

屋崙中華醫學會通訊

acma news

The Official Newsletter of the
AUCKLAND CHINESE MEDICAL ASSOCIATION

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this issue

From the Editors 1

From the President 2

May CME Notes 3

Prostate Cancer Screening and Erectile Dysfunction

Mr John Tuckey

Chinese Community in New Zealand

Vivien Wei Verheijen

Notices/Announcements 7

Getting to know us... 8

Dr Grabiell Ng

YACMA and Spotted 9

Events for this year
ACCMA Conference Report
Board games night

from the editors

Greetings everyone,

We hope that you are managing to keep warm this winter despite the rain and the chills. On the flip side we hope there is better snow to compensate!

Indeed we have a pretty full year, with the conference during the Easter weekend, the recent CME on Urology (notes on page 3) and an upcoming CME next week. It will be an interesting change from the usual Chinese food to Indian cuisine. We hope that this change would "spice" up our winter cold and make our continued professional development more exciting.

For the students who are already getting bored, don't worry! We have a few more exciting events in the near future, with an upcoming careers evening night and a surgical skills weekend planned for July. Extremely good value compared to your membership fees. YACMA hopes to make a positive impact on your medical education.

On our part, we are working hard to keep you informed through the newsletter. It is a bit of a struggle juggling it with our medical studies and our involvement in YACMA, but we are enjoying our work and things have been good so far. It is indeed a privilege to serve our fellow members.

For this edition we interviewed Dr Grabiell Ng, a proud Otago graduate and the new CME coordinator. We learn the shocking revelation behind her taking the role being the CME coordinator, the origins behind her name and her interesting hobbies. Catch up on all the gossip on page 8!

We would like to thank (again) 5th year student Jerry Wu who featured brief reports from the top medical journals, clinical research and medical cases for your interest. The cases and papers are selected to be clinically relevant and we hope will provide a valuable learning tool for medical students and physicians alike.

Mr Wu is also going provide the case for our next special edition where we feature an in-depth clinical case to test your diagnostic skills.

Last but not least, we welcome contributions to the newsletter throughout the year to make this newsletter (correction: **your** newsletter!) more interesting.

Yours truly,

Choonwei and Chen Luo
The Editors

The ACMA Team

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Dr Gee Hing Wong

Past President

Dr Alex Ng

Vice President

Dr Linda Lum

Secretary

Dr Catherine Yang

Treasurer

Dr Adrian Wang

CME Coordinator

Dr Grabiell Ng

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Dr Daniel Wu

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Dr Colin King

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Mr Norman Quek

Clinical Representatives

Ms Hayley Hu

Mr Vitt Hemstapat

Preclinical Representatives

Ms Helen Jiang

Mr Thomas Wong

Student Secretary/Treasurer

Mr Lance Yuan

Editors

Mr Choonwei Wee

Mr Chen Luo

Contact us: info@acma.org.nz

from the president

Dear Colleagues,

I would like to take this opportunity to report and reflect on the various activities undertaken by ACMA in the first half of 2010.

17th Australasian Council of Chinese Medical Associations (ACCMA) Annual Conference and Annual General Meeting.

The 17th ACCMA Annual Conference was held at Auckland Stamford Plaza on Saturday 03 April 2010 and it was a very successful and well attended event. There was also a large contingent from the YACMA membership. The Conference was opened by Dr Paul Hutchison MP, the Chair of the Parliamentary Health Select Committee. In his opening speech, he gave the Conference attendees a macro view on the current health/medical external environment in New Zealand and detailed the Government's commitment to shift the budget spending from bureaucracy to frontline health services.

On behalf of the Association, I would like to thank all our speakers who had given up part of their Easter long weekend to address the Conference. The speakers for the Conference were Ada Cheung (keynote speaker), Drs Yvonne Ng, Garsing Wong, Colin King, Dennis King (Melbourne), Adrian Mar (Melbourne), Candy Vong and the YACMA team led by Dr Richard Yu - Jin Gao, Helen Jiang and Norman Quek. The sponsors for the Conference were Dr Alex Ng (Breast Associates), Douglas Pharmaceuticals and Medical Books (NZ).

