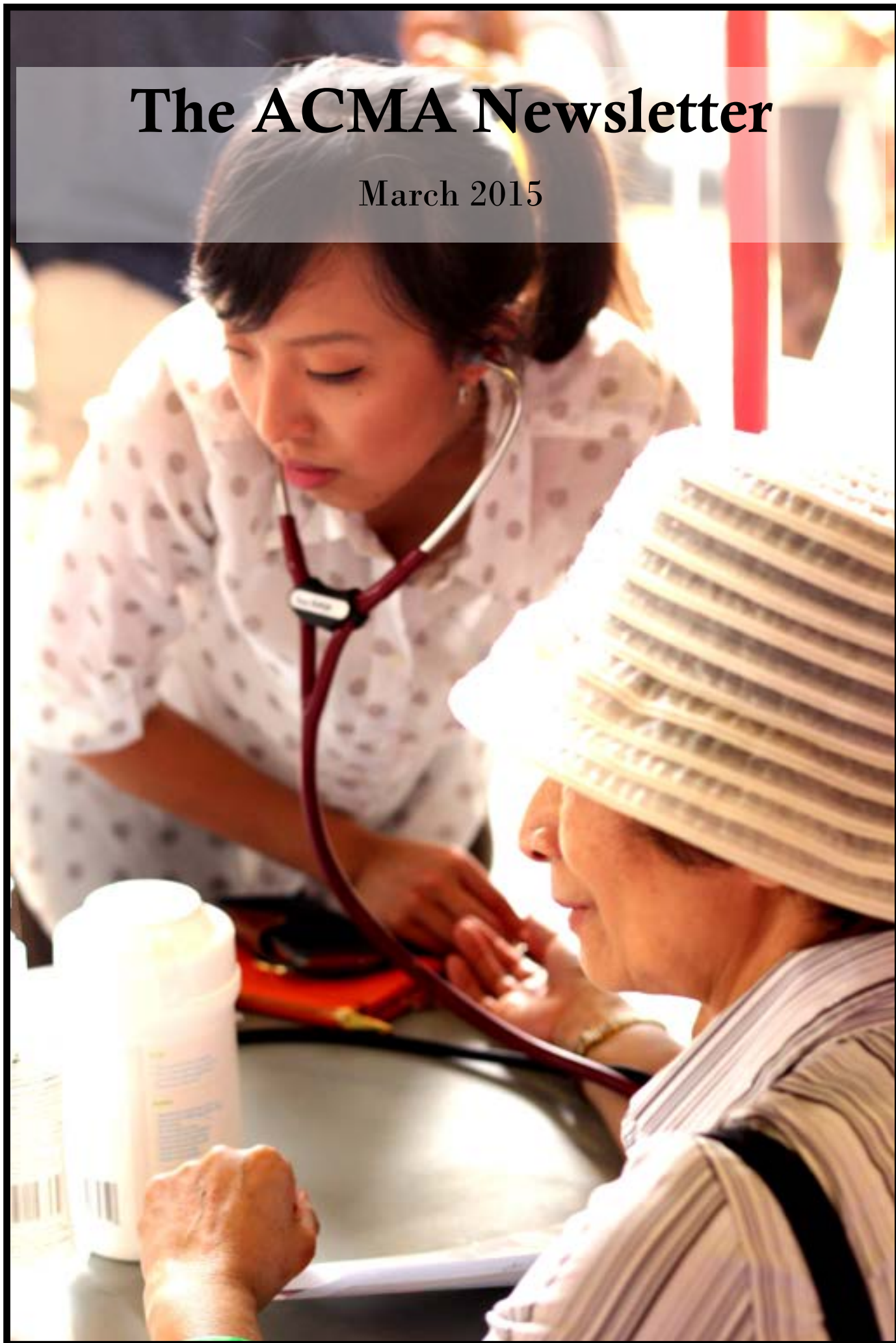


The ACMA Newsletter

March 2015





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President's Address

Dear Member,

What a great year of the Ram it has been so far. I hope everybody had a good break over the summer. We just had a well received CME with Dr Stephen McBride and Dr Andrew Baker. It was a good opportunity to catch up and meet new members too.

I have a great executive committee who are full of enthusiasm and we are looking forward to serving you this year.

The main highlights of 2015 will include:

- Community Work to raise Health Awareness – Chinese New Year, Mid Autumn Festival as well as other events
- Continued work with the Chinese Health Awareness Initiative NZ (CHAINZ) – website, other community work
- Fundraising – Round the Bays
- Combined ACMA/YACMA social events
- ACMA conference 25th July 2015 – details to come soon
- CMEs – March/May/September/November
- Mentorship – to foster relationships

Please refer to our website for up to date news and the latest information. Also the CHAINZ website www.chainz.org.nz as a valuable resource for your Chinese patients.

We are looking for ideas to increase membership and thus far have been successful in recruiting RMOs. We would like to welcome all new members.

If you have any ideas, suggestions or comments, please don't hesitate to contact me.

Here's wishing you a prosperous year of the Ram.

Derek Luo

ACMA President 2015

president@acma.org.nz





Upcoming events

3rd of May 2015:

The Second CME
Professor Man-ying Ip – Asian Studies – topic TBA

29th of September 2015:

The third CME –TBA

*This year's ACMA conference is planned for the 25th of July
2015

Last year, the TO THE FUTURE: CHINESE HEALTH IN NEW ZEALAND conference was extremely well received and it was one of ACMA's first conferences presented by Chinese speakers in their native tongue, all of whom were healthcare professionals ranging from counsellors and pharmacists to physicians from over 10 different specialties.

They provided a fascinating insight into a wide range of health topics concerning the health and wellbeing of the Asian and Chinese populations of New Zealand proving this conference to be a great success.

This year, the ACMA conference is bound to be a compelling educational experience. Details are still to be confirmed but keep an eye out for updates about the location and theme for this year.



Recent Events

Chinese New Year Stall:

What's a good way to spend Valentine's Day? Volunteer at the Chinese New Year Festival of course! This year at the annual Chinese new year festival, both ACMA and YACMA members had a chance to collaborate to promote health awareness with free for all basic health checks. It was the first event of the year and it sets the scene well for a year in which ACMA and YACMA will have more opportunities to cooperate and interact with each other. Overall, it was a Saturday well spent; both having fun and the sense of satisfaction from doing something meaningful. Best way to spend Valentine's Day ever.



Cornwall Park ACMA & YACMA social/ family day:

Our first combined social event of the year with both ACMA and YACMA members was a relaxing picnic on a perfect day at the iconic Cornwall Park. Both doctors and students had a great time mingling with each other. It was a casual event where some of the doctors even brought their kids and spouses. Musicians nearby at a music event conveniently added to the atmosphere.



Recent Events

Orientation week Grafton YACMA stall

It was the first week of university for new and old med students and the cheerful YACMA executive members were hard at work at our stall recruiting new members and advertising the many wonderful opportunities available from being a part of the YACMA family. Three giant boxes filled with fried rice were extremely well received by the medical students and by the end of 2 hours and a long queue for sign ups, we received over 100 new members! The enthusiasm in the atmosphere was evident, and there was a buzz of excitement amongst the students as they heard about the wonderful range of events run by YACMA including the yum cha and BBQ days, educational talks, scavenger hunts, quiz nights and so much more.

