

# 屋崙中華醫學會通訊

# acma news

The Official Newsletter of the  
AUCKLAND CHINESE MEDICAL ASSOCIATION  
Issue No. 20 September 2010



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## from the editors

Kia Ora,

Things have been busy the last two months! We had two very educational CME dinners at Punjabi Palace and Mecca Stonehouse. The topics that were selected were very relevant for our continuous professional development, particular on women's health and common skin conditions. We are here to serve the members so please email Grabiell at [grabiell\\_120@hotmail.com](mailto:grabiell_120@hotmail.com) for future CME topics and she will try her best to accommodate you.

On the education topic, in this very **special** issue the infatigable 5<sup>th</sup> year Jerry Wu has written an interesting clinical problem solving case in the NEJM-style. Keep your wits about you as you navigate through this challenging and educational case! See the appendix.

We have also published 8500 copies of the Doctor's list which will be coming to your favourite Asian food store. Many thanks to our president Gee Hing for his hard work in getting the sponsorship and putting this together.

For YACMA we had just concluded our annual Careers Evening featuring great speakers from our very own Dr Colin King and many other Asian registrars within the Auckland region. We also conducted a very successful clinical skills workshop for pre-clinical students. It is aimed to give them a taste of their future clinical career. We also received three applications for the ACMA Medical Studentship for electives in Asian countries and have set up a subcommittee to look into the applications.

The ACMA term will be coming to an end in the near future and we will have our next AGM on 28 November 2010 where you will have the opportunity to vote in the next Executive Committee to carry ACMA forward onto 2011. The nomination form is attached to this newsletter as well as available on the website.

We will like to thank all members for their continuing support and subscription as you are the backbone of our association. We hope that ACMA will continue to be a voice as a body of doctors committed to the health of our community and providing a platform where we could network, collaborate and dynamically work together for the wellbeing of Chinese New Zealanders.

The recent September article of the North and South magazine discussed the changing demographics in our NZ medical workforce, titled: "The disappearing white male doctor". It is heartening to hear Professor Des Gorman, former head of the Auckland medical school gave assurance that our system is a 'merit-based system' based on the rigorous selection of medical students who display high academic, leadership and social capacities regardless of *ethnicity, gender or family background*. That is something to cheer for.

Yours truly,

Choonwei and Chen Luo  
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**Contact us: [info@acma.org.nz](mailto:info@acma.org.nz)**

Dear Colleagues

At a dinner function, one of my GP colleagues commented that he has heard of the excellent CME sessions organized by ACMA. However, he has never thought of joining ACMA because he has 'disqualified' himself on the basis that he is not a Chinese. You can imagine that I almost choked on my food when I heard that. I quickly corrected him on that statement. ACMA was formed in 1988 and has been a registered charitable entity under the Charities Act 2005 since June 2008. Its membership is opened to *all* New Zealand registered medical practitioners who share our passion 'to develop and promote the cultural and professional well-being of Chinese New Zealanders'.

I have held the Association's Presidency for two consecutive terms and will step down in November 2010. It has been an honour and great privilege to serve ACMA as its President. Together with the Executive Committee, we have achieved a lot in strengthening the governance and financial position of the Association. The Association should continue the effort in growing its membership number, and we still have a long way to go in achieving a self-sustaining financial position.

On that note, I would like to inform you that the nomination form for all positions on the Executive Committee is now available on our website. The positions on the Executive Committee are: President, Vice-President, Secretary, Treasurer, CME Coordinator and General Committee Members. As usual, an election will be held at the upcoming AGM (28 November 2010). I would encourage you to put your hands up and help out with the Executive Committee in 2011. You can fax the completed nomination forms to me at 09-478 3007 by 28 October 2010. Please ring me on 021 800 189 if you have any questions regarding the nomination and election.

I look forward to meeting you at our next CME on Sunday 12 September 2010.

Regards,

*Dr Gee Hing Wong*

## Overactive Bladder: Pitfalls and Effective Therapy

Anil Sharma MB ChB (Leicester) DGM FRCOG  
CCST(UK) FRANZCOG

- Stress Urinary Incontinence (SUI)
- Overactive Bladder (OAB)
- Mixed Incontinence
- Remember sinister causes

### History

- Is a poor tool for accurate diagnosis
- 1/3 women who initially report SUI have OAB not SUI
- 2/3 with mixed symptoms do not have OAB component

### Micturition

- Urgency
- UI +/- or SI
- Frequency D/N
- Dysuria, Haematuria
- Faecal Incontinence
- How long? How bad? How often?
- Previous treatment? Current management?
- Does she want anything done?
- Fluid intake?

