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CONTENTS:

Fastum® Gel ketoprofen 2.5%

Non-steroidal Anti-inflammatory Drug

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TRIPLE ACTION FORMULA

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2 **Superior diffusion at the inflammation site**[2]

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1. Montastier P, Poiraud T, Poelman MC. Etude de la cinétique de diffusion in vitro de quatre AINS destinés a la voie percutanee. *Med du Sport* 1994;68:40-42. 2. Coeciioli S. Ketoprofen 2.5% gel: a clinical overview. *Eur Rev Med Pharmacol Sci.* 2011;15:943-949. 3. Topical analgesics: A review of reviews and a bit of perspective. Bandolier extra. March 2005. Available at http://www.medicine.ox.ac.uk/bandolier/Extraforbando/Topextra3.pdf. Accessed November 11, 2013.

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We are all patients

Rodger Charlton

There is nothing like being a patient to focus our minds to remind us how important it is to have ready access to a doctor and why, when illness strikes.

Access to physicians is changing worldwide, not least through social media, the use of email and smartphones. But, the basic idea of the doctor-patient relationship, the consultation, is essentially the same. However, the value of access to physicians varies from country to country and also within countries where socio-economic status is a large determinant.

The role of family physicians and secondary care specialists differs in that family physicians are likely to see the same patient many times and learn a new part of their life story or narrative in relation to their health and possible illness. It is the family physician's, or personal physician's ability to provide continuity of care through the episodic nature of an illness and ongoing pro-active and reactive care for those with long-term conditions that is most valued by patients.

Doctors are generally held in very high esteem by the public and for this reason patients have considerable expectations in relation to the consultation and getting satisfaction from each meeting with their doctor. I attended a lecture many years ago given by a doctor who worked for social services and I still recall the four points that she made about the possible outcomes of the consultation. These were: (1) being given a prescription, (2) getting a referral to a specialist, (3) being given a sick note and (4) the fourth, which is perhaps the most important of all; receiving a bit of love. The best doctor is the one who perhaps himself has been there, in the seat of the person opposite with an illness and so one who is able to understand, or failing this, the one who at lease tries to understand a patient's plight and circumstances.

Times of distress, which may be brought on by illness or complicated by psychosocial issues in patients' lives, are times of extreme vulnerability and our patients may hang on every word that a doctor says. But, it is not just the words that the doctor utters, but the manner in which the words are delivered that matters, showing whether the doctor is seen as sympathetic

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and where possible, empathetic. So frequently in medical school teaching, we emphasise communication, both verbal and non-verbal, but do we ensure it is always delivered to the highest quality possible?

A general practice (GP) professor, Professor Roger Neighbour, is best known in the United Kingdom for his book and consultation model, "The Inner Consultation".[1] There are many consultation models and it could be argued that there is no ideal model and eventually each doctor develops their own individual style. I was privileged to listen to Professor Neighbour recently speaking at a postgraduate meeting and he has come up with an alternative model which is very straight forward and has come about following considerable reflection. It is: (i) shut up, (ii) listen, (iii) know your medicine and (iv) care. It is the latter that is so important and is contained within the College mottos of the United Kingdom, New Zealand and Australian Royal Colleges of General Practice; *"Cum Scientia Caritas"*, which means "scientific care with loving kindness".[2]

But it is more than sympathy, empathy, care and, the term that now attracts much of our attention in medical education, "*professionalism*." Sadly, it is possible to demonstrate professionalism, but sometimes without truly caring. And perhaps it might be best to go back to the phrase '*bedside manner*', which has been superseded by the word professionalism. Genuine professionalism must include compassion.

Compassion is almost undefinable, but the current pace and pressure of modern medicine means it is squeezed out as we see more patients, more frequently and with shorter consultation time. Compassion is more than empathy, it is the wish to relieve suffering, where the degree of compassion is our desire to want to help and so, in turn, to show kindness (love) and care. This is the embodiment of altruism in health care. Caritas, continuity and compassion are what GPs do best and it is time to embed it as a theme in health care for the foreseeable future. With an increasingly frail elderly population with multiple co-morbidities through long-term conditions, the emphasis should be on caritas balanced appropriately with scientia. The 3Cs for us in the future will be continuity, caring and compassion and these Cs should be the new professionalism. ■

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The usefulness of primary care physician-led motivational interview in a substance abuse check-up clinic: a retrospective study

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Summary

Objective: *To assess the outcome of a structured health check-up clinic for substance abusers.*

Design: *Retrospective study on 73 participants who attended a health check-up clinic led by primary care physicians using motivational interviewing. Participants were assessed by a self-report questionnaire, before and 3-12 months after motivational interviews.*

Subjects: *Attendees aged 13-36 years with history of psychoactive drug abuse.*

Main outcome measures: *One month and three months psychoactive drug abstinence rate, pattern of drug use and subjective usefulness of clinic visits.*

Results: *87.7% (64 out of 73) participants completed both pre- and post- interview questionnaires. The post-intervention 3-months abstinence rate was significantly higher (59.4 %) when compared to pre-intervention (9.6%; p<0.001). The total drug score and number of drugs used reduced significantly both in the past 1 month and 3 months. 93.2% found the service helpful, and 86.2% found that motivational interview could increase their confidence of abstinence.*

Conclusion: *A structured programme consisting of substance abuse health check-up clinic with motivational interviewing by primary care physician is effective for abstinence and reduction in drug-use.*

Keywords: *Substance-related disorders, motivational interviewing, primary health care*

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摘要

目的：對一家為藥物濫用者而設之結構化體檢診所結果進行評估。

設計：採用動機性訪談，對73名到由基層醫生主導的體檢診所就診的參加者進行回顧性研究。在動機性訪談前以及之後3-12個月，通過自我報告問卷，對參加者進行評估。

研究對象：有精神藥物濫用史的13-36歲就醫者。

主要測量內容：一個月和三個月精神藥物戒斷率，藥物濫用模式，到診所就醫是否有用的主觀感受。

結果：87.7%（64/73）的參加者完成了訪談前問卷和訪談後問卷。干預後三個月的戒斷率（59.4 %）明顯高於干預前（9.6%；p<0.001）。過去一個月和三個的藥物總分和用藥數量均顯著減少。93.2%的人認為提供的服務有用，86.2%的人認為動機性訪談可增加他們對戒斷的信心。

結論：由藥物濫用體檢診所和基層醫生開展動機性訪談所構成的結構化專案，能有效戒斷和減少藥物濫用。

主要詞彙：藥物相關性障礙，動機性訪談，基層保健

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Introduction

Substance abuse among young people is a significant problem worldwide. In 2010, 230 million people or 1 in

20 adults were estimated to have used an illicit drug at least once.[1] The evolution of a drug problem has been influenced by demographic trends, socioeconomic and sociocultural factors such as value systems, religion and youth culture.

According to the Hong Kong Central Drug Registry of Drug Abuse,[2] there were 10,939 reported number of drug abusers in 2012. 14.5% were aged less than 21 years old. 96.6% of these young drug users reported using psychotropic substances, and 49.9% were previously convicted.

The total cost of treatment, rehabilitation, counselling, preventive education, and research related to substance abuse in 2010 was $301.42 million dollars.[3] Unfortunately, there is currently insufficient training, no organisation, or reimbursement to screen, assess, and refer those with drug dependence or abuse disorders to appropriate services.[4]

Multi-discipline partnership, adopting multi-systemic therapy approach, is a viable option for substance abuse treatment programme.[5] In addition, primary care physicians have a role in routine drug use screening during our consultation,[6,7] screening for physical and psychological co-morbidities and complications, providing brief motivational interviewing for their drug abuse behaviour, and co-ordinating referrals to appropriate parties.[8,9]

Motivational interviewing is useful in the treatment of a broad range of behavioural problems and diseases,[10,11] which is defined as "a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence".[12] Evidence suggests that motivational interviewing is useful for substance abuse treatment,[13,14,15] able to reduce drug use by teenagers[16,17] and can be performed by primary care physicians.[18]

Motivational interviewings (MI) are already employed by psychologists[19] and psychiatrists[20] in some of Hong Kong's substance abuse treatment programmes. However, data on the efficacy of MI employed by primary care physicians, especially in our locality, is lacking.

The substance abuse check-up clinic in Our Lady of Maryknoll Hospital was established in September 2009. It is run by primary care physicians who provide health check-up, group activities and motivational interviewing to young subjects and is part of a project supported by Beat Drug Fund of the Hong Kong Government.

This paper describes the impact of this primary care-led MI-based substance abuse check-up programme.

There are 8 primary care physicians in the team; the team leader is experienced in motivational interviewing and he is responsible for training of the team members, designing guideline for motivational interviewing. All team members are given 3 hours of training including materials for motivational interviewing, based on Miller and Rollnick's motivational interviewing theories.[12] Briefing sessions and peer sit-in sessions are held before the start of seeing subjects.

The pre- and post- intervention questionnaires on drug use are adopted from evaluation questionnaire of Project Astro Mind.[21] Permission was granted by Prof Daniel Shek of Hong Kong Polytechnic University to use the questionnaires of the programme.

The Hong Kong Playground Association, which is a non-government organisation, recruits young drug users in the community. The drug users should be Hong Kong citizens and are suitable to manage in primary care setting. Their social workers interview the subjects individually at baseline, to gather background and drug use information in a confidential way.

During the interview, the social workers fill in the intake forms and pre-intervention questionnaires accordingly (see **Appendix**). After an interview by social workers, subjects are arranged into group activities including an educational talk by social workers and doctors, and group sharings with ex-drug users.

An individual health check-up session in Our Lady of Maryknoll Hospital is then implemented, which includes body weight, height, memory test, urinalysis, complete blood count, liver and renal function tests. After all tests results are available, subjects are arranged a 45-60 minutes of medical consultation with motivational interviewing by a family physician.

During the consultation, the doctors explain check-up results, screen for physical and psychological co-morbidities and complications, and perform a motivational interview. The motivational interview consists of 2 phases: building up motivation for change followed by strengthening commitment for change.

Follow-up visits by family physicians for other health problems, referral to psychiatrists, paediatricians, or other specialty doctors are arranged if needed. All subjects are followed up by social workers after consultation for at least 3 months, followed by a post-intervention questionnaire, describing their drug use pattern from 3 months to 1 year after the motivational interview, and also their opinions about the service.

Methodology

Study Design

This was a retrospective study on attendees of a substance abuse check-up clinic.

Inclusion criteria

All subjects aged 13-40 years who attended the check-up clinic between 9/2009 and 1/2013; and who had self-reported any history of substance abuse.

Exclusion criteria

Those who only abuse alcohol and/or tobacco were excluded. This was consistent with definition of substance abuse by the Hong Kong Government.[22]

Data collection

Drug-use information was gathered by self-report, as self-report of drug users had been found to be reliable in previous studies.[23,24]

The intake forms, pre- and post- intervention questionnaires and medical records of the subjects were reviewed by the attending doctors.

Information gathered included socio-demographic data: age, gender, referral source, living status, drinking status, smoking status, occupation, education level, financial status, and criminal record; information on health; drug-use pattern including age at first drug abuse and type of drugs used ever at baseline.

For change in drug-use in the past 1 and 3 months before and after motivational interviewing, we reviewed number of drugs used, total drug score based on frequency and abstinence. There was also a section on patient's subjective feeling about usefulness of the programme.

Outcome measures

Change in abstinence rate, frequency and number of drugs used

Our main outcome measures were to compare (1) abstinence rate, (2) total drug score reflecting drug-use frequency, and (3) number of drugs used during past 1 and 3 months, at baseline and after motivational interview.

Statistical analysis

All statistical analyses were conducted using SPSS version 20 for Windows. Descriptive statistics of defaulters and non-defaulters were compared using Chi-square and independent t-test, where appropriate. Changes in continuous variables including number of drugs used and total drug-score between pre- and post-intervention were compared by paired t-test. Binary categorical variables including 1 and 3 months abstinence were analysed by McNemar test.

This study was approved by the Hong Kong Hospital Authority, Kowloon West Cluster Clinical Research Ethics Committee.