Many were also excited about the prospect of meeting ACMA doctors and were very interested in being more involved with us in the future as well as learning a bit more about YACMA and ACMA. This year, a whole range of ethnicities signed up and it was wonderful to see YACMA being so well received by the University of Auckland medical students.



YACMA BBQ

The first YACMA event of the year was the annual traditional BBQ which attracted hundreds of medical students to Outhwaite Park on a sunny Friday afternoon. The atmosphere was fun and lively, with the tables laden with food and all the new and old students intermingling and getting to know each other. This day perfectly captured the three f's of the YACMA spirit; family, fun and food. Sausages were eagerly received, salads were quickly depleted, and the chocolate scones were quickly devoured by the hoard of hungry medical students. Luckily, there was enough food for all and by the end of the day, we had a happy and satisfied crowd.



Recent Events

Round The Bays

On a lovely fine Sunday morning a group of ACMA members skipped the usual Sunday sleep in to take part in the annual Round the Bays. The atmosphere was remarkable with lots of families participating together (some even pushing prams!). And others whether representing their company, association or charity were running for a cause that played a significant part in their lives.

Among the participants were also some runners that didn't let their age restrict their capabilities. Despite being over the retirement age they surpassed many of their younger counterparts.

Everyone left with a sense of satisfaction with doing an 8.4km run that was made even more difficult with flying water cups, the scorching sun and endless people to maneuver around.

Congratulations to the ACMA team "Docs running for a cause" who managed to raise beyond their target of a thousand dollars for Alzheimer's Auckland! An amazing feat!



Recent Events

Korean BBQ

The first RMO event of the year was organised with everyone's two favourites in mind; buffet and a Korean barbecue buffet at that! This was a great chance for first year house surgeons to meet and get to know each other along with other doctors of higher stages in the medical and hospital system. What could be better than bonding over delicious food!



Greenlane talk:

The date 14th of March marked our second event involving community work since our highly successful event at the Chinese New Year festival. This time with a free health Seminar by our very own ACMA president and Dr John McEwan. This talk covered the relationship between stress and its effect on the gastrointestinal system; highly relevant for a lot of people in this society today. Subsequently, free health checks were also provided which gave students yet another chance to practice their clinical skills.



Interview with Dr. Adrian Wan

Dr Adrian Wan graduated from Auckland Medical School in 1995. Upon graduating, he undertook postgraduate training in surgery in Hamilton and Wellington before switching to Auckland's Middlemore Hospital Emergency Department after undertaking further training in Community Emergency Medicine. 5 years later he switched focus from acute care to chronic care and became a General Practitioner by joining as a partner in Belmont Medical Centre. He is currently married with 3 young daughters.



1. Hello Adrian, thank you for agreeing to the interview, can you please explain your current role at the hospital and the clinic?

In general practice we mainly liaise between patient and tertiary hospital level care. Keeping our population healthy as primary prevention.

2. Can you tell us about some of the most interesting cases you have seen?

Um?! Not necessarily interesting but exciting for general practice. Cutting out a strange lump in arm it which turned out to be an Australian tick on histology, or cutting out a melanoma on a woman and having histology on axillary sentinel biopsy. Comes back with no melanoma but breast cancer so 2 cancers for one case. Diagnosing childhood diabetes which is sad but gratifying since i have only seen one in general practice but probably lots in hospital system.

3. You are married and have 3 daughters! Congratulations! For your fellow doctors and doctors to be, do you have any tips regarding balancing family and work life?

It is not easy balancing career and family life. Usually there are calculated sacrifices that are made. Hopefully not missing out on the major milestones is important as we only see those once. Reprioritising the importance of family over work constantly as most of us can be workaholics. However look after number 1 first then family and then patient's health.

4. You worked in the emergency department, what inspired you to choose that speciality among the many available?

Tried Emergency for 6month rotation and really enjoyed it but also love primary healthcare and the chronic and acute stuff.



Interview with Dr. Adrian Wan

5. Then it seems you moved onto more chronic care and started working as a GP, can you explain the reasons that inspired you to change specialities?

I felt there must be more to acute medicine which is great as no follow up by you specifically required and someone else would look after but really you have no connection with patients. So I looked to general practice where you see urgent problems and usually people you know and you can see children grow up before your eyes and unfortunately old people dying also. Some days I enjoy chronic care and some days acute care depends on which side of bed I got up on.

6. On a normal working day, what does your daily schedule look like?

General practice especially if it is your own business you can adjust your day to fit in your life. Dentist gym accountant kids school sports events. Otherwise it can be 8-6 mon to fri most days

7. To all those aspiring med students, do you have a word of wisdom and advice?

Try out as much specialities as you can get some GP rotations. You might find you like certain "runs". If you end up in General practice your experience will be wide and don't forget you can sub-specialise in GP i.e. do what you enjoy most e.g. kids women men ENT dermatology. Be a GPSI (general practice with special interest) in the hospital as well.

8. What do you usually do during your free time?

My free time away from work would be with family, 3 girls and a dog. Family is very important including the extended family and friends. Don't work yourselves to death losing sight that we normally work to live not live to work

9. Now as a final farewell question, tell us something interesting about yourself.

I am your standard kiwi boy who liked to take things apart as a kid and find out how it all worked now I do it with people figuratively speaking. Freak? Hope not.

Mentorship programme

The ACMA Mentorship programme aims to provide support for budding young doctors as they progress through their medical journey. It was launched in August last year, with the additional aim to strengthen ties between YACMA and ACMA. The program was well received by both doctors and students, with 53 students and 13 doctors taking part. There were many benefits; for students, who got an insider's look to the life of a clinician, helpful advice and (for some) treated to a meal!

The ACMA doctors also found the programme a rewarding experience and have given valuable feedback in a survey we sent out in Nov 2014. Below is a summary of the survey results.

We had a very good response with 80% of the ACMA mentors completing the survey. Overall, they were satisfied with mentor matching and turnout to meetings. Most meetings were held face-to-face, and took between 1-3 hours. They covered a breadth of topics, including career guidance, choosing a specialty or GP, and work-life balance. Some mentors found it difficult to organise a time suitable for everyone, admittedly because the mentees had different schedules due to different stages of their study. It was suggested that an introductory social gathering between mentors and mentees will be beneficial for the programme at the beginning of the year.



Mentorship programme



The students shared the sentiment of the doctors, with the mentoring program meeting most expectations. They found the face-to-face meetings to be most effective, and overall, found the mentors very approachable. The prospect of pre-clinical students being mentored by clinical students was one which was very well received. The mentoring programme runs for one year to maintain a continuous relationship between students and their current mentor. Students are encouraged to take up this fantastic opportunity to talk with doctors, swamp them with questions and show interest!



We understand that having students at different levels of study may make it difficult to find a suitable time to meet. However, we feel this diversity has the advantage of students in their latter years sharing experience with the younger students.



This year, we have added 3 new mentor groups due to overwhelming student interest in participating in the programme. Lastly, we would like to thank all of the mentors who give their time and make this programme possible. If you would like to be mentor, please find the mentor signup form on the homepage of the ACMA website.