### Associations

- Childbirth
- Recurrent UTIs
- Menopause
- Prolapse
- PMH, DH (eg Prazosin, diuretics, oestrogen?)
- Cigarettes
- Asthma
- Fluid intake
- Constipation
- Caffeine, Alcohol

### Frequency/volume diary

- Improves history
- Information about learned behaviour
- Fluid intake information
- Lifestyle questionnaire
- Frequent small painful voids point to interstitial cystitis

### Physical Exam

- General e.g. leg oedema and nocturia
- Pelvic (prolapse, tone, mass, fistula)
- Local neurological
- UVJ hypermobility
- Post void residual? (in-out catheter or scan <100mls is normal, >200 abnormal)
- Cough test of some use
- Dipstick / MSU / ?cytology of EMUs

### Urodynamic Assessment

- A test to exclude OAB and outflow obstruction
- Homework and Pad test
- Voiding flowmetry and then catheter for PVResidual
- Attach lines and pressure transducers incl rectal
- Filling phase up to around 500ml
- Stress test lying and standing
- Bladder syringe attached to catheter, held 15 mls above symphysis and filled with 60ml increments
- When no more can be tolerated, watch meniscus
- Normal capacity is 350-400ml. Suspect Interstitial Cystitis if <300, rule out if >350
- Supine positive empty stress test ?ISD

### Pathophysiology

- Urination involves the higher cortex, pons, spinal cord, peripheral autonomic, somatic, and sensory afferent innervation of the lower urinary tract and the anatomical lower urinary tract itself.
- Disorders of any of these structures may contribute to OAB usually with involuntary contractions of the detrusor muscle.
- The normal bladder is like a compliant balloon. With the initiation of normal urination, urethral resistance decreases and a phasic contraction of the detrusor muscle empties the bladder.

### Overactive Bladder

- Urgency +/- urge incontinence usually accompanied by Frequency and Nocturia
- Freq (>10 in 24 hours)
- Nocturia (>1)
- DD severe SUI, stone, fistula, infection, tumour
- Neurological causes (MS, CVA, PD)
- Prolapse, Drugs, Idiopathic

### Treatment

- Bladder (re)Training cures 10% with urge incontinence
- It makes 60% much better
- eg void every hour whether you want to or not and increase the interval fortnightly by 15-30 minutes until 2.5-3 hours gap achieved
- Pelvic floor exercises

## Drugs; Oxybutynin (Ditropan)

- Muscarinic Acetylcholine antagonist
- 2.5mg up to 5mg tds
- 20-50% reduction in incontinence episodes
- Side effects include dry mouth, constipation, blurred vision, drowsiness, dizziness, urinary retention, delirium
- Contraindications; narrow angle glaucoma, bowel obstruction, toxic megacolon, paralytic ileus
- Imipramine 10-25 mg up to tds (anticholinergic and alpha-adrenergic to increase urethral tone)

## Solifenacin (Vesicare)

- Antimuscarinic agent with relative selectivity for the bladder (M3)
- Well tolerated
- Subsidised
- 'Any relevant practitioner'
- Must have documented intolerance to Oxybutynin
- Royal Hallamshire Study 2003: placebo vs Detrusitol vs Vesicare
  - Over 1000 patients
  - Mean episodes of urgency stat significantly lower only with Vesicare 5 and 10mg
  - Mean episodes incontinence stat significantly lower only with VC
  - Mean number of voids in 24 hours stat lower with both (similar but Vesicare better)
  - Dry mouth (mainly mild); placebo 5%, VC5mg 14%, Det 19%, VC10mg 21%
  - Constipation with VC around 7% Blurred vision 3%
  - Discontinuation for Side-effects was highest in the placebo group 3.7%!
- Drugs continued
  - Basra (2008) continuation rates at one year 63% (Oxy), 62%(Det), 81%(VC)
  - Discontinued because of SE 24,15,4.7
  - My (anecdotal) findings suggest worse figures with Oxybutynin and similar with Vesicare
- Percutaneous Posterior Tibial Nerve Stimulation
  - 12, weekly treatments
  - 50% improve significantly but unsustainable we think (needs further evaluation) vs 21% improvement for sham treatment
  - cost and ongoing treatments restrictive
- The Magnetic Chair for OAB
  - Extracorporeal magnetic innervation (ExMI)
  - Japanese study 2004 20 patients
  - 20 min, twice a week for 8 weeks
  - Evaluations; bladder diaries, one-hour pad weight testing, quality-of-life surveys and urodynamic studies
  - 5 cured (25.0%), 12 better (60.0%)

- 8 patients with urge incontinence recurred within 24 weeks after the last treatment
- Expensive

## Botox for OAB

- Via cystoscope
- Works for around 6 months
- Good results
- Expense

## Summary for OAB in General Practice

- Assess including examination
- MSU
- Refer if microscopic or more haematuria
- If symptoms suggest OAB lifestyle (fluid etc), medications review, retraining / PFEs? and Oxybutynin...Vesicare
- Any doubt or no success, refer

## Treating Stress Urinary Incontinence

- Pelvic floor exercises to hypertrophy the denervated pelvic floor muscles
- It will take 3 months of 3 sets of 20 for 4s each (and 'quick flicks' for fast fibres). 50% can achieve significant improvement
- Electrical stimulation (reflex relaxation of the bladder)
- ERT?
- Devices eg pessaries and plugs