I also chaired the ACCMA AGM on the Friday 02 April 2010, attended by representatives from NSW, Victoria, South Australia, Western Australia and Queensland. Drs Allen Liang and Adrian Wan were present as observers. Dr Adrian Mar from Victoria tabled a working party report on ACCMA constitutional review; and the AGM witnessed a constructive debate on the future direction and governance structure of ACCMA. I retired as the ACCMA President at the AGM and handed the Presidential Medallion to the incoming President, Dr Theong Low from Victoria.

As part of ACMA's commitment to continuing medical education, we had held two CME events so far in 2010. The first CME event, sponsored by Pfizer, was held on 21 February 2010. The second event was held on 23 May 2010 and sponsored by Eli Lilly NZ. The third CME event is scheduled for Sunday 20 June 2010. Dr Grabiell Ng, our CME Coordinator, has worked really hard to secure sponsorships for our CME events and has done a marvellous job in the midst of shrinking sponsorships.

Looking forward, ACMA plans to publish its Doctor's List in print format, to be distributed to various community groups, governmental agencies and at major retail outlets. I am currently in discussion with a potential partner agency to sponsor the publication of the Doctor's List. I'll also be representing ACMA at the 4th International Asian Health and Wellbeing Conference, chairing a concurrent stream from 10am -2.30pm on 06 July 2010. You may also know that the Associate Health Minister had announced a further consultation on the proposal to remove tobacco retail displays. I would reiterate ACMA's support in legislating to remove tobacco retail displays in shops.

I look forward to meeting you at the next CME event.

Dr Gee Hing Wong

Prostate Cancer Screening

Mr John Tuckey. Urologist. MB ChB, MMedS, FRACS

Recent Studies

- Multicentre Scandinavian Study 1989-99 over 695 men randomised to surgery or observation. PSA up to 50, 76% T2, Median follow up 8 years. Bill-Axelsson et al *NEJM* 2005 352 1977-85

	Surgery	Observation
Local progression	19%	44%
Metastases	14%	23%
Disease spec mort	9%	14%
Overall survival	76%	70%

Takes around 7 years to see a difference. Largest difference in progression/mets

- European Randomised Study, 1991-2003 over 182,000 men aged 50-74.

PSA every 4 years. Biopsy if PSA >4 ng/ml (DRE), Average number of PSA's = 2, Average follow-up @ 9 years. Acceptance of screening at least 1=82%, PSA positive 16%, biopsies 85%

	Screening	Controls
Prostate Cancer	8.2%	4.8%
Prostate ca deaths	0.8	1.0
Death rate		
o screened	0.29%	0.36%
o diagnosed	3.5%	7.5%

20% reduction in mortality overall, 27% for those screened. Early difference only noted after 7 yrs. Suboptimal screening. 48 treated to prevent one death.

- Prostate, Lung, Colorectal and Ovarian Screening (PLCO) Trial, USA 1993-2001

76,793 aged 55-74. Annual PSA 6yrs, DRE every 4 years. Cut-off PSA > 4ng/ml. Follow up 7 years. No significant difference.

	Screening	Controls
o PSA testing	85%	52%

So where are we?

- Current studies either too short or too contaminated. There is likely to be a difference in results
- 2 new studies to come PIVOT (USA) and ProtecT (UK)

Urological Society of Australasia Recommendation:

- No to population screening
- PSA in 55-69 age group as European study shows reduced mortality
- PSA in men over 40 to evaluate their risk
- PSA level does not predict volume or aggressiveness
- Active surveillance for small volume low grade
- Monitor those over age-median

Overdiagnosis

Microscopic cancer	50% + of men over 50
Clinical cancer	10% of men
Death	3% of men
Lifetime risk in USA	19% in 2000-2002

Active Surveillance

- Small volume - 3 cores or less
- Low grade - Gleason 6 or less
- Low stage - T1c

Active Surveillance should be

- Cautious
- 1/3 require treatment at 2-3 years
- Poorer results may be due to patient selection and follow up protocols

Who to Refer?

