

SYNAPSE

JANUARY 2009 RESTRICTED TO MEMBERS ONLY

HONG KONG COLLEGE OF PHYSICIANS
香港內科醫學院



Sapientia et Humanitas



“Fury over Mt Fuji”

CL Lai

Contents

3 Special Articles

- The President's Annual Report 2008* KN Lai
The President's Address at the Fellowship Conferment Ceremony 2008 - "Medical Ethics" KN Lai
The 13th AJS McFadzean Oration 2008 York Chow
Hong Kong As a Medical Hub : Fantasy or Reality? York Chow
The Gerald Choa Memorial Lecture 2008 SP Lee
Measuring health: For goodness and fairness SP Lee

14 Council News

18 Scientific Section

- Sir David Todd Lecture* Anthony Chan
Towards Individualized Therapy in Nasopharyngeal Carcinoma Anthony Chan
Best Thesis – Gold Award Winner Catherine Yuen
Detection of Subclinical Synovitis in Patients with Rheumatoid Arthritis in Clinical Remission Catherine Yuen
Best Thesis – Silver Award Winner Nicola Chan
Extramammary Paget's disease Nicola Chan
Best Thesis – Bronze Award Winner KL Chow
Changes in Crohn's Disease Phenotype over time in the Chinese Population KL Chow

20 Announcements

21 Examinations and Results

22 Training

- Statistics on No. of Trainees in all Specialties*
Statistics on No. of Fellows in all Specialties

27 Profile Doctor

- The Right Hon. The Lord Turnberg* John Mackay

SYNAPSE



Room 603
Hong Kong Academy of Medicine Jockey
Club Building
99 Wong Chuk Hang Road
Aberdeen
Hong Kong

Tel 2871 8766
Fax 2556 9047
email enquiry@hkcp.org
College Website <http://www.hkcp.org>

Synapse Editorial Board

Editor : Dr Carolyn PL KNG

Assistant Editor : Dr John MACKAY

Co-Editors : Dr TF CHAN
Dr Johnny WM CHAN
Dr Jenny YY LEUNG
Dr ML SZETO

Ex Chief-Editor : Prof Philip KT LI
Prof Mathew MT NG

All Copyrights reserved by
the Hong Kong College of Physicians
and no part of the Synapse can be reproduced without
the prior approval from
the Hong Kong College of Physicians.



The President's Annual Report 2008

KN Lai
President, HKCP

In the year of the Rat 2008, Hong Kong SAR has sustained a peaceful progress. With a vigilant and attentive approach, our medical community has successfully smothered the constant threat of Avian flu and local food safety issues. Two events in the summer, namely the Beijing Olympics and the LEGCO election gave us excitement and pride.

This is my fourth annual report since elected to the Presidency in 2004. I appreciate greatly the support from the Council and I would like to thank all Fellows and Members for having given me the opportunity and honor to serve you. Our College maintains strong academic links and collegiate friendship with overseas physician colleges in London, Edinburgh, Glasgow, Australasia, Malaysia and Singapore. Moving into the third decade since the founding of our College, we aim to consolidate our global networking with other major physician colleges and rekindle our interaction with physician societies in China. In May 2008, I attended the 75th Anniversary celebration of the Royal Australasian College of Physicians in Adelaide. We exchanged views to facilitate physician training between different countries such that young clinicians can extend their horizons by learning different systems of medical practice. On the local front, our College continues to improve our computerization system in training and examination matters allowing paper documentation to be conducted from the desktop computer using the Web.

The Annual Report outlines the various events and achievements of all the College Committees that require no further elaboration. My heartiest gratitude and appreciation goes to all Chairmen, Members of the Committee, the Boards and the Secretariat for having done such a magnificent job. Briefly, I would like to highlight some of the important changes.

Education and Accreditation Committee

Under the very capable Chairmanship of Dr. Loretta Yam the committee had improved the examination

format, scoring system, remedial training program, and written guideline of the dissertation thesis. Several new developments in training were established in the last 12 months.

1. The College has been collaborating with HA to develop an Affirmatory Proficiency Test (APT) – Self Learning Tool (SLT) for basic physician trainees, to raise awareness of trainees about clinical risks with improving the view to clinical management.
2. The Specialty boards had conducted annual assessments for 229 trainees and exit assessments for another 109 candidates.
3. The CME Board had made amendments to the CME/CPD Operational Guidelines under "College-approved Quality Assurance report", whereby the Board decided that all future applications to accredit Audit Meeting, Mortality and Morbidity Meeting for CME will not be approved. The revised version of the CME/CPD Operational Guidelines has been uploaded to the College website and published in Synapse (July 2008). The statistics on the pass and failure rates of Exit Assessments in 1997-2006 have been sent to all Specialty Boards, so that they can review the training programs of hospitals with relatively lower passing rates. Regular updates on examination results will continue to be distributed to the Specialty Boards.

National and International Liaison Committee

Under the dedicated Chairmanship of Professor W.K. Lam, continues to liaise with national and international professional bodies in Medicine on matters of mutual interest, including postgraduate training, professional examinations, scientific and academic interaction and continuous professional development in the practice of Internal Medicine.

Our College continues to provide input and professional assessment to the three Royal Colleges of Physicians in United Kingdom with regard to local clinicians nominated for College Fellowship.

Our College and the Glasgow College co-hosted the inaugural “William and Elizabeth Davies Foundation Trust International Meeting” on 10-11 May 2008 in the Academy of Medicine Building in Hong Kong. The theme of the Meeting was “Pushing the Boundaries in Multidisciplinary Cancer Care”. There was 1 Plenary Lecture namely the Davies Memorial Lecture and 5 Plenary Sessions including “Screening & Imaging”; “Surgical Oncology”; “Adjuvant Therapy”; “Advanced Diseases” and “Palliative Care” with 9 RCPSG and 9 HKCP speakers. A total of 178 participants attended the meeting including 29 speakers and chairmen; 17 RCPSG delegates and 20 Chinese delegates, who were supported by 10,000 pounds by the William and Elizabeth Davies Foundation.

The RCPSG Fellowship Admission Ceremony, conducted by Prof Brian Williams, FRCPS (Glasg), was also held on 10 May 2008. Prof Sir David Todd received the Honorary FRCPS(Glasg) (*Summa Cum Laude*) at the ceremony. Prof TK Chan, Prof KN Lai, Prof WK Lam and Prof Richard YH Yu received the Honorary FRCPS(Glasg) (*Honoris Causa*). Fifty-eight newly admitted Fellows attended the ceremony.

Examination Committee

Annually, two written Part I, three written Part II, and two clinical PACES examination are now held in Hong Kong. The local PACES examination centers have increased to ten. Prof Matthew Ng is serving the MRCP(UK) Part I Examining Board as HK representative while Prof KN Lai is the HK representative at the MRCP (UK) Part II Examining Board and Policy Board.

Scientific Committee

The Scientific Committee had organized a Scientific Meeting of Hong Kong College of Physicians on October 13-14, 2007 with over 500 participants.

The Gerald Choa Memorial Lecture was delivered by Father Alfred J. Deignan, S.J. Professor John Leong gave the AJS McFadzean Oration entitled: “Higher Education in Hong Kong - Opportunity to be an International Hub?”

Research Committee

The Research Committee had selected three young investigators for Distinguished Research Paper Award. All

were invited to present their papers in the Annual Scientific Meeting of the College in October 2008, with a medal awarded to the best presenter.

Membership Committee

As of 31 August 2008, 80 applicants were proposed for Membership and 34 applicants for Fellowship.

Professional and General Affairs Committee

The Committee continues to handle issues related to professional and general medical affairs this year. The Committee organized a lecture on "ERCP in the Management of RPC" on 28 November 2008. The lecture was delivered by Prof Joseph W. C. Leung from the University of California at Davis.

SYNAPSE

SYNAPSE continues its important role of fostering communication between the College and its Fellows, Members and trainees. Updated statistics on the number of Higher Physician Trainees in all Medical Specialties in Hong Kong are published regularly as a reference for trainees deciding on their career pathway.

During the past year, Synapse was greatly privileged to interview Professor John Vallance-Owen and Professor Yeoh Eng Kiong as profile doctors who have contributed vastly to medicine in Hong Kong.

Administration and Finance Committee

We are grateful to our Hon Treasurer for his very shrewd book-keeping such that the College remains in a healthy state financially.

Finally no word of appreciation or thanks can express my gratitude to the two Vice-Presidents, Chairpersons of different committees, College Council members, and the previous Presidents for their invaluable support and advice. My final vote of thanks goes to all the very hardworking secretaries of the College who have maintained our engine running smoothly.

The President's Address at the Fellowship Conferment Ceremony 2008 - "Medical Ethics"

KN Lai
President, HKCP



Today is a great day for the College. Ninety-three 93 physicians will be admitted to the Fellowship and another 51 to our Membership, following their success in qualifying examinations. Let me extend the College's congratulation to the new members and fellows. In this year's conferment ceremony, I will address the issue of "ethics" – ethics which pertain to our medical profession. Four years ago when I planned my first presidential address, I intended to speak on ethics – a fundamental cornerstone of our profession. Yet this is such an important and sacred subject that I initially found it too formidable to tackle perhaps until the second term of my office. One may remember among the epic space series of Star War movies, Episode IV was first released in May 1977, followed by episode V and then VI. Finally, Episode I was only released twenty-two years later in 1999, at the turn of the last century. On this occasion, I speak on Episode I of Medical Practice – "Ethics" – as applies to our profession. One may wonder with the teaching program of the medical schools and the mandatory PACES and higher physician training examination in ethics, are we not already well equipped and henceforth able to hold the reins of

this issue? If we read Professor P.D. Skegg's book entitled "Law, ethics, and medicine" published by the Oxford University Press in 1988 and the latest 2007-2008 edition of the American Medical Association Code of medical ethics, apparently, we are certainly practicing our profession in a highly ethical manner. We care for our patients and our community, we respect patient rights, we respect the law, we uphold standards of professionalism and we seek out informed consent. Then, why should we continue to raise concerns on the subject of medical ethics?

In fact, we need to address this topic for two reasons. First, our profession should never be complacent with self-satisfied dignity. Second, our trainees have the right to question whether appropriate standards are applied universally and being practiced by their supervisors. As supervisors, teachers and academics are perceived to hold the moral high ground, the ethical standards we ourselves practice should be no less stringent than what we would expect of our trainees and fellows. Surprisingly, this may not be the case. Let me quote you news published in the public domain. From the South China Morning Post in July 2007, it reads "Doubts over

university scrutiny of academics: new probe urged on plagiarism claims". Again from South China Morning Post in June 2008, news heading reads "*University hepatitis expert resigned over the article*". On the May 31, 2008 issue of the British Medical Journal, it reads and I quote: "*Dean is charged with fraud*". Unfortunately, these are not isolated incidences. The issue of abridging medical ethics is silently yet rapidly eroding the integrity of our profession in Hong Kong. Relatively mundane examples brought forward to the Medical Council are not at all uncommon, but other much more fundamental ethical transgressions are scarcely ever addressed.

The following examples are taken from the media, published documents in the public domain or case reports from this region. I will categorize these issues with regard to four areas.

First, we examine the issue of patient management. Our profession has developed the concept and practice of holistic care. The fundamentals of holistic care are to provide the patient with a balanced, evidence-based and proven treatment in the interest of the patient's health and comfort, the last aspect being especially pertinent to terminal illness. However, we have all seen patients with wide-spread documented malignancies undergoing procedures, such as resection of only part of the primary tumor (with newer instruments). Yet the patients were told that the procedure offered a cure. At the end of the day, the patient underwent a procedure that was not indicated, that increased suffering and delayed effective adjuvant or comforting treatment of a palliative nature. In all developed countries, standardized, evidence-based treatment regimes or treatment guidelines are accessible to the public. Unorthodox treatments have to be sanctioned by the health authority. Experimental treatment is conducted only in designated centers, under the surveillance of an ethics committee. Often unorthodox treatment is not tightly regulated in Hong Kong. This is an important ethical issue our profession must not shy away from.