## The Magnetic Chair for SI

- Turkish Study 2008
- 27 patients with USI 20 min, twice a week, for 6 weeks
- Follow-up was done at 3, 12 and 24
- 8 cured (29.7%) and 13 improved (48.1%) at 3 months.
- Effect gradually decreased to baseline at the 2nd year after therapy
- Further studies are needed
- Cost

## Surgery for SUI

- Tension-free Obturator Tape (mid-urethral)
- Classic Tension-free Vaginal Tape
- Elevation of the Bladder Neck e.g. Burch Colposuspension
- Laparoscopic Burch Colposuspension

## TOT

- Similar efficacy to TVT
- Avoids retropubic space, vessels (bleeding 2% vs. 10%)
- Less bladder injuries (0% vs. 10% in 99 patients) and also bowel
- Overcorrection highly unlikely with decreased post-op voiding difficulty

## A brief History of the Chinese Community in New Zealand: Part II

*Mr. Arthur Loo. Chairman of the Auckland Chinese Community Centre and the Leukaemia & Blood Foundation. Partner, Loo & Koo Barristers & Solicitors*

The talk is part two of the cultural talk given earlier. It chronicles the discrimination by law against the Chinese community in the early 20<sup>th</sup> century.

New Zealand was primarily intended to be a European settlement and Asians especially the Chinese were to be excluded. This was articulated by Sir George Grey, the governor general of New Zealand in 1879. New Zealand was to be the "Britain of the South."

However there were legal problems with this approach. Since New Zealand was a British colony, it was subject to British common law. Britain entered into a series of treaties with China with the aim of penetrating the Chinese market. Part of the treaty gave reciprocal rights to legally enter each other's territory.

So, New Zealand came up with other ways to prevent Chinese entry. The legal concept of Aliens developed which encompasses all foreigners with legal right restrictions. Naturalization depended on race so a Chinese became a race alien. Other methods such as a poll tax of 100 pounds and a reading test were implemented.

However these methods were ineffective resulting in a Chinese community developing in NZ. To prevent further increases in the Chinese population, immigration was restricted to a permit system with governmental discretion. Chinese woman in particular were excluded to prevent natural increase in the Chinese population.

However the question remained of the NZ born Chinese. This was first challenged by Joel Lum in 1907 which reached all the way up to the Supreme Court. He wanted his NZ born children to get a Chinese education in China but the question remained: would his children would have to pay re-entry poll tax. Under British law - nationality is determined by not by one's parents but where one is born. Hence, the judges ruled that NZ born Chinese have NZ nationality and should be accord the same legal rights.

However this was ignored by NZ customs where an internal memo circulated in 1951 states equivocally that Chinese are to be treated as Chinese **whatever their nationality**. This policy continued until 1960s. Furthermore with the advent of the welfare state, there were provisions to exclude Chinese from benefits such

as: Pension act, widow's pension and the family allowance act. This was only repeated in 1955.

## Common dermatological conditions

*Dr. Vania Sinovich. MBChB (Witwatersrand) MRCP (Lond), FRACP*

### Atopic Dermatitis

- Complex genetic and environmental factors.
- Atopic history is important. Atopic triad of asthmas, eczema and hay fever.
- Causes of eczema: genetic barrier defect causing increased skin permeability with increased penetration of allergens.
- Presentation:
  - Infant – usually on the face with the napkin area usually spared with extensor involvement.
  - Pre-school - flexural aspects. Less extensor involvement. Skin is dry and lichenified.
  - School - flexural both also eyelid.
  - Teenage - avoidants of traditional
- Differential diagnosis:
  - Eyelid dermatitis – allergic vs seborrheic dermatitis (associated with increased androgen levels) – more proximal.
  - Allergic dermatitis usually with make-up in young girls. Use patch testing.
  - Lip dermatitis – persistent dermatitis with protein contact in food. Use emollients.
  - Vesicular dermatitis – Not usually itchy with clear fluid. Settled with steroids.
  - Discoid dermatitis – classically coin shaped. Vesicular and weeping.
  - Adult dermatitis – usually hand dermatitis linked to certain occupations (wet water work). Increased exposure to contact allergens. Usually bilateral. If unilateral need to exclude Pagets.
- Complications of eczema:
  - Secondary infection bacterial and viral (Eczema herpeticum)
  - Molluscum contagiosum. Aldara useful (but off license).
- Treatment of allergic dermatitis:
  - Think control rather than cure
  - Remove aggravating factors (use soap substitutes, dust mite minimization)
  - Emollients
  - Topical steroids
  - Flucloxacillin
  - Anti-histamine: sedating more effective as it affects unconscious scratching
  - Wet wraps to increase emollient and steroid uptake and prevent scratching.
  - Phototherapy with narrow UV band. Very effective.
  - Prednisone in short courses for uncontrolled eczema.