Any questions and comments may be sent to Dr Kristine Ng (ACMA committee - mentor representative) or Eileen Zhou (YACMA committee - mentee/student representative).

JUST JOKES

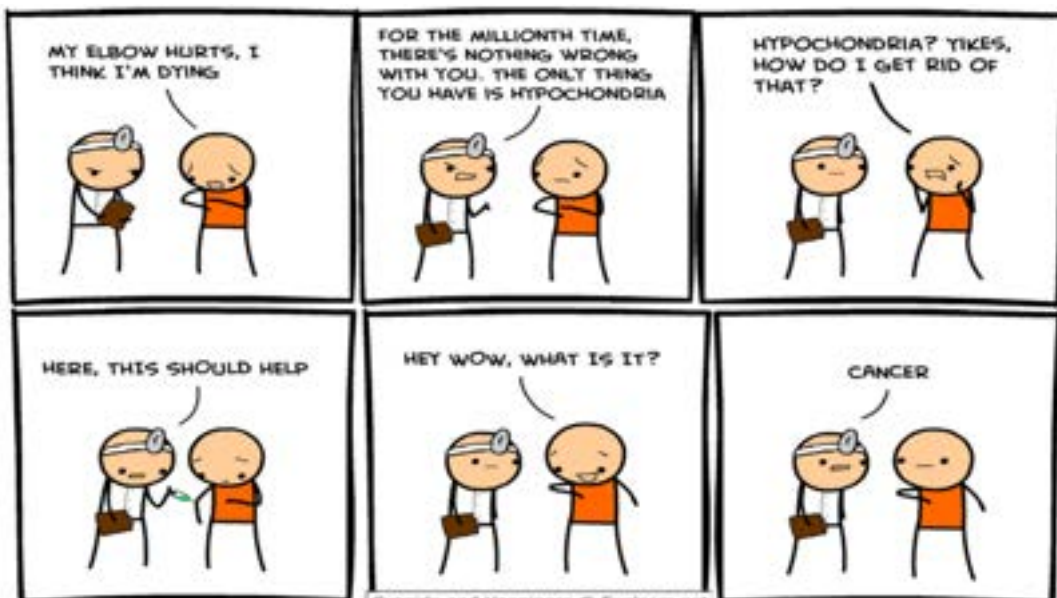
-Doctor: I have some bad news and some very bad news.
Patient: Well, might as well give me the bad news first.
Doctor: The lab called with your test results. They said you have 24 hours to live.
Patient: 24 HOURS! That's terrible!!
WHAT could be WORSE? What's the very bad news?
Doctor: I've been trying to reach you since yesterday



What is the difference between stress, tension & panic?

Stress is when wife is pregnant,
Tension is when girlfriend is pregnant &
Panic is when both are pregnant

Jaypee Choices have consequences. When I was young, I was to go to medical school. In the entrance exam we were asked to rearrange the word PNEIS to form the name of an important human body part. Those who answered SPINE are today doctors while the rest of us are on the internet, doing some shit.
Unlike · Reply · 257 · 14 hours ago





Quirky medicine

Drunk on chips

Now we've all had those Saturday nights where you drank one cocktail too many and end up feeling a bit giddy, then sick then wake up the next day with half the day gone with a headache. But to some with this syndrome they call that Monday night after a hearty meal.

A British man named Nick Hess is one of many who have been diagnosed with auto-brewery syndrome, a rare and controversial syndrome that is supposedly caused by an overgrowth of yeast in the gut causing them to ferment carbohydrates into alcohol in the stomach. Bottom line is that after each hearty meal with a bit of rice or a bit of pasta will have this man wasted on the floor. Perhaps not your Saturday night out.

Nick would often find himself feeling all the tell-tale signs of inebriation (acting goofy, getting vulgar) after a simple meal and even went through accusations of being a closet alcoholic from his wife before this alternative diagnoses was brought to light.

Some may say, free booze! Awesome! But sadly for Nick, getting drunk for free also meant he would get hungover each time, for free (not so great).

Still the disease is under a lot of speculation with Wayne Jones, a forensic toxicologist saying that the yeast imbalance is not enough to cause such a rise in blood alcohol level as the alcohol must bypass the liver first.

So the party in Nick's stomach still has a long way to go before it can be put to an end.

Find out more about this story at

<http://www.bbc.com/future/story/20150305-the-man-who-gets-drunk-on-chips>





Mrs Keegan! You're your own twin!

Ever had your mother tell you, you were picked up from under a bridge, or been tricked by your pesky older brother that you were adopted?

Well how would you feel if it came out that you were actually genetically unrelated to your own children when you know you've given birth to them? Talk about being careful what you wish for!

Now this is a very unusual case that most would blow off to be impossible, but to some people this is not only reality but a matter that subjected them to a nightmare of a time. Karen Keegan, a mother of 2 boys was waiting to undergo a kidney transplant when an absurd news came from the doctors that she wasn't actually related to her own children.

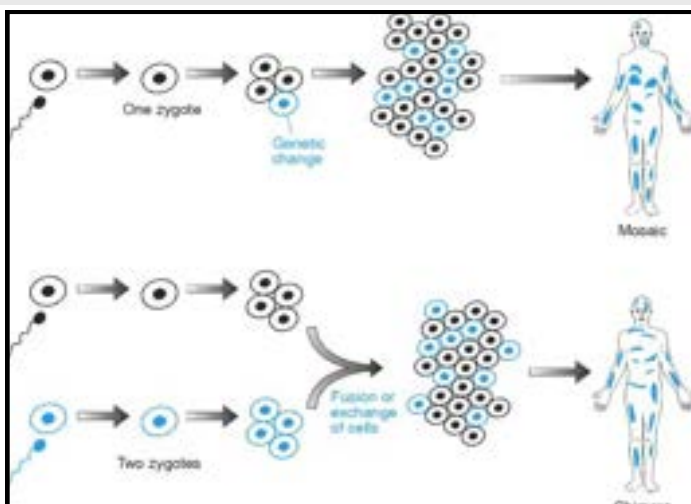
After extensive investigation, including digging up DNA from other parts of the body, the scientists finally could confirm that Mrs Keegan had a very rare condition called Chimerism, defined by a single organism having cells of distinct genetic nature. Meaning someone can end up with two blood types or in cases like this having organs of different genetic makeup.

The course of events for Chimerism of this scale is due to fusion of two genetically different foetuses in the womb during development, so i.e. non identical twins fuse early in development during the zygote level. So you really can be your own twin.

For others however Chimerism wasn't just an interesting topic to bring up during tea, Lydia Fairchild nearly lost her children under accusation of welfare fraud due to her DNA not matching her children's.

Read more about this story at

<http://abcnews.go.com/Primetime/shes-twin/story?id=2315693>





CME

The CME was held at a wonderful location in Parnell, a modern Chinese restaurant attracting doctors from all over Auckland from all kinds of specialties bustling around socialising, greeting old friends and meeting new ones.

Derek, our president started off the CME with an overview of ACMA and its direction for the year, as well as some of the interesting events that were on the way. This was followed by our speakers of the evening, Dr Stephen McBride and Dr Andrew Baker who talked about the Ebola virus and allergies respectively.