- Abnormal PSA (age specific)
- Recheck 6/52
- If up 3/52 antibiotics, recheck 6/52
- Abnormal DRE

Detection rates

PSA <10	25%
DRE abnormal	25%
Both abnormal	50%

Other markers

Nothing ready to use
Free/Total ratio in some situations
Velocity - >0.75 ng/ml/yr
PCA 3 in ejaculatory fluid

Diagnosis

- Prostate biopsy transrectal route with LA or sedation. 12 core technique. 90% detection rate
- Local anaesthetic infiltration - more comfortable, sedation increasing

	Sensitivity	
6 core	80-85%	be aware of anterior tumours
12 core	90-95%	

Summary

- Studies too short but a difference exists in the best study
- PSA testing for those interested, at 40 to judge risk and yearly 50
- Refer those with abnormal PSA or DRE
- Active surveillance for those with low risk disease
- Surgery or radiation depending on patient preference

Erectile Dysfunction

Mr John Tuckey. Urologist. MB ChB, MMedS, FRACS

According to a UK study, there's high rate hyperlipidemia, hypertension and diabetes associated with Erectile Dysfunction.

Solomon H. et. al. *Int J Clin Prac* 2003 57:96-99

Investigations

- Morning testosterone
- Lipids
- Fasting Glucose
- Prolactin - hyperprolactinemia lowers libido and increase impotence. Prolongs refractory period.

Options for Improving Erectile Function

Oral Agents

- PDE-5 antagonist
 - Prolongs and strengthens erection
 - Effective in 80 -90%
 - First-line agent, give sample packs
 - 30 mins prior, well tolerated
 - ACC fund 1 tablet per week (\$20-25) for ED secondary to injuries
- Confidence in safety strong
 - Cialis Placebo/(1000pt yrs)
 - MI 0.26 0.41
 - CVS mortality 0.12 0.26

Difference in Selectivity

- More potent (IC₅₀)

	Viagra	Vardenafil	Cialis
• PDE 5	3.5	0.7	1
• PDE 6	36	157	730

But similar efficacy and side effects

Cialis

- Daily dosing - half life is 17.5 hours
- Plasma [] steady state after 5 days
- 5 mg in NZ
- (Porst et al J Sex Med 2008) Daily dosing

- Safety data up to 2 years. Well tolerated. Efficacy maintained
- Improved satisfaction, improved erections and sexual ability
- Daily dosing vs On demand
 - McMahon J Sex Med 2005
 - 10mg daily vs 20 mg on demand, Cialis
 - 145 men
 - Better IIEF scores with daily dosing
 - Higher rate for successful intercourse
- Which dose of daily dosing?
 - Porst et al Eur Urol 2005, 5mg and 10mg has similar efficacy compared to placebo
- Non-responder to PDE-5 inhibitor?
 - McMahon J Sex Med 2004 Its worth trying daily dosing?
 - Respond 42% on demand 69% daily
- Why better results with daily dosing?
 - Experimental support for less endothelial dysfunction and corporal fibrosis
- Other indications for PDE-5 inhibitors
 - BPH
 - Overactive bladder
 - Pulmonary hypertension
 - CHF
 - Cardioprotection and endothelial function

Vacuum device

- Vacuum pump +/- penile constriction band
- More acceptable for those in long term relationships
- Some only require constriction band
- Hinge effect
- Cost around \$250

Intracavernosal injections

- Very effective
- Starting dose 5 mcg
- 2.5 -5 mcg increments
- Caverject largest dose 20 mcg
- Warn about side effects : Pain and Priapism. If >6hrs priapism, manage with cold shower, pseudoephedrine, corporal drainage.