## Psoriasis

- Strong genetic component. Flares aggravated by: stress, infection and winter
- Presentation: Classically presents with white scaly patches that can be scratched off. It affects the extensor surfaces bilaterally and spares the face.
- Flexural psoriasis – “inverse psoriasis”. Smooth well-defined patches with secondary infection common.
- Scalp psoriasis – thick scale in hair leading to hair loss
- Guttate – sudden dramatic onset of small tear drop lesions usually after streptococcal infection. Very responsive to narrow band UVB.
- Palmoplantar pustulosis - Itchy and painful. Use potent topical steroid.
- Treatment:
  - Topical:
    - Tar
    - Topical steroids with Vitamin D like compounds
  - Phototherapy.
  - Oral medications:
    - Methotrexate
    - Cyclosporine
    - Biologics if severe

## Hair Loss

- Structure understanding around the hair cycle
- Alopecia areata – asymptomatic bald patch. Rule of thirds: complete recovery, partial, no regrowth. Use intralesional steroids. Autoimmune disease.
- Male pattern hair loss – think Wayne Ronny with frontal hair loss.
- Scarring alopecia - Infection (staph, tinea, ringworm).
- Discoid lupus erythema.

## Melanoma detection

Asymmetry

Border irregularity

Colour variation (within tumour)

Diameter over 6mm

Evolving (within weeks)

Dermoscopy – is very useful to differentiate benign versus malignant. There are good courses on <http://www.dermnet.org.nz>.

## Basic research

### **CPR with chest compression alone or with rescue breathing. Compression-only CPR or standard CPR in out-of-hospital cardiac arrest.**

These two recently published randomised controlled trials have shown that in CPR instituted by laypersons in the community setting, chest compressions alone achieved similar efficacy as compared to the chest compression plus ventilation strategy. These data provide further evidence that compression only CPR may be the technique of choice for bystanders to use when responding to cardiac arrests in the community.

N Engl J Med 2010;363:423-42 (Jul 29)

## Interactive medical case

### **Hard to conceive.**

A 31-year-old woman without significant past medical history was evaluated after unsuccessful attempts at pregnancy for 18 months. The leading causes of infertility (defined as the inability to become pregnant after having unprotected coitus for one year) include male factors, problems with ovulation, and fallopian tube pathologies. Test your diagnostic and therapeutic skills with this interactive case from the popular NEJM series.

N Engl J Med 2010;363:e11 (Aug 12)

*Suitability: Year 3 & +*

### Clinical review

#### **Acute pulmonary embolism.**

- D-dimer testing is most useful when pretest probability of PE is low to intermediate.
- Suspect PE in patients with unexplained dyspnea, chest pain, hypotension or tachycardia.
- Right ventricular dysfunction is an important risk factor for adverse outcome.
- CTPA is the imaging modality of choice in patients with high clinical suspicion of PE or high D-dimer level.
- Initial anticoagulant therapy should use a low-molecular-weight heparin (e.g. enoxaparin). Vitamin K antagonist (e.g. warfarin, with target INR between 2 – 3) is the treatment of choice in the long term.

N Engl J Med 2010;363:266-74 (Jul 15)

*Suitability: Year 2 & +*

#### **Acupuncture for chronic low back pain.**

- Important pathologies to rule out in patients presenting with low back pain include infection, cancer, rheumatological disorders, vascular disorders (e.g. AAA), & orthopedic disorders (e.g. spinal stenosis).
- Acupuncture originated in China, the therapy involves the insertion of fine, solid metallic needles into or through the skin at specific sites along the meridians.
- Traditional Chinese medicine focuses on body harmony and *qi* (body's vital energy). The insertion of acupuncture needle is supposed to restore the proper flow of *qi*.
- Randomised controlled trials have shown that acupuncture may be more effective than usual care in treatment of chronic low back pain but it is no superior to sham acupuncture.
- Acupuncture induces the release of endogenous opioids in the brain.

N Engl J Med 2010;363:454-61 (Jul 29)

*Suitability: Year 2 & +*

**ACMA and MercyAscot would like to invite you to our...**

## **September CME Meeting**

**Venue:** Troy Restaurant,  
161 Ponsonby Rd,  
Auckland.

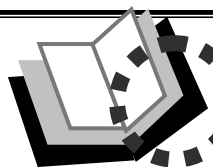
**Date:** Sunday 12th September 2010

**Schedule:**

5.30pm Arrival and Registration  
6.00pm Introduction by Dr. Gee Hing Wong  
6.05pm YACMA Research Presentations  
Topic: TBA  
6.30pm The Latest Advances in PET / CT in  
New Zealand by Mercy PET / CT  
6.50pm The Latest Advances in Radiation  
Oncology by Prof. Chelleraj Benjamin  
Clinical Director, Auckland Radiation  
Oncology  
7.10pm Breast Cancer: Updates & Advances in  
Management by Mr. Alexander Ng  
General, Breast & Trauma Surgeon  
7.30pm Dinner

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](mailto: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 Wan via cheque.

### **Looking for new members**

Please introduce the Association to your colleagues.

### **Sister Organization**

On our website ([www.acma.org.nz](http://www.acma.org.nz)), under the "Links" section there are links to our sister organizations in Australia. We have reciprocity agreements with them and members can join their activities and their conferences. They always enjoy having ACMA delegates from New Zealand.