Both talks were fascinating and incredibly pertinent to doctors present which was apparent with the flurry of questions by the guests especially on topics of how to use these new information to better help their practice. Furthermore, the talk was inspirational for many of the medical students present, myself included providing a window into what some of the specialties entail and how they operate.

Then came the flood of food, which everybody seemed to enjoy, seeing as how the dishes were being taken away faster than they were being carried out.

With the good food, good company and valuable knowledge, this truly was a fantastic start to the CMEs for 2015.



Ebola Virus Disease and New Zealand



Dr Stephen McBride
Clinical Head of Infectious Diseases
Middlemore Hospital

Overview

- Virus
- Disease
- Outbreak
- Local context
- Local response
- Conclusions

Ebola Virus Disease and New Zealand

OR: How to become a national "expert" in a disease you've never seen...

Dr Stephen McBride
Clinical Head of Infectious Diseases
Middlemore Hospital

Virus



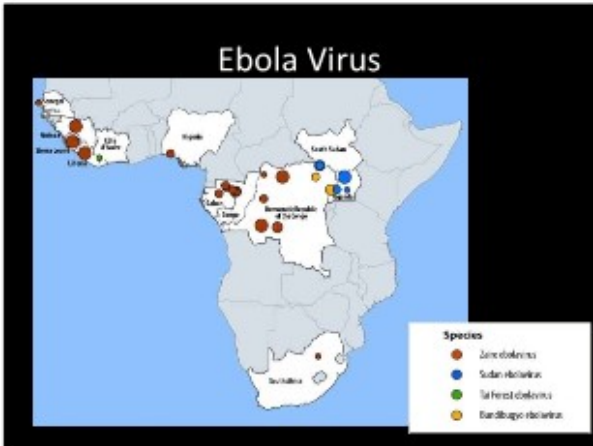
Acknowledgements

- Slides and graphics shamelessly plundered from the internet, particularly cdc.gov
- My co-workers on the EVD response at Middlemore Hospital:
 - Dr David Holland, Dr Susan Taylor, Dr Genevieve Walls, Dr Christopher Luey
 - Terry Rings, Elizabeth Bryce
 - Dot McKeen, Susan Robertson, Vicki Wright

Ebola Virus

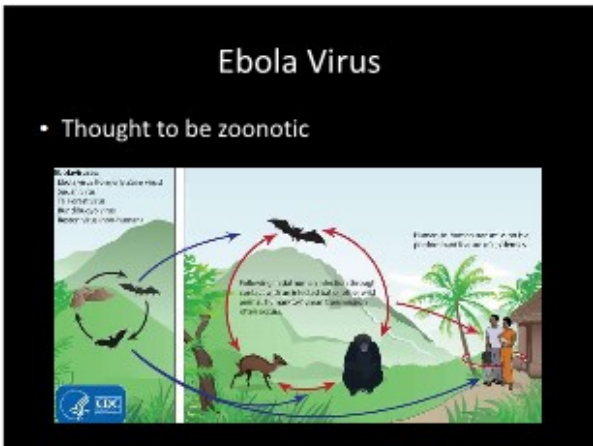
- Prototype VHF pathogen
 - Filovirus: enveloped RNA virus
 - Severe disease, high case fatality
 - No tested and effective specific treatment/vaccine
 - 5 species of virus (genetically distinct)
 - Current outbreak caused by Zaire species
- >20 previous Ebola or Marburg virus outbreaks





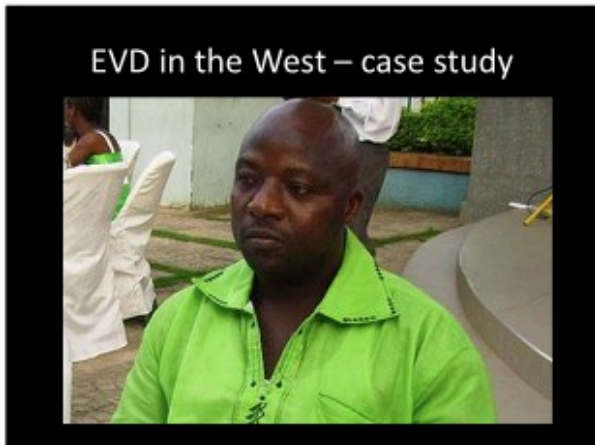
EVD

- Symptoms and signs non-specific
 - Fever
 - Headache
 - Muscle pain
 - Weakness/Fatigue
 - Diarrhoea/Vomiting
 - Abdominal pain
 - Unexplained hemorrhage (bleeding or bruising)



EVD

- Incubation period 2-21 days
 - Median 8-10 days
 - Not thought to be infectious during incubation period
- Transmission via:
 - Infected blood and body fluids
 - Once symptomatic
 - Airborne/droplet nuclei (???)
 - Controversial



The Dallas Patient – T Duncan

- Liberian male
- Returned to USA following stay in Liberia
 - Transported person with probable EVD to treatment centre
- Presented to ED in Dallas with febrile illness
 - Reportedly denied exposure to EVD
- Prescribed antibiotics and discharged
 - Returned extremely unwell 3 days later

EVD – the West African Outbreak

- Largest ever outbreak - significant transmission in:
 - Guinea
 - Sierra Leone
 - Liberia
- Healthcare transmission from imported cases in:
 - Nigeria
 - Mali
 - USA
 - Spain
- Cases imported to other countries
 - UK
 - Germany

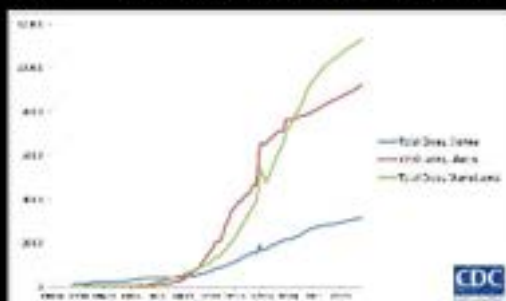
The Dallas Patient – T Duncan

- Unfortunately developed unsupportable multi-organ failure and died despite supportive treatment
- Cross-transmission to two clinical nurses
 - Provided care based on US CDC standards at the time
- No transmission to family or laboratory workers

What determines and outbreak?

- Population groups
 - Susceptible
 - Exposed/latent
 - Infectious
 - Recovered/removed
- Disease characteristics
 - R_0 – Basic reproductive number
 - Number of cases infected by each case
 - Extensively influenced by non-disease factors such as number of contacts

EVD – the West African Outbreak



What determined *this* outbreak?

- My theory:

What determined *this* outbreak?

