiority of long acting bronchodilators (LABA) over conventional short acting bronchodilators in symptom control. The GOLD (Global Obstructive Lung Disease) guideline committee has reviewed the use of LABA and incorporated it into the updated GOLD guideline published in 2003. Yet, Professor Tan from Singapore also highlighted that the application of GOLD guideline in SEA should take into account of the socio-economical situation of the society / country. As there is still inadequate breakthrough in the management of the disease (in contrast to asthma), prevention of COPD with smoking cessation should be enforced.

One of the difficulties in the management of COPD acute exacerbation is the poor definition of "exacerbation" which is currently very subjective and arbitrary. Chest physicians are looking for a more objective definition. Potentially, it may include biochemical markers on system inflammation plus airway inflammation.

Persistent Chronic Cough: the condition is defined as persistent cough for 3 weeks without prior URTI illness and unaccountable by other lung diseases. Several conditions have to be considered:

1. GERD (15%): this can occur without GI symptoms, a therapeutic treatment trial can be used as a diagnostic tool;
2. Postnasal drip syndrome (26%): many a times, this is associated with nasal polyps and consultation to ENT colleagues would be helpful in the diagnosis;
3. CVA (28%) (Cough Variant Asthma – and that emphases the need of clarification when we use abbreviations!!!) and EB (15%) (Eosinophilic Bronchitis). The former usually presents with exercise induced asthma / nocturnal shortness of breath in associated with "chronic cough". EB is considered as "milder" form of asthma with chronic cough and >3% eosinophil in induced sputum, yet there is negative spirometry results even if a bronchial airway challenge test is performed.

"Resistant" Asthma: about 40-70% of "resistant" asthma are associated with poor drug compliance / administration and pre-disposing / precipitating factors not removed. Management of "resistant" asthma should also start with a review on diagnosis labeling, excluding other causes of poor lung function, identifying clinical sub-types / phenotypes and treatment of aggravating factors.

Bronchiectasis: Professor K Tsang from HKU acknowledged that there was little advancement in the understanding and management of the condition in the past 15 years. Yet respiratory physicians have re-focused to the area. The lines of interventions are directed towards: modifying ciliary movement (use of bronchodilators?), reduction in inflammation by reducing bacteria flora in the airways (pseudomonas Vs non-pseudomonas subgroups, use of intermittent antibiotics for secondary prevention in different sub-groups), treatment regime (duration of treatment) on acute bacterial infection. Mucolytic agents (insufficient evidence-based) / antitussive agents (doing more harm than good) are considered not to be recommended

Community Acquired Pneumonia in SEA: International guidelines have been published by many professional organizations. Yet a review of evidenced based medicine showed that less than 40% of recommendations are evidence-based. Guidelines should be based on the epideminology locally. Collaboration from SEA countries / areas (including Hong Kong) has shown that among those "no pathogen identified" groups, about 20% had evidence of atypical pneumonia (NOT SARS!) by paired serology test 2 weeks apart. About 20% who presented as "acute pneumonia" turned out to be pulmonary tuberculosis. Thus, the use of fluoro-quinolones as first line empirical antibiotics in CAP management (as recommended by guidelines by overseas professional bodies) is NOT recommended. Suggested empirical treatment for CAP based on local data being Penicillin group with extended activities against B-lactamase plus a macrolide.

The above are snapshots of the meetings. Those who are interested to learn more of the Congress can approach me directly at email: lumcm@ha.org.hk. I look forward to reading more of these Sponsored Meetings Report in the coming HKGS Newsletters.