Results

Demographic characteristics

A total of 73 subjects were seen (42.5% males) and 64(87.7%) completed the programme; none of the subjects was excluded. For the 64 non-defaulters, 14 subjects completed at 6-12 months and 1 completed at 38 months when called back, and 9 defaulters were not reachable, despite efforts to call by our social workers. Their demographic data are shown in **Table 1**. When we compared demographic characteristics of defaulters with non-defaulters, we found no significant differences between 2 groups.

Drug pattern

The mean age of first drug-use was 14.7 years old (**Table 1**). The most commonly used drug was ketamine (94.4%), followed by methylamphetamine (60.6%) and ecstasy (46.5%) (**Table 2**). 16.4% of our subjects used more than 1 type of drugs in the past 1 month; 24.7 % used more than 1 type of drugs in the past 3 months (**Table 3**).

Co-morbidities

7 (9.7%) were found to have history of suicidal attempt(s), 6 (8.3%) had depression, 1 (1.4%) had

Table 1a: Socio-demographic characteristics of adolescent at pre-assessment

Characteristics		Total (n=73)	Completed only pre-assessment (n=9)	Programme completed (n=64)	P-value
Socio-demographic (%)					
Age (Mean±SD)		20.84±5.26	20.89±5.67	20.83±5.25	0.974
Gender	Male	31 (42.47%)	2 (22.22%)	29 (45.31%)	0.189
	Female	42 (57.53%)	7 (77.78%)	35 (54.69%)	
Referral source	social worker	48 (65.75%)	7 (77.78%)	41 (64.06%)	0.417
	others	25 (34.25%)	2 (22.22%)	23 (35.94%)	
Lives with	single parent +/- siblings	17 (23.61%)	3 (33.33%)	14 (22.22%)	0.645
	parents +/- siblings	40 (55.56%)	5 (55.56%)	35 (55.56%)	
	others	15 (20.83%)	1 (11.11%)	14 (22.22%)	
Drinking status	drinker	34 (58.62%)	3 (42.86%)	31 (60.78%)	0.227
	non-drinker	13 (22.41%)	1 (14.29%)	12 (23.53%)	
	ex-drinker	11 (18.97%)	3 (42.86%)	8 (15.69%)	
Smoking status	active smoker	58 (92.06%)	6 (85.71%)	52 (92.86%)	0.510
	ex-smoker	5 (7.94%)	1 (14.29%)	4 (7.14%)	
Occupation	sales or clerical	6 (8.70%)	2 (25.00%)	4 (6.56%)	0.293
	food service	10 (14.49%)	1 (12.50%)	9 (14.75%)	
	manual worker	10 (14.49%)	1 (12.50%)	9 (14.75%)	
	unemployed	26 (37.68%)	1 (12.50%)	25 (40.98%)	
	student	17 (24.64%)	3 (37.50%)	14 (22.95%)	
Education level	Primary school	3 (4.48%)	0 (0.00%)	3 (5.17%)	0.758
	F.1-F.3	36 (53.73%)	6 (66.67%)	30 (51.72%)	
	F.4-F.5	26 (38.81%)	3 (33.33%)	23 (39.66%)	
	F.6-F.7	2 (2.99%)	0 (0.00%)	2 (3.45%)	
	University or above	0 (0.00%)	0 (0.00%)	0 (0.00%)	
Attending school	F.1-F.3	11 (15.94%)	2 (22.22%)	9 (15.00%)	0.884
	F.4-F.5	4 (5.80%)	1 (11.11%)	3 (5.00%)	
	F.6-F.7	1 (1.45%)	0 (0.00%)	1 (1.67%)	
	University or above	1 (1.45%)	0 (0.00%)	1 (1.67%)	
Financial status	Self finance	30 (44.12%)	4 (44.44%)	26 (44.07%)	0.524
	Rely on family	31 (45.59%)	5 (55.56%)	26 (44.07%)	
	CSSA	7 (10.29%)	0 (0.00%)	7 (11.86%)	
Criminal record		32 (45.71%)	4 (44.44%)	28 (45.90%)	0.935

Table 1b: Drug use patterns of adolescent at pre-assessment

Characteristics		Total (n=73)	Completed only pre-assessment (n=9)	Programme completed (n=64)	P-value
Health and drug use patterns (%)					
Past health	good past health	46 (68.66%)	5 (71.43%)	41 (68.33%)	0.867
	significant medical illness	21 (31.34%)	2 (28.57%)	19 (31.67%)	
Age at first drug abuse (Mean±SD)		14.66±1.99	14.33±3.00	14.70±1.84	0.606
Urinary symptom		36 (49.32%)	2 (22.22%)	34 (53.13%)	0.083
Suicidal attempt		7 (9.72%)	0 (0.00%)	7 (11.11%)	0.293
Active psychiatric problems		11 (15.28%)	0 (0.00%)	11 (17.46%)	0.173
Family history of drug use		12 (17.14%)	0 (0.00%)	12 (19.67%)	0.144

Note:
** P-value of testing significance using independent t-test or Chi-square test, where appropriate*

Table 2: Type of drugs ever used

Drugs	Total (n=72)*
Ketamine	68 (94.4%)
Ecstasy	33 (46.5%)
Methylamphetamine	43 (60.6%)
Cannabis	17 (23.9%)
Nimetazepam	18 (25.4%)
Cough mixture	6 (8.5%)
Inhalants	6 (8.5%)
Cocaine	29 (40.8%)
Others	3 (4.2%)

Note:
** One subject did not response to the drug types used.*

attention-deficit-hyperactivity disorder and 1 (1.4%) had conduct disorder. 57 (78.1%) were found to have physical symptoms. 36 (49.3%) of all drug users had urinary symptoms, while 60% (27 out of 45) of ketamine users had urinary symptoms (**Table 1**).

Change in drug-use after programme completion

The total drug score ($p<0.001$) and number of drugs used ($p<0.001$) reduced significantly at both 1 month and 3 months after programme completion. The abstinence rate (9.6% vs 59.4 %; $p< 0.001$) was significantly higher in 3 months after programme completion compared to baseline (**Table 4**).

Programme evaluation

93.2% found the service helpful in changing their drug use behaviour and 86.2% found motivational interview could increase their confidence of abstinence.

Discussion

This study focused on the change in drug-use pattern after a motivational interviewing-based programme. The population reviewed in this study was younger and had more female drug users. The higher prevalence of ketamine abuse was likely related to our younger population. Otherwise the population was similar to previous local studies.[2]

It seems that the programme helped subjects to decrease and quit drugs. Subjects in our programme decreased their drug-use at 1 and 3 months after programme completion. A similar study revealed that the percentage of regular drugs users decreased from 44% to 13% at 6 weeks, then increased to 18% at 6 months.[20] This is likely due to the fact that both studies have similar population and intervention. The finding is also consistent with previous systematic review[14] in that motivational interviewing reduces substance-use during

Table 3: Total drugs score and number of drugs types used in the past one and three months

Total Drug	During the past month		During the past 3 months	
Score (n, %)	Pre (n=73)	Post (n=64)	Pre (n=72)	Post (n=64)
0	21 (28.8%)	32 (50.0%)	7 (9.7%)	38 (59.4%)
1	6 (8.2%)	7 (10.9%)	8 (11.1%)	5 (7.8%)
2	12 (16.4%)	8 (12.5%)	4 (5.6%)	6 (9.4%)
3	10 (13.7%)	6 (9.4%)	13 (18.1%)	5 (7.8%)
4	15 (20.5%)	10 (15.6%)	11 (15.3%)	4 (6.3%)
5	5 (6.8%)	0 (0%)	16 (22.2%)	5 (7.8%)
6	3 (4.1%)	1 (1.6%)	6 (8.3%)	1 (1.6%)
7	1 (1.4%)	0 (0%)	1 (1.4%)	0 (0%)
8	0 (0%)	0 (0%)	3 (4.2%)	0 (0%)
9	0 (0%)	0 (0%)	0 (0%)	0 (0%)
10	0 (0%)	0 (0%)	3 (4.2%)	0 (0%)
No. of Drugs	**During the past month**		**During the past 3 months**	
(n, %)	**Pre (n=73)**	**Post (n=64)**	**Pre (n=73)**	**Post (n=64)**
0	21 (28.8%)	32 (50.0%)	7 (9.6%)	38 (59.4%)
1	40 (54.8%)	28 (43.8%)	48 (65.8%)	22 (34.4%)
2	7 (9.6%)	4 (6.3%)	13 (17.8%)	4 (6.3%)
3	3 (4.1%)	0 (0%)	2 (2.7%)	0 (0%)
4	1 (1.4%)	0 (0%)	2 (2.7%)	0 (0%)
5	1 (1.4%)	0 (0%)	0 (0%)	0 (0%)
6	0 (0%)	0 (0%)	1 (1.4%)	0 (0%)

Table 4: Change in total drug score, number of drugs used, abstinent rate and action stage from pre-assessment to post-assessment

Total drug score	**Score (Mean±SD)**			
				% of Reduced Use
	Pre (n=73)	***Post (n=64)***	***P-value****	
Within 1 month	2.33±1.94	1.36±1.65	<0.001	34 (53.13%)
Within 3 months	3.83±2.42	1.23±1.79	<0.001	50 (78.13%)
Number of drugs used	**Number used (Mean±SD)**			
				% of Reduced Use
	Pre (n=73)	***Post (n=64)***	***P-value****	
Within 1 month	0.99±0.95	0.56±0.61	<0.001	22 (34.38%)
Within 3 months	1.29±0.95	0.47±0.62	<0.001	41 (64.06%)
Abstinent rate (n, %)	***Pre (n=73)***	***Post (n=64)***	***P-value****	
During the past 1 month	21 (28.77%)	32 (50.00%)	0.169	
During the past 3 months	7 (9.59%)	38 (59.38%)	<0.001	

Note:
** P-value of testing significance using paired t-test or McNemar test, where appropriate*

short follow-up. The long-term effects are however unknown as we did not have long term follow-up in the programme.

There is another local treatment programme organised by paediatricians, which consisted of interview, cognitive and motor function testing, followed by debriefing and counselling. 51.9% of their subjects could abstain for at least 3 months;[25] it is only slightly lower than 59.4% in our programme. Though that study was not targeted for abstinence rate, it was possible that other non-MI based treatment programmes were also effective for young drug users.

Limitations

There are some limitations in this study. Firstly, our sample size was very small despite our much efforts, which restricted analysis of associations between abstinence rate and demographic factors, including smoking. Secondly, we relied on subjects' self-report about their drug-use; there were no objective measures to verify their drug-taking; some subjects had post-intervention assessment more than 6 months after programme completion, due to various reasons like defaults and being in hostels. These results could be inaccurate and prone to recall bias. Lastly, there was no control available in the study so the effect of the programme may be over-estimated, because some reduction of drug-use may be attributed to natural time course only.

Despite these limitations, this study provides preliminary local evidence that a structured programme involving motivational interviewing by primary care physicians is effective and feasible for the care of these young drug users.

Extension of similar service with expansion to other districts can be considered in view of the positive impact. Future service improvement may include motivational interviewing for smoking cessation,[26,27] as there is high proportion of smokers in this programme. On the other hand, smoking cessation may actually enhance outcome success as well.[28]

Future randomised control study in this aspect with longer follow-up duration may help to further verify efficacy and effectiveness of substance abuse management by primary care physicians. More research is also needed to understand the mechanisms of change, the impact of motivational interventions on adolescent developmental transitions and to understand how to disseminate these interventions effectively to those adolescents who need them most.[29]

Key messages

1. Multi-discipline partnership adopting multi-systemic therapy approach is a viable option for substance abuse treatment programme.
2. Motivational interviewing by primary care physician is effective in increasing psychoactive drug abstinence rate, decreasing drug-use and increasing confidence to abstinence.
3. Provision of smoking cessation service targeted for drug users should be considered.
4. Small sample size is the key limiting factor in local drug abuse research.

Conclusion

A local structured programme with motivational interviewing is effective for abstinence and reduction in drug-use in primary care setting. Small sample size is the key limiting factor in local drug abuse research.