- My theory:



Local context

- Currently (since Nigeria ceased active transmission)
 - ~1 person/week enters NZ from affected countries
 - Almost all are returning healthcare workers
 - Significant exposure risk
 - No children
 - Some under-reporting likely
 - Mine consultants or others not wishing to alert IRD to secondary overseas income

What determined this outbreak

- Major societal change in Africa during last 10 years – widespread availability of mobile telephony
- Previously:
 - EVD outbreak devastates village on edge of forest
 - Starts with one villager getting sick and dying
 - Care for the sick provided by villagers
 - Care and traditional funeral practices > extensive spread in village
 - Village happened upon by visitor/relative
 - Villagers either dead or recovered
 - R_0 low, because susceptible hosts burned out prior to transmission event

Local context

- Arrival of EVD into New Zealand
 - Very unlikely
 - BUT

What determined this outbreak

- Now
 - EVD outbreak starts in village on edge of forest
 - Starts with one villager getting sick +/- dying
 - Villagers send texts or call relatives in "nearby" villages
 - Care for ill person and funeral practices provided by relatives/friends from other villages
 - Carers/relatives return to their own village and become sick
 - Cycle perpetuates
 - R_0 higher, wider pool of susceptible hosts and increased mobility of those hosts to new communities of susceptibles

Local context

- Arrival of EVD into New Zealand
 - Very unlikely
 - BUT
 - Consequences of arrival without preparation are dire
 - Whilst internationally this is a tragedy, locally it represents a significant opportunity to upgrade preparations for this and future outbreaks

Local context

- Regional Ill Traveller Protocol
 - Existing agreement between DHBs, Public Health, Auckland Airport and others
 - Middlemore Hospital to act as receiving hospital for ill travellers from Auckland International Airport
 - Auckland City Hospital to act as receiving hospital for ill travellers from Ports of Auckland

Video

Local response



Local response - Protocol

- Team set up
 - Infectious Diseases
 - Clinical Microbiology
 - Infection Prevention and Control
 - Management/administration
- Others brought in as required
 - Paediatrics
 - Occupational health and safety
 - Bereavement care/mortuary
 - Others

Local response – Biocontainment Unit

- Scale of outbreak recognised during NZ General Election campaign
 - Initial central government direction absent
 - Local/regional initiatives in Auckland
 - CMH decision to develop BioContainment Unit (BCU) facility given proximity to airport and Regional Ill Traveller protocol
 - BCUs also developed at Auckland City Hospital, Wellington Hospital and Christchurch hospitals

Local response - Protocol

- International literature/guidelines reviewed

Local response - Protocol

- International literature/guidelines reviewed
- International literature/guidelines discarded
 - US (CDC)
 - Theoretically adequate but practically useless (as demonstrated by the Dallas case)
 - Unable to be generalised to other illnesses needing ICU care
 - UK (PHE)
 - Overly complex – 5 different levels of PPE
 - Unable to be generalised to other illnesses needing ICU care

Future plans

- Multiple ongoing work streams
 - Complete Plan (so far as this is possible)
 - Simulation to “road-test” Plan
 - Ongoing recruitment and training of staff for ICU
 - Redevelop/reimagine Plan to cope with other diseases/scenarios
 - For some diseases this will be simple
 - For SARS or other more highly-transmissible diseases, this is a major challenge
 - Planning for future developments at national level

Local response - Protocol

- ~100 page document developed
 - Personal Protective Equipment
 - 2 levels
 - Red Zone (providing patient care, direct patient contact)
 - Orange Zone (removing red zone PPE, initial ED triage/transport)
 - Standard Operating Procedures
 - Staffing
 - Patient transport
 - Waste
 - Management of the deceased
 - Limitations of care

Conclusions

- Ebola Virus Disease is a terrible disease
- The 2014 West African EVD outbreak is a tragedy
- New Zealand is (relatively) well-prepared
 - Work is ongoing

Demonstration

Allergy Update

ACMA CME March 2015
 Dr Andrew Baker FRACP
 Clinical Immunologist

World Health Organization survey regarding asthma
 Doctor –diagnosed asthma 4.5%
 Current World Population Of 7 Billion Translates To 315



The prevalence of clinical asthma varied widely amongst the 70 participating countries, ranging from 1.0% in Vietnam to 21.5% in Australia, who reported the highest rate of doctor diagnosed, clinical/treated asthma, and wheezing

World Health Organization (WHO) Survey of Asthma Prevalence in 70 Countries. *Journal of Allergy and Clinical Immunology*, 2004; 114: 1022-1028

- Introduction,
 - Prevalence
 - Ethnic and Geographical variations
- Desensitisation update
- Interpreting specific IgE (RASTs)
- Breaking news on peanut
- Anaphylaxis – what is the risk?
- Practical tips

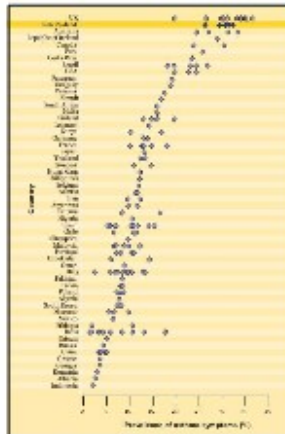


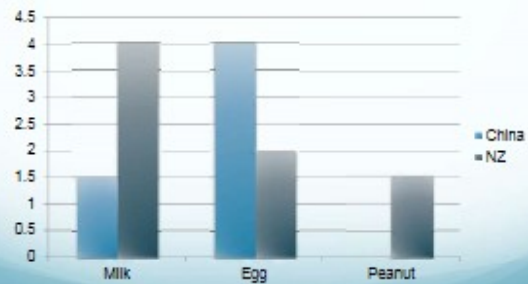
FIGURE 2: 12-month prevalence (%) of self-reported asthma symptoms from written questionnaires in 13-14-year-old children in different countries (Reprinted with permission from Elsevier Science, *The Lancet* 1988; 331: 1228)

Observations on prevalence

- Asthma and allergic rhinitis 2 to 20%
- Admissions anaphylaxis doubled in 10 years in 1990s UK, Aus, NZ
- Food related anaphylaxis increased by 5x in Australia
- Healthnuts study cows milk allergy 10% 12 mths

Food allergy

average numbers quoted
 (significant interstudy variation)

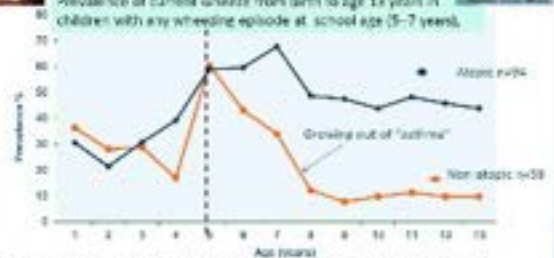


Desensitisation update

Dr Andrew Baker – MBChB FRACP
Immunologist - Waitemata Allergy Clinic
Feb 2015

Perennial allergen sensitization early in life and chronic asthma in children: a birth cohort study

Prevalence of current wheeze from birth to age 14 years in children with any wheezing episode at school age (5-7 years).



