The Hong Kong Geriatrics Society Newsletter

The Hong Kong Geriatrics Society

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May 2009

Editorial

We talked about the future of Geriatrics in the last issue. In the coming Annual Scientific Meeting, Dr CB Law will discuss with us his finding from his series of Young Geriatrician Forum and the questionnaire survey conducted earlier. We are also very privileged to have Prof Nair from Newcastle, Australia writing for us in this issue about Geriatrics training in Australia and why we need more geriatricians.

This year Annual Scientific Meeting and dinner are special in that they will be held in different places. The Annual Scientific Meeting will be held in the Hong Kong Academy of Medicine while dinner will be served at the Hong Kong Country Club. So make sure you find the right place and book your seats.

Tony Ko
Editor

Message from the President

Dr. Chan Hon Wai Felix

Photo taken at Prof. John Pathy's home in Cyncoed, Cardiff, 2005.

As I was writing this article, I was deeply saddened by the passing away of Professor M S John Pathy, who died on Thursday 9 April 2009. Prof. Pathy was my mentor and friend, and the reason and role model for me to take up Geriatric Medicine as my career.

Professor Pathy's medical education started at the Kings College University of London where he qualified in 1948. He then held a number of posts in dermatology, general medicine, paediatrics, casualty, and infectious diseases at various London hospitals, before moving to Wales where he became the first ever appointed Professor of Geriatric Medicine, inspiring and teaching many of today's senior geriatricians in the UK and all around the world. He pioneered the close collaboration of the work of health and social services. He championed the establishment of day hospitals and post-discharge services for older people, and developed a wider role for the community nurses. Respected around the world for his contribution in the

field of geriatric medicine, Professor Pathy was the author of numerous peer-reviewed papers and was the editor of "Principles and Practice of Geriatric Medicine", the essential reference book for our profession. According to an ex-colleague of mine who works in Wales, John, at the age of 85, was still talking to her about the authors of a book chapter they are working on together in the morning of 8th April 2009. What an amazing man!

In the beginning of January, our Society took part as a co-organizer of the Scientific Meeting of the 10th Anniversary of the Guardianship Board. It was a well-attended event with participants from the legal, social work, allied health, nursing and medical professions, as well as parents/ family members of mentally incapacitated persons. In February, we co-hosted an evening symposium on updates of the treatment of Parkinson's Disease with the HK Neurology Society.

The current hot topic among our profession must be swine influenza. Many of us are working day & night, reinforcing infection control, enhancing precautionary measures, keeping close surveillance of infectious diseases & monitoring the health of elderly people in the hospital and in residential care homes. As geriatricians, apart from reminding ourselves of FTOCC (Fever, Travel, Occupation, Contact & Cluster) for suspects of swine flu, we must bring to the awareness of our colleagues the possibility of non-specific and atypical presentation in the elderly in order to prevent the H1N1 virus sneaking into our medical, surgical or even orthopaedic wards! The lessons from SARS in 2003 hopefully have made us wiser and better equipped to fight this battle with swine flu.

As a member of the examination board for the post-graduate diploma in community geriatrics, I have been working closely with the Family Medicine Unit of the University of HK and the Royal College of Physicians & Surgeons of Glasgow in setting questions for the forthcoming examination in June. I must take this opportunity to thank the dedicated staff of Queen Elizabeth Hospital for hosting the clinical exam this year. Thanks also to Dr. Bernard Kong and his team for their hard work in organizing the Annual Scientific Meeting (ASM) on 20 June 2009, which will be held, for the first time, in the auditorium of the HK Academy of Medicine.

I look forward to meeting you in the ASM, which will be immediately followed by our Annual General Meeting and Annual Dinner.

Council news

Dr Wu Yee Ming Jimmy
Hon. Secretary, HKGS

1. ASM 2009 will be held on 20 June 2009 (Saturday). This year the meeting venue is changed to the Hong Kong Academy of Medicine. Dinner will be served at the Hong Kong Country Club.

2. HKGS will support and organize two symposia in the coming International Association of Gerontology and Geriatrics Congress, Paris, 5-9 July 2009. Call for applications for sponsorship to attend the conference has been advertised to members.