Council news

Dr. KK Mo, Hon. Secretary

- The holding of joint diploma examination with the Royal College of Physicians and Surgeons of Glasgow and the Diploma in Geriatric Medicine examination in Hong Kong as an overseas center is undergoing active negotiation and in good progress. The earliest date for trial implementation may be in 2005/6. Please pay attention to the ongoing development if you are interested.
- The examination centres for the Postgraduate Diploma in Community Geriatrics are Kwong Wah Hospital & Ruttonjee Hospital for this year. Dr. Iain M Lennox will be our overseas examiner.
- The social activity of hiking initially scheduled on 7 Dec 2003 was cancelled due to inadequate response.
- The Annual General Meeting cum Annual Scientific Meeting 2004 is scheduled on 19 June 2004. It will be held in the Marco Polo Hongkong Hotel at Harbour City, Canton Road, Kowloon. Professor Henry Krum from Melbourne and Dr Iain M Lennox from Glasglow will be our overseas speakers for the coming function. There will be also new features like photo competition in the coming ASM. So please mark your calendar for this important function. Looking forward to seeing your active participation.
- The membership subscription for 2003/04 is already overdue. Please send a cheque of the appropriate amount ie HK$200 per year for regular member and HK$100 per year for associate member together with the enclosed reply slip to our Hon. Treasurer Dr. Wong Tak Cheung c/o Department of Medicine, Tsang Kwan O Hospital, Tsang Kwan O at your earliest convenience. Eligibility for our Society's activities including conference sponsorship and social activities are only applicable to paid-up members. If you have any enquiries about your paid-up status, you can approach our Hon. Treasurer, Dr. Wong at 22080585.

We welcomed our new member: Dr. Shea Tat Ming as regular member.

LOCAL News

The Department of Health has reviewed the **infection control measure** in 756 sub-vent and private **residential care homes for the elderly** in Hong Kong. It was found that isolation or cohort facilities were available in 70% of the homes. However there were 18 homes (2%) where the environmental hygiene was considered to be below standard. The Social Welfare Department will follow up the issue and if there is no improvement shown, this will affect the further licensing of the homes. The survey also found that 34% of the chefs in the homes did not wear masks during cooking and 3.4% of them still worked even though they were having gastroenteritis symptom. Since November 03, the Department of Heath has requested all homes to appoint an infection control officer to coordinate infection control at the homes. The Social Welfare Department has set up a special fund with an amount of HK$ 17,000,000 to help the homes to improve their environment but so far they have only received enquiries rather than formal application. **(Ming Pao Daily News 23/12/2003)**

A local Hong Kong umbrella company has designed a **special walking stick umbrella for the elder**. These special umbrellas are made of double support skeleton of stainless steel with good fitting grip handle and non-slip rubber tip. They also offer free of charge service for changing of the rubber tips if they are worn out. **(Oriental Daily 4/1/2004)**

A study involving 143 **non-CSSA receiving elderly** found that the median monthly income was only $1132, which was mainly came from the disability allowance and old age allowance. Moreover, these elderly only used $714.8 for their monthly meals (i.e. $23.8 for food per day). The average expanses used for breakfast, lunch and dinner were $4.7, $7.9 and $8.5 respectively. Furthermore, their monthly medical expanse was $154.5 and over 65% of these non-CSSA receiving elderly would try not to seek medical treatment even when they fall sick. **(HK Economics Daily 17/11/2003)**

A Hong Kong billionaire has donated money to build a Care and Attention Home for the Elderly in Shanghai. As in many other countries, the **population in Mainland China is ageing**. In Mainland China, the population aged 60 or above is growing at an annual rate of 3%. At present, there are 132 million people aged 60 or above which is about 10% of the total population. It is estimated that in the year 2050, these aged 60 or above will increase to 400 million. **(HK Economics Daily 25/10/2003)**

The Hong Kong Geriatrics Nurses Association was registered as a limited company and was renamed as "HONG KONG NURSES ASSOCIATION OF GERONTOLOGY". They have produced a VCD learning package about enteral feeding care & dementia care. It is a joint project by the Soroptimist International of Hong Kong, HK Alzheimer's Disease & Brain Failure Association and the Association. Dispatching to patients, POAH, C&A or NGO are free of charge. Interested members can contact them for details. **(Hong Kong Nurses Association of Gerontology)**