If everything fails, Penile Implants

- Types of prosthesis
 - Malleable rod
 - 3-piece inflatable
- Who is suitable? Non-responders to other treatments
 - Diabetics
 - Peyronie's disease
 - Priapism
 - Complex reconstruction
 - Advantages: Spontaneity and Efficacy
- However, must come with realistic expectations
 - cold glans
 - penile shortening

- rigidity only
- potential complications
- Satisfaction rate
 - Montorsi *Euro Urol* 2000;37:50-55
 - 59 month follow-up of AMS 700
 - 92% using prosthesis 1.7 times per week
- Erection satisfaction

Excellent/satisfactory

Patient	48%/50%	Total = 98%
Partner	17%/66%	Total = 83%

- Sexual activity satisfaction

Excellent/satisfactory

Patient	70%/22%	Total = 92%
Partner	28%/68%	Total = 96%

Chinese Community in New Zealand

Vivien Wei Verheijen, Office of Ethnic Affairs

The Office of Ethnic affairs is focused on those whose culture and traditions distinguish themselves from the majority in New Zealand, including new migrants and refugees. It is a standalone unit in the Department of Internal affairs to represent the ethnic sector needs and voice to the government. It also handles issues with birth certificates, marriage and passport issues within the ethnic communities.

The office has a few roles, namely advisory, networking, capacity building and catalyst builder.

- In terms of advisory, it provides ministerial advice, develop ethnic policies which seeks to increase the ethnic diversity of NZ statutory boards, advising the government and NGOs to ensure that the needs of ethnic communities are reflected in NZ policies. For example, they have developed the NZ Settlement Strategy and Action Plan recently with the Department of Labour to enhance ethnic integration with NZ society.
- The office also runs strategic networking programmes with and for ethnic communities in key areas including economic development, culture and heritage maintenance, leadership and capacity building to build strong and independent ethnic communities. They also seek to improve the visibility of ethnic communities, and working with other ministries like the Ministry of Social Development to improve funding for community groups.
- They also develop tools to help government agencies to develop cultural awareness,

competency and catalyse diversity management and initiatives, providing advice on diversity management in the work place. Besides, they create educational resources about and for ethnic communities in NZ.

- They also engage key international and local thinkers in the area of diversity and provide them a platform to share their views with wider NZ, keeping updated through research and debate on trends in diversity.
- They also operate a Language Line, a free telephone interpreting service offering accuracy and confidentiality to people who speak little or no English, when dealing with core government agencies. It covers 40-60 languages with Mandarin, Korean, Samoan, Cantonese and Tongan as the most popular.

Statistics

In 2006, about 10% of NZ-ers are from an ethnic background, 400,000. In 2026, it is projected to increase up to 16%, 790,000.

In the 2006 Census, 23% of the New Zealand population are born overseas with 200 ethnic groups. Chinese are the biggest ethnic group with 139,000 people, followed by people from the Indian subcontinent at 97,000, and Koreans at 35,000. The Asian population grew 50% from 2001-2006.

About 17.5% people in NZ speak 2 or more languages.

Chinese Community in NZ

1865

Early Chinese migrants to Otago suffered discrimination in form of Poll Taxes

1960-1980s

Chinese business, investors and professional migrants arrived from East and South East Asia

70% of Chinese in NZ are recent immigrants arrived in NZ < 10 years ago, and 60% of Chinese population live in Auckland.

Recently, Jenny Wang was awarded with the Queen's award for her work with the Chinese Community.

2003

NZ previous PM, Helen Clark apologised for the Chinese Poll taxes on behalf of the NZ government. Started Chinese Poll Taxes Heritage trust and initiated the New Zealand Parliament CNY celebrations.

2006

National roadshow with the Chinese community explaining the superannuation deduction and chinese community group funding options.