3. A series of Young Geriatricians Forums were conducted by Dr. CB Law purporting to collect members' opinions on the direction and strategies of the development of Geriatric Medicine. Discussions from the forums formed the basis of a questionnaire which was sent to members and fellows in geriatric medicine. The statistics and analysis of the survey will be presented after the upcoming AGM in June.

4. HKGS is the co-organizer of the following upcoming symposia:
(a) *A World without Alzheimer's: a Synopsis of Possibilities and Reality*
Speaker: Prof. Peter Whitehouse
The Ball Room 1-2, 18/F, the Mira Hong Kong, 118 Nathan Road
9 Jun 09 6:30pm
(b) *Thinking Beyond the Concept of Advance Directives*

Rayson Huang Theatre, Rumme Shaw Building, University of Hong Kong
22 Jun 09 9am-5pm
(c) *Conference on Holistic Living towards Successful Ageing*
5-7 Nov 09
Interested members are advised to visit the HKGS website for details.

5. The Council will invite the SIG on Fall to incorporate osteoporosis into their scope. Re-organization of the SIGs is expected to take place in the near future and will take into consideration the suggestions and recommendations in the final report of the Young Geriatricians Forum.

Asia Pacific Geriatric Conference 2008

Dr Wong Tze Wing
Tai Po Hospital

The Asia Pacific Geriatric Conference 2008 was held on 13th-16th November 2008 in Bali, Indonesia with the conference hosted by the Indonesia Geriatric Society. Experts and researchers from different countries and regions, including Indonesia, Malaysia, Australia, and Hong Kong had made active participations and contributions. It was my great pleasure to have the opportunity to attend this important Conference.

The theme of the Conference was "Geriatric Giants: The New Epidemic in the 21st Century". This highlighted the surge of geriatric problems in our daily practice and the need of awareness of the potential threats to the quality of life of our elderly population.

The Conference was sparked off by the opening ceremony. The programme consisted of several plenary lectures, satellite symposia and free paper presentations covering areas like nutritional problems, urinary incontinence, cardiovascular diseases, musculoskeletal problems, infections and immunology, dementia and neuropsychiatric problems, metabolic syndrome and geriatric health care services. Dr. Edward MF Leung and Dr. Bernard MH Kong gave presentations on the topics related to urinary incontinence and vaccination respectively. We also had a free paper presentation by Dr. Jenny SW Lee and a poster presentation by Dr. TW Au Yeung.

The HKGS Council 2008-2009 The Hong Kong Geriatrics Society
Annual Scientific Meeting 2009
Scientific Programme

20th June, 2009 (Saturday)
Hong Kong Academy of Medicine
G/F Pao Yue Kong Auditorium

12:30-14:00 **Registration & Lunch (1/F Run Run Shaw Hall)**

14:00-14:30 **Welcome addresses by:**
Dr Bernard Kong Chairman, Organizing Committee, ASM 2009
Dr Felix Chan, President, The Hong Kong Geriatrics Society

Opening Address by:
Professor Gabriel M Leung JP, Under Secretary for Food And Health
Professor Sum-ping LEE, Dean, Li Ka Shing Faculty of Medicine, HKU

14:30-15:45 **Symposium on Global Disease Burden in HK 2030**
Chairmen: Dr CB Law, Dr Yim Ting Kwan

Chronic Obstructive Pulmonary Disease
Professor Mary Sau-man IP
Chair Professor Respiratory Medicine
Personal Professor and Division Chief
Li Ka Shing Faculty of Medicine, HKU

Colon and Rectal Cancer
Dr Samuel Kwok
Consultant Surgeon
Pedder Clinic Hong Kong

15:45-16:00 Tea Break

1600:-17:15 **Free Paper Presentation (Competition for Chan Sik, YY Ng, and NS Ng Prizes)**
Moderators: Dr SL Szeto, Dr Carolyn PL Kng
Asian Journal of Gerontology and Geriatrics Best Paper Presentation

17:15-18:30 **Symposium on Management of Disease in Advance Stage**
Chairmen: Dr MF Leung, Dr Michael CK Cheng

Management of solid tumour of elderly beyond surgery
Professor Brigette Buig-yue Ma
Clinical Oncology Department
CUHK