The Effect of Group Exercise on Physical Functioning and Falls in Frail Older People Living in Retirement Villages: A Randomized, Controlled Trial
JAGS 2003; 51: 1685-92

551 people aged 62-95 (mean 79.5±6.4) were randomized to the weight-bearing group exercise (GE n=280) intervention that was designed to improve the ability of subjects to undertake activities for daily living, or randomized to the control arm (n=271) attended flexibility and relaxation (FR) classes (n=90) or did not participate in a group activity (n=181). After adjusting for age and sex, there were 22% fewer falls during the trial in the GE group than in the combined control (CC) group (incident rate ratio=0.78, 95% confidence interval (CI)=0.62-0.99), and 31% fewer falls in the 173 subjects who had fallen in the past year (incident rate ratio=0.69, 95% CI=0.48-0.99). At 6-month retest, the GE group performed significantly better than the CC group in tests of choice stepping reaction time, 6-minute walking distance, and simple reaction time requiring a hand press. The groups did not differ at retest in tests of strength, sway, or leaning balance. The author concluded that group exercise could prevent falls and maintain physical functioning in frail older people.

Editor's choices

Is grip strength a useful single maker of frailty?
Age and Ageing 2003; 32: 650-656

Chronological age is widely used as a marker of frailty in clinical practice. However there can be wide variation in frailty between individuals of similar age. Grip strength may be a better predictor of frailty. 717 elderly, aged 64-74, involved in the study and the number of significant associations between grip strength and the ageing markers (e.g. cognitive function, hearing threshold, lens opacity, visual acuity, number of teeth, walking problem, arthritis … etc.) was compared with numbers between chronological age and the ageing markers. It was found that grip strength was associated with more markers of frailty than chronological age within the narrow age range studied.

Stroke prevention with the oral direct thrombin inhibitor ximelagatran compared with warfarin in patients with non-valvular atrial fibrillation (SPORTIF III): randomised controlled trial
Lancet 2003; 362:1691- 8

A randomised controlled trial of stroke prevention using the oral direct thrombin inhibitor ximelagatran. 3410 patients with non-valvular atrial fibrillation and one or more stroke risk factors were randomised to received fixed-dose ximelagatran 36 mg twice daily or adjusted-dose warfarin dose to maintain an INR of 2-3. The primary endpoint was stroke or systemic embolism. After a mean follow up period of 17.4 months the primary event rate was 2.3% per year with warfarin and 1.6 % per year with ximelgatran (p=0.10). Rates of disabling or fatal stroke, mortality, and major bleeding were similar between the two groups but combined major and minor haemorrhages were lower in the ximelagatran group with a relative risk reduction of 14% (p=0.007). The authors concluded that in high-risk patients with atrial fibrillation fixed-dose oral ximelagatran was at least as effective as warfarin for prevention of stroke and systemic embolism.

Intense Tai Chi Exercise Training and Fall Occurrences in Older, Transitionally Frail Adults: A Randomized, Controlled Trial
JAGS 2003; 51: 1693-1701

291 women and 20 men aged 70 to 97.in 20 congregate living facilities were randomized to an intense tai chi (TC) exercise program and the wellness education (WE) program of 48 weeks. The risk ratio (RR) of falling was not statistically different in the TC group and the WE group (RR=0.75, 95% confidence interval (CI)=0.52-1.08), P=.13). Over the 48 weeks of intervention, 46% (n=132) of the participants did not fall; the percentage of participants that fell at least once was 47.6% for the TC group and 60.3% for the WE group. The author concluded that TC did not reduce the RR of falling in transitionally frail, older adults but TC may be clinically important and should be evaluated further in this high-risk population.