The second area relates to untrue or misleading certificates and other professional documents as stated in section III, part A3 of the Professional Code and Conduct of our Medical Council. Quite

often, the Medical Council deals with issues related to inaccurate sick-leave certification or letters of attendance. Now, we hear from the media about false receipts, unexplained billing and even false documentation of treatment records. The nature of the procedure being recorded was changed, in order that aberrant billing could be issued.

This brings me to the third area. The Medical Council stresses the importance of patient privacy in section III, part A1 of the Professional Code and Conduct. This applies not just to the patient record in the hospital or the clinic. For example, we can frequently read the entertainment pages of local tabloid newspapers, in which doctors who are interviewed name celebrities as their patients. Some even tell the media what disease and treatment such celebrities are having. This is an absolute breach of patient privacy, and to some extent it amounts to advertising. Astonishingly, some of these doctors are senior clinicians or renowned academics!

Now let me come to the fourth and final area - plagiarism and research misconduct. My university has recently conducted several workshops on research integrity, targeted at postgraduate students. The contents included misconduct such as falsification, and data mismanagement such as inappropriate disclosure and ownership. Our own College also scrutinizes dissertations and case reports submitted for assessment of higher physician training. Students and trainees are informed that computer software is available to detect plagiarism or similarity of their manuscript with published articles. Nevertheless, from the news media, we begin to learn about more sophisticated forms of plagiarism in our medical profession. How are these perpetrated? The simplest way is to submit data from a study to two separate journals with fewer numbers of patients in the first and a more complete list in the second. Due to simultaneous submission (usually electronically), the respective editors will not have a clue as to such duplicate publication at the time of review. Another way is to submit the manuscript twice to two different journals, after changing the title and the summary, but retaining almost identical methods, results and discussion. The last and the most



imaginative way is to fake the result – that may be termed creative instead of scientific writing. These types of writing include fabrication of patient numbers, patient status, treatment duration and pathological findings. How are such irregularities discovered? Again, according to information from the public domain, exceptionally, a few are reported by co-investigators who have no idea that their names are on a paper prior to its publication. Most are discovered after the event, by the editors or other colleagues who read the literature or conduct a mega-analysis. Most remarkable of all, one such incident was even discovered by a pharmaceutical company. Thus, if the data from the relevant publication was true, the company was supposed to have sold 126 million dollars of a specific drug. In fact, the real sell figure was only a fraction of this. What happened to these dubious publications? Nothing much happens in this locality. In typical fashion there may be an internal enquiry by a selected committee, with findings to be released in the future but with an unspecified time frame. Neither clinical nor laboratory data are quarantined nor is an independent investigation instituted. Contrast this to the co-recipient of the Nobel Prize for Medicine and Physiology in 2001 who realized that results in a Nature paper she co-authored could not be reproduced, she retracted the paper and denounced the findings publicly. All her work that contributed to her Nobel Prize was re-examined by an independent committee. What a difference from the approach in this part of Asia! One may argue that this issue is only related to scientific publication and has nothing to do with medical ethics. Wrong! These deeds directly violate Section B, Parts 5.4, 7.1 and 9.1 of the Professional Code and Conduct of the Medical Council.

Finally, why are these very senior clinicians or academics involved in such issues of research integrity? I can think of three reasons. First, the pressure to publish or perish. With the numbers game so important in ranking of academic institutions, certainly this could be a contributory factor. Fame is another stimulus. An unusual research practice has developed in our vicinity over the last decade. Instead of working with scientists or spending time to acquire laboratory training, some clinicians simply employ scientists

to work for them. Even grant applications are written for them by these employees. The worse scenario is that the research is never closely supervised, nor is the project leader able to adequately monitor what his/her team is doing. The last reason is greed. Seniors are listed as authors, despite making no contribution, which amounts to just an academic gift or should we say, tariff. In one of the sagas that I just quoted, most coauthors denied reading or acknowledging a manuscript which was found to contain fabricated information. Mind you, as editor of several international medical journals, I am fully aware most journals now insist that authors must reconfirm by writing (or electronically) their involvement even before initiating a review. In many ways this intriguing mystery is akin to the conclusion of the film “Rashomon (羅生門)” directed by Akira Kurosawa (黑澤明). In this tale, there are many versions of the story, but the truth is never revealed.

When I first graduated from medical school, being a doctor was considered respectable as the public knew that we honored and valued our professional merit and code of conduct. Three decades later, despite the few negative incidents that have raised doubts in the minds of the public, I still have faith in our colleagues’ ability to uphold medical ethics. Confucius in his Analects (論語) said, and let me quote “The virtue of propriety, justice, honesty and honor are the four moral cornerstones of our society” (禮義廉恥 · 國之四維). Marcus Aurelius, the Roman Emperor who was also known as a Philosopher, wrote about ethics in his book, called Meditation. From the latter work I quote: “If it is not right do not do it; if it is not true do not say it” Certainly, medical ethics is simple but it must be practiced by all. This includes junior and senior doctors, working in the public or private sector, and irrespective of whether they are academics or non-academics. No one can be exempted from this bounded duty.

I think I have already spoken too much. As mentioned last year, here is a Slovenian proverb: “Speak the truth, but leave immediately after.” With this, I wish you every success in your future career and a very pleasant evening.

Thank you.

The 13th AJS McFadzean Oration 2008

Hong Kong As a Medical Hub : Fantasy or Reality?



York Chow

*Secretary for Food and Health
Food and Health Bureau, HKSAR*

As a student of Prof. McFadzean, I feel both honoured and privileged to deliver the McFadzean Oration this year. Prof. McFadzean was, in his favourite expression, “without a shadow of doubt”, the most respected and “feared” teacher during my time as a medical student in the Medical Faculty of the University of Hong Kong. I still remember how students fondly called him “Old Mac (老麥)” and how they rushed from the morning lectures at Sassoon Road to attend his tutorials at the Professorial Block of Queen Mary Hospital, fighting to occupy the seats in the back rows of the lecture room to avoid being asked one of his challenging questions. Once, the contest was so fierce that a student actually collapsed after running up the steep incline of Sassoon Road and climbing those demanding steps. At another time, a student uttered, “I don’t know”, even before he was questioned by the dear Professor.

To cope with the immature minds of we medical students, the Professor needed to convert complex medical knowledge and concepts into simple principles and examples. I will always remember how he described the common terminal illness of the elderly, bronchopneumonia, as “the old man’s friend”, when he emphasized the futility of unnecessary resuscitation and the importance of “doing no harm” for our patients, and respecting the course of nature and God’s designed destiny for each and every one of us.

I also recall a tutorial when the choice of career pathways for medical students was discussed. Prof. McFadzean

remarked, “The brightest students will take up (internal) medicine, and the least able ones will become surgeons.” I was quick to ask, “what about orthopaedics?” He responded instantly, “They are not even homo sapiens!”

I, therefore, found it tough to decide on the topic of this oration. Over the past four years as the policy secretary for health in Hong Kong, I was constantly asked, by people I met, whether Hong Kong should become a medical hub. Some even said that Hong Kong already is one. When I asked them how to define a medical hub, I received a wide spectrum of definitions and descriptions. I shall therefore attempt, this evening, to share some of my views with you, and hopefully stimulate more discussion and initiatives within this elite audience; many of whom, no doubt, will contribute to shaping the healthcare and medical development of Hong Kong. I shall try to define a “medical hub” according to my own interpretation: what it should be (and what it should not be), how qualified we are at present, and what we need to do if we want to embark on this journey.

Looking back at the history of renowned medical centres, it is not difficult to define a “medical hub”. London, Glasgow, Edinburgh and Dublin were the early centres of medical discoveries for the English-speaking world, together with Paris, Frankfurt, Rome and Bologna in continental Europe. In the nineteenth century, American centres started to form, interestingly, not necessarily in big cities. The Mayo Clinic and John Hopkins are classic examples. Many of those cities and places are still the preferred training centres for doctors,



and particularly, preferred places to have treatment by patients from all over the world.

If one examines these centres closely, one will discover the following common factors :-

1. There are one or more renowned medical schools, with a strong commitment to produce quality graduates.
2. There has always been a sizable group of research scientists and clinical researchers, who worked together, helping each other in developing medical innovations.
3. There have been consistently outstanding medical leaders, popular clinicians and dedicated teachers, who have worked tirelessly to care for patients, teach students and train the younger generation of doctors. They set high standards and maintained discipline and acted as role models for their followers.
4. There has been a strong tradition of medical ethics, which perpetuated throughout generations of medical graduates and trained doctors. This cultural foundation of moral and ethical standards, together with professional expertise and experience, constituted the integrity and trustworthiness of the medical services, and were the main reasons for patients coming to seek advice and treatment.

A “medical hub” is therefore a place of preferred treatment, education, training, research and professional development. It is not, I repeat, it is not, a place where people are lured to have cheap health-checks, often with free tours and spa treatments thrown in as added attractions. Neither is it a place where doctors just make a lot of money treating patients from neighbouring countries, taking advantage of their relatively lower standard of care. Nor is it a place where there are merely glamorous facilities filled with expensive equipment and flashy furniture. One might argue that Hong Kong is an obstetrics service hub as a result of the large number of imported cases. It is, however, difficult to conclude if those cases choose to come here because of our medical standard or otherwise. Some of you might have different opinions, but it would be inappropriate to call these opportunistic initiatives “medical hubs”.

There are also additional success factors required for medical hubs for today, as globalization and the expansion of and access to information have changed the whole world. People, patients (or consumers) are more knowledgeable, inquisitive and demanding. We are also witnessing increasing professional advertising that sometimes goes beyond the boundaries of health education and medical information. Publicizing immature research, unproven technology and inaccurate medical outcome data might help self-promotion for some, but it also misleads the public and creates unrealistic expectations, thus seriously

undermining the respect and credibility of the medical profession. A transparent, objective and responsive peer monitoring mechanism within the medical profession is essential for maintaining high healthcare standards anywhere in the world. It is not just the responsibility of the Medical Council alone, but all institutions, hospitals, healthcare organizations and associations should maintain the same level of scrutiny and objectivity.

With globalization, a medical hub should have the ability to attract the most capable physicians and scientists from around the world, to gravitate to a place where they can excel and develop the full potential of their talents, either clinical or research, and teach their peers from local or foreign places. Networking with other medical hubs is important for keeping track of international developments, and mutual recognition of qualifications of excellence should be explored to permit ease of participation from teams of international experts. A number of Asian countries have already progressed in this direction with some visible success.

Let us look at Hong Kong, and decide whether it qualifies to be a medical hub. We have certain areas of strength :-

1. Hong Kong can be justifiably proud of its high health indices, such as infant mortality, life expectancy and even the low infectious diseases statistics. This is largely due to a universally accessible healthcare system heavily subsidized by the government and the highly efficient and professional teams of doctors, nurses and other healthcare professionals.
2. The two medical schools and our dental school, together with nursing schools and tertiary institutes that train allied health professionals and traditional Chinese medicine practitioners have all acquired high international recognition. This allows Hong Kong healthcare workers to stay on a par with international standards. I am confident the quality of these human resources can be kept in the future.
3. Despite the limited academic and research funding for tertiary institutes, Hong Kong has developed a team of scientists and researchers who have consistently produced good quality research, particularly in clinical research.

There are, however, multiple challenges being faced by Hong Kong :-

1. The healthcare system, with its polarized public and private providers, often gives rise to service barriers and difficulty in retaining experts in the public or academic institutes after they leave the public sector. Such a brain drain results in a lack of continuity and momentum in developing medical innovations and quality healthcare teams. More open and flexible

employment terms should be explored to allow our elite and committed professionals to work in both sectors, and to continue to pursue their academic interests.