Acknowledgements

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Appendix

「清新專線」反青少年吸食危害精神毒品社區綜合計劃
「青少年診所」社工接見表格

個案編號：R _____

個案姓名：_____

年齡：_____ 性別：_____

接見社工：_____ 接見日期：_____

Part A 背景資料

1. 轉介來源 ❑社工：_____ (請註明機構/服務單位)
   ❑學校：_____ (請註明學校/工作崗位)
   ❑警方：_____ (請註明工作部門/單位)
   ❑社區：_____ (請註明服務單位)
   ❑其他：_____ (請註明來源)

2. 參加計劃原因：_____

3. 社會背景：
   3.1 同住家庭成員：❑ 父 ❑ 母 ❑ 兄弟姊妹 ❑ 其他：_____
   3.2 在學就業情況：❑ 全職 ❑ 兼職 (每月收入約 _____)
   ❑ 在學 ❑ 輟學 ❑ 待學 ❑ 待業
   3.3 最高教育程度：_____
   3.4 財政狀況：❑ 自給自足 ❑ 倚賴家人 ❑ 領取綜援 ❑ 欠債
   3.5 餘暇活動：_____

4. 法令及犯罪紀錄：
   4.1 過往及現在是否有以下紀錄
   ❑ 兒童保護令(過往 / 現在) 原因：_____
   ❑ 警司警誡令(過往 / 現在) 原因：_____
   ❑ 感化令(過往 / 現在) 原因：_____
   ❑ 不適用
   4.2 其他犯罪紀錄：_____

5. 使用毒品/濫用藥物情況：
   5.1 第一次吸食年齡：_____

5.2 當時吸食的原因：_____

5.3 目前仍然吸食的原因：_____

5.4 曾吸食過的毒品/藥物：_____

5.5 最長時間吸食之毒品/藥物：_____

5.6 最喜歡吸食之毒品/藥物：_____

5.7 使用量：_____

5.8 頻密程度：_____

5.9 依賴的嚴重程度：_____

5.10 現時使用毒品/濫用藥物的情況：
- ❑ 間歇使用者
- ❑ 定期使用者（未形成藥物依賴）
- ❑ 成癮的使用者（藥物依賴）
- ❑ 已戒斷使用：_____年 / 月

5.11 有否混合多種毒品/藥物吸食：有 / 否

5.12 家人有否吸食毒品/濫藥：有 / 否

朋友有否吸食毒品/濫藥：有 / 否

男女朋友有否吸食毒品/濫藥：有 / 否 / 不適用

6. 吸毒/濫藥後遺症：

6.1 身體方面：_____

6.2 精神方面：_____

7. 曾否接受戒毒/戒藥治療：

7.1 有 / 否

7.2 戒毒方式及結果（如適用）：_____

7.3 過往是否曾減少吸食或完全戒斷毒品/藥物： 是 / 否

如有，請註明使用那種方式：_____

7.4 對上一次接受戒毒治療或濫藥輔導服務的時間 / 機構：_____

8. 過往求診紀錄：

8.1 過去十二個月診症或見醫生的紀錄:

A. 私家診所 有 / 無 次數:_____ 是否關於用藥後遺症? 是 / 否

B. 私家醫院急症室 有 / 無 次數:_____ 是否關於用藥後遺症? 是 / 否

C. 政府普通科門診 有 / 無 次數:_____ 是否關於用藥後遺症? 是 / 否

D. 政府醫院急症室 有 / 無 次數:_____ 是否關於用藥後遺症? 是 / 否

8.2 你有否主動向醫生提出你曾吸毒/濫藥 有 / 無

8.3 醫生有否問你藥物使用/濫用的情況 有 / 無

Part B 評估及跟進建議

1. Balance Sheet (Reflect client's Ambivalence on drug use)

戒毒的好處	分數*	戒毒的壞處	分數*
1.	( )	1.	( )
2.	( )	2.	( )
3.	( )	3.	( )
4.	( )	4.	( )

不戒毒的好處	分數*	不戒毒的壞處	分數*
1.	( )	1.	( )
2.	( )	2.	( )
3.	( )	3.	( )
4.	( )	4.	( )

註： * 分數由0-10分，越高分即表示該項對個案來說越重要

2. 個案在戒毒重要性方面的評估

_____

_____

_____

3. 個案在戒毒信心程度方面的評估

_____

_____

_____

4. 個案在戒毒準備方面的的評估

_____

_____

_____

5. 改變動機：

- ❑ 完全沒有想過要改變（懵懂期）
- ❑ 覺得自己需要日後考慮完全戒斷或減少用藥（沉思期）
- ❑ 覺得自己應該完全戒斷或減少用藥，但尚未準備好（沉思期）
- ❑ 開始思考如何作出改變（決定期）
- ❑ 正採取行動完全戒斷或減少用藥（行動期）

6. 就著以上1-4項的分析作出的跟進建議

- ❑ 需要接受健康檢查
- ❑ 參與計劃的活動：_____
- ❑ 轉介至其他社工跟進：_____
- ❑ 其他：_____

_____

~完~

「清新專線」反青少年吸食危害精神毒品社區綜合計劃
「青少年診所」前測問卷

個案編號: R _____
查核社工:_____

個案姓名：_____　　年齡：_____　　性別：_____

填寫日期：_____

Part A　吸食危害精神毒品的看法

這部分沒有對與錯之分，閱讀後請根據你對以下句子的同意程度，圈出你認為最能反映你意見的數字答案。

	非常不同意	不同意	中立	同意	非常同意
1. 吸食危害精神毒品並無不妥	1	2	3	4	5
2. 危害精神毒品令你看來更有型	1	2	3	4	5
3. 吸食危害精神毒品的青少年較容易結識朋友	1	2	3	4	5
4. 若男/女孩吸食危害精神毒品，異性會喜歡他/她	1	2	3	4	5
5. 青少年吸食危害精神毒品是剛強的表現	1	2	3	4	5
6. 吸食危害精神毒品帶給你許多歡樂	1	2	3	4	5
7. 吸食危害精神毒品的青少年看來很愚蠢	1	2	3	4	5
8. 吸食危害精神毒品的青少年愛表現自己	1	2	3	4	5
9. 吸食危害精神毒品會影響身體健康	1	2	3	4	5
10. 吸食危害精神毒品可以幫助減低壓力	1	2	3	4	5

Part B　吸食危害精神毒品的行為

1. 在過去的1個月中，你有多少次吸食以下毒品？　　(總和數值：　　)

	從來沒有	試過 1-2次	每星期 1-2次	每星期 3-6次	每天都有
E仔(搖頭丸)	0	1	2	3	4
K仔(茹)	0	1	2	3	4
冰	0	1	2	3	4
大麻(草)	0	1	2	3	4
5仔	0	1	2	3	4
咳水	0	1	2	3	4
天拿水	0	1	2	3	4
可樂(coke)	0	1	2	3	4
其他：	0	1	2	3	4

2. 在過去的3個月中，你有多少次吸食以下毒品？ （總和數值：　　）

	從來沒有	試過1-2次	每星期1-2次	每星期3-6次	每天都有
E仔(搖頭丸)	0	1	2	3	4
K仔(茄)	0	1	2	3	4
冰	0	1	2	3	4
大麻(草)	0	1	2	3	4
5仔	0	1	2	3	4
咳水	0	1	2	3	4
天拿水	0	1	2	3	4
可樂(coke)	0	1	2	3	4
其他：	0	1	2	3	4

Part C　戒毒動機評估

1. 戒毒重要性方面(Importance)：對你現時來說，你認為戒毒有多重要呢？假如0分代表完全不重要，10分代表最重要，請你給予一個分數。

0　1　2　3　4　5　6　7　8　9　10

2. 戒毒信心程度方面(Confidence)：假如你現在決心戒毒，你認為能夠成功戒毒的信心有多大？假如0分代表完全沒有決心，10分代表最大決心，請你給予一個分數。

0　1　2　3　4　5　6　7　8　9　10

3. 戒毒準備方面(Readiness)：你自己有為戒毒而作出一些準備嗎？請說明。

_____

_____

4. 現時改變動機：
   - ❑ 完全沒有想過要改變
   - ❑ 覺得自己需要日後考慮完全戒斷或減少用藥
   - ❑ 覺得自己應該完全戒斷或減少用藥，但尚未準備好
   - ❑ 開始思考如何作出改變
   - ❑ 正採取行動完全戒斷或減少用藥

~完~

「清新專線」反青少年吸食危害精神毒品社區綜合計劃
「青少年診所」後測問卷

個案編號: R _____
查核社工:_____

個案姓名：_____ 年齡：_____ 性別：_____

填寫日期：_____

Part A 吸食危害精神毒品的看法

這部分沒有對與錯之分，閱讀後請根據你對以下句子的同意程度，圈出你認為最能反映你意見的數字答案。

	非常不同意	不同意	中立	同意	非常同意
1. 吸食危害精神毒品並無不妥	1	2	3	4	5
2. 危害精神毒品令你看來更有型	1	2	3	4	5
3. 吸食危害精神毒品的青少年較容易結識朋友	1	2	3	4	5
4. 若男/女孩吸食危害精神毒品，異性會喜歡他/她	1	2	3	4	5
5. 青少年吸食危害精神毒品是剛強的表現	1	2	3	4	5
6. 吸食危害精神毒品帶給你許多歡樂	1	2	3	4	5
7. 吸食危害精神毒品的青少年看來很愚蠢	1	2	3	4	5
8. 吸食危害精神毒品的青少年愛表現自己	1	2	3	4	5
9. 吸食危害精神毒品會影響身體健康	1	2	3	4	5
10. 吸食危害精神毒品可以幫助減低壓力	1	2	3	4	5

Part B 吸食危害精神毒品的行為

1. 在過去的1個月中，你有多少次吸食以下毒品？ (總和數值：)

	從來沒有	試過 1-2次	每星期 1-2次	每星期 3-6次	每天都有
E仔(搖頭丸)	0	1	2	3	4
K仔(茄)	0	1	2	3	4
冰	0	1	2	3	4
大麻(草)	0	1	2	3	4
5仔	0	1	2	3	4
咳水	0	1	2	3	4
天拿水	0	1	2	3	4
可樂(coke)	0	1	2	3	4
其他：	0	1	2	3	4

2. 在過去的3個月中，你有多少次吸食以下毒品？ (總和數值：)

	從來沒有	試過1-2次	每星期1-2次	每星期3-6次	每天都有
E仔(搖頭丸)	0	1	2	3	4
K仔(茄)	0	1	2	3	4
冰	0	1	2	3	4
大麻(草)	0	1	2	3	4
5仔	0	1	2	3	4
咳水	0	1	2	3	4
天拿水	0	1	2	3	4
可樂(coke)	0	1	2	3	4
其他：	0	1	2	3	4

Part C 戒毒動機評估

1. 戒毒重要性方面(Importance)：對你現時來說，你認為戒毒有多重要呢？假如0分代表完全不重要，10分代表最重要，請你給予一個分數。

0 1 2 3 4 5 6 7 8 9 10

2. 戒毒信心程度方面(Confidence)：假如你現在決心戒毒，你認為能夠成功戒毒的信心有多大？假如0分代表完全沒有決心，10分代表最大決心，請你給予一個分數。

0 1 2 3 4 5 6 7 8 9 10

3. 戒毒準備方面(Readiness)：你自己有為戒毒而作出一些準備嗎？請說明。

_____

_____

4. 現時改變動機：

- ❑ 完全沒有想過要改變
- ❑ 覺得自己需要日後考慮完全戒斷或減少用藥
- ❑ 覺得自己應該完全戒斷或減少用藥，但尚未準備好
- ❑ 開始思考如何作出改變
- ❑ 正採取行動完全戒斷或減少用藥

Part D 對健康檢查部分的意見

1. 你認為「參與健康檢查」和「見醫生」對你有否幫助?