### **TI Scholarship**

This will be announced in the AGM.

## **Medical Research**

### **Identification of late-onset hypogonadism in middle-aged and elderly men. Adverse events associated with testosterone administration.**

In a prospective trial involving 3369 men between the ages of 40 and 79 years in Europe, Wu et al. found that the presence of at least 3 sexual symptoms (poor morning erection, low sexual desire, erectile dysfunction), a total testosterone level of less than 11 nmol/L, and a free testosterone level of less than 220 pmol/L suggested the presence of late-onset hypogonadism. In the same issue of the Journal, Basaria and colleagues reported the result of a small NIH (National Institute of Health, USA) funded randomised controlled trial that showed testosterone supplementation was associated with an increased risk of cardiovascular adverse events in elderly men with low serum testosterone and high prevalence of cardiovascular risk factors. However, no firm conclusions can be drawn from this trial because of its small size and premature termination.

N Engl J Med 2010; 363: 109-35 (Jul 8) *Suitability: Year 2 & +*



Close-up with ACMA! For this edition we interviewed Dr Richard Yu, our YACMA student coordinator and the first year ACMA member...

**How's life?** I've just started working this year and earning a bit this year. However with more money, comes more worry about how to spend that money? A lot of my colleagues are saving up for trips to Europe, but for me I am saving up probably to do some property investment

**How's the transition into HO year?** Its interesting and exciting, especially when you have to do your own ward round after years of just participating in someone else's. Its also interesting to have students following you around, and that boosts your ego up a bit, 'feeling more important'.

**What would be your biggest challenge?** To go home on time is one of the biggest challenge. Another challenge is to go through 2/3 of the run without a registrar, hence I am doing a 2-person job. Besides there's a lot of things competing for your attention, for example recently when I was busy sorting out some cases on the wards, there's a call from the mortuary to fill up death certificates immediately. That makes me wonder whether I should first attend to the living or to the dead?

I also faced situations where I don't know what to do, and many times I learnt how to make important decisions. There was this chap who was supposed to be NBM prior to surgery, but I got a phone call from the nurse asking me about what to do, because he apparently swallowed chewing gum!

**Work hours?** 60-65 hours a week. Some weekends off, like every 3rd weekend. Mostly B and C runs.

**What's up with the Single's club?** Oh it was a self-dissolved singles club, originally the idea of a classmate of mine. Most of our classmates were already dating in med school when we first started it, but since many has broken up now (due to work stress), we may have more members joining \*laughs\*.

**So why did you choose to work in Auckland?** It is a familiar place, and I thought that it would be helpful being in such environment during the work transition as it is closer to my social circles. I do also have emotional attachment to Auckland. I am also thinking of Canada, as I liked the place very much when I visited there for my holidays. I may possibly do some postgraduate

studies there.

Since I am interested in general practice, I am thinking of doing some courses on Traditional Chinese Medicine (TCM) from reputable institutions overseas.

**Why TCM?** Since as a GP, we will see a variety of patients and could not avoid working with Chinese patients. Hence having some knowledge of TCM will help me to understand better the Chinese model of health, and be able to engage them.



**Why GP?** Wasn't my highest option but since this year it has become stronger. I am thinking of the bigger scheme of life and what do I value etc. I value 'balance'. Someone once mentioned that you got to be 'happy outside of work to be happy at work'. A lot of hospital staff look fatigued, and I don't really want to look like that for the rest of my life.

To avoid burn out, I also stay away from locums although it can be lucrative. I don't earning more money because our income is already sufficient.

**History?** I wanted to do an arts paper during med school on "Qing and Ming dynasty", but the school did not let me do so because our regime is so rigid.

Qing dynasty is a bit random its more of a Manchurian rather than Chinese dynasty. They do random things like making people wear ponytails. Ming is the real last Chinese dynasty and the longest, possibly due to its great government machinery [despite some lousy Emperors]. There is this emperor that put patchwork on his robe but also the one who signed the treaty that disadvantaged China.

Recently I visited Arrowtown as well, which is an ex-Chinese goldminer settlement near Queenstown. I highly recommend people to visit it.

**Chinese linguistic ability for physicians?** Quite helpful. A lot of patients can't speak English -- especially the elderly and the extended family, and many words can get lost in translation. Recently also many of my church members were asking me a lot about medical related stuff, and that encouraged me to communicate medical terms into Chinese more.



The YACMA committee is busy behind the scenes working hard to bring you bigger and better events this year. Events to look forward to: ACMA AGM (talks and dinner), YACMA AGM (voting and dinner), ACMA CME dinner and the Karaoke night!

YACMA Committee



## ... spotted

### YACMA Surgical Skills Workshop



This year's Surgical Skills Workshop (7<sup>th</sup> August) was a great success with about 30 pre-clinical students who came for our event at Middlemore Hospital!

Meant for pre-clinical students who are disillusioned with their textbooks and dry biomedical knowledge, we hope to give them a foretaste of what clinical medicine and on-the-job skills as a clinician is about!

