

屋崙中華醫學會通訊

acma
news

The Official Newsletter of the
AUCKLAND CHINESE MEDICAL ASSOCIATION
Issue No. 3 July 2006



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president's message

Hi all and welcome new members,

Here is my report on the conference just gone. ACCMA/ACMA (SA) conference June 9-11 2006 held at the Radisson Hotel Adelaide. The theme for the meeting was Medical Structure, Practice issues, technologies and more held over 2 days. The New Zealand Delegation included Drs Gee Hing Wong, Catherine Hong, Wilson Young and me.

This was a must go to conference, rather than the hum drum topics of academic medicine, it was a refreshing look at everything they should have taught you in medical school, but didn't. Politics was covered by the President of the Australian Medical Association coming to talk about what the AMA could offer it's members. It appeared that compared to the NZMA it was certainly more vocal, and perhaps even had more teeth in these circles. Next up were topics about practice management such as the value of practice managers, what should be included in practice agreements, and 10 common employment bloopers. Morning tea was forgone due to the interest in these topics. And just before lunch a brief look at dealing with intrusive and angry patients, and dealing with medical boards.

While the lucky delegates had lunch I went to the ACCMA meeting, which sorted out the posts for the coming year. I landed the job of secretary taking over from Patrick Tan who had done a fine job for the last few years. A progress report regarding the next ACCMA meeting was presented, to be held on the Gold Coast at Conrad Jupiter on Australian Queens birthday weekend *(weekend after New Zealand's Queen's Birthday weekend). The 2008 conference is likely to be held in either WA or NSW, pending ACMA in WA.

After lunch which included some salads, wraps sandwiches and the obligatory visit to the trade displays, we headed straight into the use of technologies in practice, computers, software and the associated forms of digital communication. From here the next session was titled good communications, and was about different health care professionals perspectives and what was considered effective communications between each group, also what hindered effective communication. Wait there's more to fit in this afternoon, 2 more sessions actually. The first session was on alternative business options. This included an interesting talk about intellectual property, and expanding the business options with in medicine such as setting up a medical implant company, and an alternative medicine enterprise. There was a reminder that Full time hospital practice in a Australian public hospital was all that bad either. The final session of the day looked at alternative investment options such as wine making (an obvious choice in South Australia), self-managed funds and an extremely interesting presentation about the antique trade.



Important Notice!

The 5th ACMA Conference: "Making a Difference"

Registration Form available on-line: www.acma.org.nz.

Finally after a big day there was some wine tasting to end the afternoon. This was followed by the Gala Dinner. This was held in the South Australian Art Gallery. There were the usual presentations including the ACCMA president handover from Richard Heah to Alex Loo (Queensland CMA president), also with a bottle of port presented to each of the WA and the NZ delegates in recognition of the distances we have had to travel to get to Adelaide. The next day's program was more subdued looking at medical lifestyles, including looking after yourself, the different roles doctors play and retirement. The afternoon program involved a wine tour of McLaren Vale or the annual golf tournament.

Overall this was a well worthwhile conference to attend; as it covered many topics that I personally feel should be discussed more often. Although the favour of business was obviously Australian, there were many concepts and principles that could be easily applied to the New Zealand situation.

Fast approaching is the 29 July and the ACMA conference. We are going to include some modern interactive technologies with some of the talks. Please remind all your medical colleagues about this conference. Obviously, the more the merrier.

Best Regards
Dr Colin King



CULTURAL TALK

The Chinese Language Cards Project
Dr Sybil Au - Alzheimer's Counties Manukau (ACM)

Alzheimer's Counties Manukau (ACM):

- One of Incorporated Societies under Alzheimer's New Zealand
- Operates from Alzheimer Centre in William Roberts Road, Pakuranga, Manukau
- For more info – phone 576 7776 or 0800 004 001
- Email - info@alzcm.org.nz

ACM Services:

The Core Business is the provision of Information; Specialist Dementia Assessment; Support; Education; and Public Awareness