Sensitization to perennial allergens developing in the first 4 years of life was associated with a loss of lung function at school age. 90% non-atopic wheeze

W. J. et al. JAMA 2008

- New Zealand in the allergy world
- Desensitisation – summary of evidence
- Desensitisation – whats new?
 - long term asthma
 - Decreases asthma symptoms
 - More patients "asthma free"
 - Preventing new onset asthma
- Preventing new allergies

Progress last 10 years

- Increased allergen content
- More specific allergen
- Dosing schedule and duration
- Subcutaneous (SCIT) vs Sublingual (SLIT)

Asthma in NZ

- 15-25% children
- 1/6 adults
- Rate in pacific islanders moving NZ: 13% 
- 8000 hospitalisations per year in NZ
- 60-80 deaths per year



Effective Health Care Program

Corporate Information for
HHS-111

US Dept of Health
March 27 2013

**Allergen-Specific
Immunotherapy for the
Treatment of Allergic
Rhinoconjunctivitis and/or
Asthma: Comparative
Effectiveness Review**

- RCTs
 - Allergic rhinoconjunctivitis
 - And/or
 - Allergic asthma
- Immunotherapy alone, or combination with usual care
- 7714 citations
 - 74 SCIT
 - 60 SLIT
 - 8 SCIT vs SLIT

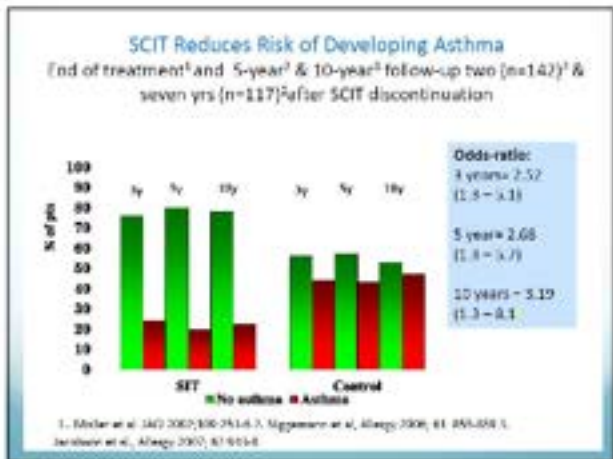
Dose-response Effect On Persistence of Asthma

- Dose-dependent response in terms of presence of asthma
- Authors' conclusions:
 - Allergen immunotherapy is clinically effective in children with asthma when administered as a multiple allergen mix to multiply sensitized patients.
 - It is dose-dependent with the highest tolerated dose resulting in maximum efficacy

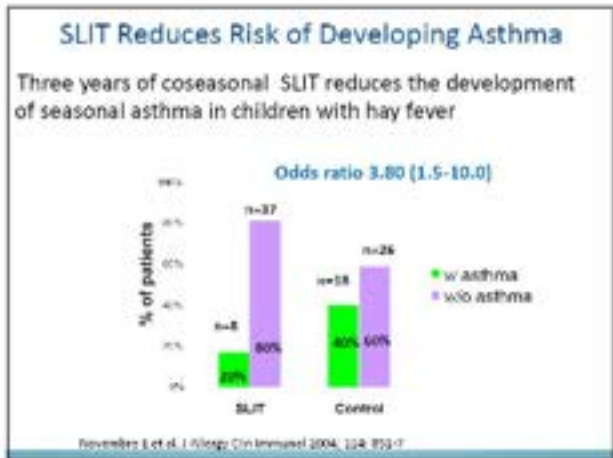
Dose group	"Free of Asthma" After 4 years of SIT	Age 16 year—end of SIT
• Placebo and lowest dose	18%	23%
• 1/5,000 w/v	38%	66%
• 1/250 w/v or "highest tolerated"	82%	78%

Johnstone DL, Dutton A, Pediatrics 196842:793-802

- ## Desensitisation evidence
- Asthma and rhinitis/conjunctivitis
 - Symptom scores – strong
 - Medication requirement – 80%
 - Quality of life – strong
 - Up to 20 years afterwards
 - SCIT vs SLIT

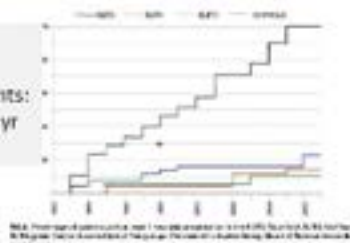


- ### THE VALUE OF HYPOSENSITIZATION THERAPY FOR BRONCHIAL ASTHMA IN CHILDREN—A 14-YEAR STUDY
- Douglas E. Johnstone, M.D., and Arthur Dutton, Ph.D.
- **Subjects:** Prospective controlled study of 210 children with asthma referred to the pediatric allergy clinic of between 1953-1955.
 - **Tested** to multiple inhalants: pollens, cat, horse, dust, molds, etc.
 - **Randomly** assigned to one of 4 groups: saline, or extract mixtures at: 10⁻¹, 1/5,000 or "highest tolerated up to 1/250 w/v concentration of each allergen to which they had a positive skin test.
 - **Assessed** for presence asthma at age 16 years (N=131). Diagnosis determined by mothers' diary and clinic assessment of a "blinded" allergist
- Johnstone DE, Dutton A, Pediatrics 196842:793-802



4-year duration of SLIT is the optimal choice

New sensitizations in all control subjects
 Less than 25% SLIT patients:
 21% 3yr, 12% 4yr, 11% 5 yr



SLIT for 4 or 5 years= 8 years of control.

CONCLUSION: "... it can be suggested that a 4-year duration of SLIT is the optimal choice because it induces a long-lasting clinical improvement similar to that seen with a 5-year course and greater than that of a 3-year vaccination."

Marrero et al. J Allergy Clin Immunol. 2002;110(3):909-13

SLIT AND SCIT for Asthma

Can they both prevent the progression of allergic disease?

Yes, both in terms of asthma and new allergen sensitizations

Pharmacotherapy only treats the 'tip of the allergy iceberg' with Allergen immunotherapy is the only immune modifying treatment. Sustained benefits after discontinuation and possible prevention of allergic disease progression



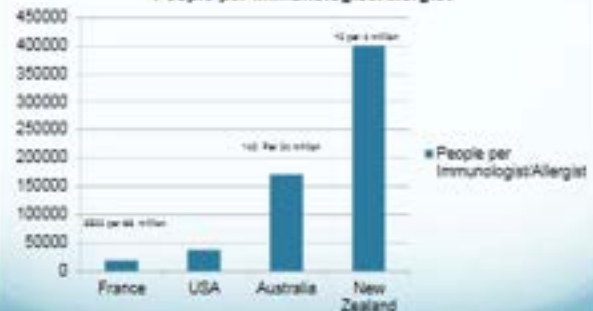
SiT in children monosensitized to HDM alters the natural course of allergy in preventing the development of new sensitizations.

- New sensitizations was significantly less in monosensitized children who received SiT than in children in the control group ($p < 0.001$).
- Ten of 22 (45%) who received SiT did not develop new sensitivities
- Zero in the control group, did not develop new sensitivities

New sensitivities (number of patients)

Initial sensitivity	No. of patients	None	Can	Dog	Alt	Grass
SiT group	22	10	0	4	2	1
Control group	22	0	12	0	0	0

People per Immunologist/Allergist



SLIT versus SCIT For Asthma

- Are they both effective?
 - Yes, several meta-analyses have demonstrated efficacy of both symptoms & medication use secondary outcomes
- If so, are they equally effective?
 - Magnitude may be greater for SCIT
- What determines efficacy for each method?
 - Quality of extract, duration, other exposures for both
 - Dose for SCIT range 5-20mcg, but SLIT effect may vary with allergen extract formulation
- Are they safe and how does safety compare between the two methods?
 - SLIT appears to be safer but anaphylaxis has been reported & risk factors for SLIT not clearly identified



- Promote
 - GPSI allergy
 - Paediatricians interest in allergy
 - Immunologist/Allergist training
 - Immunologist FTE in public health system
 - Availability desens in public system