Serum Vitamin D and Falls in Older Women in Residential Care in Australia
JAGS 2003;51:1533-8

A prospective study was done to determine the prevalence of vitamin D deficiency in older people in residential care and the influence that the level of vitamin D may have on their incidence of falls. 667 women in low level care and 952 women in high level care, mean age 83.7 years were studied. Vitamin D deficiency was defined as serum 25-hydroxyvitamin D (25D) level below 25nmol/mol. Vitamin D deficiency was present in 144 (22%) women in low-level care and 428 (45%) in high-level care. The log serum 25D level was independently associated with time to first fall and the adjusted hazard ratio of 0.74, implying a 20% reduction in the risk of falling with a doubling of the vitamin D level.

Red wine ingredient resveratrol protects from β-amyloid neurotoxicity.
Gerontology 2003;49:380-383.

Epidemiological studies had suggested a possible protective role of moderate daily consumption of red wine against Alzheimer's disease. Resveratrol is a natural polyphenol found in red wine with antioxidant properties which has shown to be cardioprotective. In this experimental study the investigators examined the neuroprotective effect of resveratrol against β-amyloid induced oxidative stress in a neuroblastoma cell medium. Physiological concentration of resveratrol was added in the cell mediums either prior to or following the β-amyloid incubation. They found that in both circumstances resveratrol maintained cell viability and exerted an anti-oxidative action by enhancing the intracellular free-radical scavenger glutathione. Red wines could be protective against Alzheimer's disease through the action of resveratrol.

Members' Corner

Geriatrics in Australia

(Dr Stephen Wong kindly provided us a very good account of his geriatric training experience in Australia.)

It has always been a great and pleasurable experience in working in Concord Repatriation General Hospital in Sydney, where I had spent my internship year in 1993. In year 2000, the year of Sydney 2000 Olympic Game, I went back to Concord Hospital for my 6-month elective in Geriatric Medicine. It was like meeting an old friend who has been known for long time.

Concord Hospital is a 550-bed teaching hospital of the University of Sydney. The hospital has a long tradition of providing care to the Veteran community. The hospital has a long established reputation of excellence in the provision of Aged and Extended Care services, which acts as an umbrella for all the community based aged care health services in the local area.

Australia has a three-tiered system of aged care – nursing homes, hostels and a range of services which support people living in the community, and geriatricians have ensured that appropriate services are available to all frail older people. Hostels provide accommodation and associated support services, such as domestic services (laundry, cleaning), assistance with daily tasks (moving around, dressing, personal hygiene, eating) and occasional nursing care. Hostels target frail elderly with physical, medical, psychological or social care needs which cannot be met in the community.

In the past, home-based care services in Australia were scanty and poorly coordinated. The problem had been raised in a succession of government reviews and inquiries, and in 1984, the Home and Community Care (HACC) program was announced, which aimed at substantially improving the quantity and range of services available to frail and disabled elderly living at home. In addition to the more commonly available areas of home nursing, home help and delivered meals, there was an expansion of center-based and in-home respite services, transport services, gardening, and home handyman assistance in recent years.

In Australia, two programs provide more intensive home-based care under brokerage-type arrangements – community options projects and community aged care packages. The former is the first government-led initiative to develop a more intensive form of home-based support, and the projects were expanded under the aegis of HACC program. They aim to reduce inappropriate admissions to institutional care among highly dependent people and those with complex care needs, but who could nonetheless remain at home with appropriate support. A more ambitious scheme was then launched to provide an alternative home-based service for the elderly who would otherwise require admission to a hostel at the "Personal Care" level of admission.

Flexible care services are intended for people whose needs are not easily met in mainstream facilities and services. These include multi-purpose services which operate in small rural communities lacking the population to support stand-alone services, and which provide a range of aged care services. Home nursing care packages provide high quality care nursing and personal care services to high dependency people living in their own homes.

Australia also provides an example of a process governing admission to nursing homes with a national assessment program in which multidisciplinary Aged Care Assessment Teams (ACATs) determine eligibility for admission across the entire continent. ACATs are approving over half of the admissions to nursing homes and hostels, and the teams are usually based at a hospital, geriatric center, or community center, but can visit people in their own homes. Today, there is a network of 121 regionally based multidisciplinary ACATs which provide services across Australia. The assessment links with the person's regular medical attendant, and it also includes assessment of carer support, advice on equipment, respite care, and measures to maintain independence.