2. Too much local medical and clinical research is done in isolation, with limited data and samples. More multi-centred research and large-scale surveys should be encouraged, which would help to capture the diseases patterns and evaluate treatment outcomes.
3. One of the most significant changes in medical practice over the recent three decades is the increasing application of commercial practices in the medical services. The traditional professional doctor-patient relationship has moved towards a “service provider – consumer” relationship. The proliferation of advertisements, service promotion and the involvement of some medical doctors in non-medical trades have changed the competition platform of the medical profession. Coupled with the influence of a profit-focused mentality in many of our neighbouring places, I am concerned whether our traditional ethical and moral values can withstand the challenge of time.

As a government which highly values its medical services and profession, Hong Kong is committed to maintain, improve and develop healthcare services. A robust and strong public service, (i.e. the Hospital Authority and the tertiary institutions), coupled with a vibrant and responsive private sector, can sustain our international standard and image. This commitment is even stronger now as we experience the global financial crisis and the food safety

crisis on the Mainland. We must exploit our autonomy and continue to develop ourselves as a unique international city of China.

The government will invest in the medical profession and healthcare services in many ways. An increase in healthcare funding, building and redeveloping hospitals and clinics, developing the universal electronic health record system, pilot initiatives to bring public and private providers closer together, positioning the prioritization of public services are already carried out. Centres of excellence for certain specialties to encourage collaborations and partnerships are being developed. All these should provide a healthier environment for future development for the benefit of patients and the whole of society.

Medical care is a professional service provided by people: people with knowledge, expertise, and experience. More importantly, it relies on professionals who possess strong compassion, and high standards of honesty and morality. We are indebted to Prof McFadzean who acted as our great teacher and role model. Those who followed him, such as Prof. David Todd, Prof. Rosie Young, Prof. Richard Yu and Dr. CH Leong have passed those essential qualities to generations of students who make up our medical professions today. Let us treasure those values and principles, and continue to develop young doctors to be capable, caring, conscientious and confident professionals. Let them enjoy the trust and respect of our citizens. As long as they can achieve that, I could not care if Hong Kong is a medical hub or not !





The Gerald Choa Memorial Lecture 2008

Measuring health: For goodness and fairness

Sum-ping Lee

Dean

Li Ka Shing Faculty of Medicine
The University of Hong Kong

Professor Richard Yu, ladies and gentlemen – it is a rare honour to be invited to address you, and I thank you.

Dr. Gerald Choa was a legend, embracing the values of public health, academic scholarship and education. Above all, he cared deeply about medical ethics and the common good. In receiving this intimidating assignment, my challenge is to come out of the comfort zone where I am well protected by my own esoteric research, and think about the role of the medical profession and its interaction with the community. I am compelled to give up looking just at the leaf, but to adopt a more expansive view to include the tree, the entire forest, and their interaction with the hills and valleys, waterfalls and streams.

Timing of a perfect storm

The Book of Change (*I Ching*) states that “Everything in this universe is ephemeral. The only constant is change.” This timeless saying is most poignant at this tumultuous and yet defining time for Hong Kong. The

unique dynamic remodeling of the history and the geopolitics in the evolution of our people, has created all the necessary and at the same time, unavoidable, elements ready to breed the next perfect storm. Medical science is accelerating at a breakneck speed. We are undergoing a period of unprecedented technological advances and breakthroughs. Post-genomic science, the power of supercomputers and robotics, and the development of new drugs are speeding forward, leaving us behind in a daze. They have raised the cost of medicine and healthcare to a level beyond reach for the general public, and have challenged the limit of societal tolerance and ethics. Fueled by to-the-minute real-time internet information, and overt promotional activities by drug companies and medical device manufacturers, the public has acquired an insatiable demand and feeling of entitlement to the “newest and the best”. Very few thinkers in the medical profession, or amongst healthcare analysts and policy makers, realize that more powerful and sophisticated tests, more potent and toxic medications and invasive procedures do not equate better care. There is no one measuring the evidence. Who pays for medical care is also an unsettled question.



The economy, we have come to realize through bitter lessons, is fragile and fickle and can sway to the outcomes of the interplay of incompetence, greed and fear of corporations and individuals, man-made wars, natural disasters, or a mere point mutation of a viral gene. The time has arrived for a change of the old paradigm on healthcare.

I recall a movie, “Roshamon”, directed by Akira Kurosawa which impressed me with the moral that there can be many versions of a piece of “truth”. In the movie, a man was stabbed to death. The murder scene was described by several characters, each from a different background and who knew just a little more of the peripheral relationships and actions of the dead man (house maid, housekeeper, brother/cousin, spouse, mistress). As the same take was replayed, like variations upon a theme, by each of these characters, you would be absolutely persuaded and convinced to believe what was to be the motive and who was the murderer. When each case was stated, it was perfectly logical and conclusive. The only truth was that a man was dead. Who told the truth?

Who cares for health?

The egalitarian: The egalitarian view that all individuals are entitled to a certain level of rights and respect would argue that it is the government's responsibility to provide universal healthcare. This view resonates with the traditional Chinese cultural thinking and societal attitude in ethics. Therefore, from a rather Utopian viewpoint, the theory of justice would suggest that health is a moral and ethical responsibility of the state. Yet in real truth, the benevolence of any government cannot and will not sustain universal healthcare coverage for all levels of care *ad infinitum*. Because of increasing longevity, the burden of cost of chronic cardiovascular, neurodegenerative diseases, a diminishing workforce and rising expenses, this scenario is unsustainable.

The libertarians: The libertarians, on the other hand, argue that there should be equal opportunity and choice for everyone. You should take care of yourself and you are responsible for yourself. Health, the doctrine explains, is a self-determined state. If you choose to smoke and drink excessively, use illicit drugs or lead a lifestyle that is conducive to the development of obesity-associated diseases, then do not expect the government or others to take care of your medical bills. And if you have not thought of saving some of your money to take care of yourself, that is too bad. The government's role is to take care of the unfortunate and the poor (through

no fault of their own), and everybody else should take care of themselves. We have witnessed disasters like the healthcare system in the United States, which is driven by market and the level of affluence. This fractures society into differing classes of citizenship. Here, I am reminded of a song, written and sung by Joan Baez (~ 1965). In “All My Trials”, she wrote about dying and going to heaven, and she sang with that soulful haunting voice: “If religion were a thing that money could buy – the rich will live, and the poor will die”. The libertarians will replace the word “religion” with “healthcare” in 2008.

The utilitarians: Then there is utilitarianism which wants to do “the best good for the largest number of people for the longest time”. Healthcare has to compete within its own category intrinsically, as well as extrinsically with other societal priorities including education, security and crime control. Out of the competition and assignment of priorities may rise the shadow of rationing.

The pragmatist and the realist: And then of course the pragmatists and the realist (aka politicians) are always there to solve the immediate problems. They do what needs to be done and what can be done. Without foresight, long term planning or vision, they just put their finger in the leaking dyke. Reactive and not proactive, they do what is necessary as the opinion polls indicate. Whatever is needed to stay in office for another term.

The medical profession and healthcare system

The interaction of the medical profession with the public and community leaders and policy makers has dramatically undergone phenotypic transformation. The medical profession, by and large, still clings on to its hierarchical, paternalistic and self-regulating culture. There has been much more open discussion, patient-centered healthcare delivery with a level of transparency and accountability. But there is yet much more to improve. The public, empowered and enabled by ready information access, and an increasing demand for entitlement, assisted by the power of the media, has developed into a doctor-bashing culture. The public does not understand the plight of the medical practitioner whose professional life is highly stressed and super-saturated. They have to work and perform under situations that the public themselves would shun. The public have no sympathy towards the medical profession, because of their high expectation and the image of the



doctor, traditionally held at a high pedestal of knowledge and authority. They can easily understand and forgive Tiger Woods for missing a shot on the green, or Michael Jordan a free-throw penalty shot in the deciding moment of a NBA final championship game. This is human error. Whenever there is human judgment and performance involved, there will be human errors. On the other hand, for the public, any error in Medicine is inexcusable. The doctor is not protected by the general belief that “to err is human”. Unhappiness with medical service is often accompanied by uninformed interpretations, anger, and presented through the media with much distortion and exaggeration. There is a clear need to set up an ombudsman type of mechanism which is autonomous and independent that can provide impartial processing of complaints of perceived errors and substandard professionalism. The media cannot be used as a surrogate agency to present and provide judgment of an alleged incident.

But let a warning be heard by the people of Hong Kong. If there is no better communication with the healthcare providers, the “doctor bashing” attitude will result, like the U.S., in the practice of defensive and extremely expensive Medicine in order for the providers to protect themselves. Furthermore, the method of medical practice would be modified to be one of checking boxes of algorithms. The litigious nature of medicine will erode into the empathy, compassion and other humanitarian qualities of this noble profession. This will be replaced by a robotic approach by following template guidelines and doctors functioning as technicians dispensing medications and tests. Everyone suffers. Sadly, over 80% of U.S. doctors who had practiced medicine for 35 years or more responded to a survey - “Knowing what you know about medicine now, if you can turn back the time clock, would you still want to be a doctor?” by saying no. The same physicians also indicated that they would not recommend their children to follow a career of Medicine. There is a real danger for the policy makers, the public and the people who measure medicine and who are “watchdog” organizations, that they will turn the medical profession into an assembly line like service. This should never be allowed to happen in Hong Kong. We need to help the public to understand the nature of the practice of Medicine. The public needs to support the nurture and the training of men and women who will serve the

profession with passion, generosity, benevolence and preserve that touch of idealism and altruism.

Measuring health: for goodness and fairness

I propose a unified effort, including contributions from the College, the academic institutions, the government and non-government organizations to generate vigorous scientific evidence for Hong Kong. These include, but are not limited to, the followings:

- A. To measure healthcare data prospectively, compare our data with those of other countries, including China. To educate and inform policy makers about the burden of disease, healthcare priorities, cost effectiveness and decision making, and mechanisms of financing healthcare.
- B. To create a forum for a multidisciplinary approach in the education, training, and recognition of scientists, investigators who contribute to healthcare at a community and public health level
- C. To unite fragmented academic, government and non-government groups to synergistic collaboration, resulting in a much more productive, cohesive, and parsimonious thematic program. The effort would yield important, original results and insights into healthcare, benefiting and impacting not only Hong Kong, but regionally and internationally.

Hong Kong has evolved into a pluralistic society thriving on diversity of thinking and vocal political debates. We are entering into a new era of health care, both in its global interconnectedness and its local disease profile, culture, need, and expectations. The only way to understand and respond to these issues is for the medical profession to purposefully generate credible scientific evidence, derived from sound metrics and evaluation. In our complex and contradictory world, science remains the guiding force for enlightened social transformation and health care delivery. The medical profession has the responsibility and ability to ensure that in this new era to come we deliver our full potential for improving the wellbeing of the people of Hong Kong.

Professor Richard Yu, ladies and gentlemen, I am acutely aware of the honour bestow upon me today. Again I thank you.

21st Annual General Meeting, 10th Congregation and 22nd College Dinner



From left to right Dr TF Tse (Hon Treasurer), Prof WK Lam (Vice President), Prof KN Lai (President), Dr L Yam (Vice President) and Prof P Li (Hon Secretary).



Professor Richard Yu was conferred Hon Fellowship, HKCP by Professor KN Lai, President, HKCP

At the AGM, Professor KN Lai reported the continuing work and achievements of the College's various subcommittees in the past year to improve the education, accreditation and academic standards of physicians in Hong Kong. The College maintained strong academic ties with physician colleges in the United Kingdom, China and internationally. Dr TF Tse, the Honorary Treasurer, gave a detailed summary of the College's healthy financial budget.

The ceremony proceeded with the conferral of Fellowships and Memberships to 60 and 21 doctors respectively,

officiated by a distinguished platform party. Honorary Fellowship was conferred to Prof Richard Yu, Immediate Past President, Hong Kong College of Physicians following an introduction by Professor WK Lam.