Probabilities with IgE testing

Dr Andrew Baker - Immunologist
MChB FRACP
Waitemata Allergy Clinic

- Investigators search for
 - 95% positive predictive value (PPV)
- Many children/adults kept avoiding food due to high specific IgE with no food challenge
- 6 month old girl
- Cows milk specific IgE = 15 kuAVL

Over 1000 articles on food allergy prevalence
18 used blinded food challenge

Self reported food allergy

- Parents reporting 5.5-17%
- 11 year olds 11.6%
- 15 year old 12.4%
- Adults 12.4%

Allergy on food challenge

- Food challenge 2.2%
- DBPCFC 1.6%
 - (2-5% another study)
- Cows milk 1.2-17%
- Egg allergy 0.2 – 7%
- Peanut 0 -2%

Samson et al 95% PPVs

Table 1. Predictive value of food allergy specific immunoglobulin E tests (Samson et al 2007)

Allergy	10% Prevalence (PPV)	Positive predictive value (PPV)
Egg	7	95
Milk + Egg	7	95
Milk	5	95
Egg + Milk	5	95
Peanut	4	100
Wheat	20	100
Soy + Milk	15	95
Soybean	16	95
Wheat	26	95

- DBPCFC gold standard diagnose food allergy
- Costly time consuming



PPV

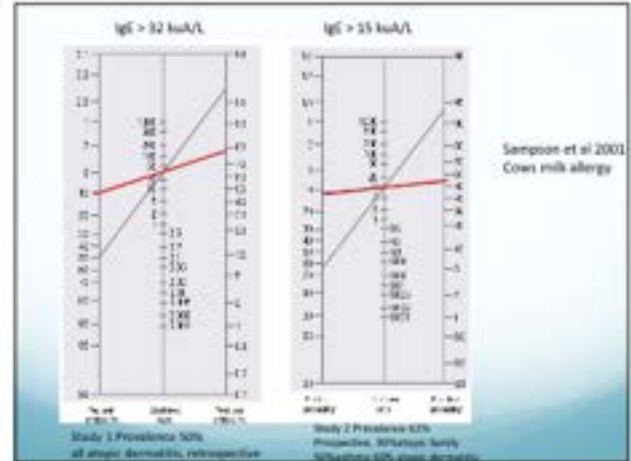
- PPV Positive predictive value
- Proportion of positive tests which are true positives
- Depends on prevalence of disease

Samson and Ho 95% PPVs

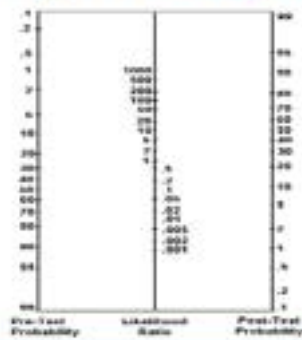
Title: Predictive value of the allergen-specific IgE test in the diagnosis of cow milk allergy (2008)

Age group	50% Sensitivity (95% CI)	95% Predictive value (95% CI)
59	7	90
Infants <1yr	7	90
1-6	19	76
Infants <1yr	5	90
7-12	17	83
13-17	23	80
18-24	15	80
25-34	33	72
35-44	25	74

Prevalence = 50%



Fagan's Nomogram



Over 1000 articles on food allergy prevalence
18 used blinded food challenge

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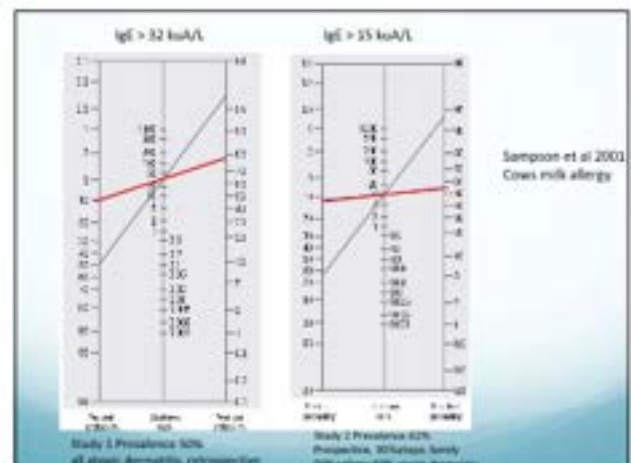
Allergy on food challenge

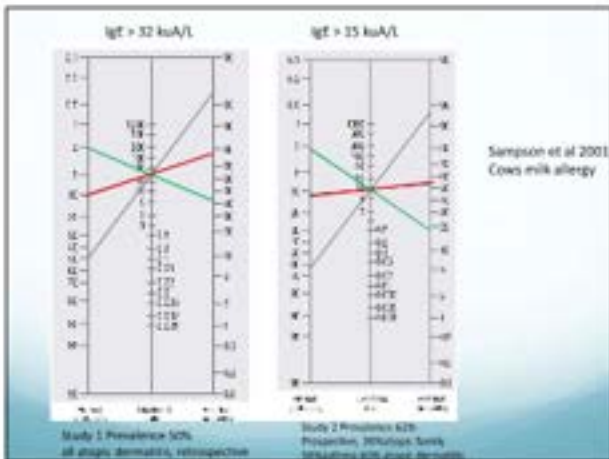
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 - (2-5% another study)
- Cows milk 1.2-17%
- Egg allergy 0.2 - 7%
- Peanut 0 - 2%

Likelihood ratio

- Assess the value of a diagnostic test
- Assess whether the test usefully changes the probability that a condition or disease state exists

$$LR (+) = \frac{\text{sensitivity}}{1 - \text{specificity}}$$

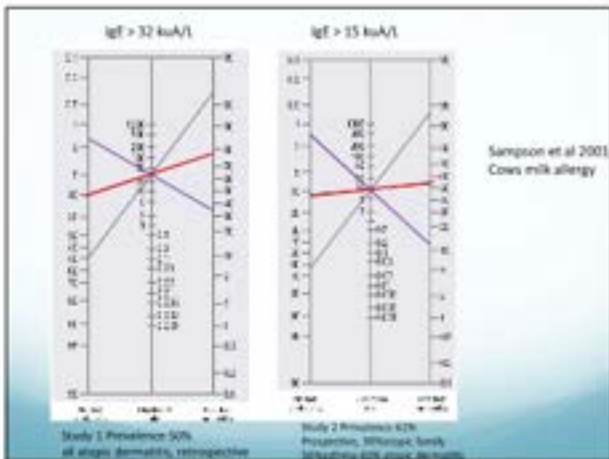




Cows milk specific IgE = 15 kuA/L

Pre-test Probability?

- 6 month old girl
 - no other food allergy, no eczema, no sibling food allergy
 - Never drank milk
 - 2%
- 6 month old girl
 - no other food allergy, diffuse eczema, brother peanut allergy
 - Never drank milk
 - ?
- 6 month old girl
 - No other food allergy, diffuse eczema
 - Drank milk, acute perioral erythema
 - ?
- 6 month old girl
 - diffuse eczema
 - Drank milk, single hive chest
 - ?



Cows milk specific IgE = 15 kuA/L

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 - 10%
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 - Drank milk, acute perioral erythema
 - 50%
- 6 month old girl
 - diffuse eczema
 - Drank milk, single hive chest
 - ?