Having planted the seeds of elderly care in my fertile mind when I was an intern in Concord Hospital, I had been inspired to pursue geriatrician as a career. After all, it has been a privilege for me to take care of the elderly, and I am proud to be one of the geriatricians being trained in Concord Hospital.

Dr Stephen Wong, PYNEH

漫話中國茶

司徒士諾醫生

喝茶，在許多人看來，是平凡不過的事情，茶不外是眾多飲料之一。其實，茶作為一種飲料，本身就有著許多的學問，此外，茶作為一種文化的載體，學問就更大了。茶發源於中國，其後流傳至其他國家。茶由藥用轉為飲用，大抵為戰國或秦代以後的事，中國茶文化少說也有千年以上的歷史。有說「茶通六藝」，試想，能跟茶扯上關係的，又豈止六藝：植物學、農學、地理學、氣象學、造茶工藝、陶瓷工藝(特別是紫砂陶藝)、歷史、詩詞文學、音樂、書畫篆刻藝術、哲學、宗教、人際交往、社會文化等等，當然，茶亦是一項很大的產業和利潤可觀的生意。茶作為健康飲料和防治某些疾病(特別是癌症和心血管病)近年亦成為熱門課題。

中國茶可分為六大類：
一. 綠茶：不發酵的茶類，最有名的是龍井和碧螺春
二. 白茶：由大白茶品種茶樹經特定工序造成的茶類，包括壽眉
三. 黃茶：造茶工序包括燜黃的茶類，代表茶為君山銀針
四. 青茶：即烏龍茶，泛指半發酵的茶類，包括福建北部出產的武夷岩茶(如大紅袍、水仙等)、福建南部安溪出產的鐵觀音、廣東潮州附近出產的單欉茶類和台灣出產的多種烏龍茶
五. 紅茶：全發酵的茶類，如祁門紅茶、雲南滇紅等
六. 黑茶：經過一項稱為渥堆的造茶工序或後發酵的茶類，普洱便是其一
(茶葉的發酵指茶葉裏的多酚化合物經脢促反應後的氧化過程，此過程可通過加熱防止或停止，造茶術語稱為「殺青」)
此外花茶亦是一種常被飲用的茶類，花茶指經過鮮茶窨製的茶類(窨花茶，一般以綠茶作茶胚，最常用的花是茉莉花)，亦指茶葉混合花朵沖泡的茶(拌花茶)，甚或單純以花朵沖泡的茶(近年流行的花草茶不屬於中國茶類)。

魯迅先生說過：「有好的茶喝，會喝好茶，是一種清福。不過要享這清福，首先必須有功夫，其次是練習出來的特別感覺。」(後者指品茶的文化修養)要喝一杯好茶並非艱難或昂貴的事，但必須具備起碼的知識。有說「水為茶之母，器為茶之父。」隨了質量好的茶葉外，適當的泡茶用水和茶具也是必須的，此外正確的沖泡技巧亦是十分重要的。有關中國茶的種種，以後有機會在本欄再談。

以下是一個資料非常豐富的有關茶的網址：
http://www.wwwart.com.tw/tea/

What is the most important part of the treatment process? The answer is "diagnosis". The first and most important task of any healer is making the right diagnosis. Without an accurate diagnosis, subsequent treatment has little effect. The word diagnosis, in its most original and profound meaning is knowing through and through (gnosis = knowledge; dia = through and through). One can see that the first and most important aspect of all healing is an interested effort to know the patients fully, in his/her entity.