OEA Economic Exchange with the Chinese business and community network

2008

Chinese Community Network meeting and CNY celebration.
Chinese Community Funding workshop
Special Program "Enhancing Social Cohesion : Cross cultural program" with workshops and cultural programs
Christchurch Law and Order consultation with the Chinese community

2009

Chinese Community Forum
Chinese Entrepreneur Forum
Nationwide Language Line Roadshow (2009-2010)

2010

Chinese Newspaper Trade Information Services

Looking forward:

- 1) Increase in economic development opportunities
- 2) Working with Ministry of Health, DHBs and PHOs to address ethnic health needs.

From left: Dr Theong Low (2010/2011 ACCMA President), Dr Gee Hing Wong, Dr Adrian Mar (ACMAV President), Dr Allen Liang - picture taken at the ACCMA Conference 03 April 2010



Interactive medical case

Stalking the diagnosis.

A 58-year-old woman was admitted to the hospital because of dizziness, weakness, urinary frequency, fever, dysphagia and dry mouth. Her past history was significant for cutaneous lupus, osteoporosis, frequent UTIs, hypothyroidism and a left oophorectomy. Family history included oral and bladder cancers, Grave's disease, hemochromatosis and ITP. Physical examination revealed hypotension, dry mucous membrane and a 2 cm cervical lymph node. Visit NEJM.org today to access this stunning new *Journal* feature.
N Engl J Med 2010;362:e16 (Feb 11) *Suitability: Years 3 & +*
A print version of this interactive case can be found in Mar 4 issue (2010;362:834-9).

Clinical review

Outpatient management of severe COPD.

COPD represents a growing public health problem. It is defined as a syndrome of progressive airflow limitation caused by chronic inflammation of airways and lung parenchyma that shows limited reversibility. In this concise review, the author summarises the clinical and diagnostic features of COPD, followed by a presentation of evidence based management strategies.
N Engl J Med 2010;362:1407-16 (Apr 15) *Suitability: Years 2 & +*

***Helicobacter pylori* infection.**

H. pylori infection and the use of NSAIDs are the main causes of gastric and duodenal ulcers. In addition to ulcer development, *H. pylori* infection is also associated with increased risk of gastric cancer and gastric mucosa-associated lymphoid-tissue (MALT) lymphoma. The use of a proton-pump inhibitor or bismuth preparations plus two antibiotics is usually recommended for the eradication of this pathogen.
N Engl J Med 2010;362:1597-604 (Apr 29) *Suitability: Years 2 & +*

Basic research

Transcribing neonatal diabetes mellitus.

Permanent neonatal diabetes mellitus is a rare disorder characterised by the absence of insulin production due to beta-cell deficiency. Clinically, this disorder manifests as neonatal hyperglycemia and its treatment mandates the use of insulin. A recently published basic science research in the journal *Nature* identified the molecule RFX6 as a key transcription factor for the development of pancreatic endocrine cells.
BMJ 2010;340:c644 *Suitability: All*

ACMA and CSL would like to invite you to our...

June CME Meeting

Venue: Punjabi Palace,
164 Ponsonby Rd,
Auckland.

Date: Sunday 20th June 2010

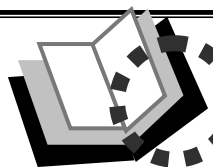
Schedule:

5.30pm Arrival and Registration
6.00pm Introduction by Dr. Gee Hing Wong
6.05pm Cultural talk Topic: TBA
6.30pm CME: Dr. Anil Sharma, Consultant
Gynaecologist and Urogynaecologist
Topics:
1. Overactive Bladder: Pitfalls and
Effective Therapy
2. Where are we with Slings and Mesh?
7.30pm Dinner

Please note that there is a cap of 80 attendees at this meeting on a first-come-first-served basis.