The annual dinner concluded the first day of the meeting. The highlight of the dinner was not only the delectable food and wine but the AJS McFadzean Oration given by Dr York Chow, Secretary for Food and Health, HKSAR on this ceremonial occasion. The title was "Hong Kong as a medical hub: Fantasy or reality?"



The HKCP Council with the official Platform Party and distinguished guests at the Fellowship Conferment Ceremony 2008

Annual Scientific Meeting (11-12 October 2008)

The theme of this year's meeting was "Guidelines and practices". Over 400 doctors attending the two day conference were updated in current guidelines in nephrology, palliative care and critical care medicine. The Gerald Choa Memorial Lecture was eloquently delivered by Professor SP Lee, Dean of the University of Hong Kong Li Ka Shing Faculty of Medicine. His captivating and thought provoking speech on "Measuring health : for goodness and fairness" is included in this edition of Synapse for readers to share.

The second day of the meeting started with presentations of the Best Thesis Award and the Distinguished Research Paper Award for Young Investigators. This year, the prestigious Sir David Todd Lecture was delivered by Professor Anthony Chan on his research contributions "Towards individualized therapy in nasopharyngeal carcinoma".



Prof YL Kwong, Chairman of the Scientific Committee, not only organized the annual scientific meeting but delivered the closing lecture on novel antifungal agents in haematological practice to an appreciative audience.



Sir David Todd Lecture

Towards Individualized Therapy in Nasopharyngeal Carcinoma

Professor Anthony Tak Cheung Chan

Distinguished Research Paper Award for Young Investigators 2008

The following doctors received the awards on behalf of their research teams at the Annual College Dinner.

Dr Ronald Ching-Wan MA, PWH

Erectile Dysfunction Predicts Coronary Heart Disease in Type 2 Diabetes

R. C. W. Ma, W. Y. So, X. Yang, L. W. L. Yu, A. P. S. Kong, G. T. C. Ko, C. C. Chow, C. S. Cockram, J. C. N. Chan and P. C. Y. Tong

Journal of the American College of Cardiology, May 27, 2008; 51: 2045 - 2050.



Dr Nelson Lai Shun LEE, PWH

Hypercytokinemia and Hyperactivation of Phospho-p38 Mitogen-Activated Protein Kinase in Severe Human Influenza A Virus Infection

N. Lee, C. K. Wong, P. K. S. Chan, S. W. M. Lun, G. Lui, B. Wong, D. S. C. Hui, C. W. K. Lam, C. S. Cockram, K. W. Choi, A. C. M. Yeung, J. W. Tang and J. J. Y. Sung

Clinical Infectious Diseases, Sep 2007, Volume 45, Issue 6, Page 723-731.



Dr Vincent Wai-Sun WONG, PWH (presented lecture on behalf of Dr Henry Lik-Yuen Chan)

High Viral Load and Hepatitis B Virus Subgenotype Ce Are Associated With Increased Risk of Hepatocellular Carcinoma

H. L. Y. Chan, C. H. Tse, F. Mo, J. Koh, V. W. S. Wong, G. L. H. Wong, S. L. Chan, W. Yeo, J. J. Y. Sung and T. S. K. Mok

Journal of Clinical Oncology, Jan 10 2008: 177-182.



The HKCP Council 2008-2009



| | |
|---------------------------|--|
| President | <i>Professor Lai Kar Neng</i> |
| Vice-Presidents | <i>Professor Lam Wah Kit Dr Yam Yin Chun, Loretta</i> |
| Honorary Secretary | <i>Professor Li Kam Tao, Philip</i> |
| Honorary Treasurer | <i>Dr Tse Tak Fu</i> |
| Council Members | <i>Prof Chan Tak Cheung, Anthony Dr Kng Poey Lyn, Carolyn Professor Kwong Yok Lam Dr Lai Sik To, Thomas Dr Leung Man Fuk, Edward Dr Li Chung Ki, Patrick Dr Li Chun Sang Professor Matthew Ng Professor Sung Jao Yiu, Joseph Dr Szeto Ming Leung Dr Tong Kwok Lung, Matthew Dr Wong Chun Por Professor Wong Ka Sing, Lawrence Dr Chan Wai Man Johnny (co-opted) Dr Tse Man Wah, Doris (co-opted)</i> |

| | |
|---------------------------|---------------------------------------|
| Founding President | <i>Prof Sir David Todd</i> |
| Past President | <i>Professor Yu Yue Hong, Richard</i> |
| Hon Legal Advisor | <i>Mr Jacob YS Tse</i> |
| Hon Auditor | <i>Walter Ma and Company</i> |

Chairmen of College Committees

| | |
|--|------------------------------------|
| Examination Committee | – Prof Matthew Ng |
| Education and Accreditation Committee | – Dr Yam Yin Chun, Loretta |
| National and International Liaison Committee | – Professor Lam Wah Kit |
| Professional and General Affairs | – Dr Wong Chun Por |
| Scientific Committee | – Professor Kwong Yok Lam |
| Membership Committee | – Dr Patrick Li |
| Administration and Finance Committee | – Dr Tse Tak Fu |
| Research Committee | – Professor Wong Ka Sing, Lawrence |
| Synapse | – Dr Kng Poey Lyn, Carolyn |

Welcome Dinner for Visiting Presidents

The HKCP Council hosted a dinner for Professor Ian Gilmore (President, RCP London) and Professor Kwong Ming Fock (Master, Academy of Medicine, Singapore) on 15 November 2008. They were in Hong Kong to attend the International Association of College and Academy Presidents (IACAP) meeting held to discuss the topic "Maintenance of standard in specialist training in an era of reduction of working hours – should training scope be more focused?"



Dinner at the Hong Kong Club. From left to right: Dr Loretta Yam, Prof Joseph Sung, Prof WK Lam, Prof Ian Gilmore, (PRCP, London), Prof KM Fock (Master, Academy of Medicine, Singapore), Prof KN Lai, Prof Richard Yu, Prof Philip Li

List of New FRCPs

Congratulations to our Fellows who were elected to Fellowship of the Royal Colleges of Physicians in United Kingdom in the past two years!

Elected FRCP (London)

2007

Dr Chan Kin Wing
Dr Fong Ka Yeung
Dr Hui Che Fai Andrew
Dr Kung Nam Shing Nelson
Dr Kwan Kwok Leung Patrick
Dr Leung Chi Bon
Dr Leung Wai Keung
Dr Wong Kim Ming Francis
Dr Wong Kin Shing
Dr Wang Yee Moon Angela
Dr Yuen Man Fung

2008

Dr Szeto Cheuk Chun
Dr Mok Chi Chiu
Dr Chan Wai Man Johnny
Dr Mok Yun Wing Thomas
Dr Chau Mo Chee Elaine
Dr Kwok On Hing
Dr Lam Tse Fun Cathy

Elected FRCP (Edinburgh)

May 2006

Dr Wong Muk Chun Alfred
Dr Yuen Man Fung
Dr Wu Young Yuen Adrian

November 2006

Dr Lam Tse Fun Cathy

March 2007

Dr Cheung Hon Ming
Dr Wu Che Yuen Justin

November 2007

Dr Lau Kam Piu
Dr Mok Kin Ying Boniface
Dr Tang Chi Wai Sydney
Dr Wong Yuk Hwa Teresa

Elected FRCP (Glasgow)

May 2008

Hon FRCPS(Glasg) (*Summa Cum Laude*)
Prof Sir David Todd

Hon FRCPS(Glasg) (*Honoris Causa*)

Prof Lai Kar Neng
Prof Chan Tai Kwong
Prof Yu Yue Hong Richard
Prof Lam Wah Kit

FRCP(Glasg)

Prof Chan Tak Cheung Anthony
Dr Chan Chi Kuen

Dr Chan Kwok Wing Fridreich
Dr Chau Tai Nin
Dr Kung Wai Chee Annie
Dr Leung Kwok Fai
Dr Lo See Kit Raymond
Dr Luk Nai Ming Tommy
Dr Miu Ka Ying Doris
Dr Mok Mo Yin
Dr Sham Mau Kwong Michael
Dr Tang Chi Wai Sydney
Prof Tse Hung Fat
Prof Yeo Winnie
Dr Yuen Man Fung
Dr Chan Wai Kwong
Dr Chan Hon Wai Felix
Dr Cheung Kam Leu
Dr Choi Kin Lam
Dr Chow Shu Lap
Dr Chow Wai Hung
Dr Ko Kwai Fu
Dr Ko Pat Sing Tony
Dr Kong Pik Shan Alice
Dr Kong Ming Hei Bernard
Dr Kong Tak Kwan
Dr Lau Ka Ho
Dr Lo Ying Sui Archie
Dr Mo Ka Keung Loar
Dr Mui Chung Wo
Dr Tsang Tse Shu Michael
Dr Wong Chi Ming
Dr Wong Wai Ming
Dr Yeung Non Ming Jonas

SIR DAVID TODD LECTURE

Towards Individualized Therapy in Nasopharyngeal Carcinoma



Anthony TC Chan

Department of Clinical Oncology
The Chinese University of Hong Kong
Prince of Wales Hospital

Nasopharyngeal carcinoma (NPC) is a unique disease in its geographical distribution, biological association with the Epstein-Barr virus (EBV) and its sensitivity to radiotherapy (RT). Until the end of the 20th century RT was the mainstay treatment for NPC achieving satisfactory local control but significant proportion of patients who initially present with locoregionally advanced disease will develop distant metastases resulting in a 5 year overall survival rate of around 55% only. The first prospective randomized study demonstrating the superiority of concurrent cisplatin-RT over RT alone in locoregionally advanced NPC was undertaken at the Prince of Wales Hospital, demonstrating an improvement of 5 year overall survival from 58.6% to 70.3%, establishing this treatment as the new standard in endemic areas^[1,2].

Patients at particularly high risk of distant metastases may further benefit from the addition of neoadjuvant chemotherapy with biomarker monitoring^[3]. Following the discovery of the highly sensitive and specific biomarker EBV DNA, a prospective study demonstrated for the first time that elevated EBV DNA at 6-8 weeks after primary treatment for NPC was associated with an increased risk of death (hazards ratio 8.6), providing an opportunity for intensification of therapy at this time point^[4]. A multi-centre phase 3 trial using post-treatment EBV DNA for risk stratification involving 1,500 patients from all 6 centres in Hong Kong is currently being undertaken under my leadership as principal investigator.

Epidermal growth factor receptor (EGFR) is highly expressed in NPC and the first multi-centre study of an anti-EGFR antibody cetuximab in metastatic NPC was conducted under my leadership in the Cancer Therapeutics Research Group involving Singapore, Australia and Taiwan^[5]. With encouraging results of concurrent cetuximab-cisplatin-IMRT in locoregionally advanced NPC with correlative studies identifying predictive markers undertaken in our centre, future studies will further investigate the use of targeted agents in an individualized manner.

The immunodominant EBV genes are epigenetically silenced in NPC. A pilot study using Azacitidine in treatment-refractory locally recurrent NPC patients demonstrated for the first time the successful demethylation of latent and lytic EBV promoters in post-treatment NP biopsies, achieving pharmacologic reversal of dense CpG methylation in tumour tissue^[6]. A follow-up study adding a

histone deacetylase inhibitor is being conducted to further pursue the therapeutic potential of treatment targeted at reactivating the expression of epigenetically silenced genes in NPC.

EBV-associated tumours, including NPC, express the EBV-encoded proteins EBNA1 and LMP2. NPC patients demonstrate weak but nonetheless detectable CD8+ and CD4+ T cell responses to these proteins. In collaboration with the University of Birmingham with the support of Cancer Research UK, we have developed a novel recombinant MVA vector encoding both the EBNA1 and LMP2 proteins to stimulate both the CD8+ and the CD4+ arms of the T cell immune response. A phase I dose escalation trial of recombinant MVA-EBNA1-LMP2 vaccine in EBV positive NPC patients in clinical remission is currently being undertaken. This vaccine is well tolerated and even at the low initial doses tested appears to reactivate CD8+ and CD4+ T cell memory responses. Determination of the immunogenic dose with minimal toxicity will lead to trials designed to demonstrate anti-tumour effects and prevention of recurrence following primary treatment in high risk patients.