   ❑有 →在哪一方面?_____

   ❑沒有 →為什麼?_____

2. 你認為和醫生面談，是否可增 你現在或將來戒毒的決心？

   ❑是 →為什麼?_____

   ❑否 →為什麼?_____

3. 你對整個「健康檢查」部分有什麼意見？ _____

~完~

Delivering medical care – attempt to think out of the box

John CY Leong 梁智仁

It is generally acknowledged that Sun Yat Sen is the father of modern China. What is not that often acknowledged is that he played an important role in the introduction of Western Medicine into Hong Kong, and in turn, to China. This was, in part, achieved by his being educated in the art and science of Western Medicine when he was one of the two first graduates of the Hong Kong College of Medicine in 1887. Twenty-five years later, the University of Hong Kong was established, with the Faculty of Medicine as one of the three founding faculties.

Dr Sun was a general practitioner in the widest sense, because there was certainly no specialisation in those early days. A hundred and ten years later, the Hong Kong Academy of Medicine was established, opening up the formal training and accreditation of medical specialties. General practice has taken on a new meaning, and it has become recognised that a period of formal and well-planned supervised training, after undergraduate education, is needed to enhance general practice of medicine to the specialty of Family Physicians.

The reason why the colonial British Government in the 1880s decided to set up the Hong Kong College of Medicine was that the Chinese population at that time almost entirely consulted Chinese Medicine practitioners for their illnesses. Only when their illnesses were so serious that Chinese Medicine was unable to deal with that they sought help from Western Medicine practitioners. The latter were almost entirely Caucasians, rendering communication between doctor and patient difficult because of the language barrier. The then Government took a wise decision to start an institution for education of the Chinese population in the art and science of Western Medicine. This was the beginning of a public medical service for in-patients as well as out-patients.

Fast forward to the Post Second World War era, the public medical and health service was under the authority of the then Medical and Health Department. The main mission at that time was the need to safeguard and promote the general public health of the community as a whole; and the need to ensure the provision of medical and personal health facilities for the people of Hong Kong, including and particularly that large section of the community which relied on subsidised medical attention.

The gradual but sustained immigration into Hong Kong from the Mainland after the establishment of the communist regime continued to put heavy pressure on the public medical service. Although the medical care was of international standard, the facilities and hardware of public hospitals were below par and could not catch up with the ever increasing volume of patients. The formation of the Hospital Authority in 1991 was a commitment by the then Government to upgrade all aspects of the public medical service. Indeed, it has achieved much towards that goal. However, in some ways it has become a victim of its success.

The subsequent presentation and discussion of this oration will refer to only the in-patient aspect of the public medical service. It will highlight the existing pressure in terms of demand (**Figure 1 & Figure 2**) and projected requirements to the next decades, the hardware and facilities required to satisfy the demands of a growing population, and an increasing percentage of the elderly population (particularly the so-called "Old Old", i.e. people over the age of 80 or 85).

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Chairman,
Hospital Authority

Correspondence to: Prof John CY Leong, Hospital Authority Building, 147B Argyle Street, Kowloon, Hong Kong SAR, China.

The oration will attempt to suggest looking at ways other than the present established modes of planning to deal with the ever increasing demand.

Ideas to be discussed include the shifting of certain types of patients occupying acute hospital beds to subacute rehabilitation beds in rehabilitation

Figure 1: Overall Number of Patient Headcount Treated in Hospital Authority

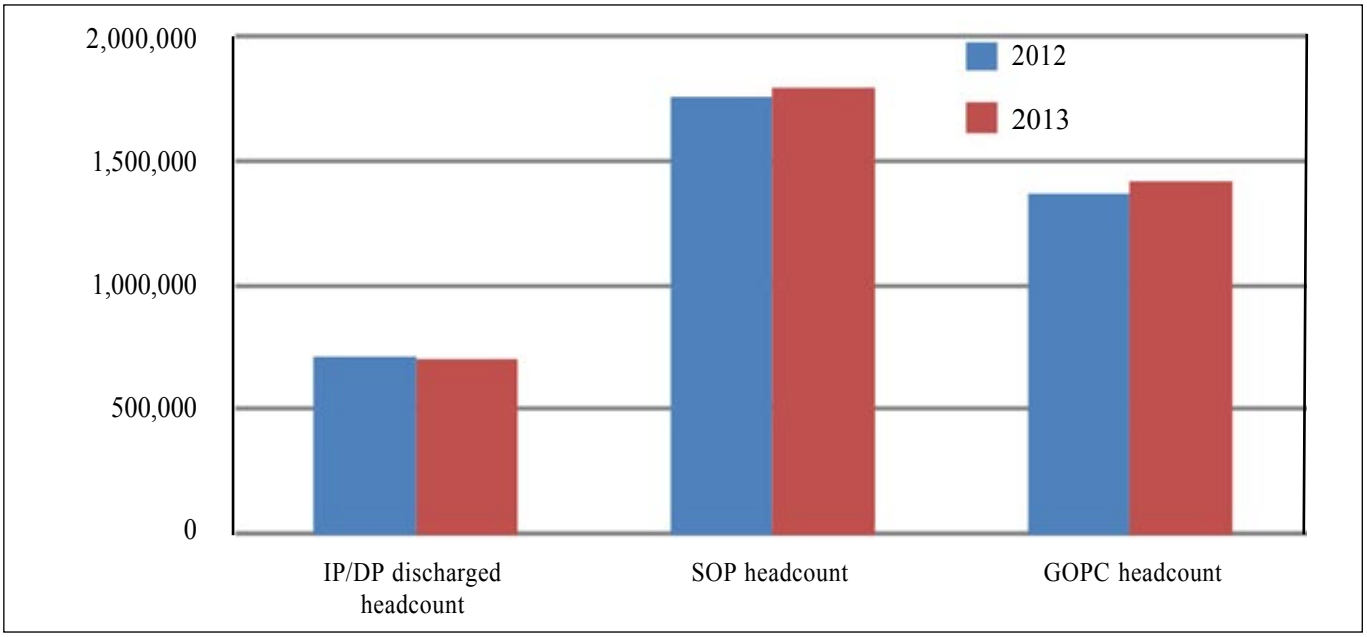
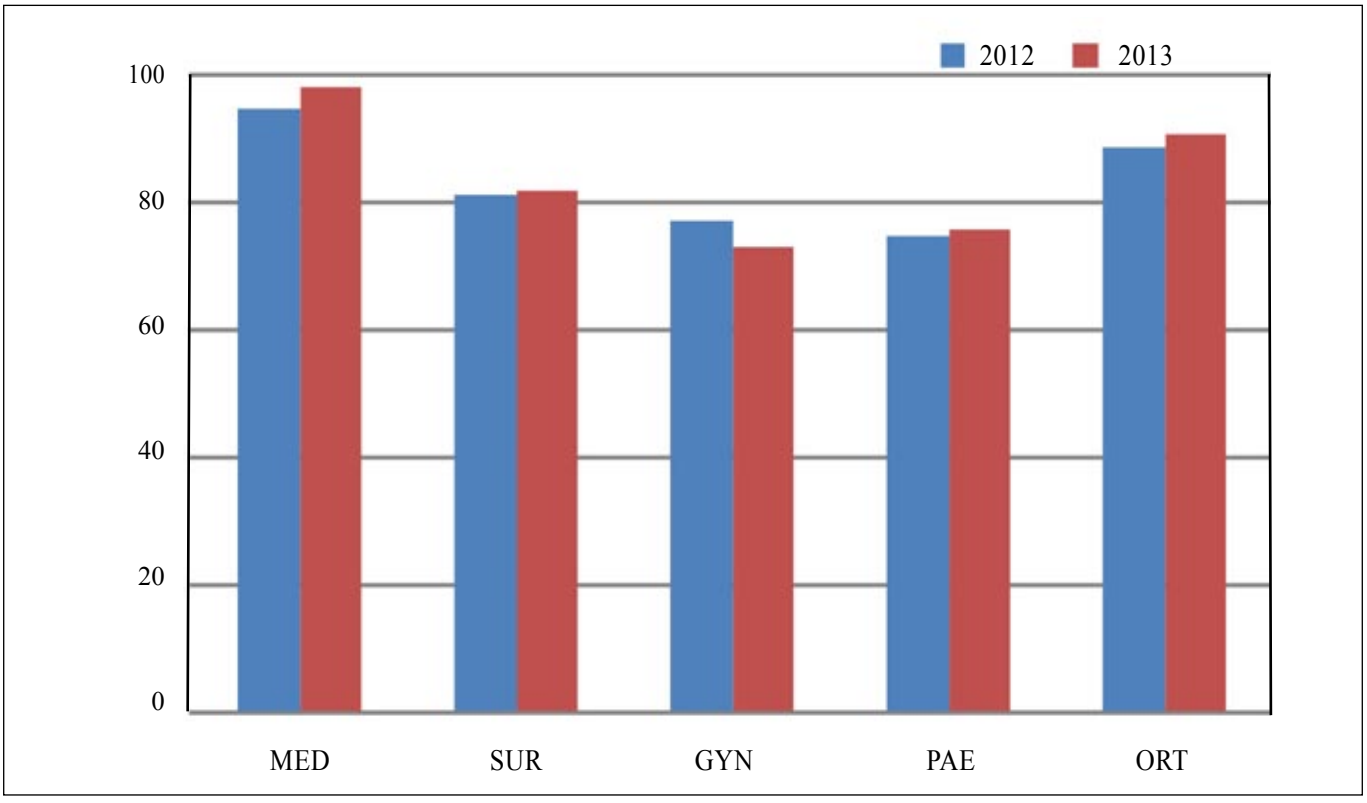


Figure 2: Average Inpatient (IP) Acute Bed Occupancy Rate (%)



blocks near to acute hospitals (**Figure 3 & Figure 4**), concomitantly upgrading of the nursing care in the rehab blocks to be able to handle these subacute patients.

Examples will be given of the average length of stay (ALOS) of the most commonly admitted groups of patients in the Medical & Geriatrics Ward, i.e. respiratory, cardiac, and stroke (**Figure 5**). Estimations of how reducing one-third (**Figure 6**) and half (**Figure 7**) of the ALOS can theoretically vacate a significant number of beds in acute wards for emergency admissions. Discussion will be offered as to how patients, with privately purchased medical insurance or medical service provided by employers, presently being treated in the public acute hospitals (**Figure 8**) can be shifted to private hospitals (**Figure 9**). Also, how