This meeting has been endorsed by ACMA and counts for 1.5 educational hours (1.5 credits) for AVE (accreditation) and MOPS purposes (NB: endorsed by the College of GPs only).

yacma2010@gmail.com



Key Reminders & Announcements

Membership

We would like to invite existing members to renew their membership through the membership forms available from the ACMA website or through the Membership secretary. Membership fees can be paid to the Treasurer Dr Adrian Wang via cheque or online banking (with your name as reference). Please introduce the Association to your colleagues.

Looking for new members

Please introduce the Association to your colleagues.

Condolences

Dr Eddie Cheung, one of our members, passed away recently. On behalf of the Auckland Chinese Medical Association Inc, Dr Gee Hing Wong had written to Dr Cheung's family to convey our deepest sympathies

Medical Rooms For Hire in Albany

Are you a medical specialist/ allied health professional looking for a medical suite/room at fast-growing Albany on the North Shore? Up to 350 sq metre ground floor space for lease, can be divided. GPs and a pharmacy on site. Contact Dr Gee Hing Wong for a confidential discussion. Ph: 021 800 189.

Medical Cases

A woman with lethargy, confusion, and abnormalities on brain imaging.

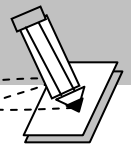
Test your clinical reasoning and problem solving skills with this interesting case of a 69-year-old woman who presented to the hospital with a 2 months history of deterioration in mental status. It is advisable that you revise the differential diagnosis of confusional states before starting this case to maximise your learning opportunities.
N Engl J Med 2010;362:1431-7 (Apr 15) *Suitability: Years 3 & +*

All in the family.

A middle-aged woman presented to the hospital because of an acute onset aphasia and right-sided hemiplegia. Neurological examinations revealed right-sided homonymous hemianopia, facial droop and complete paralysis of the arm. Another highly recommended case from NEJM!
N Engl J Med 2010;362:2114-20 (Jun 3) *Suitability: Years 3 & +*

close up with ACMA

... coffee with Dr Grabiell Ng



Close-up with ACMA! For this edition we met Dr Grabiell Ng the beautiful (and mysterious) new CME coordinator. Who is she? Why is her name so odd? Your faithful editors are going to find out...

What does your name stand for? Initially I thought that my name was spelled wrongly, until I found out that Grabiell is actually a valid Portuguese name for 'Gabriel'.

Why did you pick up the position as a CME coordinator? I actually didn't volunteer for it. I was having dinner with someone when I suddenly got a phone call from Gee Hing saying that I am the CME coordinator for next year and he just hung up!

Err? Yeah. Ask him - he can't deny it!

Ok... So how are you finding your job? It's not really an easy job asking people for money. There are sponsors who are keen to sponsor, but there quite a few turn us down. But CME dinners are popular avenues for marketing for the sponsors as its one of the most efficient way to target GPs.

Anything you want to say to our members?

Actually, yes! To make the CMEs more relevant for our members, it would be really good if ACMA members could email me suggestions on clinical topics and good venues for food. Speaking of food... I am planning a western 3-course meal! Fingers-crossed!

What are your interests? I have a lot of interests and I am a crazy coffee addict. I have one in the morning, lunch and a decaf at night. I am still perfecting my art of making good coffee from scratch. There are too many variables in making good coffee but... I am getting there [Editors: She makes pretty good coffee].

What do you think of Starbucks? They are not too bad actually.

Do you have any other hobbies?

One of my passions is wine collecting. I am still learning through constant practice [Editors: daily consumption records are confidential] - trying to taste the uniqueness in each bottle but after a few glasses

they all taste the same! I have a huge wine collection from all around the world in my secret wine cellar.

I am also a keen surfer. I learnt the basics in Piha and learnt so much in Hawaii where... for some reason I kept on getting free lessons from the guys there!

Which medical school did you graduated from? Otago of course! Is there another in NZ??!

When did you graduated from medical school? It's actually secret (laughs), since you'd be able to guess my age then.