End of life care in an aging world – A Scottish and UK perspective
Dr Brendan J Martin MB ChB, MD, FRCP(Glasgow)
Consultant Geriatrician Hairmyres Hospital, East Kilbride
Clinical Director, Older Peoples Services, NHS Lanarkshire

19:00-19:15 **Annual General Meeting**

19:15-19:30 **Report on Young Geriatricians' Forum**
Dr CB Law

19:30–22:00 **ASM Dinner – Hong Kong Country Club**
188 Wong Chuk Hang Road, Deep Water Bay, Hong Kong
(fellows/trainees of Geriatrics and invited guest only)

HKGS Awards Presentation
Free Paper Awards Presentation
Entertainment

Providing End-of-life Care for our Older Generations- a litmus test

Dr Raymond Lo
Consultant (Geriatrics and Palliative Medicine), Shatin Hospital;
Chief of Service, Bradbury Hospice.

How we care for the dying is an indicator of how we care for all sick and vulnerable people. It is a measure of society as a whole and it is a litmus test for health and social care services.[1] There should be no ageism of course in the care for our older people in this regard. In HK, the age-specific death rate of older than 85 amounts to 118.2 per 1000 population.[2] Our health care and community services must be strategically re-shaped to meet this very challenge. Ageing and dying is a priority issue.

Palliative medicine as a specialty has grown in recent years, and the development is akin to that of geriatric medicine over the last few decades. Geriatricians ultimately aim to disseminate our approach to all specialties and disciplines involved in caring for older people. Likewise, palliative care physicians hope to promote end-of-life care to all concerned colleagues. More discussion may be needed on differentiation of level of care, on what would constitute a basic geriatric and basic end-of-life care approach for all. Regardless, synergistic efforts by both specialties with sharing and crossover of expertise must be the way forward.[3] The mode of collaboration will of course vary on the local setting, and we can surmount the logistic issues.

The older people have palliative needs which can be similar, yet different from the younger age-groups. Pain is always most feared by patients of all ages. Despite much advances in pain management with alternative opioids, the application of such drugs in the elderly need to be with caution. Transdermal fentanyl patch does not allow fine titration as needed in elderly with unstable pain, and safety of methadone is limited by its long half-life and propensity for drug accumulation [4] Symptom profile of the older hospitalised patients at end of life may also be different. In an end-of-life care programme for patients suffering from advanced non-cancer illnesses in Shatin Hospital, dysphagia, oedema and weakness are the top symptoms as observed by staff (data in submission). Checklist of the prevalent symptoms in elderly will certainly be beneficial, and care pathway such as the Liverpool Care Pathway[5], is a worthy reference for those focused in quality end-of-life care.

Local research has shed more light into the psycho-spiritual needs of our elderly. Existential needs have already been shown to be an important aspect of well-being for palliative care patients. Age alone, family support and staff support are the three most important determinants in predicting an overall good quality of life of older patients with cancer.[6] Compared with the young, older patients may feel better in psychological well-being, but fare poorer in support. Similar finding is also seen in another cohort of community dwelling patients, mean age 68, attending palliative day care centre.[7] Many advanced conditions especially with non-cancer diseases run a prolonged disease trajectory, and carers of elderly people would also need enhanced and unfailing community support.

For promoting community palliative care, the Gold Standards Framework was developed in the UK initially for cancer patients but now is being used for any patient with a life-limiting illness. It aims to upscale generalists in palliative care for all patients. It includes non-cancer patients, care homes, advance care planning, education, and care pathways. Three suggested criteria for alerting health professionals in the need for palliative care are particularly useful: 1. patient raised the need for palliative care; 2. surprise question: would you be surprised if the patient were to die in the next 6 months to a year; 3. presence of clinical indicators e.g. secondaries in cancer, New York Heart Association Stage 3-4 etc.[8] While the set up and structure of our local community care is completely different from that of UK, the conceptual principles would still be useful and relevant.