In summary, much progress has been made towards the individualized therapy of NPC patients based on the individual risk of treatment failure, with multi-modality approach for patients with high risk disease, risk stratification using biomarker, incorporation of molecular targeted agent against EGFR and immunotherapeutic approaches in EBV positive tumours.

References:

1. Chan A.T. et al. Concurrent chemotherapy-radiotherapy compared with radiotherapy alone in locoregionally advanced nasopharyngeal carcinoma : progression free survival analysis of a phase III randomized trial. *J Clin Oncol* 02;20:2038-44.
2. Chan A.T. et al. Overall survival after concurrent cisplatin-radiotherapy compared with radiotherapy alone in locoregionally advanced nasopharyngeal carcinoma. *J Natl Cancer Inst* 05;97:536-9.
3. Chan A.T. et al. Phase II study of neoadjuvant carboplatin and paclitaxel followed by radiotherapy and concurrent cisplatin in patients with locoregionally advanced nasopharyngeal carcinoma - therapeutic monitoring with plasma Epstein-Barr virus DNA. *J Clin Oncol* 04;22:3053-60.
4. Chan A.T. et al. Plasma Epstein-Barr virus DNA and residual disease after radiotherapy for undifferentiated nasopharyngeal carcinoma. *J Natl Cancer Inst* 02;94:1614-9.
5. Chan A.T. et al. Multi-center, phase II study of Cetuximab in combination with carboplatin in patients with recurrent or metastatic nasopharyngeal carcinoma. *J Clin Oncol* 05;23:3568-76.
6. Chan A.T. et al. Azacitidine induces demethylation of the Epstein-Barr virus genome in tumors in patients. *J Clin Oncol* 04;22:1373-81.

Best Thesis Award – **Gold Award Winner**

Detection of Subclinical Synovitis in Patients with Rheumatoid Arthritis in Clinical Remission

By **Catherine Ka Yan YUEN**

Department of Medicine
Queen Mary Hospital

Objectives:

To detect the prevalence of subclinical synovitis in patients with rheumatoid arthritis (RA) in clinical remission by musculoskeletal ultrasonography (USG) and to define possible predictors for the presence of subclinical synovitis.

Methods:

37 RA patients receiving disease modifying anti-rheumatic drugs (DMARDs) with disease in clinical remission were recruited. They were subject to clinical, laboratory, functional status or quality of life and radiographic evaluation at baseline. Disease Activity Score 28-joint assessment (DAS-28) was calculated. Musculoskeletal USG including both gray-scale and power doppler techniques to the dorsal aspect of both wrists and all metacarpophalangeal joints was performed on each subject.

Results:

9 out of 37 RA patients with clinical remission were found to have increased power doppler signal by USG, signifying the presence

of subclinical synovitis, the prevalence rate being 24.3%. The continuous DAS-28 with 3 variables version using C-reactive protein (DAS-28 CRP v3) was the only independent predictor for the presence of USG detected subclinical synovitis in the multivariate analysis with the odds ratio (OR) of 8.158, $p=0.052$. The cut off value of DAS-28 CRP v3 was found to be 2.32 with the sensitivity of 66.7% and specificity of 78.6% for the presence of USG detected subclinical synovitis.

Conclusion:

Musculoskeletal USG is more sensitive than clinical assessment to detect subclinical synovitis. USG with gray-scale and power doppler in combination with clinical assessment allows more accurate evaluation of the disease status, especially for the definition of true remission. DAS-28 CRP v3 may be used as a guide to stratify those relatively higher risk stable RA patients for proceeding to musculoskeletal USG examination to delineate the true disease status and to optimize maintenance therapy.



Best Thesis Award – **Silver Award Winner**

Extramammary Paget's disease

By **Nicola Pui Yiu CHAN**

Private Practice

Background: Extramammary Paget's disease (EMPD) is an uncommon cutaneous neoplastic condition which can be associated with underlying internal malignancies. It predominantly affects anogenital regions in the elderly population. Immunohistochemistry has been shown to be useful for distinguishing EMPD of cutaneous origin (primary EMPD) from those of extracutaneous origin with associated malignancies (secondary EMPD). Limited data is available on the disease's profile in the local Chinese population.

Aim: This study aimed to review the epidemiology, clinicopathological features, associated malignancies, treatment and outcome of EMPD in the local population. It also examined the immunohistochemical profile of the cases with a panel of markers consisting of cytokeratin 7 (CK7), cytokeratin 20 (CK20) and gross cystic disease fluid protein-15 (GCDFP-15). The differences in profile between primary and secondary EMPD were studied.

Methods: A retrospective, multi-center, case cohort study was carried out to review newly diagnosed EMPD cases between 2000 and 2005 from the Social Hygiene Service, Queen Mary Hospital, Queen Elizabeth Hospital and Prince of Wales Hospital. Immunohistochemical analyses with CK7, CK20 and GCDFP-15 were performed for all cases.

Results: Fifty patients were recruited in this study. All the patients were Chinese. The male-to-female ratio was 2.3:1, and the mean

age at diagnosis was 72.84. Majority of the patients presented with pruritis. The penoscrotal region was the commonest site of involvement. 84% of patients had primary EMPD, and 8% had secondary EMPD associated with concurrent internal malignancies. Immunohistochemical phenotype of CK7+/CK20-/GCDFP-15+ was observed in the majority of primary EMPD, whereas CK7+/CK20+/GCDFP-15+, CK7-/CK20-/GCDFP-15- and CK7+/CK20+/GCDFP-15- were seen in secondary EMPD associated with carcinoma of the anus, rectum and colon. 62% of patients underwent wide local excision, and 20% received radical radiotherapy as their first-line treatment. A 27.5% recurrence rate was seen in the 80% of patients who achieved clinical remission with a mean follow-up of 32.12 months. 18% of patient died of EMPD or related malignancy. Primary EMPD had a better cumulative survival compared to secondary EMPD.

Conclusion: The present study represented the largest conducted on a Chinese population. Although the disease behaviour was similar to the Caucasian in many aspects, EMPD in Chinese appeared to have a male predominance with frequent involvement of the penoscrotal site. Furthermore, secondary EMPD appeared to be less common in Chinese compared with Caucasian. CK7, CK20 and GCDFP-15 as a panel were useful in differentiating primary from secondary EMPD.



Best Thesis Award – **Bronze Award Winner**

Changes in Crohn's Disease Phenotype over time in the Chinese Population

By **Kai Lai CHOW**

*Department of Medicine and Therapeutics
Prince of Wales Hospital*



Crohn's disease (CD) causes significant morbidity and excess mortality. Phenotypic evolution of CD occurs in Caucasians. Whether phenotypic evolution also takes place among Hong Kong Chinese CD patients remains largely unknown. Additionally, CD with upper gastrointestinal tract involvement is shown to carry excess risk of recurrence in Caucasians but such correlation remains unclear in Chinese. In this report, we present two studies on Hong Kong Chinese with CD diagnosed according to stringent diagnostic criteria. First, a retrospective longitudinal study of consecutive Chinese CD patients was conducted. The evolution of disease behavior and location was evaluated. Our study showed

that phenotypic changes in CD also occurred in Chinese patients in the same way as Caucasians. Second, a prospective cohort including 132 Chinese CD patients who were followed for 770 person years was studied. Demographic data including disease behavior and location, details of surgery and hospitalization were collected. Kaplan-Meier method was used to estimate the probabilities of further hospitalization and major surgery followed by Cox proportional hazards regression to determine if clinical variables independently predicted the endpoints. Our study revealed Chinese CD patients had more upper gastrointestinal tract phenotype which predicted the need of subsequent hospitalization.

Announcements

The Royal College of Physicians (Edinburgh) would like to inform readers of the forthcoming "Update Course in Elderly Medicine" to be held in Edinburgh from Monday 11 to Friday 15 May 2009. This course is primarily designed to appeal to non-UK based consultants, specialists and senior trainees in Elderly Medicine from around the world. It offers a valuable opportunity to discuss clinical issues in Elderly Care. Places are limited to 60 so early application is advised. If registering before 30 March 2009, weekly rate £700 and daily rate £180. Late registration fee: £50 if registering after that date

Each day will focus on a single clinical topic

- Brain Failure: Delirium and Dementia
- The Ageing Heart
- Sans everything?: Frailty and Loss in Older People
- Cancer and the Older Person
- The Blood and the Kidney

For more information, please access the website

<http://www.rcpe.ac.uk/education/events/update-elderly-med-08.php>

New Regulations for the Joint HKCPIE/MRCP(UK) PACES examination

The new regulation for Joint HKCPIE/MRCP(UK) PACES examination will take effect from February 2009 onwards. The College decided that applicants for PACES must have passed MRCP(UK) Part I Examination within 7 years, or have exemption from it, and have spent not less than 12 months after registration in continuing care of emergency medical patients. Candidates should have commenced 18 months Basic Physician Training before attempting PACES. Because of the format of PACES, the quota in each diet is limited to 75. If the number of applicants is more than this, it has been agreed that priority should be given to (1) registered trainees of our College and (2) applicants who have passed the MRCP(UK) Part II (Written) examination. If the number on this priority list still exceeds 75, the College will draw lots immediately after the local closing date.

Pass list of the Joint HKCPIE/MRCP(UK) Part II PACES - October 2008

| | |
|------------------|--------------------|
| Au Wing Chi Lisa | Chan Myles |
| Chan Pak To | Chan Yung |
| Chang Wai Man | Chiu On Pong |
| Chow Chi Wing | Ha Chung Yin |
| Ho Cheuk Wah | Ip Hing Lung |
| Jeung Chung Yee | Kwong Hoi Yi Joyce |
| Lam Chung Man | Lee Savio |
| Luk Shik | Luk Tsan Hei |
| Ma Hon Ming | Ng Sui Cheung |
| Ng Yiu Ping | Poon Ka Yan Clara |
| Shum Chun Keung | Sze Yuen Lei |
| Tam Chor Cheung | Tang Wing Han |
| Wong Chun Pong | Wu Wai Fuk |
| Yau Kit Yee | Yip Choi Wan |
| Young Albert | |

Examination Pass Rates

Joint HKCPIE/MRCP(UK) Part I examination (2002-2008)

| | Sitting | Pass |
|-----------------------|---------|------------|
| Sep 02 | 100 | 33 (33%) |
| Jan 03 | 124 | 55 (44%) |
| May 03 (SARS Special) | 21 | 7 (33%) |
| Sep 03 | 54 | 29 (54%) |
| Jan 04 | 93 | 39 (42%) |
| Sep 04 | 29 | 16 (55%) |
| Jan 05 | 96 | 68 (70.8%) |
| Sep 05 | 24 | 15 (62.5%) |
| Jan 06 | 95 | 74 (80%) |
| Sept 06 | 21 | 13 (62%) |
| Jan 07 | 87 | 67 (77%) |
| Sep 07 | 23 | 12 (52%) |
| Jan 08 | 56 | 38 (68%) |
| Sep 08 | 47 | 32 (68%) |

Joint HKCPIE/MRCP(UK) Part II PACES examination (2001-2008)

| | |
|---------------|-------------|
| October 2001 | 36/72 = 50% |
| February 2002 | 34/74 = 46% |
| October 2002 | 29/72 = 40% |
| February 2003 | 30/69 = 43% |
| October 2003 | 27/59 = 46% |
| March 2004 | 39/64 = 61% |
| October 2004 | 26/69 = 38% |
| March 2005 | 35/75 = 47% |
| October 2005 | 28/75 = 37% |
| March 2006 | 36/75 = 48% |
| October 2006 | 16/73 = 22% |
| March 2007 | 44/74 = 59% |
| June 2007 | 44/74 = 59% |
| October 2007 | 36/55 = 65% |
| March 2008 | 36/74 = 49% |
| October 2008 | 29/65 = 45% |