Figure 3: Possible Solution

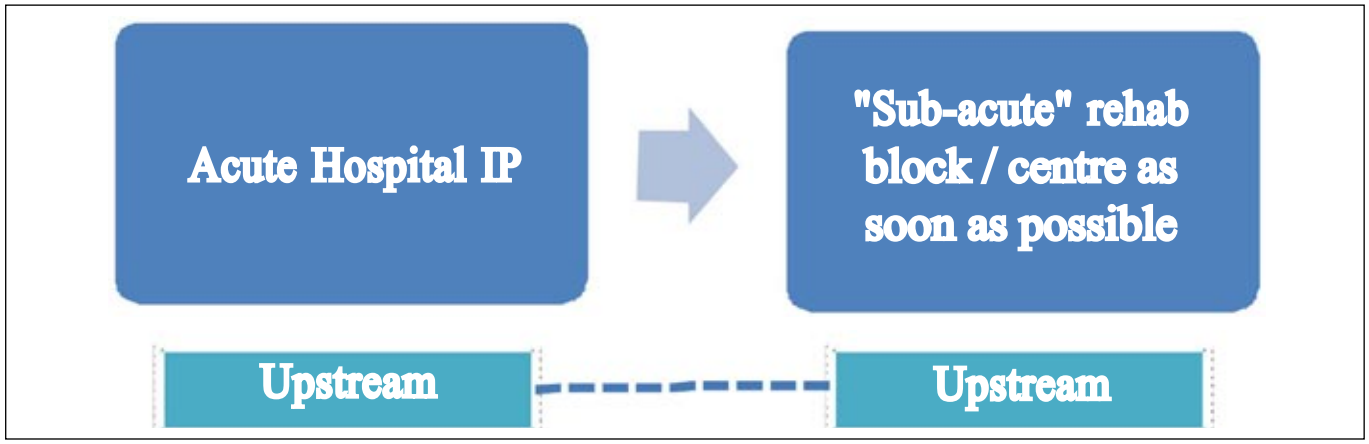
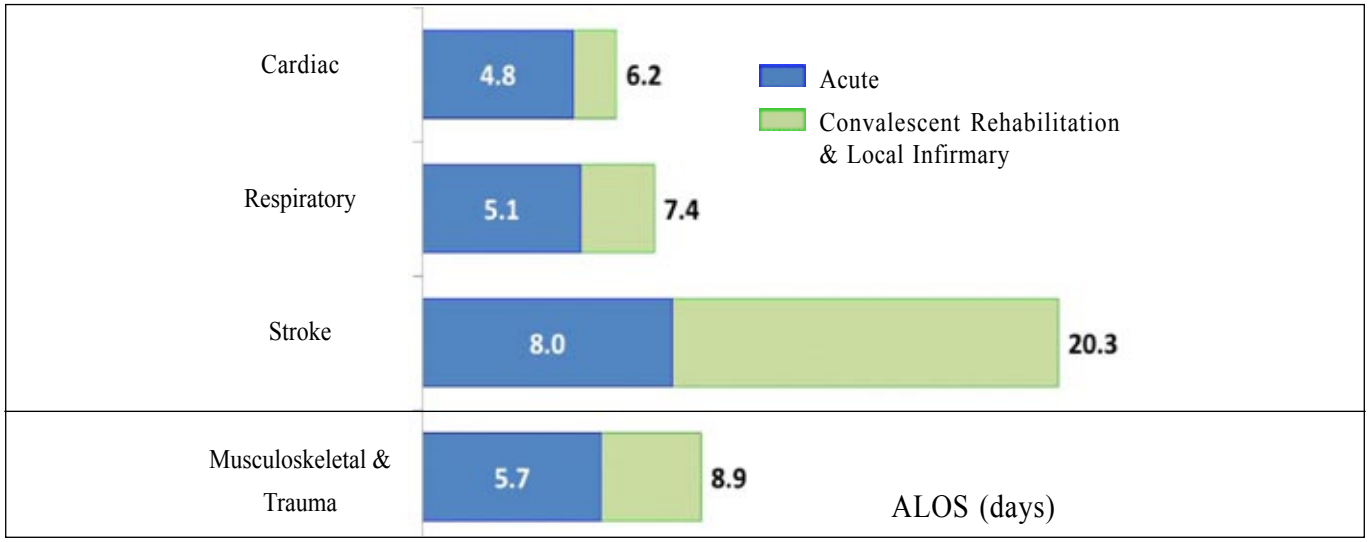


Figure 4: Prerequisites

- **Sub-acute rehabilitation facility is near to acute hospital**
- **Level / expertise of nursing care can handle the "sub-acute" patients**
- **Back up of doctor consultation, if necessary, from the nearby acute hospital**
- **Sub-acute rehab block / centre should be included in the planning process of new hospitals**
- **Sub-acute rehab block / centre to be added to existing hospitals whenever an opportunity arises**

Figure 5: Average Length of Stay of the 4 Major Disease Groups



to attract Family Physician Fellows not only to work within the public medical service, but to mentor general practitioners to become competent enough to deal with the large volume of patients with chronic diseases to shift them from Specialists outpatient clinics to the General outpatient clinics. It is argued that thinking out of the box, rather than just following established planning policies and procedures, can contribute towards coping with the high demands of the public medical service. ■

Figure 6: Impact on Acute Inpatient Bed Occupancy Rate of 3 Major Disease Groups (Cardiac, Respiratory and Stroke) in MED by Reducing Length of Stay by One-Third

	2013 MED	Scenario Hypothetical Calculation
No. of Acute Medical Episodes	440,357	440,357
Average Acute Bed Days Occupied	4.4	3.6
IP Bed Occupancy Rate (%)	98.1%	81.3%
No. of Acute Beds Equivalent which can be Potentially Vacated	~	1,066

Figure 7: Impact on Acute IP Bed Occupancy Rate of 3 Major Disease Groups (Cardiac, Respiratory and Stroke) by Reducing LOS by Half

	2013 MED	Scenario Hypothetical Calculation
No. of Acute Medical Episodes	440,357	440,357
Average Acute Bed Days Occupied	4.4	3.3
IP Bed Occupancy Rate (%)	98.1%	72.9%
No. of Acute Beds Equivalent which can be Potentially Vacated	~	1,599

Figure 8: Hospital Admissions of Persons Covered by Private Health Insurance / Medical Benefits

Insured	213,700	33%	
Treated in public hospitals	115,800		54%
Treated in private hospitals	97,900		46%
Not Insured	427,300	67%	
Treated in public hospitals	385,500		90%
Treated in private hospitals	41,800		10%
Total	**641,000**	**100%**	

Source: Census and Statistics Department data

Figure 9: High Cost of Hospitals

High-tech,
Most advanced equipment / facilities

Can there be
private hospitals with lower cost for
common surgical procedures?

INFORMATION FOR AUTHORS

Circulation and Content

The Hong Kong Practitioner is published quarterly by The Hong Kong College of Family Physicians.

The Journal is indexed in *EMBASE/Excerpta Medica as 'HK Pract'*. It has a circulation of 4000, distributed to all members and some non-members of the College, academic institutions as well as private subscribers in Hong Kong and overseas.

The aim of the journal is to promote the development of quality family medicine/general practice in Hong Kong and the region, by publishing editorials, original articles, update reviews, letters to the editor, and self-assessment materials.

Manuscript Criteria - General

Papers submitted for publication should fulfil the following criteria:-

a. Manuscript to be accompanied by covering letter, signed by all authors stating that it is original and no part of it has been submitted for publication elsewhere and identifying any possible conflict of interest, and the contribution of each author.
b. Typed in double line spacing with 3cm margins.
c. Submission of manuscript should be the preferred Microsoft Word (DOC) format, and sent to "priscillali@hkcfp.org.hk" with one printed copy of the manuscript to the Editor.
d. List of full names (both in English with Western name(s) first, then Chinese names hyphenated or initials, and then family name and if applicable in Chinese characters) with a maximum of six authors, giving basic and higher qualifications and current appointment of each.
e. A maximum of four qualifications will be included for each author. All qualifications should be identified and include name of awarding body or institution.
f. The principle author should give his or her address for correspondence.
g. Authorship details should be on a sheet separate from the main text to assist in sending papers 'blind' to referees. Spelling should conform to the Oxford Dictionary.
h. Abbreviations should be spelt in full when first used.
i. Generic names of drugs must be used. Proprietary names may be used in parentheses on the first occasion if necessary.
j. SI units should be used, with traditional units in parentheses.
k. Tables and illustrations should be on separate sheets and clearly labelled. The titles should enable interpretation without reference to the text.
l. Photographs should be labelled on the reverse.
m. References should conform with the Vancouver style as used in this journal, and must be clearly numbered in the correct order in the text. Journal titles should be abbreviated to Index Medicus Style. List all authors and/or editors up to three; if more than three, list the first three and *et al*.
n. While a liberal policy is adopted in matters of controversy, no personal attacks, explicit or implied, are permitted.
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p. Ten copies of reprints will be provided free to the authors if requested. Additional copies may be purchased and should be ordered when the proofs are returned.
q. All articles described in this Information for Authors are peer-reviewed. At least one of the reviewers will be a family physician.
r. All articles are subject to editing.
s. Correspondence should be addressed to the Editor, *The Hong Kong Practitioner*, The Hong Kong College of Family Physicians, Room 803-4, 8th Floor, HKAM Jockey Club Building, 99 Wong Chuk Hang Road, Hong Kong.

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Categories of Articles

Original Research Papers

Papers on original research relating to primary care in Hong Kong are particularly welcome.

They should be set out in a standard format with an Introduction giving background and objectives; Method giving details of subjects, study design and measurements, interventions, outcomes, and statistical methods; Results; Discussion; Conclusions; References; and Acknowledgements.

Papers should be between 1,500 and 3,500 words in length.

Graphs and tables should be limited to six and references to 40.

A structured summary of up to 200 words should be set out under the headings of Objective, Design, Subjects, Main Outcome Measures, Results, and Conclusions. Up to five keywords should be given to aid index cross-reference.

Educational Update Articles

They should be relevant to the Family Physician who is trying to keep up to date with recent advances in primary care.

Articles should be between 1,500 and 3,500 words, and structured with a summary, introduction, and main body of article with appropriate subheadings.

Graphs and tables should be limited to six and references to 40.

Discussion Papers

Papers on topics and issues of relevance to primary care are welcome. They should present a hypothesis or problem, and offer a way of solving it or a solution for discussion. They should be between 1,500 to 3,500 words, and structured with a summary, introduction, and main body of article with appropriate subheadings.

Case Reports

These articles should be up to 1,500 words reporting cases of particular interest, difficult management, unusual presentations or outcomes, carrying a useful message to other doctors; with no more than one table or illustration and five references.

Letters to the Editor

Letters should be up to 500 words with no more than one table or illustration and five references.

This gentleman has got this rash on his hand for a few years

King-man Ho 何景文

Readers are invited to participate in the Clinical Quiz. A prize draw, sponsored by Pfizer Corporation Hong Kong Limited, will be undertaken among the successful entries. For entry into the draw, simply answer the question, fill in the reply slip and return it to the College by 21 November 2014. Each reader is allowed to submit one entry only. The name of the winner and the answer will be published in the December 2014 issue.

Clinical history:

This gentleman has got this rash on his hand for a few years.

What was the clinical diagnosis?

A. Psoriasis
B. Chronic lichenified eczema
C. Tinea
D. Discoid lupus erythematosus

The Hong Kong Practitioner
Clinical Quiz – September / 2014

Answer :

Name : _____

Tel. No. : _____

Address : _____

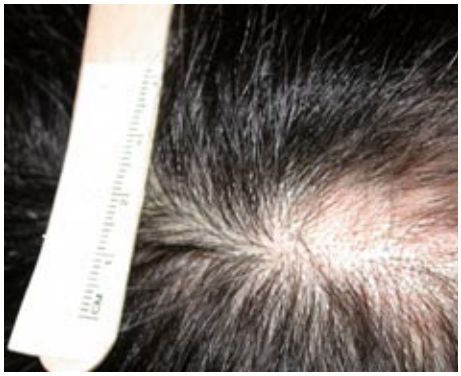
_____

Date : _____

Please send your answer to :- **HKCFP**
Room 803-4, 8/F, HKAM Jockey Club Building, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong.

The slide and the question were prepared by:
Dr King-man Ho, FRCP (Glasg, Edin), MRCP (UK), FHKCP, FHKAM (Medicine)
Consultant Dermatologist-in-Charge,
Social Hygiene Service, PHSB, CHP, DH

Answer to last month's Clinical Quiz



Question:

This lady presented with patches of alopecia for unknown duration.

Answer:

C. Discoid lupus erythematosus

Discoid lupus erythematosus (DLE) is a scarring alopecia. Superficial scaling is hardly noticeable.

The clinical approach to alopecia is to first differentiate whether the alopecia is localised or diffuse. For localised alopecia, we next differentiate whether it is scaring or non-scarring alopecia. Scaring alopecia is defined by the absence of hair follicle in the bald patch. For the purpose of case definition in scarring alopecia, clinical presence of a "scar" is not required. Common causes of non-scarring alopecia include alopecia areata, tinea capitis, trichotillomania and traction alopecia. While there are many causes of scaring alopecia, most causes such as trauma, congenital, hamartomas and other growth will be easily recognised; discoid lupus erythematosus and lichen planus (LP) are the two important inflammatory dermatoses which the clinician should consider whenever they encounter localised scaring alopecia.

DLE lesion presents as an inflammatory erythematous patch or plaque at the initial stage. There may be follicular plugging and the typical carpet tack sign demonstrated. The patch will end up with an atrophic bald patch with hypopigmented centre and hyperpigmented rim. The head is the site of predilection of DLE. The clue to diagnosis in this case is that though there are residual hair follicles, when the density is compared to the surrounding scalp, it is clear that the number of follicle is reduced (Because this photo is taken at the recovery stage after treatment, we can manage to save a few of the follicles). Other sites such as the ear, nose and other bodily sites should also be examined for the presence of DLE lesion. (As lichen planus is another differential diagnosis, the other sites for lichen planus lesions including volar aspect of the wrists, buccal mucosae and nails also should be examined). For this case, skin biopsy and immunofluorescence study confirmed the diagnosis of DLE.