Community elderly in long term care facilities may have needs even more pressing than hospitalised cancer patients. In a palliative care programme for old age homes, author encountered clients having spiritual suffering worse than that of terminal cancer patients, with existential well-being scores of only 3 out of 10, on the McGill Quality of life-HK scale.[9] Spiritual enhancement programme[10] and

workshops based on anticipatory grief [11] were designed and piloted as psychosocial interventions for these vulnerable elderly in our programme. The interventions were received with good response, accompanied with qualitative and quantitative improvement, illustrating the important principle in geriatrics that older people need not suffer, physically or psycho-spiritually.

Advance care planning forms a significant component of elderly care, which should be incorporated and promoted. It provides opportunities for discussion of treatment and intervention options. International literature has shown that advance planning could instilled peace of mind and positive preparation.[12] If facilitated well with good communication process and partnership decision-making, advance care planning is especially helpful in clinical settings at end of life. A good advance care planning can serve more than just a written document of advance directive.

Providing good end-of-life care requires seamless integration of the existing components of health services with good continuity of care. A discharged patient needs to be closely followed up at home or in institution. Direct admission should be assisted when necessary. Patients admitted into acute care would benefit from palliative care hospital support teams. Geriatric and palliative care teams need to outreach support to each other. Bereaved relatives may need support from community organisations. In sum, close linkage must be established between hospitals and community, professionals and volunteers, government and NGOs, in caring for our older clients with changing and deteriorating conditions. A shared mission across different stakeholders in society is crucial.

When Dr Marjorie Warren, mother of geriatrics, first developed her services in West Middlesex Hospital in London, the patients were elderly infirm and incurable.[13] Compassionate elderly care with palliation would have been the beliefs and goals of care at that historical time in 1935. This origin of geriatrics should be remembered. And through caring for death and dying, professionals will further nourish to better understand our life and living.

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Reflections on Geriatric Training in Australia

Prof B Kichu Nair, FRCP, FRACP
Clinical Professor of Medicine, Associate Dean of Continuing Medical Professional Development, School of Medicine and Pubic Health
Director of Continuing Medical Education & Professional Development, Hunter New England Health. Newcastle, Australia

In this article, I will argue for more geriatric training in Australia. I believe the situation will be the same in Hong Kong.

Australia has excellent medical and public health services. This success story is reflected in the ageing of the population. At present, the female life expectancy is 84, while male life expectancy is 79 years. When we look at healthy life expectancy, Australia is 3rd in the world at 74 and 71 years for females and males.

Australia spends around 9 % of Gross Domestic Product on health. However our health care expenses are on the rise and often the ageing of the population is blamed for this. Coory has shown that only 10% of the annual rise can be attributable to the older population; the 90 % is caused by the medications and investigations. This may be acceptable, if the elderly are getting the appropriate treatment and appropriate medications by all medical practitioners.

But are they really? We know that up to 25 % of older people admitted to a general hospital will have some drug related problems. Approximately 30 % of medical inpatients and 50 % of surgical patients have delirium. Almost all patients with fracture neck of femur are elderly with multiple co-morbidities. The average age of general medical patient in our own tertiary teaching hospital is 71 and has over 8 co-morbidities, while the mean age of cardiology patient is 66 with 6.6 co-morbidities. Whilst these patients get the excellent care for the primary presenting problem, their co-morbidities get neglected with no assessment of their physical and mental functions. It is well known after an acute medical episode the older patients will take weeks to regain their physical and mental functions. A recent study on the lag time between onset of cognitive impairment and the family seeking the general practice help was 24 months, whilst the definite diagnosis took another 12 months to be confirmed.

So what is the solution for all this? There should be enough geriatricians.

The challenge for the medical educationalists is there will not be enough geriatricians for a very long time to come. The only solution at present and in the near future is to have sufficient exposure and training in geriatric medicine in undergraduate and postgraduate levels. This is easily said than done for various competing reasons.

Last century was a century for acute diseases whilst this century is defined as a century of chronic diseases. However the chronic diseases management is not as "sexy" for the young undergraduates, postgraduates or even for the medical administrators till their families need geriatric care! Then they realize caring is as important, if not more, than curing.

There is gradual realization in Australia that we need to revise the curriculum to meet the societal needs. My view is that we need to design down the curriculum. We have to look to see what should be the new graduate be doing on qualification and then will have to rewrite the curriculum. If we go by the societal needs, most graduates are going to look after older patients with physical, cognitive and medical needs. The doctors are not going to work in isolation. If one needs to provide total care, they should work in teams and the doctor should be the leader of that inter-disciplinary team. (Can Med 2000). All these mean that we need more geriatric medicine in our curricula.