This year we had 4 clinical students who oversaw the whole workshop; Vitt Hemstapat (Suturing Station), Hayley Hu (Coordinator), Norman Quek (Cannulation), and Choonwei Wee (Plastering). It was a great place for them to practice the skills they obtained from their clinical runs as well as the opportunity to show it to their juniors.



As for the juniors, they were very enthusiastic to learn and had a great time in all three stations; plastering, suturing and IV cannulation. I must say that they did very well for first-timers, suturing through pork foot (which can be quite challenging, compared to the more well 'endowed' pork belly). The plastering station was messy but fun with plasters splattered all over the place and playing with the electric cast drill! The IV cannula station was great as well, as we poke through fake hand trying

to get our needle in. Luckily no real arm was hurt in the process ☺



Indeed it is one of the most popular events organized by YACMA and it is indeed a great day for all. Hope that next year's committee will continue this great tradition. *Choon Wei Wee*

### YACMA Careers Evening



The YACMA Careers Evening was held on Wednesday 28<sup>th</sup> of July at Grafton campus with the mingling of students over sushi, pizza and juice provided by YACMA to start off the evening. Speakers ranged from GP (Dr Daniel Wu), general surgery (Dr Don Lee), plastic surgery (Dr Simon Chong), orthopaedics (Dr Godwin Choy), anaesthetics (Dr Michael Tan Dr and Dr Colin King) and a house officer from overseas. There was an excellent turnout, making the event worthwhile for both YACMA and the speakers who were kind enough to give up their time to share their knowledge and wisdom. The students without a doubt gained a huge amount in their understanding of each specialty; overall it was a most successful YACMA event.

**A 75-year-old European lady was admitted to the hospital because of a bleeding laceration to the scalp following a fall.**

The bleeding should be stopped to prevent hemodynamic compromise. Injuries from falls in the elderly require a careful medical assessment and I would like to rule out serious injuries, especially an intracranial bleed and fractures first. In addition to a careful history and physical examination, a computed tomography (CT) of the head is warranted for this lady. Mechanical falls must be distinguished from falls secondary to organic disease, particularly pathologies of the cardiovascular or neurological systems.

**On the day of admission, the patient had dizziness and then noticed increased heart rate after she got out from the bed. This was followed an episode of blurry vision, postural swaying, partial loss of consciousness and collapse. Her head hit a glass cabinet and sustained the laceration to the scalp. The bleeding had stopped by the time she arrived at the hospital.**

It is reassuring that the bleeding had stopped. The sensation of dizziness may represent a variety of head sensations or gait unsteadiness but in the current context, lightheadedness or faintness may best describe the symptoms of visual blurring and postural swaying, but vertigo should also be ruled out. Lightheadedness suggests insufficient blood supply to the brain and it commonly occurs prior to a syncopal event. The change of position from lying to standing makes postural hypotension a plausible explanation for the syncope but the patient's palpitation raises the concern of syncope due to arrhythmia although this may be a normal physiological compensatory response to the increased sympathetic activation secondary to the postural change. Other causes of syncope including stroke, transient ischemic attack (TIA) and cardiac outflow obstruction must be excluded. Syncope should also be differentiated from seizures.

**The loss of consciousness lasted less than 5 seconds and the patient recovered spontaneously. There was no associated postictal confusion, loss of vision, chest pain, dyspnea, limb weakness, aura, seizure like activities or urinary/fecal incontinence before or after the collapse. She had had 10 similar episodes of presyncope, all occurred while she was trying to stand up quickly, over the past 2 years without sustaining any physical injuries. She reported a tendency to faint since her adolescence.**

The brief loss of consciousness with spontaneous recovery that is not associated with confusion is characteristic of a syncopal episode. The absence of visual deficit and limb weakness make stroke or TIA

unlikely. I presume "seizure like activities" means the absence of convulsions. A spontaneous recovery within seconds makes seizure unlikely and the lack of aura, convulsions and incontinence further argue against this diagnosis. The absence of chest pain and dyspnea is reassuring but an account from the bystander may be helpful if this was a witnessed episode. For example, the presence of cyanosis point towards a cardiac cause for the syncope. The current and previous episodes seem to be postural in nature and I would like to evaluate her medications, especially the use of antihypertensives and antidepressants and other factors that may contribute to the orthostatic hypotension. Fasting blood glucose is helpful to rule out diabetes mellitus with resultant autonomic dysfunction as the cause of her symptoms. Other causes of neurogenic orthostatic hypotension should also be excluded given the recurrent nature of her symptoms. Are there any stressors that put her at increased risk for neurocardiogenic syncope?

**The patient had been in her usual state of health until 4 days earlier when a mild non-bloody diarrhea and a sore throat developed. She noticed passing liquid stool up to four times a day, abdominal pain and feeling nauseous but reported no cough, fever, chills, blood in stool, vomiting or hematemesis. A boarder who stayed with her was reported to have experienced similar symptoms. She reported good fluid intake.**

Her symptoms are likely to be caused by a self-limiting viral illness. Diarrhea probably resulted in the dehydration and hence contributed to the postural syncope. Adequate fluid intake may not have compensated fully for the fluid deficit from the diarrhea. Measuring her lying and standing blood pressure will be helpful to confirm the diagnosis of orthostatic hypotension. Although she denied seeing blood in her stool, a PR exam should still be performed to rule out a gastrointestinal bleed as the cause of her postural symptoms.