Tinea capitis usually occurs predominantly in prepubertal children. The most common dermatophyte causing tinea capitis in Hong Kong is *Microsporum canis (M canis)* which is a zoophilic dermatophyte. *Microsporum canis* can be acquired from infected dogs and cats which are the natural host of this fungus.

Tinea capitis can present in the following patterns: seborrhoeic pattern, non-scarring patchy alopecia, kerion and favus. In the seborrhoeic pattern, dandruff-like scaling is found on the scalp. Prepubertal children presenting with suspected seborrhoeic dermatitis on the scalp should be presumed to have tinea capitis until proven otherwise. In the patchy pattern, patchy bald patch with black stumps of broken hair shaft due to breakage of hair near the scalp are found. In kerion, boggy masses covered with pustular folliculitis are found and scarring may ensue after wards. In favus, most frequently caused by *Trichophyton schoenleinii*, yellow saucer-shaped adherent crusts made up of hyphae and spores occur around the hairs. With the exception of flavus and kerion, the common type of tinea capitis will not cause scarring alopecia.

Alopecia areata is a not uncommon non-scarring localised alopecia which more commonly affects young people. The aetiology and exact mechanism is not yet known. Though an inflammatory process is believed to be involved, there is usually no clinical sign of skin inflammatory by the time the patient presents to a doctor. The involved patch is usually annular in shape. The clues to diagnosis of alopecia areata include the bald patches which are usually well delineated and complete hair loss, the skin of the involved patch is normal looking i.e. density of hair follicle normal, without scale, not atrophic, not inflamed, nor there is any folliculitis or follicular plug. Another important clue to diagnosis is the exclamation mark hair – very short minimally pigmented hair often

split at the distal end, tapering and pointed at its proximal part just above the follicle. The presence of exclamation mark hair is not only indicative of the diagnosis but also of active disease process.

Trichotillomania is a non-scarring localised alopecia which resulted from self-plucking behaviour knowingly or not knowingly to the patient, more commonly affecting women, children and teenagers. The clues to diagnosis of trichotillomania include the bizarre shaped patch of hair loss, and hair loss in the bald patch may not be complete, or there are stubs of short hair of variable length within the bald patch (the patient cannot pluck away those very short but newly regrown hair), follicular haemorrhage and folliculitis may sometimes be present. As trichotillomania is pertained to non-scaring alopecia, the density of hair follicle in the bald patch will be normal.

The winner of the June 2014 Clinical Quiz is **Dr Yuen Ka Wai**

Further investigation is not required for confirming the diagnosis of an otherwise typical case of alopecia areata or trichotillomania. If the diagnosis of tinea capitis is contemplated, skin scraping for fungal culture is now the recommended method of sampling for fungal culture. Hair plugging is no longer recommended for this purpose. As *M canis*, the most common dermatophyte causing tinea capitis locally, will show green fluorescence under Wood's light in contrast to non-fluorescent *Trichophyton tonsurans* (supposedly the most common dermatophyte causing tinea captitis in many Western countries), Wood's light examination is still a very useful diagnostic test in approaching suspected tinea capitis in Hong Kong. Wood's light may also guide the clinician to sample the infected region for skin scraping.

In scarring alopecia without an obvious cause, skin biopsy has to be performed to establish and differentiate the diagnosis. A biopsy sample of size equivalent to at least two 4 mm punch biopsy with depth down to the fat layer is required. Another fresh piece of skin should also be sent for immunofluorescence study if DLE is suspected.

Spiritual pain at end-of-life in a changing world

Rodger Charlton

Summary

Patient care traditionally addresses the physical, psychological and social aspects of holistic care, but neglects that there may also be 'spiritual' needs.

摘要

傳統上的全人護理，注重解决病人身體，心理和社會各方面問題，但可能忽略了病人'精神'方面的需要。

HK Pract **2014;36:107-112**

Introduction

This paper summarises a presentation, given at the 20th Hong Kong International Cancer Congress (HKICC) 14th November 2013, as part of the Family Medicine Symposium.[1] The objectives of the address were to consider the concept of a spirit, spiritual health and spiritual pain with a particular emphasis on spirituality in end of life (EOL) care as a possible overlooked component of primary care and palliative care.

Defining "spiritual"

Medical teaching focuses an increasing emphasis on holistic care, and so, on the whole person. In this context, when asking what is meant by the spirit, everyone has a different viewpoint. Is it important to ascertain if there is a reliable definition? If so, questions one might ask are; is it physical, mental, is it in the mind and what is the nature of the spirit or soul? In fact, there are more questions than answers. It is not a new concept and it does not necessarily refer to a religious faith although the two may overlap. The late Dame Cicely Saunders, who is attributed as the founder of the modern hospice movement, coined the phrase "total pain" in the 1960s which she referred to as the physical, psychological, mental, emotional, social, as well as the spiritual aspects.[2]

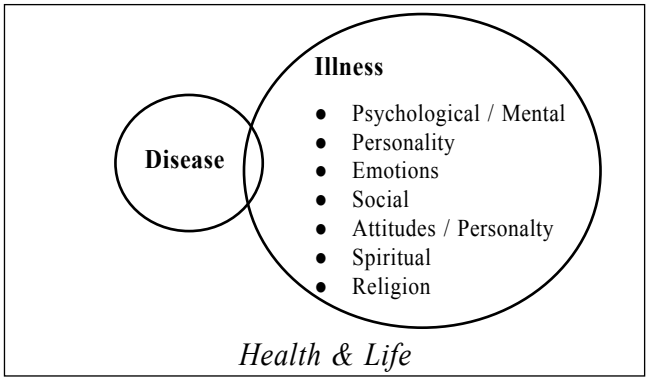
Spiritual is included in the European Association of Palliative Care (EAPC) definition of palliative care as follows;

"Palliative care is the active, total care of the patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of social, psychological and spiritual problems is paramount."[3]

Similarly, spiritual needs appear in the World Health Organisation definition.

Twenty years ago, I sought the views of New Zealand medical students on this subject and in the free text of the survey one student made the poignant point: "I think that there are more important things to learn in our overfull course than putting more into it about this kind of thing. Please do not recommend more extraneous stuff to be put in our course or more messy and pointless 'ethical & philosophical' kind of time consuming garbage".

Maybe the student had a point and one should respect all views and reflections regarding such an opinion.[4] One can try to illustrate spirituality in a Venn Diagram as follows:



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Recurrent themes reflecting on "spirituality"

During teaching and presentations on this topic, groups of trainees and practitioners provide recurrent themes. For example, when asked to reflect on the characteristics of the spirit in a health context, these include:

- Feeling of a meaning / purpose in life, perhaps something existential or internal.
- Acknowledging that there are a wide variety of views.
- Being aware that there are many religious faiths of varying commitments.
- Remembering that everyone's reality is different and everyone's truth is different.
- Respecting that interpretations are different and so perspectives.

Similarly, when asked to consider the concept of spiritual health it might comprise recurrent themes like:

- Strength of will (Those fighting cancer may do better).
- Extent of optimism (Hope).
- Happiness (GPs - see many who are sad).
- If it exists, what is it? (Difficult to define).
- When one is spiritually 'well' one is at peace.
- What makes it better? What makes it worse?
- Like all aspects of health it fluctuates.
- Does it vary according to physical health?
- Distinguishing between Spirituality and Religion.

Subjectivity and objectivity

It is challenging to provide objectivity, where possible, in what is an area of subjectivity. Therefore, in relation to the term spirituality, there are several possible definitions. For example, spirituality as a mechanism which allows a person to experience transcendent meaning in life or it could be as is often the case something which is frequently expressed as a relationship with God. Spirituality can also be about nature, art, music, family, or community and so whatever beliefs and values give a person a sense of meaning and purpose.[5]

A USA paper considered the factors important at the EOL by patients, family, physicians and other care providers.[6] A random national survey was conducted in 1999 of seriously ill patients (n = 340), bereaved (n = 332), physicians (n = 361), and other carers (including nurses, social workers, chaplains, hospice volunteers; n = 429). The paper found 44 attributes of quality at EOL as important. The key findings of this paper were the following issues which were important to patients and others but not so important to physicians ($p < 0.001$):

1) Be mentally aware
2) Be at peace with God
3) Not be a burden to family
4) Being able to help others
5) Prayer
6) Have funeral arrangements planned
7) Not be a burden to society
8) Feel one's life is complete

Doctors considered that the following would be of the upmost importance:

- Pain control
- Symptom control
- Depression
- Cure

However, overall "Freedom from pain" and "Being at peace with God" were ranked as most important (and were statistically equivalent) by patients and doctors.

Death as a taboo subject

Death may almost be viewed as a taboo subject where a taboo is literally a social prohibition or ban. In the 1960s, Elizabeth Kubler Ross, a Swiss born psychiatrist working in the United States was someone who also had a considerable influence on the modern hospice movement. She is perhaps best known for her proposed five stages of anticipatory grief of which the last stage is when the patient moves from depression to acceptance of their illness.[7] As part of the taboo it could be argued that it is rare to experience a patient who is dying that reaches the stage of acceptance, but rather more appropriately they are resigned to their fate and so in a state of resignation, thus adding a sixth stage to the original proposal.

Then the part of palliative care which is defined, but receives minimal attention arises. This is because it is not seen as a "medical" issue and is the process of bereavement or grieving. For some time after death it may appear more that the loved one or friend "has left" rather than died. A continued concept of taboo in this area is avoidance of the term "death" which is fundamentally scary where a loved one has in fact died.

A further part of the taboo is the limited possibility of patients dying at home which is rare in Hong Kong and far from common in the UK where perhaps only 25% of terminally patients die at home. Patients have an anxiety whether or not they can look after themselves at home and for many reasons primary care is not set up or prepared for EOL care at home. This leaves a further dilemma as to whether some of the suffering that patients go through if they are dying is the anxiety about where they will die. As a part of this relatively taboo subject they feel not able to talk about this.

The EAPC have provided a working definition of spirituality in 2010 and it is as follows:

"Spirituality is the dynamic dimension of human life that relates to the way persons, individual and community experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred."[8]

To understand the concept of spirituality and spiritual pain necessitates the understanding of people, something which family physicians are very good at. This, however, involves considering the following aspects when caring for patients and applying the concept of spirituality:

- Understanding oneself and developing an appreciation of seeing people from other backgrounds / faiths.
- Getting to know people in their context.
- Acknowledging that the values of medicine differ between doctors.
- Being aware that each human interaction changes future actions and so judgments.
- Being open to continuously redefining life.

The transition from "Being" to "Un-being"

To understand spirituality and spiritual pain it can be considered by reflecting on the author of the novel 'Ring of Bright Water' (Gavin Maxwell) which was set in rural Scotland. He is reported to have recalled the great pain of the solitary moment of moving from "being to un-being" when he was dying of cancer. Doctors are rarely present at the moment when patients die and tend not to have the conversation, "What will it be like when I die?", as it is unusual for patients to ask this question. However, it could be argued that reducing spiritual pain is facilitating a person to the transition from "being" to "un-being".[9]

As well as ameliorating physical pain and symptoms for a cancer patient it is facilitating this transition which may be wide ranging, for example, about personal conflicts with family members or friends and so enabling a person to re-order their priorities and let go. Getting involved in these conversations and circumstances is something that doctors tend not to do and so for both doctors and the public, who are future patients, death is a 'taboo subject'. This is accentuated for members of the public as:[10]

- It is rare for the majority of the public to see a dead body.
- Dying has been 'medicalised' in UK institutions where > 70% of people die; and > 90% die, in Hong Kong.
- Death has been transformed from being an accepted everyday occurrence and natural part of the life cycle, into a 'taboo subject'.
- Dying has been medicalised, professionalised and sanitised to such an extent that it is now alien to many people's daily lives (The lost art of Dying).

And yet this is contradicted by all that we know. As long ago as 1612, Sir Francis Bacon suggested that death is part of the natural life cycle:[11] *"To die is as natural as to be born"*. Death is a 'rite of passage' in which we will all participate as family member, provider, or eventually, patient.