Why did you want to become a GP? Long story! I initially wanted to be a Paediatrician but on my OE in postgraduate 3rd year I went to Ireland. There, I cold-called GPs and luckily found locum work in a semirural 1 room (no nurse!) practice 20 minutes from Dublin.. Since there's no nurses around, you actually do the injections, immunisations and all the other procedures, and feel like you are actually doing something. And... I loved it! I became really close and good friends with the female GP I locumed for and just had a fantastic time

Being a GP is like a "real doctor" because they have experience with what everyday people present with. Besides, that is important because when friends or family approach you with a problem then you would know what to do whereas I wouldn't have a clue if I worked in the hospital.

My Irish employer wrote me a very good reference for my application to the NZ GP training program, and I got a phone interview from the other side of the world! It was rather nice being interviewed in the middle of the night in your bed wearing your PJ-s with my 'model answers' scattered around.



Rapid Responses

I thought we put you through a 3-stage recruitment and selection process, and chosen you out of 12 strong candidates!

- Dr Gee Hing Wong



The YACMA committee is busy behind the scenes working hard to bring you bigger and better events this year. Events to look forward to career's evening (food provided!), skill's workshop (including suturing, plastering and IV cannulation stations), ACMA AGM (talks and dinner), YACMA AGM (voting and dinner), ACMA CME dinner and the Karaoke night!

YACMA Committee



... spotted

ACCMA Conference 2010 Student Report



Nicely dressed students

The YACMA committee had the pleasure of working closely with ACMA to host the Conference this year. YACMA had the responsibility of organising folder contents for the attendees, manning the registration desk, as well as promoting Auckland Medical School and spreading the virtues of joining YACMA through minor speeches.

Twenty members from YACMA attended the Conference to take advantage of this rare opportunity to gain an insight into a conference catered to professional GPs. Student attendees ranged from the meek 2nd years to the seasoned 6th years, with this being the first educational conference for some.

An overwhelming majority of students were impressed with the caliber of the conference, and were stimulated and educated with an excellent mixture of specialised medical topics along with dietary and psychological aspects of healthcare. YACMA members seemed especially fascinated by the practical demonstration and many clambered up onto the stage for a better view.

Mealtimes provided an opportunity for students to mingle with the attending doctors and speakers. The food rivaled the caliber of the talks, with everyone getting multiple platters of tasty victuals whilst discussing the morning's topics.

Afternoon tea signaled a postprandial snooze for a few adult delegates, who subsequently missed out on the YACMA speeches shared by Richard, Helen, Jin and Norman. Richard's speech was unexpectedly cut short as the conference was inexplicably but pleasingly running overtime, possibly as a result of

the well-received, interactive and entertaining dermatology quiz.

The conference concluded to the sound of tired but satisfied attendees discussing what they had learnt, with the doctors looking forward to the conference dinner. Everyone felt that they had gained an enormous amount from attending the conference: the newly gained medical knowledge obtained from the captivating speakers and their appealing topics (which were made much more interesting than university lectures through live patient demonstrations and quizzes with a prize offered at the end); and the encounters and conversations made with fellow ACMA attendees who offered wise words of advice about their fields of experience all made the day very worthwhile.

YACMA Board Games Report



A future surgeon!

A new YACMA event for this year held at Grafton Campus, Board Games proved to be a hit with both the pre-clinical and clinical years. For the pre-clinical years, it served as a way to keep their minds off the exams looming in the not-so-distant future, and for the clinical years, simply a night to get together and have some competitive fun. Despite the clash with the NZMSA Conference in Queenstown, the turnout was still good. Favourite games for the night included Cranium, Pictionary, Poker and Articulate. A competition to win a pen torch was held which tested students' proficiency with chopsticks and marbles, and their skill in the kids' surgery game Operation. The winner of the pen torch was Albert Wu, who came first by a mere one second.