- 24 hour information
- Specialist Dementia Assessments
- Ongoing assessment and home support
- Carer Education
- Pacific Island Dementia Service
- Rural Mobile Day Care Service
- Carer Support Groups & Carer lunches
- Advice and counselling for individuals/families
- Case conferences
- Advocacy
- Activities for people with dementia
- Activities for people with dementia and their families
- Resource library - videos and books

Facts and Stats:

- One person is diagnosed with dementia somewhere in the world every 7 seconds
- Dementia is not selective – it affects all races, both genders and all ages
- In New Zealand, the disease is estimated to affect:
 - 7.7% of all people over the age of 65 years
 - Up to 5% of people under 65 years of age

- 3.8% of people aged between 65-74 years
- 6.4% of people aged between 75-79 years
- 11% of people aged between 80-84 years
- 23.6% of people aged between 85-89 years
- 40.5% of people aged 90 years and upwards

ACM Responses to the Chinese Community:

- ACM is aware of the wide ethnic diversity within the Counties Manukau Region and the number of Chinese families being referred is slowly increasing
- ACM suspected that the number of Chinese referrals was in no way representative of the known prevalence rates for dementia, that people may not admit it exists, it was under-diagnosed and there was a lack of awareness of dementia

Dementia Needs Analysis of Chinese Community - Literature Search by V Cheung & Q Ip, 2004:

- *Cultural Aspect*
 - Chinese people's understanding of dementia is limited
 - Chinese perceive symptoms of dementia as part of a normal ageing process, thus it is likely that they delay in seeking early intervention
 - Due to the lack of understanding of dementia, many Chinese perceive dementia as related to mental illness, which is strongly stigmatized in the community
 - First generation Chinese elderly migrants experienced various difficulties settling in a new country. Such difficulties include isolation, lack of proficiency to speak English, inter-generational conflicts, and lack of social support
 - Overseas literature also indicated that first generation elderly migrants experience "social change" where they understand their traditional values might not be carried on to the future generations
- *Carers Aspect*
 - Chinese people have a strong sense of filial piety and family obligations. Children are expected to take care of their parents when their parents age

- Chinese adult children feel that it is their obligation to care for their parents and feel guilty if someone external to the family looks after their parents
- Chinese believe that the ageing process makes elderly go to a “child-like” state where the older people sometimes behave like a child
- Chinese family value reciprocity where the adult children believe it is time for them to demonstrate love and respect by taking care of the aged parents
- A lot of Chinese carers do not know about dementia and think it is part of a normal ageing process, thus, in turn, hinder seeking help
- Most of the Chinese carers have various burdens where they have often been trying to meet their own family or work demands
- *Services Aspect*
 - Chinese migrants are not aware of the services in the new country and do not know where to seek help
 - Due to many Chinese migrants being unable to speak English fluently (especially elderly people), they have difficulty asking for help
 - Many services are not culturally responsive to Chinese elderly migrants. This is essentially important because Chinese elderly migrants are more likely to retain their traditional values
 - Clinical measures or tests (for diagnosis) are not culturally responsive to Chinese elderly migrants. Many clinical tests are designed for the majority population. The experiences of Chinese elderly (such as those who are in a war-torn environment in the last decade or are not formally educated) are not addressed
- *Research/Policy Aspect*
 - Research on Chinese elderly and dementia is scarce. Most have small sample sizes where they do not provide statistical robustness to profile the issues clearly
 - Overseas research looking at Chinese elderly issues also experience difficulties recruiting participants due to “dementia” being stigmatized in the community and many not familiar with the research process
 - While many Asian countries have government policies that address the needs of Chinese elderly migrants, many immigrant countries do not have policies that specifically cater for ethnic elderly migrants

Recommendations:

- That more funding is required to address the specific needs of Chinese elderly immigrants
- A partnership be established with the Chinese community to develop appropriate strategies to address the needs of Chinese elderly people
- A workforce development plan be adopted in public health service providers and other health agencies that is responsive to the needs of the diverse population

- Service providers develop policies and strategies to ensure the services are assessable and culturally appropriate to Chinese elderly migrants and their families
- Government should take a lead role and develop policies to ensure that Chinese elderly people enjoy an optimal quality of life and well-being

Chinese Pamphlet and Translation Cards:

- *Purpose*
 - to enhance communication between a variety of health professionals and care providers, and Chinese clients (either people with dementia and/or their families)
- *Objectives*
 - *To increase the possibilities of the client being able to understand and respond to questions and actions that involve them and their care needs*
 - *To develop a set of Chinese language communication cards that cover basic information required when interacting with Chinese clients in a variety of settings, and which invoke a “yes” or “no” answer*
 - *To identify basic information that would cover topics/issues such as those relating to activities of daily living such as eating, dressing, medications, hygiene, telephone use, housekeeping tasks*
- Although specifically developed and designed for people with dementia and their carers, ACM see the cards having a wider and more generic use where establishing levels of functioning, checking mental status and identifying psychiatric symptoms may be present however language is a problem
- Given the prevalence of dementia, the cards could be routinely used for older people along with their regular blood pressure, heart, and blood tests when they undergo a “warrant of fitness”
- This would allow for early interventions and services to be put in place in a timely manner
- If interest is shown in the cards and an financially viable estimate of demand is established, ACM will produce the cards for sale

UPDATES ON TRAVEL VACCINES

Dr Joan Ingram – DML and ADHB

Health Problems for travellers:

- 40% unwell
- Traditionally said to be diarrhoea followed by respiratory tract infections
- Other problems include:
 - Systemic febrile illness
 - Dermatologic disorder
 - Chest infections
- Malaria leading cause of fever from Africa
- Dengue ahead of malaria for all regions except Africa and Central America

- Dengue, typhoid and malaria virtually equal causes of fever from south central Asia
- Insect bites most common dermatologic problem closely followed by cutaneous lava migrans
- Death Rate: 1 in 100,000 dies
 - Heart attacks (49%) followed by injuries and drowning (22%)
 - Outcome of injury may be worse during travel
- When Visiting Friends and Relations:
 - Less likely to seek pre-travel care
 - May be in higher risk situations
 - Increased risk of malaria (5x), typhoid (4x), hepatitis A(3x) and TB
 - If you have such patients in your practice try and give them preemptive pre-travel advice

Need to Advise and Discuss:

- Insects
 - DEET containing repellent
 - Vitamin B does not reduce bites
 - Pregnant women more attractive to mosquitoes
- Ingestions
 - No good evidence that care with oral intake reduces rates of traveller's diarrhoea
 - Restaurant food more risky than that prepared in own kitchen
 - May reduce other food borne illnesses
 - Alcohol hand wash makes good sense
- Indiscretions
 - Travel increases the probability of casual sex
 - HIV is global (40 million infected, majority don't know it)
 - Many sexually transmitted infections are more common in developing countries and more resistant to treatment
 - Condoms lower risk
- Injuries
 - Avoid travelling alone and at night
 - Use helmets, seat belts etc
 - Avoid looking like a tourist
 - Keep valuables out of view
 - Don't swim alone or after drinking alcohol
 - Don't feed or play with dogs or monkeys
- Insurance
 - Vital for all travel
 - Check for exclusions
 - Read policy carefully to see what is covered, level of excess
 - Have a special policy if pre-existing medical conditions, working overseas, doing hazardous recreational activities
- Injections
 - Overuse of injections in many developing countries
 - Reuse of injection equipment without sterilisation is common
 - Avoid any puncturing of the skin unless the equipment is sterile
- Immobility
 - Risk related to duration of travel

- Those with pre-existing VTE risk factors are most vulnerable
- Move legs frequently
- Drink plenty of water (not alcohol)
- Wear below knee compression stockings: incidence of DVT 19 times lower
- High risk travellers should have heparin injections
- No evidence that aspirin helps
- Medication Advice
 - Take a letter from usual Doctor about any chronic illness and usual medications
 - Have vital medications in two bags in case one is lost
 - Have a self help kit as medications overseas may be fakes
- Inhalation
 - E.g. TB, influenza, bird flu
 - Dutch study showed 3.3% of travellers per year to areas of high TB endemicity are infected (2.8 per 1000 per month)
 - Advise two step pre-travel mantoux testing with repeat after return
 - BCG for young long term travellers
 - Avoid live poultry/droppings