In Australia many new medical schools with new curricula are established. When we looked at the problem cases at Newcastle and Flinders (2 of the pioneers in PBL) the average age of the patient was 31 and most of the problems resolved in 6 months. So there was a call to change these into real life patients who are older with chronic diseases. We have revised the undergraduate position paper of the Geriatric Medicine Society on medical education to reflect these demands. (http://www.anzsgm.org/posstate.asp) To make any substantial changes in the curriculum, we need champions in every medical school; more and more chairs in Geriatrics are established in Australia now. In Newcastle, we piloted an interdisciplinary ward where medical students worked along with nursing and allied health students. Hopefully these students work well in teams on graduation and will have respect for each other.

To be specialist in Geriatric Medicine, the trainees will have to do 3 years of basic physician training in general medicine, pass a written and clinical examination followed by another 3 years of advanced training. (http://www.racp.edu.au/training/adult2003/advanced/vocational/geriatric.hm) Geriatric medicine has become a very rewarding specialty here and our trainee numbers are going up. Still we have a way long way to go, if we need the right number of doctors to do the right thing for our patients in the right way!

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Overseas Scientific Meetings

Name	Time	Organizer	Contact
International Association of Gerontology and Geriatrics World Congress of Gerontology and Geriatrics	5/7/09-9/7/09 Paris, France	International Association of Gerontology and Geriatrics	www.paris2009.org
Australian & New Zealand Society for Geriatric Medicine Annual Scientific Meeting	7/9/09-9/9/09 Fremantle, Australia	Australian & New Zealand Society for Geriatric Medicine	www.asgm.org.au
4th EUGMS Symposium Palliative Care and End of Life Issues in Older Adults	17/9/09-18/9/09 Glasgow, UK	European Union Geriatric Medicine Society	www.eugms.org
British Geriatrics Society Autumn Meeting	7/10/09-9/10/09 Harrogate, UK	British Geriatrics Society	www.bgs.org.uk

Publication subcommittee:
Dr. Ko Pat Sing,Tony
Dr. Chan Chun Man, Jones
Dr. Lam Wai Sing
Dr. Leung Ho Yin
Dr. Lo Kwun Man
Dr. Mak Ying Fai
Dr. Tam Cheuk Kwan

SIG membership application

To: ***Dr YM Wu (Hon. Secretary), Geriatrics and Rehabilitation, Haven of Hope Hospital, 8 Haven of Hope Rd, Tseung Kwan O, Kowloon, Hong Kong SAR, China.***
I am interested in joining the following SIG of HKGS:

[ ] Cognition and Cerebral Ageing SIG
[ ] Chinese Medicine SIG
[ ] Continence SIG
[ ] Falls SIG
[ ] Infectious Disease SIG
[ ] Medical Ethics SIG
[ ] Nutrition SIG
[ ] Sexuality and Older Adults SIG
[ ] Long Term Care

My personal details are:

Name:
Place of work:
Contact: e-mail *phone*
Please notify the corresponding Chairperson of the SIG to contact me for future activities.

Editor's choice

Undetected type 2 diabetes in older adults
Age and Ageing 2009; 38(1): 56-62

Despite the improved public awareness and medical knowledge, there are still a lot of patients with DM undetected. Early detection and prompt treatment of type 2 diabetes mellitus remain an important health issue.

In this cross-sectional study, the rate of undetected type 2 DM among older adults, their characteristics and a high-risk profile most suitable for screening were evaluated.

The group of 623 older adult survivors of 25-year cohort were drawn from the Israel Central Population Registry for the Israel Study of Glucose Intolerance, Obesity and Hypertension (the Israel GOH Study), an ongoing nationwide longitudinal study in which a sample of non-diabetic individuals born between 1912 and 1941 was examined and underwent a 100g OGTT during the early 1980s.

There are 53.5% males, aged 58– 93 years. They were interviewed for lifestyle habits, morbidity and use of drugs. Self-administered measurement of subjective health perception, anthropometric measurements, laboratory examinations of 12-h fasting venous blood and 2-hr oral glucose tolerance tests were carried out.