Cows milk specific IgE = 15 kuA/L

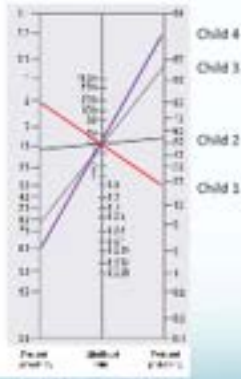
Pre-test Probability?

- 6 month old girl
 - no other food allergy, no eczema, no sibling food allergy
 - Never drank milk
 - 2%
- 6 month old girl
 - no other food allergy, diffuse eczema, brother peanut allergy
 - Never drank milk
 - 10%
- 6 month old girl
 - No other food allergy, diffuse eczema
 - Drank milk, acute genital symptoms
 - 50%
- 6 month old girl
 - diffuse eczema
 - drank milk, single live chest
 - 50%

Healthnuts

- Sensitisation
- 16.5% Egg
- 8.9% Peanut
- 2.5% Sesame
- 5.5% Cows milk
- 0.9% Shellfish
- Allergy
- 8.9% Egg
- 3% Peanut
- 0.5% Sesame
- Overall 10%

IgE > 15 kuA/L



How to proceed?

- Take a history
- Consider risk factors
- If these suggest possible/probable allergy, then test and interpret accordingly
- Do not test if there is no history to suggest allergy
- Do not do panel testing to foods
- Beware 95% PPVs
 - And ask what was the prevalence in the study)

Healthnuts Study Melbourne

- Population based
- Attended Immunisation centres
- Skin tested
- If positive invited to challenge

Breaking news!

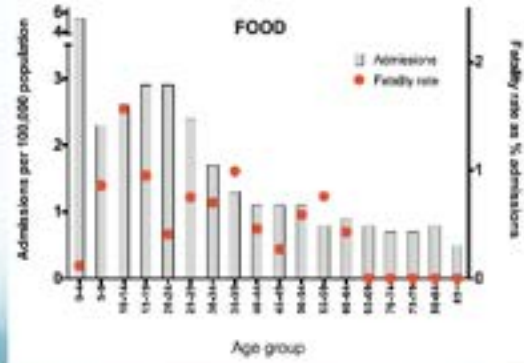
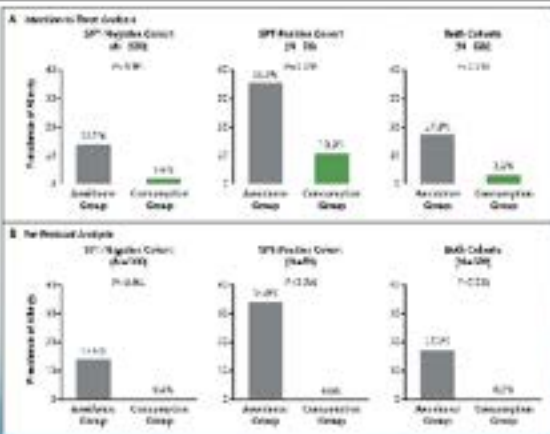
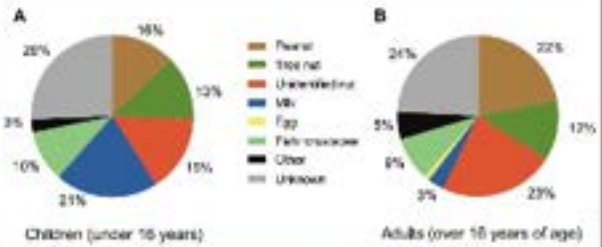
THE NEW ENGLAND JOURNAL OF MEDICINE

Randomized Trial of Peanut Consumption in Infants at Risk for Peanut Allergy

Sheepshorn M, et al. *N Engl J Med*. 2015;373:169-176. doi:10.1056/NEJMoa1410310. Epub 2015 Feb 11.

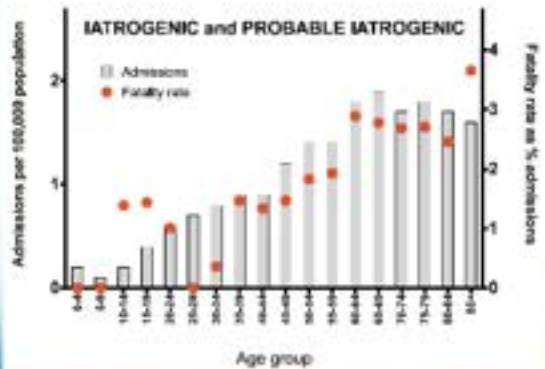
- N=640
- 4 – 11 months
- Severe eczema, egg allergy, or both
- Open label
- RCT 7g peanut twice weekly, versus avoidance
- Challenge testing double blind placebo controlled

Anaphylaxis – what's the risk? Turner et al JACI 2014?



Anaphylaxis

What is the risk?



Epipens

- Buy from www.allergypharmacy.co.nz
- Have trainer
- ASCIA website action plans

ACE inhibitor angioedema

- Can be on ACE for many years, then develop this
- Angioedema of any cause is a contraindication to ACE inhibitor
- Can continue for 3 – 6 months after stopping ACE
- Angioedema differential diagnosis?

PHOTO GALLERY

O-week & Round the Bays



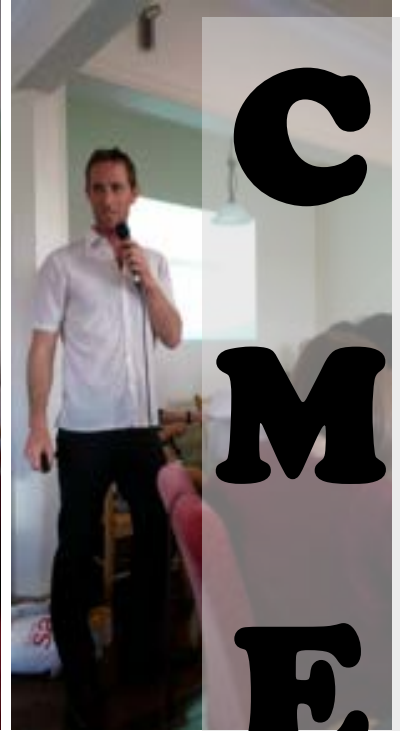


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SPONSORSHIP

Thank you to Jasper Foo from Harcourts real estate for sponsoring our food for our first combined YACMA and ACMA social event of the year at Cornwall Park. The event was well attended and the food was quickly devoured.

Also a big thank you to Nutricia for sponsoring the first CME on the 22nd of February at Enoch's Cuisine, Parnell. The food was greatly praised along with the exquisite atmosphere.





2015 ACMA & YACMA Executive

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For the public doctor's list, use this link:

<http://acma.org.nz/downloads/public-doctors-list/>



Message from the Editors

Hello everyone! I hope you have been counting the days for the return of the ACMA newsletter, because it's finally back, and this time we will guide you through the journey. Our names are Sharon, Cora, Jim and Jin and we will not only inform but also entertain your busy taxing day with our witty writing filled with not only ACMA events but also plenty of side stories and jokes.

Here's hoping for a great new year!