**The patient's past medical history was significant for a left bundle branch block, first-degree heart block, intermittent supraventricular tachycardia, hypertension and psoriasis. An echocardiogram in 2009 revealed a small left ventricular cavity and severe hypertrophy of the basal septum and moderate asymmetrical hypertrophy in other regions. Significant systolic anterior mitral motion with high resting dynamic gradient, abnormal left ventricular relaxation with increased left ventricular end-diastolic pressure, and mild mitral regurgitation secondary to systolic anterior mitral motion were identified. Current review of the cardiorespiratory systems was unremarkable. She denied symptoms of dyspnea, cough, orthopnea, paroxysmal nocturnal dyspnea, chest pain, palpitation or leg swelling.**

**Her admission medications included bendrofluazide, metoprolol, losartan, simvastatin,**

calcium carbonate and multivitamin tablets. She reported good medication compliance. Her sister had died of a “heart attack” in her early sixties.

The history of first-degree heart block, supraventricular tachycardia and bundle branch block is important as it broadens the differential diagnosis to include arrhythmia as the potential cause of her syncope. The brief palpitations felt by the patient prior to the syncope argue against bradycardia. The fact that the onset of palpitation lagged behind the lightheadedness is not consistent with syncope due to arrhythmia. ECG is warranted but I still prefer of the diagnosis of postural syncope. The echocardiogram findings of asymmetrical hypertrophy, systolic anterior mitral motion and ventricular diastolic dysfunction are consistent with the diagnosis of hypertrophic obstructive cardiomyopathy (HOCM). However, syncope often occurs after a strenuous exertion in patients with HOCM, this is in contrast to our patient’s history and it is also unusual given the severity of the echocardiogram findings that the patient experiences minimal, if any symptoms related to this condition. The use of losartan and bendrofluazide puts the patient at increased risk for postural syncope and the metoprolol could potentially lead to undesirable bradycardia. The postural syncope is likely to be caused by the combined effects of volume loss due to the diarrhea and her antihypertensive use, both of which can result in further decrease in brain perfusion by reducing the preload and hence exacerbate the obstruction of the cardiomyopathy. A family history of sudden death should be sought as hypertrophic cardiomyopathy is a genetic disorder.

**The patient was a pleasant and outgoing retired dental nurse who lives in her Auckland home with a church friend. She had travelled to India one year ago to complete a missionary project. She was fully independent with her activities of daily living. The patient was physically active and went to the gym regularly.**

It is pleasing to see that the patient exercises regularly but given the echocardiogram findings of HOCM, she should be advised to avoid strenuous exercise as this puts her at increased risk of exertional syncope and sudden cardiac death.

**On examination, the patient was alert, oriented, communicative and appeared to be well nourished. She was afebrile, heart rate was 82 beats per minute, respiratory rate was 20 per minute, her lying blood pressure was 150/82 mm Hg and standing pressure after 3 minutes was 100/70 mm Hg, and her oxygen saturation was 98 percent while breathing ambient air. A non-bleeding anterior scalp laceration was noted. Cardiovascular examination revealed warm peripheries, dry oral mucosa, the JVP was 0 at 45 degrees and an ejection systolic murmur that radiated to both carotids. The murmur was best heard over the right upper sternal edge and the**

**Valsalva manoeuvre had no effect on the intensity of the murmur. The remainder of the physical examination was normal.**

The physical examination will help me to narrow down my differential diagnosis. The lying and standing blood pressures confirm the presence of postural hypotension, most likely to be the result of dehydration and diuretic use. The low JVP and dry oral mucosa are consistent with a fluid deficit state. The ejection systolic murmur with bilateral carotid radiation suggests aortic stenosis but may also represent murmurs due to HOCM although carotid radiations in these conditions are unusual. The Valsalva manoeuvre often intensifies the murmur in HOCM whereas the opposite is seen in aortic stenosis. Because the Valsalva manoeuvre had no effect in our patient, it is certainly plausible that her murmur was due to a combination of aortic stenosis and HOCM. I wonder if a new echocardiogram should be requested for this patient but this is unlikely to change her management plan.

**The serum sodium, chloride, and creatinine were 130 mmol/L, 93 mmol/L, and 140 µmol/L respectively. A fasting glucose and the full blood count were normal. The CT of the head showed no acute intracranial bleeding. Electrocardiogram revealed sinus rhythm with increased PR interval, left bundle branch block, and a pattern of left ventricular strain, and chest radiography showed a normal sized heart without evidence of consolidation or pulmonary edema.**

Hyponatremia is a common side effect of long-term bendrofluazide use but it can also reflect electrolyte imbalance as a result of her recent diarrhea. The patient also has mild acute renal insufficiency that is most likely to be caused by reduced renal perfusion secondary to the dehydration from the diarrhea (i.e. prerenal failure). The normal fasting glucose rules out diabetes mellitus as the cause of her recurrent syncopal episodes. The ECG does not reveal anything new from what we already know from her past medical history. The left ventricular strain is consistent with the diagnosis of HOCM. At this point, I am confident with the diagnosis of postural (or orthostatic) syncope secondary to the diarrhea and diuretic use as the cause of her collapse.