Statistics on No. of Trainees in all Specialties

Updated in December 2008

| SPECIALTY | TRAINEES TOTAL (PP/DH/HA/ OTHERS) | TRAINEES | | | | | | | | | | | | | |
|--------------------------------------|---|---------------------------------|----|-----------------------------|---|----------------------|---|------------------------|---|--------------------|---|-----------------------------|----|------------------|---|
| | | HONG KONG EAST CLUSTER | | | | | | HONG KONG WEST CLUSTER | | | | | | | |
| | | PYNEH | | RH | | TWEH | | FYKH | | GH | | QMH | | TWH | |
| YEAR | | | | | | | | | | | | | | | |
| CARDIOLOGY | 32 | 1—I 2—II 3—I 4 | 4 | 1—I 2 3—I 4—I | 3 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2—IV 3 4 | 4 | 1 2 3 4 | 0 |
| CLINICAL PHARMACOLOGY & THERAPEUTICS | 3 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 |
| CRITICAL CARE MEDICINE | 14 | 1 2 3 4—II | 2 | 1 2 3 4 | 0 | 1 2 3 4—I | 1 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1—I 2 3 4—I | 2 | 1 2 3 4 | 0 |
| DERMATOLOGY & VENEREOLOGY | 5 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1—I 2 3 4 | 1 | 1 2 3 4 | 0 |
| ENDOCRINOLOGY, DIABETES & METABOLISM | 17 | 1—I 2 3 4 | 1 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1—I 2 3 4—I | 2 | 1 2 3 4 | 0 |
| GASTROENTEROLOGY & HEPATOLOGY | 31 | 1—II 2—II 3 4 | 4 | 1 2—I 3 4 | 1 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2—I 3—II 4 | 3 | 1 2 3 4 | 0 |
| GERIATRIC MEDICINE | 12 | 1—I 2 3 4 | 1 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1—I 2—I 3 4 | 2 | 1 2 3 4 | 0 |
| HAEM/HAEM ONCOLOGY | 10 | 1—I 2—I 3 4 | 2 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2—I 3 4 | 1 | 1 2 3 4 | 0 |
| IMMUNOLOGY & ALLERGY | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 |
| INFECTIOUS DISEASE | 9 | 1 2 3—I 4 | 1 | 1 2 3—I 4 | 1 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2—I 3 4 | 1 | 1 2 3 4 | 0 |
| INTERNAL MEDICINE | 226 | 1—VIII 2—VI 3—III 4—II | 19 | 1—II 2—II 3—II 4—I | 7 | 1 2 3—I 4—I | 2 | 1 2 3 4 | 1 | 1 2 3—I 4 | 5 | 1—X 2—XI 3—IV 4—VI | 31 | 1 2 3 4 | 0 |
| MEDICAL ONCOLOGY | 6 | 1 2—I 3 4 | 1 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1—I 2 3 4 | 1 | 1 2 3 4 | 0 |
| NEPHROLOGY | 13 | 1 2 3 4—I | 1 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1—I 2—I 3 4 | 2 | 1 2 3 4 | 0 |
| NEUROLOGY | 19 | 1—I 2 3 4 | 1 | 1—I 2—I 3 4 | 2 | 1 2 3—I 4 | 1 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2—I 3—II 4—I | 4 | 1 2 3 4 | 0 |
| PALLIATIVE MEDICINE | 6 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3—I 4 | 1 | 1—I 2 3 4 | 1 | 1 2 3 4 | 0 |
| REHABILITATION | 1 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1—I 2 3 4 | 1 | 1 2 3 4 | 0 |
| RESPIRATORY MEDICINE | 20 | 1 2 3—I 4—I | 2 | 1 2 3 4—I | 1 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2—I 3 4 | 1 | 1 2 3 4 | 0 |
| RHEUMATOLOGY | 16 | 1—I 2 3 4 | 1 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1 2 3 4 | 0 | 1—II 2—I 3 4 | 3 | 1 2 3 4 | 0 |

| | | TRAINEES | | | | | | | | | | | | |
|--------------------------------------|----------------------------------|------------------------|--------------------------------------|----------------------|------------------|--------------------|----------------------|----------------------|------------------|------------------|--------------------------|-------------------|--------------------|-------------------|
| | | KOWLOON CENTRAL CLUSTR | | KOWLOON EAST CLUSTER | | | KOWLOON WEST CLUSTER | | | | | | | |
| SPECIALTY | TRAINEES TOTAL (PP/DH/HA/OTHERS) | KH | QEH | HOHH | TKOH | UCH | CMC | KWH | OLMH | PMH | WTSH | YCH | | |
| | | YEAR | | | YEAR | | | YEAR | | | | | | |
| CARDIOLOGY | 32 | 1 2 3 4 | 0 1-I 2-I 3-III 4-I | 6 2 3 8 | 1 2 3 0 | 0 2 3 2 | 1 2 3 2 | 0 0 3 4 | 1 2 3 1 | 2 0 3 4 | 1 2 3 1 | 0 2 3 4 | 1 2 3 0 | 0 2 3 3 |
| CLINICAL PHARMACOLOGY & THERAPEUTICS | 3 | 1 2 3 4 | 0 1 2 3 | 0 0 3 4 | 1 2 3 0 | 0 2 3 4 | 1 2 3 0 | 0 0 3 4 | 1 2 3 0 | 0 0 3 4 | 1 2 3 0 | 0 0 3 4 | 1 2 3 0 | 0 0 3 4 |
| CRITICAL CARE MEDICINE | 14 | 1 2 3 4 | 0 1 2 3 | 1 2 3 5 | 0 2 3 0 | 1 2 3 1 | 0 2 3 4 | 1 2 3 4 | 0 1 3 2 | 1 2 3 0 | 1 2 3 0 | 2 0 3 4 | 1 2 3 0 | 0 2 3 4 |
| DERMATOLOGY & VENEREOLOGY | 5 | 1 2 3 4 | 0 1 2 3 | 1 2 3 0 | 0 2 3 4 | 1 2 3 0 | 0 2 3 4 | 1 2 3 0 | 0 2 3 4 | 1 2 3 0 | 0 2 3 4 | 1 2 3 0 | 0 2 3 4 | 0 2 3 4 |
| ENDOCRINOLOGY, DIABETES & METABOLISM | 17 | 1 2 3 4 | 0 1-I 2-I 3 4 | 2 2 3 4 | 1 2 3 0 | 0 2 3 1 | 1 2 3 4 | 0 2 3 3 | 1 2 3 4 | 1 2 3 0 | 2 0 3 4 | 1 2 3 5 | 0 2 3 4 | 1 2 3 1 |
| GASTROENTEROLOGY & HEPATOLOGY | 31 | 1 2 3 4 | 0 1 2-II 3-I 4 | 3 2 3 5 | 1 2 3 0 | 0 2 3 3 | 1 2 3 4 | 0 2 3 3 | 1 2 3 4 | 1 2 3 0 | 1 2 3 4 | 1 2 3 8 | 0 2 3 4 | 1 2 3 5 |
| GERIATRIC MEDICINE | 12 | 1 2 3 4 | 0 1 2-II 3 4-I | 3 2 3 2 | 1 2 3 5 | 0 2 3 4 | 1 2 3 1 | 0 2 3 9 | 1 2 3 4 | 1 2 3 0 | 0 2 3 7 | 1 2 3 10 | 3 2 3-I 4 | 1 2 3 3 |
| HAEM/HAEM ONCOLOGY | 10 | 1 2 3 4 | 0 1-II 2-I 3 4 | 3 2 3 2 | 1 2 3 0 | 0 2-I 3 4 | 1 2 3 1 | 0 2 3 4 | 1 2 3 0 | 0 2 3 4 | 1 2 3 0 | 1 2 3 2 | 0 2 3 4 | 1 2 3 0 |
| IMMUNOLOGY & ALLERGY | 0 | 1 2 3 4 | 0 1 2 3 4 | 0 2 3 0 | 1 2 3 0 | 0 2 3 4 | 0 2 3 0 | 1 2 3 0 | 0 2 3 0 | 1 2 3 0 | 0 2 3 0 | 1 2 3 0 | 0 2 3 0 | 1 2 3 0 |
| INFECTIOUS DISEASE | 9 | 1 2 3 4 | 0 1-II 2 3 4 | 2 2 3 2 | 1 2 3 0 | 0 2 3 4 | 1 2 3 1 | 0 2 3 4 | 1 2 3 0 | 0 2 3 0 | 1 2 3 0 | 1 2 3 4 | 0 2 3 4 | 1 2 3 1 |
| INTERNAL MEDICINE | 226 | 1 2 3 4 | 0 1-VIII 2-X 3-V 4-4-VII | 30 2-I 3 52 | 1 2 3 4 | 1 2 3 6 | 1 2 3 13 | 0 2 3 13 | 1 2 3 4 | 1 2 3 0 | 13 2-I 3-V 4-VI | 5 2 3 25 | 1 2 3 4 | 1 2 3 19 |
| MEDICAL ONCOLOGY | 6 | 1 2 3 4 | 0 1 2 3 4 | 0 2 3 1 | 1 2 3 0 | 0 2 3 4 | 0 2 3 0 | 1 2 3 0 | 0 2 3 4 | 1 2 3 0 | 0 2 3 4 | 1 2 3 4 | 0 2 3 4 | 0 2 3 0 |
| NEPHROLOGY | 13 | 1 2 3 4 | 0 1 2-I 3 4 | 1 2 3 7 | 1 2 3 0 | 0 2 3 4 | 1 2 3 1 | 0 2 3 3 | 1 2 3 4 | 0 2 3 5 | 1 2 3 0 | 1 2 3 7 | 0 2 3 4 | 1 2 3 2 |
| NEUROLOGY | 19 | 1 2 3 4 | 0 1-II 2 3-I 4 | 3 2 3 6 | 1 2 3 0 | 0 2 3 1 | 1 2 3 4 | 0 2 3 3 | 1 2 3 0 | 1 2 3 3 | 0 2 3 4 | 1 2 3 2 | 0 2 3 4 | 1 2 3 0 |
| PALLIATIVE MEDICINE | 6 | 1 2 3 4 | 0 1 2 3 4 | 0 2-I 3 0 | 1 2 3 2 | 0 2 3 0 | 1 2 3 1 | 0 2 3 4 | 1 2 3 0 | 0 2 3 4 | 1 2 3 0 | 1 2 3 4 | 0 2-I 3 4 | 1 2 3 0 |
| REHABILITATION | 1 | 1 2 3 4 | 0 1 2 3 4 | 0 2 3 0 | 1 2 3 0 | 0 2 3 4 | 0 2 3 2 | 1 2 3 1 | 0 2 3 4 | 1 2 3 0 | 0 2 3 4 | 1 2 3 4 | 0 2 3 4 | 0 2 3 0 |
| RESPIRATORY MEDICINE | 20 | 1 2 3 4 | 0 1 2-I 3 4 | 1 2 3 7 | 1 2 3 5 | 0 2-I 3 4 | 1 2 3 1 | 0 2-I 3 4 | 1 2 3 3 | 1 2 3 2 | 1 2 3 0 | 1 2 3 4 | 0 2-I 3 4 | 1 2 3 1 |
| RHEUMATOLOGY | 16 | 1 2 3 4 | 0 1 2-I 3 4 | 0 2 3 2 | 1 2 3 0 | 0 2 3-I 4 | 1 2 3-I 2 | 0 2-I 3-I 4 | 1 2 3 1 | 1 2 3 4 | 0 2-I 3 4 | 1 2 3 1 | 0 2 3 4 | 1 2 3 0 |