Spiritual distress

If one is looking for a definition of spiritual distress there are many and the one following is helpful:[12]

"Spiritual distress is defined as disruption in the life principle that pervades a person's entire being and that integrates and transcends one's biological and psychological nature."

When doctors see patients on a day-to-day basis, they may encounter some common verbal expressions of spiritual distress including:

- Unfairness - (Why me?)
- Unworthiness - (I don't want to be a burden.)
- Hopelessness - (What's the point?)
- Guilt & punishment - (My disease is a punishment, but I have led a good life.)
- Isolation and anger - (No one understands me.)
- Confusion - (Why is this happening to me?)
- Vulnerability - (I am afraid.)
- Abandonment - (My God, or my family, doesn't care about me.)

Spiritual health assessment

These are particularly important to consider when a patient appears to have pain or symptoms that cannot be controlled pharmacologically. In order to understand this, some authors have suggested the possibility of conducting a spiritual assessment. To make a diagnosis of suffering, and so spiritual pain, one should be looking for it and asking questions as one USA author suggests, like:[13]

- "Are you suffering?"
- "When life has been difficult for you, what has enabled you to cope?"
- "Do you have a way of making sense of the things that happen to you in life? Do you have particular beliefs that help you to make sense of life?"
- "What is really important to you at the moment? Would you like to talk further to someone about these issues?"

There are several tools that exist for clinicians when considering discussing spirituality within a clinical context and these include:

- The Mount Vernon Cancer Network spiritual care assessment tool.
- FICA (Faith/Beliefs, Importance, Community, Address in care or action).
- HOPE (Hope, Organised religion, Personal spirituality, Effects on care and decisions).
- SPIRIT (Spiritual belief system, Personal spirituality, Integration, Rituals/restrictions, Implications, and Terminal events).

Practically, and on an everyday basis for a clinician, there are many potential interventions that are available such as conducting an assessment, the most important part of which is listening and talking. But also, if appropriate, counselling, psychotherapy and the involvement of a religious chaplain if it is a faith issue.

Many years ago, I recall a patient who had uncontrollable symptoms who was dying of cancer and had a notice on the door to his room stating that certain people were asked not to enter (various family members and others). This was a good example of somebody with total pain which on reflection was spiritual due to unresolved conflicts. This underlines the message that opiates can only achieve so much.

Conspiracy of silence

Elizabeth Kubler Ross was also remembered for coining the phrase 'conspiracy of silence'[14] when thinking of a patient with a terminal illness where nobody is talking to each other or the patient, but everybody is talking about their terminal illness. So often is the case that a patient has a very good idea what is happening to them when they are dying, but no one is talking to them about it directly. Furthermore, the influence of the family is strong and who can sometimes request doctors not to disclose details of the terminal illness to the patient. Relatives may be well intentioned by not wanting their loved one to suffer through such information. However, the spiritual pain the patient will experience is the fact that information is being kept from them to which they are entitled and so they perhaps cannot make the preparations they would wish and address any unresolved conflicts. Ideally, patients should always be assured of their autonomy and confidentiality. A review of one of Kubler-Ross's books states:[15]

"[Kubler-Ross's] work has vanquished the conspiracy of silence that once shrouded the hospital's terminal wards….. In so doing, it has shown how, and with

Key messages

1. This paper is to stimulate reflection rather than provide a heavily referenced treatise.
2. Everyone's reality is different and everyone's truth is different.
3. A doctor's perspective is not necessarily the same as that of their patients.
4. Spirituality as a concept may or may not overlap with a religious faith.
5. Acknowledging that death remains a taboo subject.
6. Whatever spirituality is, it is important clinicians keep an open mind and consider making an assessment of suffering / spiritual need.
7. The key is communicating with the patient, avoiding a 'conspiracy of silence' and being aware that modern medicine has not embraced the concept of spirituality.

what quiet grace, the human spirit composes itself for extinction."

Bevins and Cole describe how technology and modern medicine at the EOL may be at odds with the concept of Spirituality:[16]

"Death is the edge of a mystery, and turning our faces toward the problematic, through the persistent use of technology, at the hour of death keeps us from having to face this mystery. Death is no problem to be solved; it resists any such formulation...by keeping our attention on end-of-life problems, we ignore the mystery of the end of life."

Why dying is so difficult

Freud in 1915 reflects and tells us why this whole subject is so difficult:[17]

"Our own death is indeed unimaginable and whenever we make the attempt to imagine it we can perceive that we really survive as spectators ... at bottom no one believes in his own death, or to put the same thing in another way, in the unconscious every one of us is convinced of his own immortality."

A final reflection on taboo in death and dying:

- Is it death we are frightened of or not being here and a part of everything?
- Is it the anxiety and fear through the anticipation of dying?

Until there is illness and so suffering, spiritual pain is unlikely. Spiritually, one is 'healthy'. And so everything changes when we are ill and so things are no longer going well:

- Is this how it is for our patients?
- Is this spiritual anxiety / pain?

Conclusion

Defining spirituality and spiritual pain is difficult and what part it plays in suffering. When trying to help patients who are dying or suffering with severe illnesses it is important to remember that everyone's reality is different, everyone's truth is different and the perspective of doctors is not necessarily the same as that of their patients. It may help in the assessment of such patients to take a spiritual history, which in years to come may become a routine part of the care of a person with an advanced illness. Ideally, spiritual distress should not be medicalised and it should be viewed in the context of 'total pain'. When all else fails, the best we can do is to listen and be truly present with our patients on their journey and what also will be our journey.

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Isotretinoin treatment in acne patients

Louis CK Ma

Summary

Isotretinoin is an effective treatment for severe acne. It has been found to be efficacious across a dose range of 0.1-1mg/kg/day. Isotretinoin can also result in its long term remission. This article will review current literature on isotretinoin use and discuss factors that are associated with a possibility of recurrences.

摘要

異維生素A酸是嚴重痤瘡的一種有效治療藥物。每日跨0.1-1mg/kg的劑量是其有效治療範圍。與其他抗痤瘡藥物不同，異維生素A酸也可對病情造成長期緩解。本文將回顧現有文獻對異維生素A酸的使用和探討對所有與復發相關的可能性較高的因素。

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Introduction

Isotretinoin (13-cis-retinoic acid) is a vitamin A derivative. Since its widespread use in the 1980s, it has been proven to be a very effective treatment for severe acne.[1,2] It is the only medication that acts simultaneously against all four major aetiological factors of acne.[1,2] It is comedolytic and anti-inflammatory. It also reduces sebum secretion and indirectly inhibits *Propionibacterium acnes*. Inflammatory lesions generally respond faster than non-inflammatory comedones. The British National Formulary (BNF) recommends 500 microgram/kg daily, increased if necessary to 1mg/kg, for 16-24 weeks. A total of 120-150 mg/kg of isotretinoin given over 6 months is stated to be the optimal cumulative dose for acne clearance. The current product licence indications are severe forms of acne (such as nodular or conglobate acne or acne at risk of permanent scarring) and acne resistant to adequate courses of standard therapy with systemic anti-bacterials and topical therapy. Prescribers need to be aware of the many potentially serious adverse effects associated with isotretinoin including teratogenicity, hyperlipidaemia, impaired liver function and possibly depression. Other side-effects of isotretinoin include muco-cutaneous effects, musculoskeletal effects, gastrointestinal effects, ocular effects and haematologic effects.[1,2]

Because of its potentially serious complications, the prescription of isotretinoin is restricted in many parts of the world. In the United Kingdom, it's prescription is limited to dermatology consultant-led teams only. However, there is no such restriction in Hong Kong. Hence, it is important for doctors who will prescribe them to have a sound knowledge in the dosages of isotretinoin.

A case presentation

History

SK, a 17-year-old student, presented to me with acne on his face and trunk since the age of fifteen years. Different skin cleansing agents from a local pharmacy were ineffective. He received advice from his general practitioner (GP) and used topical erythromycin gel twice daily. His acne worsened after one year's usage. His GP then put him on a six-month course of oral minocycline 100mg daily and changed his topical treatment to 2.5% benzoyl peroxide in the morning and 0.01% tretinoin gel at night-time. His acne improved but flared up again 2 months later. Another six-month of minocycline 100mg was prescribed, which was again ineffective. His acne worsened and there was scarring on his face and trunk.

SK had enjoyed good past health. He was not on any drugs that could induce acne, including topical

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and oral steroids and some anticonvulsants. He lived with his elder sister and parents in a nearby residential estate. His elder sister also had mild acne, which was managed by 0.1% adapalene.

Findings

Examination of SK revealed numerous inflammatory papules, pustules and severe nodulocystic lesions on his face, chest and back. Comedones and seborrhoea were present. Significant scarring was noted over the chest. A diagnosis of rosacea was unlikely in the presence of comedones and truncal involvement. There were no discharging sinuses to suggest acne conglobata. Acne fulminans was unlikely in the absence of systemic upset and articular symptoms. SK was psychologically affected by his acne lesions but he did not have depressive symptoms. To be comprehensive, assessment of acne should include mood assessment as acne can be associated with depression.

SK suffered from severe nodulocystic acne with truncal involvement and had failed to respond to systemic antibiotics. Isotretinoin was the best available treatment for him as it works better for inflammatory lesions than comedones. Pustules can be reduced by 50% after 2-4 weeks of therapy, although truncal lesions and nodules are more resistant to treatment. Considerable or complete resolution is expected after a course of therapy. Lesions may recur, though they are usually less severe.

SK weighed 78kg. He was started on isotretinoin 40mg daily after his baseline liver function and fasting lipids results were noted to be unremarkable. He was asked to recheck his blood tests one month after starting therapy and 3 months thereafter. He was reviewed one month later. His facial lesions have slightly improved but his truncal lesions showed no noticeable improvement. The only adverse effect was mild cheilitis. His isotretinoin was increased to 70mg daily in view of his minimal response and limited side effects. One month later, his facial acne was much better while his truncal lesions started to improve. However, his cheilitis was worsened, accompanied by the development of skin dryness as well as eyes and nose irritation. These were treated with moisturisers. The same dose of isotretinoin was given for two more months, by which time his facial lesions had cleared up while only some papules remained on the trunk. Because truncal lesions were associated with higher relapse rates, the decision was made to reach a cumulative dose of 150mg/kg. After 2 more months of isotretinoin at 70mg/kg, all his acne lesions had cleared up.

SK received a total dosage of (40mg x 30) + (70mg x 30 x 5) = 11,700mg or 150mg/kg, which was in keeping with the recommendations in the BNF. SK had a mild relapse about one year post-treatment, presenting with only facial comedones and inflammatory papules. There were no nodulocystic lesions and no truncal involvement. In view of the mild severity, topical 0.1% adapalene was prescribed to which there was good response.

Discussion

Results from studies on isotretinoin treatment have been mixed.[3-7] Nevertheless, these studies suggest that a total isotretinoin dosage of at least 100-120mg/kg was effective to reduce relapses. A meta-analysis[8] of 18 articles indicated that relapse was dose-dependent and a cumulative dose of 120mg/kg/day was required to obtain optimal results. On the other hand, Ng and Goh[5] opined that cumulative dosage > 150mg/kg provided little therapeutic benefit as some therapy-resistant patients were destined to respond poorly. The same recommendation was made by Lehucher-Ceyrac D and co-workers.[9] Current guidelines[10,11] recommend isotretinoin at 0.5-1mg/kg/day for 16-24 weeks with a cumulative dosage of 120-150mg/kg.

Isotretinoin may cause paradoxical flare-ups, especially of the inflammatory lesions, during the first few weeks of therapy.[10-12] They are usually mild and subside spontaneously within 1 – 2 weeks. Severe flares necessitate isotretinoin dose reduction and a course of systemic steroids. The underlying mechanism remains elusive, although a sudden release of a large number of Propionibacterium acnes antigens is hypothesised to be the culprit.[13] These antigens produce an intense local inflammatory reaction which is manifested as acute flare-ups. Clark and Cunliffe[13] investigated 980 acne patients treated with isotretinoin 0.5-1mg/kg/day. They reported flare-ups in 59 patients, usually within 3-5 weeks of therapy. However, severe flares occurred only in those taking 1mg/kg/day. In order to reduce flares, recent guidelines[10,11] recommended starting

Key messages

1. Isotretinoin has been found to be very effective across a wide range of dosages in acne resistant to conventional therapies. The long term treatment outcome relates more to the cumulative total dosage rather than daily isotretinoin dosage or duration of therapy.