(Adapted from Reaching Out by Henri J.M. Nouwen 1975)

Fall SIG meeting **10/2/04**

A"fall" consultation program was implemented in SH. Preminlary, it was noted that useful additional intervention could be offered to improve the immediate management of patientes. Similiar program, an inter-departmental one, was run in PMH years ago. The impression was that the workload was quite significant. Also, as the patients were in the acute phase of their illness, intervention besides managing the acute illness might not be very effective. Appropriate referral of patients (e.g. recurrent falls or significant gait/balance problem) to geriatrics after the recovery of acute illness may be more cost-effective. Thus, different programs should be geared to different groups of patients (e.g. acute Vs convalescent)

A literature review on the international publication of fall prevention programs in 2003 showed that for the less fit older people (e.g. more frail, mentally impaired etc.), those previously proven useful intervention, namely Tai Chi and multidisciplinary assessment and intervention at A&E , were either not useful or needed longer period of implementation to show usefulness.

It was noted that HAHO was interested to implement a territory-wide Fall Prevention Program in the near future. The SIG members had decided to draft an action plan and submit to HKGS / Geri Subcom to reflect our understanding and experience on managing the problem. It was hoped that the geriatric expertise could contribute to the success of such program in the future.

Date of next meeting: 11/5/04 (Tue) 6:00pm

Foreign News

Hong Kong - ahead of the game

(An article written by Dr. S Allen, the external examiner of our last PDCG course - BGS Newsletter 2004 Jan issue)

In September 2003, I had the pleasure and honour to be invited to Hong Kong as the external examiner and advisor for the Post Graduate Diploma in Community Geriatrics (PDCG). The qualification is conferred by the University of Hong Kong through its Faculty of Medicine. I was the external examiner for the third such exam, following in the footsteps of Brian Williams who served in this capacity for the previous 2 years.

PDCG and GPs As one might expect, the preparation, organization and conduct of the exam were exemplary. What was of particular interest however, was the fact that the PDCG is mainly taken up by General Practitioners in Hong Kong, to enable them to deliver high quality community-based care for frail older patients living at home, or in residential homes or nursing homes. They have therefore put in place a robust system for developing General Practitioners with a special interest in geriatric medicine, based on a substantial qualification.

Part time course The examination follows a ten month part-time course which involves private study, lectures, tutorials and clinical teaching, so the standard of the candidates taking the exam is understandably very high. The course is popular, with far more applicants than places, so this has led to a need for an expansion in the course capacity for next year.

The impetus for this course originated from the clear clinical need for good community geriatric care in Hong Kong and has been supported by a collaborative arrangement involving the University of Hong Kong and the Hong Kong Geriatrics Society. The course content, teaching arrangements and candidate recruitment have been deliberately designed to attract applicants across the interface between primary and secondary care, and also a mix from both public sector and private medical practice, thereby allowing a high degree of inclusiveness across the various styles of medical practice in Hong Kong.

The prime movers of this initiative are Dr Tak-kwan Kong, a senior geriatrician from the Princess Margaret Hospital (and a BGS member), who is currently the President of the Hong Kong Geriatrics Society, and Dr Tai Pong Lam, an Associate Professor of Family Medicine in the medical faculty of the University of Hong Kong. My view is that our colleagues in Hong Kong have recognized the current and future needs for training in community geriatric medicine, both for General Practitioners and Geriatricians, and have put in place a formal and powerful mechanism to prepare their doctors accordingly. There must be a lot that we can learn from their experience, and if anyone wishes to know more about the curriculum or examination they can contact me at stephen.allen@rbch-tr.swest.nhs.uk and I will put them in touch with the appropriate colleagues in Hong Kong.

Dr S C Allen

Re: Payment of Annual subscription 2003/2004

Please be reminded that the Annual subscription for 2003/2004 is now overdue, please send it immediately with the reply slip below to the Hon Treasurer (i.e. Dr. TC Wong, Chief of Service, Department of Medicine, Tseung Kwan O Hospital).

$200 for regular members
$100 for associate members.