| | | TRAINEES | | | | | | | | | | | | | |
|--------------------------------------|---|------------------------------|------------------|-------------------------------|--------------------|--------------------------------|------------------|------------------------------|--------------------|--------------------|------------------|------------------|------------------|-------------------------------|-------------------|
| | | NEW TERRITORIES EAST CLUSTER | | | | | | NEW TERRITORIES WEST CLUSTER | | | | | | | |
| SPECIALTY | TRAINEES TOTAL (PP/DH/HA/ OTHERS) | AHNH | NDH | PWH | SH | TPH | POH | TMH | | | | | | | |
| | | YEAR | | | | | | YEAR | | | | | | | |
| CARDIOLOGY | 32 | 1 2-I 3 4 | 1 2 3 4 | 2 2-I 3 4 | 2 2-I 3 4 | 2 2-I 3 4 | 0 2 3 4 | 0 2 3 4 | 0 2 3 4 | 0 2 3 4 | 0 2 3 4 | 0 2 3 4 | 0 2 3 4 | 1 2-II 3-III 4 | 5 2 3 4 |
| CLINICAL PHARMACOLOGY & THERAPEUTICS | 3 | 1 2 3 4 | 0 1 3 4 | 1 2 3 4 | 0 0 3 4 | 0 3 3 4 | 1 2 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 1 2 3 4 | 0 0 0 0 |
| CRITICAL CARE MEDICINE | 14 | 1 2 3 4 | 0 1 3 4 | 1 2 3-I 4 | 1 2 3 4 | 0 1 3 4 | 1 2 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 1 2-I 3-II 4 | 3 2 3 4 |
| DERMATOLOGY & VENEREOLOGY | 5 | 1 2 3 4 | 0 0 3 4 | 1 2 3 4 | 0 0 3 4 | 1 2-I 3 4 | 1 2 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 1 2 3 4 | 0 0 0 0 |
| ENDOCRINOLOGY, DIABETES & METABOLISM | 17 | 1 2 3 4 | 0 1 3 4 | 1 2-I 3-I 4 | 2 1 1 4 | 1 2 3 4 | 0 2 3 4 | 0 2 3 4 | 0 2 3 4 | 0 2 3 4 | 0 2 3 4 | 0 2 3 4 | 0 2 3 4 | 1-I 2-II 3-I 4 | 4 2 3 1 |
| GASTROENTEROLOGY & HEPATOLOGY | 31 | 1 2 3 4 | 0 0 3 4 | 1 2-I 3-I 4 | 2 2 3 4 | 1-I 2-I 3 4 | 2 2 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 1-III 2 3-I 4-I | 5 2 3 4 |
| GERIATRIC MEDICINE | 12 | 1 2 3 4 | 0 1 3 4 | 1 2 3 4 | 0 1 3 4 | 1 2 3 4 | 0 4 3 4 | 0 4 3 4 | 1-I 2 3 4 | 1 2 3 4 | 1 2 3 4 | 1 2 3 4 | 0 1 3 4 | 1 2 3 4 | 0 10 3 4 |
| HAEM/HAEM ONCOLOGY | 10 | 1 2 3 4 | 0 0 3 4 | 1 2 3 4 | 0 0 3 4 | 1 2 3 4 | 0 3 3 4 | 0 4 3 4 | 0 4 3 4 | 0 4 3 4 | 0 4 3 4 | 0 4 3 4 | 0 4 3 4 | 1 2-I 3 4-I | 1 4 3 4 |
| IMMUNOLOGY & ALLERGY | 0 | 1 2 3 4 | 0 0 3 4 | 1 2 3 4 | 0 0 3 4 | 1 2 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 1 2 3 4 | 0 0 0 0 |
| INFECTIOUS DISEASE | 9 | 1 2 3-I 4 | 1 2 3 4 | 1 2-I 3 4 | 1 2 3-I 4 | 1 2 3-I 4 | 1 2 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 1 2 3 4 | 0 3 3 4 |
| INTERNAL MEDICINE | 226 | 1-I 2-I 3-I 4 | 3 17 | 1-I 2-VI 3-III 4-III | 13 12 | 1-IV 2-IV 3-III 4-VII | 18 40 | 1 2-II 3 4-I | 3 6 | 1-I 2 3 4 | 1 4 | 1 4 | 0 5 | 1-V 2-VI 3-XIII 4-II | 26 36 |
| MEDICAL ONCOLOGY | 6 | 1 2 3 4 | 0 0 3 4 | 1 2 3 4 | 0 0 3 4 | 1 2-I 3-I 4-I | 3 8 | 1 2 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 1 2 3 4 | 0 0 0 0 |
| NEPHROLOGY | 13 | 1-I 2 3 4 | 1 2 3 4 | 1-I 2 3 4 | 1 1 3 4 | 1-II 2 3 4 | 2 4 | 1 2 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 1 2 3-II 4 | 2 6 |
| NEUROLOGY | 19 | 1 2 3 4 | 0 1 3 4 | 1 2 3 4 | 0 2 3 4 | 1 2-I 3 4 | 1 3 4 | 1 2-I 3 4 | 1 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 1-I 2 3-I 4 | 2 2 3 4 |
| PALLIATIVE MEDICINE | 6 | 1 2 3 4 | 0 0 3 4 | 1 2 3 4 | 0 0 3 4 | 1 2 3 4 | 0 0 3 4 | 1 2-I 3 4 | 1 1 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 0 0 3 4 | 1 2 3 4 | 0 0 0 0 |
| REHABILITATION | 1 | 1 2 3 4 | 0 0 3 4 | 1 2 3 4 | 0 0 3 4 | 1 2 3 4 | 0 2 3 4 | 0 4 3 4 | 0 1 3 4 | 0 1 3 4 | 0 1 3 4 | 0 1 3 4 | 0 0 3 4 | 1 2 3 4 | 0 2 |
| RESPIRATORY MEDICINE | 20 | 1 2 3 4 | 0 4 3 4 | 1 2-I 3 4 | 1 2 3 4 | 1 2 3-I 4-I | 2 3 3 4 | 1 2 3 4 | 1 0 3 4 | 0 1 3 4 | 0 1 3 4 | 0 1 3 4 | 0 0 3 4 | 1 2-I 3-I 4 | 2 3 |
| RHEUMATOLOGY | 16 | 1 2 3 4 | 0 1 3 4 | 1 2 3 4 | 0 0 3 4 | 1-I 2 3-I 4 | 2 3 3 4 | 1 2 3 4 | 0 0 3 4 | 0 1 3 4 | 0 1 3 4 | 0 1 3 4 | 0 0 3 4 | 1 2 3-II 4 | 2 2 |

* Total No. of trainees is shown in upper right corner of each hospital
 ** No. of trainers is shown in italics & bold in lower right corner of each hospital

| SPECIALTY | TRAINEES TOTAL (PP/DH/HA/OTHERS) | TRAINEES | |
|---------------------------|----------------------------------|-----------------------|----------------|
| | | DH | |
| DERMATOLOGY & VENEREOLOGY | 5 | 1 2—I 3—II 4 | 3 <i>II</i> |
| IMMUNOLOGY & ALLERGY | 0 | 1 2 3 4 | 0 2 |
| RESPIRATORY MEDICINE | 20 | 1 2 3—I 4 | 1 7 |

* Total No. of trainees is shown in upper right corner of each hospital
 ** No. of trainers is shown in italics & bold in lower right corner of each hospital

Statistics on No. of Fellows in all Specialties Updated in December 2008

| SPECIALTY | FELLOWS TOTAL (PP/DH/HA/OTHERS) | FELLOWS | | | | | | | | | HONG KONG EAST + WEST CLUSTER |
|--------------------------------------|---------------------------------|------------------------|----|------|----------|------------------------|----|-----|-----|----------|-------------------------------|
| | | HONG KONG EAST CLUSTER | | | | HONG KONG WEST CLUSTER | | | | | |
| | | PYNEH | RH | TWEH | Subtotal | FYKH | GH | QMH | TWH | Subtotal | |
| CARDIOLOGY | 186 | 6 | 3 | 0 | 9 | 0 | 6 | 10 | 0 | 16 | 26 |
| CLINICAL PHARMACOLOGY & THERAPEUTICS | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 |
| CRITICAL CARE MEDICINE | 61 | 6 | 0 | 0 | 6 | 0 | 0 | 9 | 0 | 9 | 15 |
| DERMATOLOGY & VENEREOLOGY | 81 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 |
| ENDOCRINOLOGY, DIABETES & METABOLISM | 80 | 4 | 2 | 3 | 9 | 0 | 0 | 8 | 0 | 8 | 17 |
| GASTROENTEROLOGY & HEPATOLOGY | 124 | 7 | 1 | 0 | 8 | 0 | 0 | 10 | 1 | 11 | 19 |
| GERIATRIC MEDICINE | 159 | 7 | 12 | 4 | 23 | 3 | 0 | 4 | 0 | 7 | 30 |
| HAEM/HAEM ONCOLOGY | 45 | 4 | 0 | 0 | 4 | 0 | 0 | 10 | 0 | 10 | 14 |
| IMMUNOLOGY & ALLERGY | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 |
| INFECTIOUS DISEASE | 28 | 2 | 0 | 0 | 2 | 0 | 0 | 3 | 0 | 3 | 5 |
| INTERNAL MEDICINE | 950 | 51 | 23 | 10 | 84 | 1 | 11 | 70 | 7 | 89 | 173 |
| MEDICAL ONCOLOGY | 37 | 0 | 0 | 0 | 0 | 0 | 0 | 8 | 0 | 8 | 8 |
| NEPHROLOGY | 104 | 7 | 0 | 0 | 7 | 0 | 0 | 8 | 2 | 10 | 17 |
| NEUROLOGY | 73 | 5 | 2 | 0 | 7 | 0 | 0 | 5 | 1 | 6 | 13 |
| PALLIATIVE MEDICINE | 15 | 0 | 2 | 0 | 2 | 0 | 2 | 0 | 0 | 2 | 4 |
| REHABILITATION | 44 | 0 | 3 | 5 | 8 | 1 | 0 | 1 | 4 | 6 | 14 |
| RESPIRATORY MEDICINE | 153 | 8 | 7 | 1 | 16 | 0 | 10 | 10 | 0 | 20 | 36 |
| RHEUMATOLOGY | 48 | 3 | 2 | 1 | 6 | 0 | 0 | 3 | 1 | 4 | 10 |