**The patient was managed medically with intravenous fluid and bendrofluazide and losartan were withheld temporarily during her admission. She was discharged one day later with the diagnosis of postural syncope. There was no significant postural hypotension at the time of discharge.**

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## DISCUSSION

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Syncope is one of the most common causes of transient loss of consciousness.<sup>1</sup> It is defined as a sudden and brief loss of consciousness associated with a loss of postural tone, from which recovery is spontaneous.<sup>2</sup> The causes of syncope are numerous but the universal pathophysiology is a temporary reduction or cessation in cerebral blood flow. In a large, well-designed retrospective study that evaluated the incidence and prognosis of syncope among participants in the Framingham Heart Study, the multivariate adjusted hazard ratio of all cause mortality among participants with syncope from any cause, as compared with those who did not have syncope, was 1.31 (95% CI 1.14 to 1.51).<sup>3</sup> Further subgroup analysis revealed that this excess risk is attributable to syncope due to cardiovascular or idiopathic causes. Neurocardiogenic and postural syncopes, in contrast, appear to have benign prognosis. The findings from this study highlight the importance and the need for a prompt medical evaluation for patients who present with syncope.

The common etiologies of syncope include neurocardiogenic disturbance (e.g. vasovagal attack), orthostatic hypotension, cardiac arrhythmias, and neurologic disease. It should be remembered that in up to 37 percent of cases,<sup>2,3</sup> the causes remain unexplained despite extensive medical workup. Since syncope is a symptom and not a disease, the diagnostic evaluation should focus on physiologic states that could cause the loss of consciousness.<sup>2</sup> In addition to history and physical examination, electrocardiogram and base-line laboratory tests should be performed on admission and these are often adequate for making the initial diagnosis.

Postural hypotension is very common in the geriatric population<sup>4</sup> but it does not usually result in syncope unless the fall in blood pressure is particularly pronounced<sup>1</sup> so this patient's presentation suggests some significant volume depletion. In most cases, the treatment for postural hypotension needs to be started promptly and special attention should focus on volume replacement (e.g. via intravenous fluid) and adjustment to patients' medications that can cause dehydration, especially antihypertensives and tricyclic antidepressants.<sup>2,4</sup> Although unlikely in this case, autonomic failure should always be ruled out in patients who present with recurrent postural hypotension.<sup>5</sup> Given her tendency to develop postural hypotension, this patient should be instructed to rise slowly from the bed or chair and to move legs prior to rising to facilitate venous return from the extremities.<sup>6</sup> Teaching her to recognise the prodromal symptoms can also be useful. Podoleanu and colleagues<sup>7</sup> demonstrated in a randomised, single blinded trial involving 21 patients that the use of lower limb compression bandage is effective in avoiding postural hypotension and its use may be considered for this patient.

An interesting aspect of this patient's care is the treatment of hypertension in the presence of HOCM. The use of antihypertensives, especially when used at incorrect doses lead to volume depletion that in turn can result in exacerbation of the obstruction and hence increasing the risk of a more malignant syncope and even sudden death. Therefore, the use of diuretics is contraindicated in patients with HOCM.<sup>8,9</sup> There are no targeted trials to date that investigated the optimal treatment of hypertension in patients with HOCM but the dosages or regimen she's taking may need to be adjusted. The calcium channel blocker verapamil has been shown in a few small, non-randomised trials to provide symptomatic relief to patients with HOCM<sup>8</sup> and it may offer additional benefits to our patient because of its antihypertensive effects.

Patients with HOCM often complain of significant symptoms such as dyspnea, angina and dizziness on exertion so it is unusual and perhaps surprising to find that this patient experienced no such symptoms despite the very abnormal findings on the echocardiogram. This makes me wonder about the diagnosis of HOCM, could her echocardiogram findings be the result of systemic hypertension? The literature suggests that systemic hypertension may cause a condition that mimics all of the hemodynamic features, both systolic and diastolic, of obstructive HCM.<sup>8</sup> Lastly, this patient should be advised to avoid dehydration and strenuous exercise to prevent future episodes of syncope.

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# **Nomination Form**

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**Name of nominee:** \_\_\_\_\_  
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**For the position of:** \_\_\_\_\_

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**Phone:** \_\_\_\_\_

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**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The above named member is nominated by:

1. Name of ACMA member:

Signature:

Date:

2. Name of ACMA member:

Signature:

Date:

*Please fax this completed 2010/2011 ACMA Executive Committee nomination form to Dr Gee Hing Wong at 09-4783007 by 28 October 2010.*