********** Reply **********

Send to : . Dr. TC Wong, Chief of Service, Department of Medicine, Tseung Kwan O Hospital, Tseung Kwan O

My annual subscription (***payable to "Hong Kong Geriatrics Society"***) for the year 2003/2004 is enclosed:

Bank: _____ Cheque no. _____ Amount: _____

Full Name (Print) : _____ Signature: _____ Date: _____

Hong Kong Geriatrics Society

Annual Scientific Meeting 2004

Free Paper Presentation

CALL FOR ABSTRACT

One of the objectives of the Hong Kong Geriatrics Society is to encourage conduction of quality scientific research and clinical studies in our local community. There will be a free paper presentation session in our 2004 annual scientific meeting, to be held on **19 June 2004**. All submitted papers would be assessed by an expert panel. Selected participants will be invited to present their papers in the annual scientific meeting. The panel will select three outstanding papers, which will be awarded the Dr. Chan Sik Prize, Dr. Ng Yau-Yung prize and Dr. Ng Ngai-Sing Prize.

You may submit any number of papers, but only one prize will be awarded to any one participant each year. Kindly note that you should not have received any of these three awards in the past three years. The decision of the selection panel is final.

Deadline for abstract submission is 14th April 2004.

Please mail or email abstract to:

Dr Lee Ka Wing Gavin
Senior Medical Officer,
Pamela Youde Nethersole Eastern Hospital,
3 Lok Man Road, Chai Wan.
Tel: 25956111
Email: gavinlee@netvigator.com

Abstract Format

1. Title: A clear and brief title that indicates the nature of the investigation
2. Name & initials of all authors (underline the presenting author)
3. Name of the institution
4. The content of the abstract should include:
   - Introduction
   - Objective
   - Method
   - Result
   - Conclusion

The length of abstract content should not exceed **300** words with a font size not smaller than **9**.

Organization committee members:

Dr. Felix CHAN	***Chairman***	***Fung Yiu King Hospital***
Dr. H C YUEN	*Secretary*	*Tuen Mun Hospital*
Dr. C F KO	*Treasurer*	*Princess Margaret Hospital*
Dr. Carolyn KNG	*Member*	*Ruttonjee Hospital*
Dr. James LUK	*Member*	*Fung Yiu King Hospital*
Dr. S L Szeto	*Member*	*Kwong Wah Hospital*
Dr. Gavin LEE	*Member*	*PYNEHospital*
Dr. T M SHEA	*Member*	*Queen Elizabeth Hospital*
Dr. P M FUNG	*Member*	*Kowloon Hospital*
Dr. Maria TANG	*Member*	*Shatin Hospital*
Dr. Po Tin LAM	*Member*	*United Christian Hospital*

Publication subcommittee:
Dr. Mok Chun Keung (Chairman)
Dr. Leung Ho Yin
Dr. Pang Fei Chau
Dr. Yu Kim Kam
Dr. Tsui Chung Kan
Dr. Ip Pui Seung
Dr. Sheng Bun

Event: Reunion with old friends and colleagues at Bowling Green on 17 Jan 2004.
From left to right: Allan Wong, HY Wong, SY Au, KS Au, TC Tam (back from Australia), S Chan, YY Ng, TK Kong

Inter-hospital Geriatrics Meeting (04-05) 6:00 pm – 8:00 pm

Venue: HAHO Room 205S (Light meal provided)

Date	Responsible unit
27.02.04	6:00-7:00pm Pending (QEH) 7:00-8:00pm Pending (QMH)
26.03.04	6:00-7:00pm Rehabilitation of Elderly with Arthritis (PYNEH) 7:00-8:00pm Pending (AHNH)
30.04.04	6:00-7:00pm UCH 7:00-8:00pm TKOH
28.05.04	6:00-7:00pm RH/TSKH 7:00-8:00pm TWEH
06.04	Cancelled due to ASM on 19.06.04
30.07.04	6:00-7:00pm Vaccination in older people Chairperson: Dr SY Au 7:00-8:00pm KH
27.08.04	6:00-7:00pm HHH 7:00-8:00pm KWH
24.09.04	6:00-7:00pm CMC 7:00-8:00pm FYKH
29.10.04	6:00-7:00pm WTSH 7:00-8:00pm PMH
26.11.04	6:00-7:00pm SH 7:00-8:00pm RH/TSKH
17.12.04	6:00-7:00pm TMH 7:00-8:00pm PWH