| | | FELLOWS | | | | | | | | | | | | | | KOWLOON CENTRAL + EAST + WEST CLUSTER |
|--------------------------------------|---------------------------------|-------------------------|-----|----------|----------------------|------|-----|----------|----------------------|-----|------|-----|------|-----|----------|---------------------------------------|
| | | KOWLOON CENTRAL CLUSTER | | | KOWLOON EAST CLUSTER | | | | KOWLOON WEST CLUSTER | | | | | | | |
| SPECIALTY | FELLOWS TOTAL (PP/DH/HA/OTHERS) | KH | QEH | Subtotal | HOHH | TKOH | UCH | Subtotal | CMC | KWH | OLMH | PMH | WTSH | YCH | Subtotal | |
| CARDIOLOGY | 186 | 0 | 10 | 10 | 0 | 3 | 6 | 9 | 1 | 5 | 1 | 9 | 0 | 3 | 19 | 38 |
| CLINICAL PHARMACOLOGY & THERAPEUTICS | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| CRITICAL CARE MEDICINE | 61 | 0 | 6 | 6 | 0 | 2 | 6 | 8 | 5 | 5 | 0 | 4 | 0 | 0 | 14 | 28 |
| DERMATOLOGY & VENEREOLOGY | 81 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ENDOCRINOLOGY, DIABETES & METABOLISM | 80 | 0 | 6 | 6 | 0 | 3 | 4 | 7 | 2 | 3 | 2 | 6 | 0 | 2 | 15 | 28 |
| GASTROENTEROLOGY & HEPATOLOGY | 124 | 0 | 8 | 8 | 0 | 4 | 4 | 8 | 4 | 3 | 1 | 9 | 0 | 6 | 23 | 39 |
| GERIATRIC MEDICINE | 159 | 7 | 3 | 10 | 7 | 1 | 13 | 21 | 8 | 10 | 2 | 13 | 4 | 6 | 43 | 74 |
| HAEM/HAEM ONCOLOGY | 45 | 0 | 4 | 4 | 0 | 1 | 2 | 3 | 0 | 0 | 0 | 4 | 0 | 0 | 4 | 11 |
| IMMUNOLOGY & ALLERGY | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| INFECTIOUS DISEASE | 28 | 0 | 3 | 3 | 0 | 0 | 2 | 2 | 0 | 1 | 0 | 4 | 0 | 1 | 6 | 11 |
| INTERNAL MEDICINE | 950 | 5 | 59 | 64 | 9 | 20 | 44 | 73 | 27 | 36 | 8 | 59 | 4 | 23 | 157 | 294 |
| MEDICAL ONCOLOGY | 37 | 0 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 3 |
| NEPHROLOGY | 104 | 0 | 9 | 9 | 2 | 2 | 4 | 8 | 2 | 5 | 1 | 8 | 0 | 2 | 18 | 35 |
| NEUROLOGY | 73 | 0 | 6 | 6 | 0 | 2 | 4 | 6 | 0 | 5 | 1 | 3 | 1 | 0 | 10 | 22 |
| PALLIATIVE MEDICINE | 15 | 0 | 0 | 0 | 4 | 0 | 1 | 5 | 3 | 0 | 1 | 0 | 0 | 0 | 4 | 9 |
| REHABILITATION | 44 | 9 | 0 | 9 | 2 | 0 | 3 | 5 | 1 | 1 | 0 | 2 | 4 | 0 | 8 | 22 |
| RESPIRATORY MEDICINE | 153 | 6 | 8 | 14 | 6 | 3 | 5 | 14 | 6 | 7 | 0 | 4 | 6 | 2 | 25 | 53 |
| RHEUMATOLOGY | 48 | 1 | 4 | 5 | 0 | 0 | 2 | 2 | 1 | 2 | 0 | 1 | 0 | 1 | 6 | 13 |

| | | FELLOWS | | | | | | | | | | NEW TERRITORIES EAST + WEST CLUSTER |
|--------------------------------------|---------------------------------|------------------------------|-----|-----|----|-----|----------|------------------------------|-----|----------|-----|-------------------------------------|
| | | NEW TERRITORIES EAST CLUSTER | | | | | | NEW TERRITORIES WEST CLUSTER | | | | |
| SPECIALTY | FELLOWS TOTAL (PP/DH/HA/OTHERS) | AHNH | NDH | PWH | SH | TPH | Subtotal | POH | TMH | Subtotal | | |
| CARDIOLOGY | 186 | 4 | 5 | 11 | 0 | 0 | 20 | 1 | 7 | 8 | 28 | |
| CLINICAL PHARMACOLOGY & THERAPEUTICS | 5 | 0 | 0 | 3 | 0 | 0 | 3 | 0 | 0 | 0 | 3 | |
| CRITICAL CARE MEDICINE | 61 | 2 | 4 | 1 | 0 | 0 | 7 | 0 | 2 | 2 | 9 | |
| DERMATOLOGY & VENEREOLOGY | 81 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | |
| ENDOCRINOLOGY, DIABETES & METABOLISM | 80 | 2 | 2 | 13 | 0 | 0 | 17 | 0 | 3 | 3 | 20 | |
| GASTROENTEROLOGY & HEPATOLOGY | 124 | 2 | 3 | 8 | 0 | 0 | 13 | 1 | 7 | 8 | 21 | |
| GERIATRIC MEDICINE | 159 | 1 | 1 | 6 | 6 | 3 | 17 | 1 | 11 | 12 | 29 | |
| HAEM/HAEM ONCOLOGY | 45 | 0 | 0 | 4 | 0 | 0 | 4 | 0 | 4 | 4 | 8 | |
| IMMUNOLOGY & ALLERGY | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| INFECTIOUS DISEASE | 28 | 1 | 0 | 2 | 0 | 0 | 3 | 0 | 5 | 5 | 8 | |
| INTERNAL MEDICINE | 950 | 21 | 17 | 58 | 7 | 7 | 110 | 5 | 55 | 60 | 170 | |
| MEDICAL ONCOLOGY | 37 | 0 | 0 | 14 | 0 | 0 | 14 | 0 | 0 | 0 | 14 | |
| NEPHROLOGY | 104 | 3 | 1 | 6 | 0 | 0 | 10 | 1 | 6 | 7 | 17 | |
| NEUROLOGY | 73 | 1 | 2 | 6 | 2 | 0 | 11 | 0 | 3 | 3 | 14 | |
| PALLIATIVE MEDICINE | 15 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | |
| REHABILITATION | 44 | 0 | 1 | 2 | 1 | 1 | 5 | 1 | 2 | 3 | 8 | |
| RESPIRATORY MEDICINE | 153 | 4 | 6 | 6 | 0 | 1 | 17 | 1 | 7 | 8 | 25 | |
| RHEUMATOLOGY | 48 | 3 | 1 | 3 | 0 | 3 | 9 | 0 | 3 | 3 | 12 | |



Honorary Fellowship (HKCP) was conferred on The Right Hon. The Lord Turnberg on 27 May 1999.

The Right Hon. The Lord Turnberg

John MacKay

Leslie Arnold Turnberg was born in 1934 in the north of England, went to the local Grammar School where he won a couple of Form prizes. His biology teacher Mr Willy P Burch, was the one who influenced him most, stimulating his interest in botany and zoology, and no doubt being a factor in his choice of career. Pharmacy was his first thought but a friend persuaded him to try for Medicine at Manchester University.

He was the first member of his family to go to a university. His father worked in a raincoat factory on a sewing machine, only much later owning a wine and spirit shop in partnership with his brother. His mother also worked in a raincoat factory but retired early.

He graduated MB., ChB. in 1957, winning an Anatomy prize. It was only after he had graduated that he realized that he had chosen wisely and began to enjoy Medicine. The next four years were spent doing junior hospital jobs in the Manchester area, passing his Membership Examination to the College of Physicians in 1961. Armed with this qualification he acquired a three year appointment as a Registrar at University College Hospital, London.

He returned to Manchester Royal Infirmary for two years, gaining an MD in 1966. His M.D. thesis dealt with the absorption of iron after partial gastrectomy. He showed that certain forms of iron were absorbed poorly, accounting for some of the anaemia. In 1967 he moved back to London as a Lecturer at the Royal Free Hospital where he stayed for one year.

In 1968 he achieved the desirable BTA qualification (Been To America), spending a year as a Research Fellow at the University of Texas, South-West Medical School at Dallas.

“Dallas was a revelation. I first tasted how research should be done in a first rate department. Dallas itself

seemed another world, a very small down-town, large spread-out suburbs in a very flat landscape and no-one walking anywhere - just cars as a means of getting about. But I got married there to my girl friend whom I had met in London and who came out to be with me. So I have very fond memories of the place.”

His wife, Edna, was a Marriage Guidance Counsellor working for ‘Relate’. She became an instructor and supervisor in this field.

They had two children, a daughter, a speech therapist, who is married and has four children; and a son who became a doctor.

Back at Manchester he took up an appointment as Lecturer, becoming a Senior Lecturer, then the Professor of Medicine in 1973, a position he was to hold for the next twenty-four years. He was Dean of the Faculty of Medicine from 1986 to 1989. He was President of the Royal College of Physicians from 1992 – 1997.

For his services to medicine he was knighted in 1994 by Queen Elizabeth at Buckingham Palace. Many additional Fellowships and Honorary academic degrees were to follow.

As Professor Sir Leslie Turnberg he advised on the setting-up of the Hong Kong College of Physicians, being made a Fellow of the College at its inauguration.

“Hong Kong is amazing - a tremendous buzz and lots to do. I am particularly interested in Chinese ceramics and spent many a happy hour in Hollywood Road. Sometimes I even bought something.”

Professor Richard Yu remembers Lord Turnberg as a sinophile, loving Chinese antiques and being an avid collector of ceramics especially from the Sung Dynasty (960-1279AD), during his frequent visits to Hong Kong. Hollywood Road became his hunting ground, with

knowledgeable advisors in Professor TK Chan and Dr TF Tse.

In March 1997 there was a joint scientific meeting – Hong Kong College of Physicians, Royal College of Physicians London and Chinese Medical Association, Chinese Academy of Medical Science and Peking Union Medical College Hospital in Beijing. On the last morning of the conference Sir Leslie spotted a lovely vase at the antique market (王府井). During a short break after lunch he rushed to the market and carried back his prize possession before his next presentation – he achieved that in half an hour – and happily departed Beijing on the late afternoon flight to Hong Kong. He was so committed to his hobby that he even attended a course of Chinese ceramics at Sotheby's in London.

In 1999 he gave the MacFadzean Oration, choosing as his theme 'The Place in Medicine of the Clinical Scientist', a theme close to his heart having been one himself. He closed the oration with the following paragraph.

“Well, President, ladies and gentlemen what I have been trying to say is that clinical scientists provide a vitally important element within the spectrum of clinical medicine. Their role is pivotal in bringing the fruits of basic science into clinical practice, to ensure that research of relevance to clinical practice is pursued and in ensuring that that future medical practice takes advantage of all advances which have been made across the broad spectrum of science. It is vitally important that we ensure a healthy environment for clinical scientists to operate in, and although there are many hurdles to jump we cannot just stand by and wring our hands. I am sure Professor MacFadzean would have wanted no less. I have no doubt that he would have been a leader in this field, anxious to ensure that high quality clinical practice is based on excellence in research.”

Today Lord Turnberg is very busy as Chairman or President of a number of health related bodies.

“I sit on the Board of a biotechnical company specializing in improving wound healing, named 'Renovo'. I remain on The Wolfson Foundation and on The Association of Medical Research Charities of which I am scientific advisor. I recently finished my term as chairman of NC3Rs (National Centre for the Replacement, Refinement and Reduction of Animals in Research) and as President of the Medical Protection Society.”

In 2005 he was given a Life Peerage as Baron Turnberg of Cheadle and County of Cheshire.

“Being in The Lords was a revelation. I had no idea what to expect, imagining it as being a rather quiet dozy place. In fact there are many fascinating people there and I

have made a number of friends from walks of life where I have never ventured before. There are always interesting debates, many on matters of health or medical research and I find myself inevitably drawn into these. A recent example is the Human Embryology Bill which is going through Parliament at the moment. Very controversial but fascinating.”

Despite his busy life Lord Turnberg still finds time for his recreational interests such as, reading, mainly history; painting in water colour and acrylic, and of course, Chinese ceramics mainly of the Sung Dynasty.

His son, Daniel, was tragically killed in an aeroplane crash last year in Africa at the age of 37.

“He was a nephrologist, a lecturer in medicine at The Royal Free/UCH in London. He was by far the brightest in our family and I loved, admired and respected him for his humanity and character. We have set up a charity in his name”.

THE DANIEL TURNBERG MEDICAL RESEARCH INTERNATIONAL EXCHANGE SCHEME

The Fund will provide financial support for young researchers in the medical and biological sciences to spend short periods of time in a laboratory or hospital in another country. Specifically, exchanges of researchers between the U.K. on the one hand and Israel, Egypt, Jordan, the Lebanon and Palestinian Territories on the other will be supported.

The prime purposes will be to provide opportunities to gain further research experience, learn new techniques and to foster scientific collaboration between scientists. More widely it is hoped that that this might lead to a greater understanding between these countries and that is something which would have pleased Daniel.

OPERATION OF THE FUND

The Academy of Medical Sciences will administer the Scheme and a small Committee will be set up to assess applications and make recommendations for funding.

Nominations for young researchers will be sought from Heads of Academic Departments in the relevant countries. Applications may be made from within any of the broad fields of medical research, such as cancer, heart disease, mental illness as well as Daniel's own field of renal medicine. Grants will provide air fare and a subsistence allowance for periods of up to four weeks and it is expected that about ten researchers will be supported each year.