2. A paradoxical flare-up of acne may occur during the first few weeks of therapy. While an initial dose of 0.5mg/kg/day for the first four weeks is recommended for most of the patients, a lower starting dose (<0.5mg/kg/day) could be considered in those patients with risk factors of flare-up (male sex, severe acne, multiple facial comedones, and truncal nodules).

3. The dose could then be increased to 0.5-1mg/kg/day according to tolerance, with a cumulative total dosage of 120-150mg/kg in order to achieve long term remission. The higher dose (150mg/kg) should be considered in young patients with severe pre-existing acne and truncal lesions. A cumulative dosage of < 120mg/kg is associated with increased relapses. On the other hand, dosage > 150mg/kg offers no additional benefits.

isotretinoin at a low dose (0.5mg/kg/day) for the first four weeks and increasing the dosage to 1mg/kg/day afterwards. Demircay and co-workers[14] used an initial isotretinoin dose of 0.5mg/kg/day and noticed flares in 32% of their patients after a median time of 4 weeks' therapy. Most of them had mild flares that resolved spontaneously. 10% had moderate flares, necessitating a dose reduction. Severe flares that required systemic steroids were rare (4.5%). Males, severe acne, multiple facial comedones, and truncal nodules were significant predictors of severe flares. They opined that patients with these risk factors warrant a starting dose below 0.5mg/kg/day, which was in keeping with the guideline by an acne expert working group.[11] Borghi *et al*[15] compared 132 patients who were treated with a lower starting dose of < 0.2mg/kg/day with a control group of 142 patients who received the standard dose of 0.5mg/kg/day initially. They reported that 7.5% of patients on a lower starting dose flared, while 15.5% of those on the standard 0.5mg/kg/day did so during the first 4 weeks (p=0.0415). They suggested that a lower starting dose (< 0.5mg/kg/day) for selected acne patients might further reduce the possibility of flares than the standard regime. The study was, however, limited by possible surveillance bias as investigators were not blinded.

The initial dosage may also be limited by the patient's tolerance of side effects. Most of these side effects are dose-related and are quite common.[16-18] The majority of patients suffer from muco-cutaneous effects (cheilitis, xerosis, skin peeling, hair loss, photosensitivity; dryness of eyes, nasal and genitourinary mucous membranes). Cheilitis was reported in 91.3% patients treated with isotretinoin.[17] The other common adverse effects were dry skin (90%), nasal dryness and epistaxis (30-40%) and eye irritation (28%).[17] McLane[17] summarised the findings of two safety trials of isotretinoin. Cheilitis occurred within two weeks of therapy and lasted throughout the treatment period. The occurrence of dry skin and facial rash peaked at four weeks while dry eyes and nose were most common in the second month of therapy. Unlike cheilitis, these side effects tended to lessen gradually with therapy. Side effects also involve the musculoskeletal system (myalgia and arthralgia), nervous system (headaches and possibly depression) and gastrointestinal system (vomiting). Laboratory side effects (impaired liver function and hyperlipidaemia) have been reported. If the patient is unable to tolerate these side effects, the dosage should be adjusted accordingly. ■

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Appendix

Suggested protocol for oral isotretinoin

Indications:

– The current Product Licence indications are 'severe forms of acne (such as nodular or conglobate acne or acne at risk of permanent scarring) resistant to adequate courses of standard therapy with systemic anti-bacterials and topical therapy'.

Dosage

(a) Starting dose
- Start isotretinoin 0.5mg/kg/day for the first 4 weeks in order to acclimatise the patient to the muco-cutaneous side effects and to reduce the possibility of paradoxical flare-ups of acne.
- A lower starting dose (<0.5mg/kg/day) should be considered for patients with significant risk factors of paradoxical flare-ups: male sex, severe acne, multiple facial comedones, and truncal nodules.

(b) Maintenance dose
- Titrate the dose to 1mg/kg/day according to tolerance (side effects are dose-dependent) and clinical benefits.
- Females with childbearing potential should receive a daily dosage close to 1mg/kg as this allows them to complete the course of isotretinoin therapy in a relatively short period of time. This dosage regimen reduces the time period when they are most at risk of pregnancy.

(c) Total dose
- A cumulative total dosage of at least 120mg/kg over 16-24 weeks is suggested in order to achieve long term remission.
- A higher cumulative dose of 150mg/kg should be considered if patients have risk factors of relapses: young patients below 18 years of age, severe pre-existing acne and truncal acne.
- Cumulative dosage > 150mg/kg provides little therapeutic benefit as some therapy-resistant patients are destined to fare poorly.

General Remarks

- Take isotretinoin with a small fatty meal as oral absorption is enhanced by concomitant food intake.
- Patients are spared of the trouble of putting on topical therapies whilst on oral isotretinoin.
- Avoid co-prescribing of tetracyclines / minocyclines as they may cause benign intracranial hypertension.

Pre-treatment

(a) Inform patients of the possible side effects explicitly before therapy (most of these side effects are dose-related):
- Muco-cutaneous side effect: skin dryness, cheilitis, nasal dryness and epistaxis, dry eyes and conjunctivitis with decreased tolerance to contact lens, dry genitourinary mucous membranes, photosensitivity.
- Musculoskeletal side effects (myalgia and arthralgia).
- Associated laboratory side effects (impaired liver function and hyperlipidaemia).
- Teratogenicity: exposure to oral isotretinoin at whatever dosage and at any time during pregnancy is unsafe.
- Depression: current literature does not support a convincing causal link between isotretinoin and depression.

(b) Check the baseline complete blood picture, liver function and fasting lipids before therapy.

(c) Pregnancy prevention programme

- Provide detailed counseling regarding the risk of teratogenicity and ask her to sign a consent form provided by the manufacturer.
- The current Summaries of Product Characteristics recommends 'effective contraception, without interruption, one month before starting treatment, throughout the duration of treatment and one month after the end of treatment'.
- Advice on contraception: at least one but preferably two contraceptive measures; the safest combination is a hormonal measure with a barrier method.

During Treatment

(a) Look out for side effects and prescribe appropriate therapies:

- Cheilitis and skin dryness: lip balms for the lips and plenty of moisturisers for the skin.
- Conjunctivitis: artificial eye drops, ocular lubricants.
- Myalgia / arthralgia: NSAID.
- Headaches: check for evidence of benign intracranial hypertension and prescribe paracetamol.
- Photosensitivity: sunscreens.
- Look out for symptoms and signs of depression.

(b) Repeat liver function test (to look for elevated ALT) and fasting lipids (to look for elevated cholesterol and triglycerides) one month after starting therapy and 3 months thereafter.

(c) Pregnancy prevention programme with emphasis on effective contraception.

- Follow up patients monthly with medically supervised pregnancy tests; if the pregnancy test result is negative, prescribe and dispense another four weeks medication.
- Emergency contraception should be provided if unprotected sex occurs inadvertently.

Post-treatment

(a) Continue effective contraception until 4 weeks after therapy has ended.

(b) Monitor for relapse of acne: most relapses occur within 18 months.

What's on internet for family physicians – Ebola Viral Disease (EVD)

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Centre of Health Prevention, Hong Kong

http://www.chp.gov.hk/en/view_content/34199.html

Our CHP is closely monitoring the spread of the Ebola virus in West Africa, and recognises it developing into a global threat on public health. This webpage is set up for information and education of the public on the Ebola Virus Disease. The Preparedness and Response Plan for Ebola Virus Disease 2014 was introduced, and the Alert Response Level is activated. Factsheet on EVD, press releases of the epidemic, Frequently-Asked-Questions, her correspondences to doctors, and e-Resources of Ebola Virus Disease on internet can be found at **http://www.chp.gov.hk/en/her_list/463/24/34397.html.** An updated list of affected countries/areas is also available at **http://chp.gov.hk/files/pdf/evd_affected_area.pdf** and the reporting criteria of EVD is available at **https://ceno.chp.gov.hk/casedef/casedef.pdf.**

Center for Disease Control (CDC), United States of America

http://www.cdc.gov/vhf/ebola/

Apart from publishing the latest CDC Outbreak Information on their website, (**http://www.cdc.gov/vhf/ebola/outbreaks/guinea/index.html**), a lot of other background information on Ebola virus are available at their website. There is a comprehensive Questions and Answers section on Ebola (**http://www.cdc.gov/vhf/ebola/outbreaks/guinea/qa.html**), which illustrates what most people would need to know about Ebola. Information for healthcare workers is available at **http://www.cdc.gov/vhf/ebola/hcp/index.html** and EVD information for clinicians in healthcare settings can be found at **http://www.cdc.gov/vhf/ebola/hcp/clinician-information-us-healthcare-settings.html.** There is also a Ebola factsheet published at **http://www.cdc.gov/vhf/ebola/resources/pdfs/ebola-factsheet.pdf.**

World Health Organisation (WHO)

http://www.who.int/csr/disease/ebola/en/

The most up-to-date information on the Ebola outbreak can be found in the WHO website. There are reliable updates of epidemiology and surveillance data from West Africa, reporting confirmed, probable and suspected cases and deaths. **http://www.who.int/csr/don/archive/disease/ebola/en.** The column Disease Outbreak News lists all breaking news about the EVD and is available at **http://www.afro.who.int/en/clusters-a-programmes/dpc/epidemic-a-pandemic-alert-and-response/outbreak-news.html.** A pocket guide downloadable for the front-line health worker on clinical management of patients with viral haemorrhagic fever is available at **http://apps.who.int/iris/bitstream/10665/130883/2/WHO_HSE_PED_AIP_14.05.pdf.** Information on case definition recommendations for Ebola Virus Diseases can be found at **http://who.int/csr/resources/publications/ebola/ebola-case-definition-contact-en.pdf?ua=1.**

European Centre of Disease Prevention and Control (ECDC)

http://ecdc.europa.eu/en/healthtopics/ebola_marburg_fevers/Pages/index.aspx

The ECDC website has good coverage on the Ebola Virus Disease, hosting a lot of useful information including its news and epidemiological

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updates, publications on EBV, and surveillance articles. Information for health professionals can be found at **http://ecdc.europa.eu/en/healthtopics/ebola_marburg_fevers/factsheet-for-health-professionals/Pages/factsheet_health_professionals.aspx** while factsheets for the general public can be found at **http://ecdc.europa.eu/en/healthtopics/ebola_marburg_fevers/factsheet_general_public/Pages/factsheet-general-public.aspx.** Information to travellers with reference to the Ebola outbreak is available at **http://ecdc.europa.eu/en/healthtopics/ebola_marburg_fevers/information-travellers/Pages/information-travellers.aspx.**

United Kingdom Department of Health

https://www.gov.uk/government/news/ebola-government-response

The United Kingdom government is closely monitoring the spread of the Ebola virus in Sierra Leone, Liberia and Guinea. The content of the webpage on Ebola Virus Disease is updated regularly. Public Health England has also published a general information factsheet available at **http://nathnac.org/pro/misc/PHE_EBOLA_FACT.pdf.**

The New England Journal of Medicine (NEJM)

http://www.nejm.org/page/ebola-outbreak

Ebola outbreak is one of the highlighted topics in the website of the NEJM. It consists of a collection of articles and other resources on the Ebola outbreak. clinical reports, management guidelines, and commentary articles are hosted for users to view the outbreak at different prospectives. The healthmap of the Ebola outbreak at the website tracks publicly reported confirmed and suspected cases of Ebola throughout the world. The map is automatically updated to show current data on the outbreak.

Ebola Outbreak 2014: Information Resources, National Library of Medicine

http://disaster.nlm.nih.gov/dimrc/ebola_2014.html

This page connects to many links related to information resources of Ebola virus. It runs a vast list of weblinks to other useful sites related to the outbreak of Ebola Virus Disease. The links are categorised into governmental and non-governmental organisations, biomedical journal literature and reports, social media, maps, health resources for the public, and many others. ■

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