Local and Overseas Scientific Meetings

Name	Time & Place	Organizer	Contact
Birmingham Movement Disorders Course	2/4/04-4/4/04 Birmingham, UK	University of Birmingham	Susan.pope@swbh.nhs.uk
British Geriatrics Society Spring Meeting 2004	22/4/04-24/4/04 Derry/Londonderry UK	British Geriatrics Society	www.bgs.org.uk
The Inaugural Combined Rehabilitation and Geriatric Medicine 2004 ASM	27/4/04 – 30/4/04 Fremantle Australia	Australian Society for Geriatric Medicine	www.asgm.org.au
American Geriatrics Society Annual Meeting 2004	17/5/04-21/5/04 Las Vegas USA	American Geriatrics Society	www.americangeriatrics.org
Canadian Geriatrics Society AGM and CME day	28/5/04 – 30//5/04 Toronto Canada	Canadian Geriatrics Society	www.cgs-scg.ca
Hong Kong Geriatrics Society ASM and AGM	19/6/04 Hong Kong	Hong Kong Geriatrics Society	www.hkgs.org.hk
6th World Congress on Aging and Physical Activity	3/8/04 – 7/8/04 Ontario Canada	International Society for Aging and Physical Activity	www.uwo.ca/actage/wcapa

Hong Kong Geriatrics Society – Membership application / Information update Form

A). Personal information for *membership application* or *information update*

Name	
Corresponding Address	
Current Practice (HA - Hospital Authority/ DH - Department of Health / PR - Private practice / HS - Hospital Service Department / HK - HKU / CU- CUHK / OT - Others)	"√" one of the following : □ HA □ DH □ PR □ HS □ HK □ CU □ OT
Present post (e.g. MO, Cons, Prof. etc.)	
Hospital (working at)	
Department (working at)	
Home Address	
E – mail address	
Home Telephone	
Office Telephone	
Fax Number	
Basic Qualification (basic degree) and year	
Higher Qualifications and year	
Membership status to apply for or change	Please "√" either one below
□ a) I am an accredited **Geriatric Specialist** according to the criteria of HK Academy of Medicine □ b) I am currently under **higher specialty training in Geriatric Medicine** according to HKAM □ c) I am a registrable medical practitioner in HK who is interested in Geriatric Medicine but the above two conditions do not apply.	
Membership: (Official Use)	**Regular/Associate**
Approved by council at: (Official Use)	

Category a or b (Annual fee : **$200) - Regular member*
*Category c (Annual fee: **$100**) - Associate member (No voting right nor right to be elected as council member)*
For new application of membership, one has to be proposed by a **Regular Member of the Society:

Name of Proposer: _____ (Signature: _____)

B). I have the following publication/presentation of local studies / surveys in Geriatrics:

Title (Summary can be sent separately)	Journal index/ Name of meeting or seminar & dates

Please send this form to the following:

Dr. Mo Ka Keung Loar
Honorary Secretary, c/o Department of Medicine, Yan Chai Hospital, 7-11 Yan Chai Street, Tsuen Wan, New Territories, Hong Kong

✂ …… ✂ …… ✂

C). **Annual Fee for 2003/2004**
Please send a cheque payable to "The Hong Kong Geriatrics Society"
(Regular member: $ 200 – 1yr; Associate member: $ 100)

**Please tick if your want a receipt □ & your address: _____

Name : _____ Signature: _____ Date : _____

E-mail address: _____

Please send to : **Dr. Wong Tak Cheung, Honorary Treasurer, Hong Kong Geriatrics Society, c/o Dept. of Medicine, 1/F, Tseung Kwan O Hosp., 2 Po Ning Lane, Tseung Kwan O**