The prevalence of known diabetes was 18.9% and of undetected type 2 DM was 13.2%. It is more likely for males, those with systolic blood pressure >=130 mmHg, triglycerides >=1.7mmol/l (150 mg/dl) and large waist circumference to suffer from undetected type 2 DM. Compared to known diabetic patients, the undetected DM patients were predominantly males, slightly younger, rated their health status more favourably and had less co-morbidities.

There are still a large proportion of older adults with undiagnosed DM. A lot of work is needed in DM screening to improve the situation.

Advance end-of-life healthcare planning in an acute NHS hospital setting; development and evaluation of the Expression of Healthcare Preferences (EHP) document
Age and Ageing 2009; 38(1): 81 - 85

UK Hammersmith Hospitals NHS hospital trust has completed possibly the first project to design and evaluate a document to aid older adult in-patients to discuss and record end-of-life healthcare preferences.

With input from users and professionals, they developed the document named Expression of Healthcare Preferences (EHP) - consists of a form and explanatory booklet. It is enclosed with a Patient Information Pack containing a standard hospital literature. Prospective questionnaire survey is used for data collection and subsequent evaluation. It is carried out in wards for older adults. The document states that it is not a legally binding advance directive to refuse treatment.

It turns out that 95 patients (mean age 81, median MMSE 28) received the EHP. 61 (64%) read the EHP and 29 (48%) of these recorded their healthcare preferences. The form prompted end-of-life care discussions between 43% of these patients and medical staff and between 52 of these patients and “those close to them”. It was thought to be helpful (median score 8), interesting (8), informative (8) and reassuring (7) but not upsetting (1) on a score of 1 to 10.

The EHP is an end-of-life advance healthcare planning tool which can be used to prompt older inpatients to discuss and record their end-of-life healthcare preferences.

THE HONG KONG GERIATRICS SOCIETY - MEMBERSHIP APPLICATION/RENEWAL/INFORMATION UPDATE

Name	English:			Chinese:		
Correspondence address:						
Current practice: (Please tick)	❒ Hospital Authority	❒ Depart. of Health	❒ Private Practice	❒ University of H.K.	❒ Chinese University of H.K.	❒ Others
Post (e.g. MO, SMO, Prof etc):						
Hospital (if applicable):		Department (if applicable):				
Email address:						
Telephone:	Office:	Mobile:	Fax:			
Basic qualification (basic degree) and year:						
Higher qualifications and years:						
Publications/presentation of local studies / surveys in Geriatrics: (please send an attached summary sheet)						

Membership status wish to apply for, renew or change (please circle):

A. I am an accredited Geriatric Specialist according to the criteria of HK Academy of Medicine (HKAM)
(Annual fee **HK$ 200** or Life membership **HK$ 2,000** – Regular member)

B. I am currently under higher specialty training in Geriatric Medicine according to HKAM
(Annual fee **HK$ 200** – Regular member)

C. I am a registered medical practitioner in HK who is interested in Geriatric Medicine
(Annual fee **HK$ 100** – Associate member with no voting right or right to be elected as council member)

Life membership in only available in category A

For official use only	Membership: Associate / Regular/ Life	Date of Admission:

NEW MEMBERSHIP APPLICATION SECTION

Application of new membership has to be proposed by a **REGULAR MEMBER** of the Society.

Name of the Proposer:	Signature

Please send this form and cheque to **Dr YM Wu (Hon. Secretary), Geriatrics and Rehabilitation, Haven of Hope Hospital, 8 Haven of Hope Rd, Tseung Kwan O, Kowloon, Hong Kong SAR, China.**

MEMBERSHIP RENEWAL SECTION

Annual / Life membership fee: Please send this form together with a cheque (fee depends on the type of membership renew – please refer to the information above) payable to "**The Hong Kong Geriatrics Society**" to:

Dr James Luk (Hon. Treasurer), Department of Medicine and Geriatrics, 5th Floor, Fung Yiu King Hospital , 9 Sandy Bay, Pokfulam, Hong Kong SAR, China

Name:	Signature:	Date:

Version 1.3 James Luk