Vaccinate:

- Hepatitis A
 - Risk in travellers has declined 10 to 50 fold since 1970s
 - Primate studies suggest protection even when given after exposure so not too late to give it just before departure
 - Don't need to restart if long interval between doses. Excellent boosting up to 8 years after initial dose
 - Hepatitis A / hepatitis B combination or hepatitis A / typhoid combinations
- Hepatitis B
 - Most infectious of all blood borne viruses
 - Virus air dried is infectious for at least one week
 - In adults under 40 years seroprotection after 1, 2 and 3 doses is 30-55 %, 75% and 90%
 - O,1, 2 month or 0,7,21 days should be followed by 4th dose at 12 months (protection then close to 100% and higher titre)
 - With Twinrix 10 to 15% higher protection and higher titres after 2 doses
 - Higher protection rate in > 60s (88% vs 73%)
- Influenza
 - May be the most common vaccine preventable disease of travellers
 - Cruise ships attack rates 17 to 37 %
 - Promote the vaccine!
- Cholera: Dukoral
 - Inactivated: killed whole cell *V.cholerae* and recombinant cholera toxin B-subunit
 - Uncommon illness in travellers
 - Usually just for health care/ aid workers
 - Many ETEC produce toxin that is similar to cholera toxin so through the B subunit there is some protection against ETEC

- Dukoral for Traveller's Diarrhoea
 - 50 to 70 % efficacy against ETEC for up to 3 months
 - 25 to 50 % of TD caused by ETEC
 - So protection against TD about 25 %
 - Consider it for those at high risk of TD or who would tolerate it poorly

Prescribe:

- Always – Regular medications
- Sometimes – Acetazolamide, Antimalarial medication, Condoms

Sample Scenario:

Preparation for OE with round the world ticket

- 29 year old single male, travelling to:
 - South America
 - UK/ Europe
 - Africa
 - India
 - Thailand, Vietnam
- Two weeks in highland areas of Peru and Bolivia

Advice:

 - Insects less of a problem when high altitude
 - If in Amazon/ jungle parts: malaria, yellow fever, dengue, leishmaniasis
 - Ingestions
 - Insurance
 - Altitude: Lima, Peru on coast. Cuzco at 3,395m and La Paz 3,658
 - If fly to Cuzco immediate breathlessness and lightheadedness then after 4 to 6 hours may develop AMS symptoms (headache, anorexia, fatigue). Often periodic breathing
 - Suggest a few days acclimatisation at intermediate altitudes in Sacred Valley (an hour from Cuzco)
 - Coca tea no proven benefit
 - Acetazolamide:
 - Can be used as prophylaxis or treatment
 - Optimal dose is the dose that prevents or resolves symptoms with minimal side effects
 - Start with 125 mg bd, if necessary increase to 250 bd for prophylaxis
 - Start 1 day before ascent. Continue for 3 to 4 days
 - Treatment: 250mg and repeated in 12 hours
 - Dehydration may cause headaches
 - Pins and needles of fingers, altered taste
 - Stocking and glove paresthesias, circumoral numbness, lightheadedness
 - Mild diuretic effect
 - Those with a history of sulfa allergy should not take it
 - Don't go higher if not doing well

Vaccinations:

- Hepatitis A +/- hepatitis B
- Tetanus – diphtheria booster

- Yellow fever required if coming from infected areas. Not needed for own protection in high land areas. (Is recommended for Igacu Falls)
- Rabies? Certainly discuss
- No polio in region for some years so not needed
- Yellow fever vaccine:
 - Live viral vaccine so not for pregnant or immunosuppressed
 - Only timing issue is with other live vaccines (MMR, varicella, BCG). These need to be given together or at least 1 month apart
 - Systemic symptoms 5 to 10 days after
 - Severe viscerotropic disease / deaths: 1 in 400,000. Risk increases with advancing age: RR 6 in 60 to 69 year olds and 10 in those over 70

- Six month truck trip: West Africa to South Africa

Advice:

- Ingestions
- Insects
 - Evening and night time mosquitoes: Clothes, repellent, permethrin treated nets
 - Day time: ticks, mosquitoes, tsetse flies etc
 - Wear shoes, iron washing
- Indiscretions
 - Carefully and Consistently use Condoms
- Injury. Violence and accidents
- Insurance. Must include evacuation
- Immersion
- First Aid Kit
- Injections
- Climbing Mount Kilimanjaro
 - 5896m so many suffer or fail
 - Rule: after 2500m sleep no more than 300m higher than previous day and extra night every third camp
 - Impractical to spend 10 days so climb Mt Kenya or Mt Meru first
- Schistosomiasis
 - Risk throughout Africa
 - 32% of expats at Lake Malawi
 - Cape Maclear 52-74% risk from single day
 - HTD, London 18% of asymptomatic exposed travellers positive when screened
 - Ignore local advice that it's safe
 - Still shallow water and bright sunlight worse
 - Vigorously rub skin and apply DEET
 - Let water stand for 2 to 3 days or boil or treat
 - Serology 3 months after exposure

Vaccinations:

- Yellow fever mandatory
- Tetanus-diphtheria booster
- Hepatitis A / B
- Typhoid fever
- Polio booster

- Rabies
- Meningococcal meningitis

Prescriptions:

- Antimalarials

	Mefloquine	Doxycycline	Malarone
<i>Main SE</i>	Neuropsych	GI, skin	GI
<i>Dose</i>	250mg/wk	100mg/day	1 daily
<i>Start</i>	3/52 pre	2/7 pre	2/7 pre
<i>Continue after risk</i>	4 weeks	4 weeks	7 days
<i>Not for</i>	Epilepsy, depression	Childhood, pregnancy	pregnancy
<i>Cost</i>	+++	+	++++

- Loperamide
- Norfloxacin
- Acetazolamide

- India for one month, Nepal two weeks

Advice:

- Insects
 - Dengue occurs. Urban areas
 - Malaria and Japanese Encephalitis from evening/night time mosquitoes
- Ingestions
 - Food and water borne illnesses very common
- Injury
 - Many dogs to avoid
 - Rabies immunoglobulin unavailable in India
- Insurance
- Malaria
 - India: Year round but higher risk after onset of Monsoon (June to October) until December
 - Risk lower in cities but still occurs
 - Nepal: lowlands near Indian border (Chitwan National Park) and Terai plains districts
- Diarrhoea
 - Indian subcontinent and SE Asia high risk
 - Fluids/ ORS
 - Loperamide
 - If severe antibiotic as ETEC main agent. In most destinations norfloxacin single dose or 3 days. In Thailand, Nepal *Campylobacter* spp predominate (Azithromycin)
 - Rifaximin a non-absorbed antibiotic is effective unless *Campylobacter*
 - 10 % of TD in Nepal giardia infection
 - Acid suppression probably increases risk
 - 3% of patients with TD have symptoms >30 days: persistent infection (protozoal, *Clostridium difficile*), disaccharidase deficiency, malabsorption, inflammatory bowel disease or cancer. If no weight loss or malabsorption may be post infectious irritable bowel syndrome

Vaccinations:

- Hepatitis A +/- Hepatitis B
- Tetanus-diphtheria booster

- Typhoid: Indian Subcontinent highest rates (1 in 3,000/ mth cf 1/30,000 other areas), more resistant
- Polio booster
- Rabies
- JE : rural areas, second half of year
- Meningococcal: Northern India esp New Delhi

- Thailand and Vietnam 7 days each

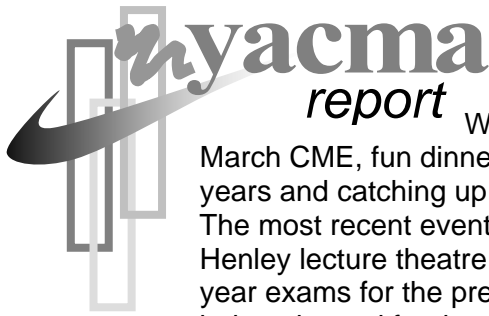
Advice:

- Insects
 - Dengue common. Urban areas
 - Malaria and Japanese Encephalitis from evening/night time mosquitoes in rural areas
- Ingestions
 - Do not eat uncooked reptiles, amphibians or snails
- Injury
 - Many dogs to avoid
 - Thai Red Cross Hospital good post bite care
- Insurance
- Malaria
 - No need for prophylaxis for travel to Bangkok, cities or resorts in Thailand
 - No need for prophylaxis for cities in Vietnam
 - Some mefloquine resistance in Thai border regions

Vaccinations:

- Hepatitis A +/- hepatitis B
- Tetanus-diphtheria booster
- For long stays typhoid and rabies
- If rural - Japanese Encephalitis
 - Rural risk
 - Pigs and wading birds are amplifier hosts
 - Transmission varies with season
 - Thailand. Higher risk in north. Season in north is May to October, peak July; in south year round with peak May- July
 - Vietnam. Highest risk around Hanoi. Season April to November
 - 3 doses on days 0, 7 and 28
 - Booster after 2 years
 - Hypersensitivity reactions about 0.6%
 - Reactions may be delayed up to a week
- Consider polio
- Fever in a returned traveller
 - always need to consider/ exclude malaria
 - may have more than one problem
 - may be a "nontropical" problem such as UTI or pneumonia
 - malaria, dengue, typhoid, rickettsia, hepatitis A and amoebiasis, acute schistosomiasis, HIV seroconversion

- By Dr Trevor Young
- Edited by Paul Cheng



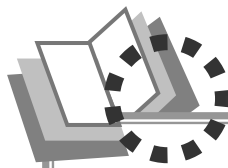
Hey people! Welcome to the July edition of the YACMA report! Winter is definitely here and I can feel the chill staying down here in Hamilton!!

We've been having a productive year so far with the introductory BBQ, March CME, fun dinner at the Korean BBQ and especially with getting to know the new 2nd years and catching up with old friends from the rest of the years.

The most recent event was the pizza/movie afternoon which was successfully held at the Henley lecture theatre and went through smoothly. June has been a bit quiet with the mid-year exams for the pre-clinical years especially but there are definitely more great things being planned for the coming months!!

Coming up soon are the Careers afternoon on the 22nd July which will be held at medical school and the karaoke fundraiser which has been set at a tentative date in September but details will be confirmed later! So keep an eye on this spot and we'll keep you posted!

Yu Hwee Tan
Clinical rep



Key Reminder

2007 Easter University of Otago Graduates Get-Together in Dunedin in association with the NZ Chinese Association's Easter Tournament

There is interest in organising a get together for Otago medical school graduates to coincide with the Easter Chinese Tournament in 2007. This should be open to all graduates of Otago University with the usual NZ Chinese Association rules applying. It would be a great opportunity to show spouses and children (if any) the venue of misspent youth!

Could you please pass this word around among colleagues as we do not have an extensive mailing list. For interest, please contact *Dr Phillip Lowe*

Address: 17 Landscape Rd, Epsom, Auckland.

Phone 631-5239 Fax 623-4958 Mobile 021-976-098



Practice Announcement from Dr Alexander Ng

Dear Colleagues,

I would like to take this opportunity to advise that I am now consulting at two locations in Auckland:



Specialists @ 105 **105 Remuera Road, Remuera**
Consulting rooms and operating theatres

Breast Associates **641 Manukau Road, Epsom**
Multidisciplinary breast care



Specialists @ 105 is a newly-established specialist and surgical centre, offering modern and comfortable facilities. The centre has Local Anaesthetic and General Anaesthetic operating rooms which allow patients convenient access to day-stay surgical treatment.

Specialist surgical services include:

- Benign and Malignant Breast Disease, sentinel lymph node biopsy
- Skin lesion excisions, Melanoma surgery
- Laparoscopic cholecystectomy, Thyroid and Hernia, perianal disorders

If you feel I can be of assistance to you or your patients please do not hesitate to contact me.

Best regards,
Alex Ng

Alexander Ng MBChB FRACS

Melanoma and Skin Cancer Surgery
Hernia, Gallbladder, and General Surgery

Specialists @ 105 **Ph: 524-1226**
105 Remuera Rd **Fax: 524-1224**